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 2024

You are currently enrolled as a member of Essentials Rx 803 (HMO). Next year, there will be changes to the plan's costs and benefits. ***Please see page 5 for a Summary of Important Costs, including Premium***.

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the Evidence of Coverage, which 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.

- **The PERS Health Insurance Program (PHIP) Annual Plan Change period is October 1 to November 15. These changes will be effective January 1, 2024.**
- **Medicare plans not offered by the PHIP have an annual enrollment period from October 15 until December 7 to make changes to your 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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctor, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ 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** your Essentials Rx 803 (HMO) Plan with PHIP you don't need to do anything. You will stay enrolled in the Essentials Rx 803 (HMO).
- If you decide a different 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 coverage will begin on January 1, 2024.
- The information below is for general Medicare enrollment; contact the PERS Health Insurance Program for details regarding their enrollment and Plan Change guidelines.
- To change to a **different plan,** you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with Essentials Rx 803 (HMO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This Plan, Essentials Rx 803 (HMO), is a PERS Health Insurance Program (PHIP) employer group plan. Disenrolling from the 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 PHIP, you may not be able to rejoin at a later date.
- Please contact our Customer Service number at 888-863-3637 for additional information (TTY: 711. We accept all relay calls). 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). This call is free.

- 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 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, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). 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).

Annual Notice of Changes for 2024

Table of Contents

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Essentials Rx 803 (HMO) in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	Premium amounts are changing starting January 1, 2023. Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2023.	Premium amounts are changing starting January 1, 2024. Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2024.
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
Inpatient hospital stays	Days 1-4: $125 per day Days 5+: $0 per day	Days 1-4: $125 per day Days 5+: $0 per day

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	**Deductible: $0** Coinsurance during the Initial Coverage Stage for up to a 31-day supply: • **Drug Tier 1:** You pay an $8 copay per prescription • **Drug Tier 2:** You pay a $15 copay per prescription • **Drug Tier 3:**You pay 40% of the total cost up to a maximum of $250 You pay a maximum of $35 per month supply of each covered insulin product on this tier • **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 You pay a maximum of $35 per month supply of each covered insulin product on this tier • **Vaccine Tier 6:** You pay a $0 copay per vaccine Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	**Deductible: $0** Coinsurance during the Initial Coverage Stage for up to a 31-day supply: • **Drug Tier 1:** You pay an $8 copay per prescription • **Drug Tier 2:** You pay a $15 copay per prescription • **Drug Tier 3:**You pay 40% of the total cost up to a maximum of $250 You pay a maximum of $35 per month supply of each covered insulin product on this tier • **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 You pay a maximum of $35 per month supply of each covered insulin product on this tier • **Vaccine Tier 6:** You pay a $0 copay per vaccine Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2023.	Premium amounts are changing starting January 1, 2024. Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2024.

- 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. Please see Section 5 regarding "Extra Help" from Medicare.

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

Medicare requires all health plans to limit how much you pay out-of-pocket for 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	2023 (this year)	2024 (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 and Pharmacy Networks

Updated directories are located on our website at www.Medicare.PacificSource.com. You may also call Customer Service for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Service so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
24-Hour NurseLine	You pay a $0 copay per visit.	24-Hour NurseLine is not covered.
Inpatient Hospital Care: Prior Authorization requirements	Prior authorization may be required depending on the procedure, except in urgent or emergent situations.	Prior authorization is not required.
Inpatient services in a psychiatric hospital: Prior Authorization requirements	Prior authorization may be required depending on the procedure, except in urgent or emergent situations.	Prior authorization is not required.
Medicare Part B prescription drugs Part B Insulin	You pay 20% of the total cost. Beginning July 2023, you pay 20% up to a $35 copay per insulin per month.	You pay 20% up to a $35 copay per insulin per month.

Cost	2023 (this year)	2024 (next year)
Outpatient mental health care: Additional Mental Health Counselors	What you pay for services does not apply to your yearly maximum out-of-pocket amount.	What you pay for services applies to your yearly maximum out-of-pocket amount.
Outpatient rehabilitation services: Physical, Occupational, and Speech Therapy Prior Authorization requirements	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.	Prior authorization is not required.
Part B Prescription Drugs: Prior Authorization and Step Therapy requirements	Requirements change yearly. Please contact Customer Service or see our Formulary to verify which drugs require prior authorization or step therapy.	Requirements change yearly. Please contact Customer Service or see our Formulary to verify which drugs require prior authorization or step therapy.
Partial Hospitalization services Prior Authorization requirements	Prior authorization is required.	Prior authorization is not required.
Skilled Nursing Facility Prior Authorization requirements	Prior authorization is required.	Prior authorization is not required.

Section 1.5 – 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", which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online “Drug List” to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Service for more information.

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 you haven’t received this insert by September 30th, please call Customer Service and ask for the “LIS Rider”.

There are four “**drug payment stages**”. The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	The deductible is $0. Because we have no deductible, this payment stage does not apply to you.	The deductible is $0. Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Please see the following chart for the changes from 2023 to 2024.

