PacificSource Medicare

Essentials Rx 803 (HMO), an Oregon Public Employees Retirement System (PERS) employer group plan, *offered by* PacificSource Medicare

Annual Notice of Changes for 2020

You are currently enrolled as a member of Essentials Rx 803 (HMO). Next year, there will be some changes to the plan's costs and benefits*. This booklet tells about the changes.*

- **The PERS Health Insurance Program (PHIP) annual plan change period is from October 1 to November 15. These changes will be effective January 1, 2020.**
- **Medicare plans not offered by the PERS Health Insurance Program (PHIP) have an annual enrollment period from October 15 until December 7.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Section 1 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?

- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2020 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click “Find health & drug plans.”
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

3. **CHOOSE: Decide whether** you want to change your plan

   - If you want to **keep** Essentials Rx 803 (HMO), you don't need to do anything. You will stay in Essentials Rx 803 (HMO).
   - If you decide a different PERS Health Insurance Program (PHIP) plan will better meet your needs, you can switch to another PHIP plan between October 1 and November 15. If you enroll in a new PHIP plan, your new coverage will begin on January 1, 2020. Look in section 2 to learn more about your choices.
   - If you decide to change to a plan outside of the PHIP program, your opportunity to change plans is between October 15 and December 7 for coverage to begin January 1, 2020.

4. **ENROLL:** To change PHIP plans, join a plan between **October 1** and **November 15, 2019**

   - If you **don't join another plan by November 15, 2019**, you will stay in the Essentials Rx 803 (HMO) plan.
   - If you **join another plan not offered by PHIP by December 7, 2019**, your new coverage will start on January 1, 2020.

Additional Resources

- Essentials Rx 803 (HMO) is a PERS Health Insurance Program (PHIP) employer group plan. Disenrolling from Essentials Rx 803 (HMO) plan will disenroll you from PHIP. If you would like to make a change, you may call PERS Health Insurance Program (PHIP) to discuss your options at 1-800-768-7377 or local 503-224-7377 (TTY users call 711) from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday. If you leave the PERS Health Insurance Program you may not be able to return to PHIP.
- Please contact our Customer Service number at 1-888-863-3637 for additional information. (TTY users should call 800-735-2900). Calls to this number are free. Customer Service is available from 8 a.m. to 8 p.m., Pacific Time, seven days a week, from October 1 through March 31. (After March 31, Customer Service is available Monday-Friday).
- If you have a visual impairment and need this material in a different format such as Braille, large print, or alternative formats, please call Customer Service.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About PERS Essentials Rx 803 (HMO)

- PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means PacificSource Medicare. When it says “plan” or “our plan,” it means Essentials Rx 803 (HMO).

Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for our plan in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at https://medicare.pacificsource.com/PERS/2020/OR or https://medicare.pacificsource.com/PERS/2020/WA. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	Your total premium is set by PHIP. Please contact PHIP for the premium amounts you will pay in 2019.	Your total premium is set by PHIP. Please contact PHIP for the premium amounts you will pay in 2020.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,400	$3,400
Doctor office visits	Primary care visits: $15 per visit Specialist visits: $20 per visit	Primary care visits: $15 per visit Specialist visits: $20 per visit

Cost	2019 (this year)	2020 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	Days 1-4: $125 per day Days 5+: $0 per day	Days 1-4: $125 per day Days 5+: $0 per day
Part D prescription drug coverage (See Section 1.6 for details.)	**Deductible: $0** Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 2:** You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 3:**You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 4:** You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 5:** You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 6:** You pay 40% of the total cost up to a maximum of $250	**Deductible: $0** Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 2:** You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 3:**You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 4:** You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 5:** You pay 40% of the total cost up to a maximum of $250 • **Drug Tier 6:** You pay 40% of the total cost up to a maximum of $250

Annual Notice of Changes for 2020

Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

You must continue to pay your Medicare Part B premium and your monthly PERS Health Insurance Program (PHIP) premiums. If you have questions about your premiums, please contact the PERS Health Insurance Program (PHIP) at 1-800-768-7377 or local 503-224-7377 from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving “Extra Help” with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. This limit is called the “maximum out-of-pocket amount.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2019 (this year)	2020 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.Medicare.PacificSource.com. You may also call Customer Service for updated provider information or to ask us to mail you

a Provider Directory. **Please review the 2020 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our in-network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.Medicare.PacificSource.com. You may also call Customer Service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2020 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2020 Evidence of Coverage.*

