PacificSource Medicare

Explorer Rx 9 (PPO) *offered by* PacificSource Medicare

Annual Notice of Changes for 2019

You are currently enrolled as a member of Explorer Rx 9 (PPO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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 Sections 1 and 2 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 2019 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 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 3.2 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** Explorer Rx 9 (PPO), you don’t need to do anything. You will stay in Explorer Rx 9 (PPO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2018**

    - If you **don't join another plan by December 7, 2018**, you will stay in Explorer Rx 9 (PPO).

- If you **join another plan by December 7, 2018**, your new coverage will start on January 1, 2019.

Additional Resources

- If you have a visual impairment and need this material in a different format such as Braille, large print, and audio tapes, 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 Explorer Rx 9 (PPO)

- 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 Explorer Rx 9 (PPO).

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Explorer Rx 9 (PPO) in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$119	$99
Maximum out-of-pocket amounts 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.)	From in-network providers: $6,700 From in-network and out-of-network providers combined: $10,000	From in-network providers: $6,700 From in-network and out-of-network providers combined: $10,000
Doctor office visits	**In-Network** Primary care visits: $10 per visit Specialist visits: $35 per visit **Out-of-Network** Primary care visits: 50% co-insurance per visit Specialist visits: 50% coinsurance per visit	**In-Network** Primary care visits: $10 per visit Specialist visits: $35 per visit **Out-of-Network** Primary care visits: 50% co-insurance per visit Specialist visits: 50% coinsurance per visit

Cost	2018 (this year)	2019 (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.	**In-Network:** Days 1-4: You pay a $400 co-pay per day Days 5+: You pay a $0 co-pay per day **Out-of-Network:** You pay 50% of the total cost	**In-Network:** Days 1-5: You pay a $350 co-pay per day Days 6+: You pay a $0 co-pay per day **Out-of-Network:** You pay 40% of the total cost
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $300 (applies to drugs in Tiers 3, 4, and 5) Co-pays/co-insurance during the Initial Coverage Stage: • **Drug Tier 1:** Standard Cost-sharing: $8 Preferred Cost-sharing: $3 • **Drug Tier 2:** Standard Cost-sharing: $17 Preferred Cost-sharing: $12 • **Drug Tier 3:** Standard Cost-sharing: $47 Preferred Cost-sharing: $37 • **Drug Tier 4:** Standard Cost-sharing: 33% Preferred Cost-sharing: 31% • **Drug Tier 5:** Standard Cost-sharing: 27% Preferred Cost-sharing: 27% • **Drug Tier 6:** Standard Cost-sharing: $0 Preferred Cost-sharing: $0	Deductible: $275 (applies to drugs in Tiers 3, 4, and 5) Co-pays/co-insurance during the Initial Coverage Stage: • **Drug Tier 1:** Standard Cost-sharing: $8 Preferred Cost-sharing: $3 • **Drug Tier 2:** Standard Cost-sharing: $17 Preferred Cost-sharing: $12 • **Drug Tier 3:** Standard Cost-sharing: $47 Preferred Cost-sharing: $37 • **Drug Tier 4:** Standard Cost-sharing: 33% Preferred Cost-sharing: 31% • **Drug Tier 5:** Standard Cost-sharing: 27% Preferred Cost-sharing: 27% • **Drug Tier 6:** Standard Cost-sharing: $0 Preferred Cost-sharing: $0

Annual Notice of Changes for 2019

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$119	$99
Monthly optional dental premium (This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.)	$22	$21

- 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 Amounts

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

Cost	2018 (this year)	2019 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.

