



Essentials 2 (HMO) *offered* by PacificSource Medicare

Annual Notice of Changes for 2017

You are currently enrolled as a member of Essentials 2 (HMO). 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.

Additional Resources

- Customer Service has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- 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 (phone numbers are in Section 7.1 of this booklet).
- Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual required for MEC.

About Essentials 2 (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 2 (HMO).

Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- Check the changes to our benefits and costs to see if they affect you. Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1.1, 1.2, 1.4 and 2 for information about benefit and cost changes for our plan.
- 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? How do the total costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.

If you decide to stay with 2017 Essentials 2 (HMO):

If you want to stay with us next year, it's easy - you don't need to do anything.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for Essentials 2 (HMO) 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 enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2016 (this year)	2017 (next year)
Monthly plan premium (See Section 1.1 for details.)	\$25	\$42

Cost	2016 (this year)	2017 (next year)
<p>Maximum out-of-pocket amount</p> <p>This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	\$3,400	\$5,500
Doctor office visits	<p>Primary care visits: \$15 co-pay per visit</p> <p>Specialist visits: \$40 co-pay per visit</p>	<p>Primary care visits: \$20 co-pay per visit</p> <p>Specialist visits: \$40 co-pay per visit</p>
<p>Inpatient hospital stays</p> <p>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.</p>	<p>Days 1-6: \$295 co-pay per day</p> <p>Days 7+: \$0 co-pay per day</p>	<p>Days 1-6: \$300 co-pay per day</p> <p>Days 7+: \$0 co-pay per day</p>

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 - Changes to the Monthly Premium

Cost	2016 (this year)	2017 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$25	\$42
Monthly optional dental premium (This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.)	\$28	\$28

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	2016 (this year)	2017 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as co-pays) count toward your maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	\$3,400	\$5,500 Once you have paid \$5,500 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 2017 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.
- When possible we will 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 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 2017 *Evidence of Coverage*.

Cost	2016 (this year)	2017 (next year)
Health and Wellness Education Programs: Silver&Fit® Exercise & Healthy Aging Program	You pay a non-refundable \$50 fee per year to join a participating Silver&Fit® Exercise & Healthy Aging Program club or exercise center. You can join the Silver&Fit Home Fitness Program for no cost.	You pay a non-refundable \$50 fee per year to join a participating Silver&Fit® Exercise & Healthy Aging Program club or exercise center. You can join the Silver&Fit Home Fitness Program for \$10 per year for up to two fitness kits per year.
Inpatient Hospital Care	Days 1-6: You pay a \$295 co-pay per day. Days 7+: You pay a \$0 co-pay per day.	Days 1-6: You pay a \$300 co-pay per day. Days 7+: You pay a \$0 co-pay per day.
Inpatient Mental Health Care	Days 1-6: You pay a \$295 co-pay per day. Days 7+: You pay a \$0 co-pay per day.	Days 1-6: You pay a \$265 co-pay per day. Days 7+: You pay a \$0 co-pay per day.

Cost	2016 (this year)	2017 (next year)
Skilled Nursing Facility (SNF) Care	Days 1-20: You pay a \$40 co-pay per day. Days 21-100: You pay a \$150 co-pay per day.	Days 1-20: You pay a \$0 co-pay per day. Days 21-100: You pay a \$160 co-pay per day.
Pulmonary Rehabilitation Services	You pay a \$35 co-pay per visit.	You pay a \$30 co-pay per visit.
Home Health Agency Care	You pay 10% of the total cost.	You pay a \$0 co-pay per visit.
Physician/Practitioner Services, Including Doctor Office Visits: Primary Care Provider (PCP) Specialist Other health care professionals	PCP Office: You pay a \$15 co-pay per visit. Specialist Office: You pay a \$40 co-pay per visit.	PCP Office: You pay a \$20 co-pay per visit. Specialist Office: You pay a \$40 co-pay per visit.
Chiropractic Services	You pay a \$15 co-pay per visit.	You pay a \$20 co-pay per visit.
Outpatient Diagnostic radiological services	You pay a \$175 co-pay per CT Scan, a \$295 co-pay per MRI, a \$295 co-pay per PET Scan, a \$175 co-pay per Nuclear test	You pay a \$180 co-pay per CT Scan, a \$300 co-pay per MRI, a \$300 co-pay per PET Scan, a \$180 co-pay per Nuclear test
Outpatient Surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	You pay a \$295 co-pay per visit.	You pay a \$300 co-pay per visit.
Ambulance Services	You pay a \$250 co-pay per one-way transport.	You pay a \$300 co-pay per one-way transport.
Vision Care - Routine: Eye Wear	You pay a \$0 co-pay. You have a \$100 allowance for eyeglasses or contact lenses once every 2 calendar years.	You pay a \$0 co-pay. You have a \$200 allowance for eyeglasses or contact lenses once every 2 calendar years.
Hearing Services - Routine	You pay a \$40 co-pay per exam. One routine exam per calendar year.	You pay a \$45 co-pay per exam. One routine exam per calendar year.

Cost	2016 (this year)	2017 (next year)
Hearing Aids	Hearing aids are not covered.	You pay a \$699 or \$999 co-pay per aid. Up to two TruHearing Flyte hearing aids every year. Benefit is limited to the TruHearing Flyte 700 and Flyte 900 hearing aids. 3 follow-up visits included with purchase of hearing aid. You must see a TruHearing provider to use this benefit.

SECTION 2 Other Changes

Process	2016 (this year)	2017 (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.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 - If You Want to Stay in Essentials 2 (HMO)

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 2017.

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 2017 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 and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You* 2017, call your State Health Insurance Assistance Program (SHIP) (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 www.Medicare.gov and click "Review and Compare Your Coverage Options". 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 Essentials 2 (HMO).
- To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from Essentials 2 (HMO).
- 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 or (800) 633-4227, 24-hours a day, 7 days a week, and ask to be disenrolled. TTY users should call (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, 2017.

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 are allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2017, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 8, 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 Oregon, 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) 722-4134. You can learn more about SHIBA by visiting their website (www.OregonShiba.org).

SECTION 6 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 co-insurance. 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 (800) 633-4227. TTY users should call (877) 486-2048, 24-hours a day/7 days a week;
 - The Social Security Office at (800) 772-1213 between 7:00 a.m. and 7:00 p.m., Monday through Friday. TTY users should call, (800) 325-0778 (applications); or
 - Your State Medicaid Office (applications).
- What if you have coverage from an AIDS Drug Assistance Program (ADAP)? The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Oregon CAREAssist Program. Note: To be eligible for the ADAP operating in your State, 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.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. CAREAssist toll-free at (800) 805-2313.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call CAREAssist toll-free at (800) 805-2313.

SECTION 7 Questions?

Section 7.1 - Getting Help from Our Plan

Questions? We're here to help. Please call Customer Service at (541) 385-5315 or toll-free at (888) 863-3637. (TTY only, call (800) 735-2900.) We are available for phone calls: October 1 - February 14: 8:00 a.m. to 8:00 p.m. local time zone, seven days a week. February 15 - September 30: 8:00 a.m. to 8:00 p.m. local time zone, Monday-Friday.

Read your 2017 *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 2017. For details, look in the 2017 *Evidence of Coverage* for Essentials 2 (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 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).

Section 7.2 - Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website.

You can visit the Medicare website (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 www.Medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2017*.

You can read *Medicare & You 2017* 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 (www.Medicare.gov) or by calling 1-800-MEDICARE (800) 633-4227, 24-hours a day, 7 days a week. TTY users should call (877) 486-2048.