Cost	2019 (this year)	2020 (next year)
Breast Cancer Screening: Diagnostic mammogram exams	You pay 10% of the total cost.	You pay a $0 copay for your first exam per calendar year. You pay 10% of the total cost for each additional exam.
Chronic Care Management Services: PCP or Specialist visit focusing on complex chronic care management services. These services include an assessment of medical and mental health needs, medication review, a comprehensive care plan and coordination of care.	You pay a $15 copay per visit for PCP. You pay a $20 copay per visit for specialist .	You pay a $0 copay per visit.
Diabetes Services and Supplies: Prior Authorization requirements	No prior authorization is required.	Prior authorization may be required for some diabetic services and supplies including continuous glucose monitors. Please contact Customer Service or see our authorization grid for additional questions.
Diagnostic Colonoscopy	You pay a $125 copay per visit.	You pay a $0 copay per visit.
Doctor Office visits Primary Care Provider (PCP) office visits for new or existing conditions when included with an annual wellness visit or annual routine physical visit.	You pay a $15 copay per visit.	You pay a $0 copay when received in conjunction with annual wellness visit or annual routine physical exam with Primary Care Provider.

Cost	2019 (this year)	2020 (next year)
Hearing Aids	You receive a $250 reimbursement every 2 calendar years. You may purchase hearing aids from any licensed, qualified provider. Batteries are not included.	You pay a $699 or $999 copay per aid. Premium Hearing aids are available in rechargeable style options for an additional $75 per aid. Up to two TruHearing Flyte hearing aids every year. Benefit is limited to the TruHearing Flyte Advanced and Flyte Premium hearing aids. 3 follow-up visits included within the first year of purchasing hearing aids. Up to 48 batteries per aid for non-rechargeable models. You must see a TruHearing provider to use this benefit.
Hearing Services - routine	You pay a $15 copay per visit.	You pay a $45 copay per visit.
Inpatient Hospital Care: Prior Authorization requirements	Prior authorization may be required depending on the procedure, except in urgent or emergent situations. Notification from your provider is required prior to admission.	Prior authorization may be required depending on the procedure, except in urgent or emergent situations. Notification from your provider is required upon admission.
Opioid Treatment Program Services	Opioid Treatment Program Services is not covered.	You pay a $15 copay per service or visit.

Cost	2019 (this year)	2020 (next year)
Outpatient Rehabilitation Services: Prior Authorization requirements	Prior authorization is required for services beyond the Medicare therapy cap limits.	Prior authorization is required for services beyond $3,000 for physical and speech therapy combined. Prior authorization is required for services beyond $3,000 for occupational therapy.
Part B Prescription Drugs: Prior Authorization requirements	Prior authorization requirements for Part B drugs change yearly. Please contact Customer Service or see our Formulary to verify which Part B drugs require prior authorization.	Prior authorization requirements for Part B drugs change yearly. Please contact Customer Service or see our Formulary to verify which Part B drugs require prior authorization.
Telehealth Services	Certain telehealth services are covered in certain rural areas or other locations approved by Medicare.	Telehealth services are provided in all locations for Home Health, PCP, Specialist, Mental Health, Psychiatric, Opioid Treatment, Substance Abuse, Dialysis, Kidney Disease Education, and Diabetes Self-Management services. These services are provided through phone and/or video. Please coordinate with your provider for these services.

Cost	2019 (this year)	2020 (next year)
Transitional Care Management Services: PCP or Specialist visit following discharge from one of these hospital settings: • Inpatient Acute Care Hospital • Inpatient Psychiatric Hospital • Long Term Care Hospital • Skilled Nursing Facility • Inpatient Rehabilitation Facility • Hospital outpatient observation or partial hospitalization • Partial hospitalization at a Community Mental Health Center	You pay a $15 copay per visit for PCP. You pay a $20 copay per visit for specialist.	You pay a $0 copay per visit.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time** temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. For 2020, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: 31-day supply of medication rather than the amount provided in 2019 (98-day supply of medication). (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Please note: If you have previously received an approved formulary exception, you may need to request a renewal of that exception to continue receiving the medication in 2020. Please consult the drug list or contact Customer Service to ask if you need to receive a new coverage determination.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you receive “Extra Help” and haven’t received this insert by September 30th, please call Customer Service and ask for the “LIS Rider.” Phone numbers for Customer Service are in Section 6.1 of this booklet.

