PacificSource Medicare

Explorer 6 (PPO) *offered by* PacificSource Medicare

Annual Notice of Changes for 2020

You are currently enrolled as a member of Explorer 6 (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 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 6 (PPO), you don’t need to do anything. You will stay in Explorer 6 (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, 2019**

- If you don’t join another plan by **December 7, 2019**, you will stay in Explorer 6 (PPO).
- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020**.

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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Explorer 6 (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 6 (PPO).

Summary of Important Costs for 2020

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

Cost	2019 (this year)	2020 (next year)
Monthly plan premium (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: $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
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	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Monthly optional Preventive Dental premium (This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.)	$21	$22
Monthly optional Comprehensive Dental premium (This is an optional supplemental benefit. This premium is paid in addition to the monthly premium above.)	Optional Comprehensive Dental is not covered.	$41

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	2019 (this year)	2020 (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.	$6,700	$6,700 Once you have paid $6,700 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	2019 (this year)	2020 (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.	$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 2020 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

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

- Even though our network of providers may change during the year, 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 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 *2020 Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Alternative Care	You pay a $20 copay per visit up to a $450 combined benefit limit per calendar year.	You pay a $25 copay per visit up to a total of 12 combined visits per calendar year.
Breast Cancer Screening: Diagnostic mammogram exams	**In-Network** You pay a $15 copay per exam.	**In-Network** You pay $0 copay for your first exam per calendar year. You pay $15 copay for each additional exam.
Diabetes Services and Supplies: Prior Authorization requirements	No prior authorization is required.	**In-Network** Prior authorization may be required for some diabetic services and supplies including continuous glucose monitors. Please contact Customer Service or see our authorization grid for additional questions.
Inpatient Hospital Care: Prior Authorization requirements	**In-Network** Prior authorization may be required depending on the procedure, except in urgent or emergent situations. Notification from your provider is required prior to admission.	**In-Network** Prior authorization may be required depending on the procedure, except in urgent or emergent situations. Notification from your provider is required upon admission.

Cost	2019 (this year)	2020 (next year)
Medical Supplies: Surgical dressings, splints, casts, and other devices used to reduce fractures and dislocations	**In-Network** You pay a $0 copay per supply.	**In-Network** You pay 20% of the total cost.
Opioid Treatment Program Services	Opioid Treatment Program Services are not covered.	**In-Network** You pay a $35 copay per visit. **Out-of-Network** You pay 50% of the total cost.
Outpatient Mental Health Services: Individual and Group sessions	**In-Network** You pay a $20 copay per visit.	**In-Network** You pay a $25 copay per visit.
Outpatient Rehabilitation Services: Prior Authorization requirements	**In-Network** Prior authorization is required for services beyond the Medicare therapy cap limits.	**In-Network** 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.
Over-the-Counter (OTC) Medications: OTC Aspirin, Calcium, and Calcium-Vitamin D combinations	OTC Medications are not covered.	You receive up to $100 reimbursement per year.

Cost	2019 (this year)	2020 (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.
Services to treat Kidney Disease: Kidney Disease Education	**In-Network** You pay a $0 copay per visit.	**In-Network** You pay 20% of the total cost.
Skilled Nursing Facility (SNF)	**In-Network** Days 1-20: You pay $0 copay per day. Days 21-100: You pay $172 copay per day.	**In-Network** Days 1-20: You pay $0 copay per day. Days 21-100: You pay $178 copay per day.
Telehealth Services	Certain telehealth services are covered in certain rural areas or other locations approved by Medicare.	**In-Network** Telehealth services are provided in all locations for Home Health, PCP, Specialist, Mental Health, Psychiatric, Opioid Treatment, Substance Abuse, Dialysis, Kidney Disease Education, and Diabetes Self-Management services. These services are provided through phone and/or video. Please coordinate with your provider for these services. **Out-of-Network** Telehealth Services are not covered.

Cost	2019 (this year)	2020 (next year)
Global Emergency and Travel Assistance Program: **Assist America, INC.** Assist America offers global emergency and travel assistance when you become ill or injured while travelling more than 100 miles from home or in a foreign country. This program offers the following services: • Hospital Admission Assistance • Emergency Medical Evacuation • Medical Repatriation Assistance • Medical Consultation • Evaluation and Referrals Assistance • Medical Monitoring For more information about these services, please call Assist America 24 hours a day, 7 days a week at 800-872-1414 (inside the United States) or 1-609-986-1234 (outside the United States).	Global Emergency and Travel Assistance Program is not covered.	**In-Network** You pay a $0 copay for covered services. **Out-of-Network** Not covered.

Cost	2019 (this year)	2020 (next year)
Optional Comprehensive Dental Coverage If you enroll in our Optional Comprehensive Dental Benefit, you pay an additional monthly premium of $41.	Optional Comprehensive Dental is <u>not</u> covered.	You pay a $0 copay for Diagnostic Services (Preventive Class 1). This includes: • Routine Exams (1 per 6 months) • Prophylaxis or Periodontal Cleanings (1 per 6 months) • Bitewing x-rays: (1 per 6 months) • Full mouth x-rays and/or Panorex: (1 per 5 years) • Non-Routine/Emergency Services You pay a 20% coinsurance after a 6 month waiting period for Restorative & Extraction Services (Basic Class 2). This includes: • Pulpotomy • Tooth Desensitization • Pulp Capping • 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: 1-2 surfaces: (1 per calendar year) • Fillings: 3+ surfaces: (1 per calendar year) • Root planning/Perio Scaling (1 per 2 years per quadrant) • Debridement (1 per 3 years not within 3 years of other cleaning) • Analgesia/Sedation: Only with surgical procedures

Cost	2019 (this year)	2020 (next year)
Optional Comprehensive Dental Coverage (Continued)		You pay a 50% coinsurance after a 12 month waiting period for Endodontics, Periodontics, Prosthodontics, Oral/ Maxillofacial Surgery (Major Class 3). This includes: • Crowns (1 per 5 years) • Inlays (1 per 5 years) • Onlays (1 per 5 years) • Dentures (1 per 5 years) • Bridges (1 per 5 years) • Denture Relines (1 per calendar year) • Implants (1 per tooth per lifetime) • Oral Surgery: Complicated, Impacted • Periodontic Surgery • Veneers (non cosmetic) • Root Canal Therapy (1 per 3 years) You pay a $100 deductible which applies to Class 2 and 3 Services You have a $1,000 annual maximum for covered services.

SECTION 2 Administrative Changes

Cost	2019 (this year)	2020 (next year)
Optional Supplemental Benefits: Dental Enrollment Periods	You can enroll between October 15 and December 31 each year, for a January 1 effective date.	You can enroll during a valid CMS election period. Please see section 4 for additional information.

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 stay enrolled as a member of our plan for 2020.

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 2020 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 *Medicare & You 2020*, 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 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, 2020.

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

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 8, Section 2.3 of the *Evidence of Coverage*.

If you enrolled in a Medicare Advantage plan for January 1, 2020, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 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 Idaho, the SHIP is called the Senior Health Insurance Benefits Advisors (SHIBA).

SHIBA is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. *SHIBA* counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call *SHIBA* at (800) 247-4422. You can learn more about SHIBA by visiting their website (www.DOI.Idaho.gov/shiba).

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).

- **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 Idaho AIDS Drug Assistance 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.

State:	Program:	Phone:
Idaho	Idaho AIDS Drug Assistance Program	(208) 334-5612

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

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

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2020. For details, look in the 2020 *Evidence of Coverage* for 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 (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2020*

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