PacificSource Medicare

Explorer 16 (PPO) *offered by* PacificSource Medicare

Annual Notice of Changes for 2022

You are currently enrolled as a member of Explorer 16 (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 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 www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* 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 don't join another plan by December 7, 2021, you will be enrolled in Explorer 16 (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, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Explorer 16 (PPO).
- If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Customer Service number toll-free at (888) 863-3637 for additional information. (TTY users should call (800) 735-2900.) Hours are: **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.
- If you have a visual impairment and need this material in a different format such as braille, large print, or other alternate 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 www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Explorer 16 (PPO)

- PacificSource Community Health Plans is a 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 16 (PPO).

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 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 www.Medicare.PacificSource.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage.*

Cost	2021 (this year)	2022 (next year)
Monthly plan premium (See Section 1.1 for details.)	$0	$0
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: $5,900 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
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 1-7: $285 per day Days 8+: $0 per day **Out-of-Network** 50% of the total cost	**In-Network** Days 1-7: $285 per day Days 8+: $0 per day **Out-of-Network** 50% of the total cost

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	No Change
Monthly optional Preventive Dental premium (This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.)	$23	Not Applicable Optional Preventive Dental is not offered. See benefit chart below for services included on your plan.
Monthly optional Comprehensive Dental premium (This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.)	$49	$57

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	2021 (this year)	2022 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-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	$5,900 Once you have paid $5,900 out-of-pocket for covered Part A and Part B services from in-network providers, you will pay nothing for your covered Part A and Part B services from in-network providers for the rest of the calendar year.

Cost	2021 (this year)	2022 (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 and your costs for prescription drugs do 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 in-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 2022 *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, we must 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 to manage 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 *2022 Evidence of Coverage*.

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Dental Services (Routine): Preventive, Restorative and Extraction services	Preventive, Restorative and Extraction services are not covered.	**In and Out-of-Network** Preventive Services: You pay a $0 copay for the following: • Routine Exams - 1 per year • Cleanings (Prophylaxis or Periodontal) - 1 per year • Bitewing x-rays - 1 per year • Full mouth x-rays, Conebeam, and/or Panorex (1 complete series) – 1 per 5 years Restorative & Extraction Services: You pay a 30% coinsurance for the following: • Pulpotomy: deciduous teeth only • Tooth Desensitization • Pulp Capping (Direct) • Oral Surgery: Simple Extractions • Stainless Steel Crowns • Core Build Up: Tooth requires root canal therapy • Bone Grafting: Only covered at time of extraction or implant placement • Fillings – 1 every 2 years • Root Planing/Perio Scaling – 1 every 2 years per quad • Debridement – 1 every 3 years not within 3 years of other prophy • Analgesia/Sedation: Only with surgical procedures Routine dental services are covered up to a combined $500 annual maximum. With this plan you can see any licensed dentist in the United States. You may pay more for services provided Out-of-Network.

Cost	2021 (this year)	2022 (next year)
Dental Services: Optional Supplemental Comprehensive Dental Plan (This plan can be purchased for an extra cost.)	You pay a $100 deductible. The following waiting periods apply: Class II: 6 months Class III: 12 months Routine exams, Problem focus exams, Cleanings, Bitewing x-rays (1 set of 4 films), and Brush Biopsy: all covered 1 per 6 months. Conebeam limited to dollar amount of a full moth series x-ray. Fillings (Reduce to amalgam): 1-2 surfaces -1 per calendar year. 3+ surfaces - 1 per calendar year.	You pay a $0 deductible. There are no waiting periods. Routine exams, Problem focus exams, Cleanings, Bitewing x-rays, and Brush Biopsy: all covered 2 per calendar year. Conebeam limited to 1 per 5 years. Fillings - 1 per 2 calendar years
Health and wellness education programs The Silver&Fit® Healthy Aging and Exercise Program	You have the following options available at no cost: • Access to over 15,000 fitness centers • Two Home Fitness kits per year. • Access to over 1,500 workout videos on silverandfit.com and mobile app. • One-on-one Healthy Aging Coaching sessions by phone with a trained health coach.	You have the following options available at no cost: • Access to over 16,500 fitness centers • One Home Fitness kit per year including options such as a Fitbit or Garmin Activity Tracker, yoga kits, pilates kits, swim kits, strength kits, and more. • Access to over 8,000 workout videos on silverandfit.com and mobile app. • One-on-one Healthy Aging Coaching sessions by phone with a trained health coach, with the addition of Brain Health.

Cost	2021 (this year)	2022 (next year)
Hearing Services (Routine) TruHearing branded hearing aids	You pay $699 per aid for Flyte Advanced through TruHearing. You pay $999 per aid for Flyte Premium through TruHearing.	You pay $599 per aid for Standard aids through TruHearing. You pay $799 per aid for Advanced aids through TruHearing. You pay $999 per aid for Premium aids through TruHearing.
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 and Step Therapy requirements for Part B drugs change yearly. Please contact Customer Service or see our Formulary to verify which Part B drugs require prior authorization or step therapy.
Physician/ Practitioner services Telehealth Services	**In-Network** Telehealth services are available for all Medicare part A and B covered services.	**In-Network** Telehealth is available for PCP, Specialist, Outpatient Rehabilitation (Physical, Occupational, and Speech Therapy), Outpatient Mental Health, and Psychiatric services.
Skilled Nursing Facility (SNF) care	**In-Network** Days 1-20: You pay a $0 copay per visit. Days 21-100: You pay a $184 copay per visit.	**In-Network** Days 1-20: You pay a $0 copay per visit. Days 21-100: You pay a $188 copay per visit.

SECTION 2 Administrative Changes

Description	2021 (this year)	2022 (next year)
Rewards and Incentives When you complete one or more of the activities listed in the calendar year, you will receive a gift card redeemable at more than 100 popular retailers.	• **Routine physical or annual wellness visit:** $50 • **Mammogram:** $25 • **Diabetic A1c (blood glucose test):** First test - $15; Second test - $25 • **Diabetic eye exam:** $25	• **Routine physical or annual wellness visit:** $50 • **Mammogram:** $25 • **Diabetic A1c (blood glucose test):** First test - $15; Second test - $25 • **Diabetic eye exam:** $25 • **Flu Shot:** $10 • **Dexa Scan:** $20 • **Colonoscopy or at-home colon cancer test:** $20

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in our plan

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 be enrolled in our Explorer 16 (PPO).

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 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan 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, there may be a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, 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 www.medicare.gov/plan-compare. **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 our plan.
    - To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from our plan.
- 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, 2022.

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 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2022, 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, 2022. 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 Montana, the SHIP is called the State Health and Insurance Assistance Program (SHIP).

SHIP 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. SHIP 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 SHIP at (800) 551-3191. You can learn more about SHIP by visiting their website (www.dphhs.mt.gov/sltc/aging/SHIP).

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 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).
- **Help from your state's pharmaceutical assistance program.** Montana has a program called Big Sky Rx Program that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).
- **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 Montana AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call:

State:	Program:	Phone:
Montana	Montana AIDS Drug Assistance Program	(406) 444-3565

SECTION 7 Questions?

Section 7.1 – Getting Help from Our Plan

Questions? We're here to help. Please call Customer Service 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 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for our plan. 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 www.Medicare.PacificSource.com. 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*).

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 (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/plan-compare).

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* 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 (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.