How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage,* which is located on our website at https://medicare.pacificsource.com/PERS/2020/OR or https://medicare.pacificsource.com/PERS/2020/WA. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (31-day) supply when you fill your prescription at an in-network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply, or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at an in-network pharmacy with standard cost-sharing: ***Tier 1 (Preferred Generic):*** You pay 40% of the total cost up to a maximum of $250. **Tier 2 (Generic):** You pay 40% of the total cost up to a maximum of $250. **Tier 3 (Preferred Brand):** You pay 40% of the total cost up to a maximum of $250. **Tier 4 (Non-Preferred Drug):** You pay 40% of the total cost up to a maximum of $250. **Tier 5 (Specialty Tier):** You pay 40% of the total cost up to a maximum of $250. **Tier 6 (Select Care Drugs):** You pay 40% of the total cost up to a maximum of $250. **Once your total drug costs have reached $5,100, you will move to the next stage (the Catastrophic Coverage Stage).**	Your cost for a one-month supply filled at an in-network pharmacy with standard cost-sharing: ***Tier 1 (Preferred Generic):*** You pay 40% of the total cost up to a maximum of $250. **Tier 2 (Generic):** You pay 40% of the total cost up to a maximum of $250. **Tier 3 (Preferred Brand):** You pay 40% of the total cost up to a maximum of $250. **Tier 4 (Non-Preferred Drug):** You pay 40% of the total cost up to a maximum of $250. **Tier 5 (Specialty Tier):** You pay 40% of the total cost up to a maximum of $250. **Tier 6 (Select Care Drugs):** You pay 40% of the total cost up to a maximum of $250. **Once your total drug costs have reached $6,350, you will move to the next stage (the Catastrophic Coverage Stage).**

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Essentials Rx 803 (HMO)

To stay in our plan you don't need to do anything. If you do not sign up for a different PHIP plan by November 15, or change to a Medicare plan not offered by PHIP or to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2020.

Section 2.2 – If you want to change plans

The Essential Rx 803 plan is sponsored by PHIP. Disenrolling from Essentials Rx 803 (HMO) will disenroll you from PHIP. If you would like to make a change, you may call PHIP to discuss your options at 1-800-768-7377 or local 503-224-7377 (TTY users call 711) from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday. If you leave the PHIP, you may not be able to return to the PHIP.

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different PHIP Medicare health plan,
- You can join a different Medicare health plan, not offered by PHIP, timely,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality**

ratings for Medicare plans.

Step 2: Change your coverage

- To change to a different PHIP Medicare Health plan, fill out an enrollment request form for the new plan coverage. You must also fill out a disenrollment form to cancel your coverage on the Essentials Rx 803 plan. Both forms must be submitted during the PHIP plan change period, from October 1 to November 15. For copies of the required forms, contact PHIP at 1-800-768-7377 or local 503-224-7377 (TTY users call 711) from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday.

- To change to a Medicare health plan outside of the PHIP, enroll in the new plan. You must also notify the PHIP in writing prior to the effective date of your new coverage. You will automatically be disenrolled from Essentials Rx 803 (HMO) plan. If you leave the PHIP, you may not be able to return to the PHIP.

- To **change to Original Medicare with a prescription drug plan,** please contact PHIP for information.

- To **change to Original Medicare without a prescription drug plan**, you must contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

If you want to change to a different PHIP health plan for next year, you can do it from October 1 until November 15. The change will take effect on January 1, 2020.

If you want to change to a Medicare plan not offered by PHIP, or to Original Medicare, you can do this from October 15 until December 7. The change will take effect on January 1, 2020.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2020, and don’t like your plan choice, you can switch to another Medicare health plan not offered by PHIP (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Oregon, the SHIP is called the Senior Health Insurance Benefits Assistance (SHIBA). In Washington, the SHIP is called the Statewide Health Insurance Benefits Advisors (SHIBA).

SHIBA is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIBA counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIBA at:

State:	Phone:
Oregon	(800) 722-4134
Washington	(800) 562-6900

You can learn more about SHIBA by visiting their website at:

State:	Phone:
Oregon	www.OregonShiba.org
Washington	www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals

living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Oregon CAREAssist Program or the Washington Early Intervention Program (EIP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

State:	Program:	Phone:
Oregon	CAREAssist	(971) 673-0144
Washington	Early Intervention Program	(360) 236-3426

SECTION 6 Questions?

Section 6.1 – Getting Help from Essentials Rx 803 (HMO)

Questions? We're here to help. Please call Customer Service at toll-free at (888) 863-3637. (TTY only, call (800) 735-2900.) We are available for phone calls: **October 1 - March 31:** 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. **April 1 - September 30:** 8:00 a.m. to 8:00 p.m. local time zone, Monday-Friday. Calls to these numbers are free.

Read your 2020 Evidence of Coverage (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2020. For details, look in the 2020 *Evidence of Coverage* for Essentials Rx 803 (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at https://medicare.pacificsource.com/PERS/2020/OR or https://medicare.pacificsource.com/PERS/2020/WA. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.Medicare.PacificSource.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on “Find health & drug plans”).

Read *Medicare & You 2020*

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.