Stage	2023 (this year)	2024 (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.** 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 1 (Preferred Generic):** You pay up to an $8 copay for each prescription filled up to a 31-day supply from a retail or mail order pharmacy. You pay up to a $16 copay for each prescription filled up to a 62-day supply from a retail or mail order pharmacy. You pay up to a $24 copay for each prescription filled up to a 93-day supply from a retail pharmacy and a $16 copay for up to a 93-day supply from a mail order pharmacy. **Tier 2 (Generic):** You pay up to a $15 copay for each prescription filled up to a 31-day supply from a retail or mail order pharmacy. You pay up to a $30 copay for each prescription filled up to a 62-day supply from a retail or mail order pharmacy. You pay up to a $45 copay for each prescription filled up to a 93-day supply from a retail pharmacy and a $30 copay for up to a 93-day supply from a mail order pharmacy.	**Tier 1 (Preferred Generic):** You pay up to an $8 copay for each prescription filled up to a 31-day supply from a retail or mail order pharmacy. You pay up to a $16 copay for each prescription filled up to a 62-day supply from a retail or mail order pharmacy. You pay up to a $24 copay for each prescription filled up to a 93-day supply from a retail pharmacy and a $16 copay for up to a 93-day supply from a mail order pharmacy. **Tier 2 (Generic):** You pay up to a $15 copay for each prescription filled up to a 31-day supply from a retail or mail order pharmacy. You pay up to a $30 copay for each prescription filled up to a 62-day supply from a retail or mail order pharmacy. You pay up to a $45 copay for each prescription filled up to a 93-day supply from a retail pharmacy and a $30 copay for up to a 93-day supply from a mail order pharmacy.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 3 (Preferred Brand):** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply from a retail or mail order pharmacy. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 62-day supply from a retail or mail order pharmacy. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 93-day supply from a retail or mail order pharmacy. **Tier 4 (Non-Preferred Drug):** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply from a retail or mail order pharmacy. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 62-day supply from a retail or mail order pharmacy. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 93-day supply from a retail or mail order pharmacy.	**Tier 3 (Preferred Brand):** You pay 40% of the total cost up to a maximum of $35 for each covered insulin prescription and $250 for each other prescription filled, up to a 31-day supply from a retail or mail order pharmacy. You pay 40% of the total cost up to a maximum of $70 for each covered insulin prescription and $500 for each other prescription filled, up to a 62-day supply from a retail or mail order pharmacy. You pay 40% of the total cost up to a maximum of $105 for each covered insulin prescription and $750 for each other prescription filled, up to a 93-day supply from a retail or mail order pharmacy. **Tier 4 (Non-Preferred Drug):** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply from a retail or mail order pharmacy. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 62-day supply from a retail or mail order pharmacy. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 93-day supply from a retail or mail order pharmacy.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 5 (Specialty Tier):** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply. A long term supply is not available for Tier 5 drugs. **Tier 6:** **(Select Care Vaccines):** You pay $0 copay for each vaccine. **Once your total drug costs have reached $7,400, you will move to the next stage (the Catastrophic Coverage Stage).**	**Tier 5 (Specialty Tier):** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply. A long term supply is not available for Tier 5 drugs. You pay 40% of the total cost up to a maximum of $35 for each covered insulin prescription filled up to a 31-day supply. **Tier 6:** **(Select Care Vaccines):** You pay $0 copay for each vaccine. **Once your total drug costs have reached $5,000, you will move to the next stage (the Catastrophic Coverage Stage).**

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in the 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 plan offered by the PERS Health Insurance Program 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 2024.

Section 2.2 – If you want to change plans

The Essential Rx 803 (HMO) plan is sponsored by PHIP. Disenrolling from the Essentials Rx 803 (HMO) plan 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 PERS Health Insurance Plan, you may not be able to return to the PHIP at a later date.

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can change to a different PHIP plan.
- 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. 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, use the Medicare Plan Finder www.medicare.gov/plan-compare, read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

Step 2: Change your coverage

- You can change to a different PHIP plan offered by another PHIP health plan. You will need to decide between October 1 and November 15.
- To **change to a different Medicare health plan,** enroll in the new plan. You will automatically be disenrolled from Essentials Rx 803 (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Essentials Rx 803 (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 so.
  - -*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 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 through November 15. The change will take effect on January 1, 2024. Please see below if you would like to change to a Medicare plan not offered by PHIP or to Original Medicare.

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

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2024, 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, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare

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

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:

State:	Phone:
Idaho	800-247-4422
Montana	800-551-3191
Oregon	800-722-4134
Washington	800-562-6900

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

State:	Phone:
Idaho	www.DOI.Idaho.gov/shiba
Montana	www.dphhs.mt.gov/sltc/aging/SHIP
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. 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. 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 for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).

- **Help from your state's pharmaceutical assistance program (Montana residents only).** 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 4 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 Idaho AIDS Drug Assistance Program, the Montana AIDS Drug Assistance Program , 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:
Idaho	Idaho AIDS Drug Assistance Program	208-334-5612
Montana	Montana AIDS Drug Assistance Program	406-444-3565
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: 711. We accept all relay calls. 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 *2024 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 2024. For details, look in the *2024 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 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*) 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

How to contact PERS Health Insurance Program (PHIP) Customer Service

For assistance with plan premiums, changes, updating your name, address, and phone numbers, please call or write to PHIP Customer Service.

Method	PERS Health Insurance Program (PHIP) Customer Service - Contact Information
CALL	**800-768-7377** Calls to this number are free. Customer Service is available from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. This number is available 24 hours a day, seven days a week.
FAX	503-765-3452 or 888-393-2943
WRITE	**PERS Health Insurance Program (PHIP)** P.O. Box 40187 Portland, OR 97240-0187 persinfo@pershealth.com
WEBSITE	pershealth.com