Cost	2018 (this year)	2019 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$10,000	$10,000 Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers 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 2019 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 network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

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 2019 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 *2019 Evidence of Coverage.*

Cost	2018 (this year)	2019 (next year)
Additional Mental Health Counselors Licensed Professional Counselors (LPC), Licensed Clinical Professional Counselors (LCPC), Licensed Marital and Family Therapists (LMFT), and Licensed Mental Health Counselors (LMHC) are available as In-Network providers	Additional Mental Health Counselors are not covered	**In-Network:** You pay a $20 co-pay per visit **Out-of-Network:** You pay 50% of the total cost per visit
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.	**In-Network:** You pay a $10 co-pay per visit for PCP You pay a $35 co-pay per visit for specialist	**In-Network:** You pay a $0 co-pay per visit

Cost	2018 (this year)	2019 (next year)
Dexa Scan Bone density diagnostic screenings	**In-Network:** You pay a $15 co-pay per visit	**In-Network:** You pay a $0 co-pay per visit
Diagnostic Colonoscopy	**In-Network:** You pay a $400 co-pay per visit	**In-Network:** You pay a $0 co-pay 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.	**In-Network:** You pay a $10 co-pay per visit	**In-Network:** You pay a $0 co-pay when received in conjunction with annual wellness visit or annual routine physical exam with Primary Care Provider
Emergency Care	You pay a $80 co-pay per visit	You pay a $90 co-pay per visit
Health and Wellness Education Programs: The Silver&Fit® Exercise & Healthy Aging Program	You pay a $50 nonrefundable annual member fee to join a participating fitness center. Or, you can enroll into the Silver&Fit Home Fitness Program for a $10 annual member fee and receive up to two home fitness kits per benefit year.	You pay a $0 annual member fee to join a participating fitness center. Or, you can enroll into the Silver&Fit Home Fitness Program for $0 annual member fee and receive up to two home fitness kits per benefit year.
Inpatient Hospital Care	**In-Network:** Days 1-4: You pay a $400 co-pay per day Days 5+: You pay a $0 co-pay per day **Out-of-Network:** You pay 50% of the total cost per day	**In-Network:** Days 1-5: You pay a $350 co-pay per day Days 6+: You pay a $0 co-pay per day **Out-of-Network:** You pay 40% of the total cost per day

Cost	2018 (this year)	2019 (next year)
Inpatient Mental Health Care	**In-Network:** Days 1-4: You pay a $400 co-pay per day Days 5+: You pay a $0 co-pay per day	**In-Network:** Days 1-5: You pay a $330 co-pay per day Days 6+: You pay a $0 co-pay per day
Outpatient Diagnostic Tests and Lab Services: Genetic Testing	**In-Network:** You pay a $15 co-pay per test	**In-Network:** You pay 20% of the total cost per test
Outpatient Hospital Services: Including services provided at hospital outpatient facilities, outpatient observation, and ambulatory surgical centers (ASC)	**In-Network:** You pay a $400 co-pay per visit	**In-Network:** You pay a $350 co-pay per visit
Other Supplemental Services: **Over-the-counter (OTC) Medications** OTC Aspirin, Calcium, and Calcium-Vitamin D combinations	You pay a $0 co-pay through the pharmacy. Prescription from provider is required.	You receive up to $100 reimbursement per year for eligible OTC medications. Prescription from provider is not required.

Cost	2018 (this year)	2019 (next year)
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	Supervised Exercise Therapy is <u>not</u> covered.	**<u>In-Network:</u>** You pay a $30 co-pay per visit **<u>Out-of-Network:</u>** You pay 50% of the total cost per visit

Cost	2018 (this year)	2019 (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	**In-Network:** You pay a $10 co-pay per visit for PCP You pay a $35 co-pay per visit for specialist	**In-Network:** You pay a $0 co-pay per visit
Vision Care: Routine (refractive) eye exams.	**Out-of-Network:** You pay 50% of the total cost per visit	**Out-of-Network:** You pay a $35 co-pay 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 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 2019, 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 2018 (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 2019. 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.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

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 the 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 7.1 of this booklet.

There are four "drug payment stages." 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*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, 4, and 5 drugs until you have reached the yearly deductible.	The deductible is $300. During this stage, you pay $8 at Standard cost-sharing and $3 at Preferred cost-sharing for drugs on Tier 1 Preferred Generic, $17 at Standard cost-sharing and $12 at Preferred cost-sharing for drugs on Tier 2 Generic, $0 at Standard and Preferred cost-sharing for drugs on Tier 6 Select Care Drugs and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, and Tier 5 Specialty until you have reached the yearly deductible.	The deductible is $275. During this stage, you pay $8 at Standard cost-sharing and $3 at Preferred cost-sharing for drugs on Tier 1 Preferred Generic, $17 at Standard cost-sharing and $12 at Preferred cost-sharing for drugs on Tier 2 Generic, $0 at Standard and Preferred cost-sharing for drugs on Tier 6 Select Care Drugs and the full cost of drugs on Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, and Tier 5 Specialty until you have reached the yearly deductible.

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	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the 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.**	Your cost for a one-month supply filled at an in-network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost-sharing:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $3 per prescription. **Tier 2 (Generic):** *Standard cost-sharing:* You pay $17 per prescription. *Preferred cost-sharing:* You pay $12 per prescription. **Tier 3 (Preferred Brand):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $37 per prescription. **Tier 4 (Non-Preferred Drug):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 31% of the total cost.	Your cost for a one-month supply filled at an in-network pharmacy: **Tier 1 (Preferred Generic):** *Standard cost-sharing:* You pay $8 per prescription. *Preferred cost-sharing:* You pay $3 per prescription. **Tier 2 (Generic):** *Standard cost-sharing:* You pay $17 per prescription. *Preferred cost-sharing:* You pay $12 per prescription. **Tier 3 (Preferred Brand):** *Standard cost-sharing:* You pay $47 per prescription. *Preferred cost-sharing:* You pay $37 per prescription. **Tier 4 (Non-Preferred Drug):** *Standard cost-sharing:* You pay 33% of the total cost. *Preferred cost-sharing:* You pay 31% of the total cost.

Stage	2018 (this year)	2019 (next year)
Stage 2: Initial Coverage Stage (continued) The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. 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.	**Tier 5 (Specialty):** *Standard cost-sharing:* You pay 27% of the total cost. *Preferred cost-sharing:* You pay 27% of the total cost. **Tier 6 (Select Care Drugs):** *Standard cost-sharing:* You pay $0 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	**Tier 5 (Specialty):** *Standard cost-sharing:* You pay 27% of the total cost. *Preferred cost-sharing:* You pay 27% of the total cost. **Tier 6 (Select Care Drugs):** *Standard cost-sharing:* You pay $0 per prescription. *Preferred cost-sharing:* You pay $0 per prescription. Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap 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 Administrative Changes

Process	2018 (this year)	2019 (next year)
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.

Process	2018 (this year)	2019 (next year)
Part D Prescription Drugs: Preferred Mail Order Cost Share	Co-pay for 90 day supply at preferred mail order pharmacy is available for 3 co-pays.	Co-pay for 90 day supply at preferred mail order pharmacy is available for 2 co-pays.
Part D Prescription Drugs: Prior Authorization requirements	Prior authorization requirements for Part D drugs change yearly. Please contact Customer Service or see our Formulary to verify which Part D drugs require prior authorization.	Prior authorization requirements for Part D drugs change yearly. Please contact Customer Service or see our Formulary to verify which Part D drugs require prior authorization.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Explorer Rx 9 (PPO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2019.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *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.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

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.**

As a reminder, PacificSource Medicare offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Explorer Rx 9 (PPO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Explorer Rx 9 (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *OR* – 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 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2019.

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, 2019, and don’t like your plan choice, you can switch to another Medicare health plan (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, 2019. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 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 Idaho, the SHIP is called Senior Health Insurance Benefits Assistance (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 (800) 247-4422. You can learn more about SHIBA by visiting their website (https://www.doi.idaho.gov/shiba/).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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 Idaho AIDS Drug Assistance Program.. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (208) 334-5943.

State:	Program:	Phone:
Idaho	Idaho AIDS Drug Assistance Program	(208) 334-5943

SECTION 7 Questions?

Section 7.1 – Getting Help from Our Plan

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 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for Explorer Rx 9 (PPO). 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. Information on where to access the *Evidence of Coverage* is included in this envelope.

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 7.2 – 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 2019*

You can read *Medicare & You 2019* 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.