PacificSource Medicare

Essentials Rx 27 (HMO) Summary of Benefits

Central Oregon, Eastern Oregon, and Mid-Columbia Gorge
January 1, 2017 – December 31, 2017

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. This information is not a complete description of benefits. Contact the plan for more information. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **PacificSource Medicare Essentials Rx 27 (HMO)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **PacificSource Medicare Essentials Rx 27 (HMO)** covers and what you pay.

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on Medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at Medicare.gov or get a copy 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.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at (888) 863-3637. TTY users call (800) 735-2900.

Sections in this booklet

- Things to Know About PacificSource Medicare Essentials Rx 27 (HMO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

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Things to Know About PacificSource Medicare Essentials Rx 27 (HMO)

Hours of Operation

- From October 1 to February 14, you can call us seven days a week, from 8:00 a.m. to 8:00 p.m. Pacific time.
- From February 15 to September 30, you can call us Monday through Friday, from 8:00 a.m. to 8:00 p.m. Pacific time.

Phone Numbers and Website

- If you are a member of this plan, call toll-free (888) 863-3637. TTY users call (800) 735-2900.
- If you are not a member of this plan, call toll-free (888) 863-3637. TTY users call (800) 735-2900.
- Our website: Medicare.PacificSource.com

Who can join?

To join **PacificSource Medicare Essentials Rx 27 (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Oregon: Crook, Deschutes, Grant, Hood River, Jefferson, Klamath*, Lake*, Sherman, Wasco, and Wheeler.

* denotes partial county

Which doctors, hospitals, and pharmacies can I use?

PacificSource Medicare Essentials Rx 27 (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You can see our plan's provider directory at our website Medicare.PacificSource.com/Search/Pharmacy

You can see our plan's provider directory at our website Medicare.PacificSource.com/Search/Provider

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more.

- **Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, Medicare.PacificSource.com/Search/Drug

Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

How much is the monthly premium?

$122 per month. You must continue to pay your Medicare Part B premium.

How much is the deductible?

For covered medical and hospital benefits: the Part A deductible: $1,288
Part B deductible: $166
Note: The Part A & B deductibles will update November 2016 per CMS.

This plan also has a deductible of $400 for Tier 3, 4, and 5 drugs.

Is there any limit on how much I will pay for my covered services?

Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Your yearly limit(s) in this plan: $6,700 for Medicare-covered services you receive from in-network providers.

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Is there a limit on how much the plan will pay?

Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits

Inpatient Hospital Care

- Part A deductible of $1,288 applies to days 1-60
- $322 co-pay days 61-90
- $644 co-pay each lifetime reserve days 91-150
- There is no coverage for 151 days and beyond

Note: This is the Medicare cost-sharing amount for 2016. This amount may change for 2017. **Prior authorization is required, except in urgent or emergent situations.**

Doctor's Office Visits

- Primary care physician visit: 20% of the cost
- Specialist visit: 20% of the cost

No prior authorization required except as noted below. Prior authorization may be required for surgery or treatment services. Prior authorization is required for non-routine dental care.

Preventive Care

You pay nothing for Medicare-approved Preventive Care.

Our plan covers many preventive services, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots. Vaccines received at your provider’s office may incur an administration fee
- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Emergency Care

20% of the cost up to $75

If you are admitted to the hospital within 72 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.

Urgently Needed Services

20% of the cost up to $65

Diagnostic Tests, Lab and Radiology Services, and X-Rays

Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost.
Prior authorization is required for Advanced/complex imaging such as: CT scan, MRI, PET Scan, Nuclear Test.

Diagnostic tests and procedures: 20% of the cost

Lab services: You pay nothing. **Prior authorization is required for genetic testing and analysis.**

Outpatient x-rays: 20% of the cost

Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost. **Prior authorization is required for some radiation services.**

Hearing Services

Medicare-covered Exam: 20% of the cost

Routine hearing exam (for up to one every year): Not covered

Dental Services

Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): 20% of the cost

Prior authorization is required for non-routine dental care.

Vision Services

Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 20% of the cost

Medicare-covered Eye wear: 20% of the cost

Routine exams and eye wear are not covered under this plan.

Mental Health Care

- Inpatient visit:
    - Part A deductible of $1,288 applies to days 1-60
    - $322 co-pay days 61-90
    - $644 co-pay lifetime reserve days 91-150

    - There is no coverage for 151 days and beyond
- Outpatient group therapy visit: 20% of the cost
- Outpatient individual therapy visit: 20% of the cost

Note: These are Medicare cost sharing amounts for 2016. These amounts may change in 2017.

There is a 190-day lifetime limit for inpatient series in a psychiatric hospital. The 190-day limit does not apply to services provided in a general hospital.

Prior authorization is required, except in an emergency.

Skilled Nursing Facility (SNF)

- Our plan covers up to 100 days in a SNF.
- You pay nothing per day for days 1 through 20
- $161 co-pay per day for days 21 through 100

Note: These are Medicare cost sharing amounts for 2016. These amounts may change in 2017. **Prior authorization is required. Limited up to 100 days per benefit period. No prior hospital stay is required**.

Outpatient Rehabilitation

- Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 20% of the cost
- Occupational therapy visit: 20% of the cost
- Physical therapy and speech and language therapy visit: 20% of the cost.
  Prior authorization is required for services beyond the Medicare therapy cap limits.

Ambulance

20% of the cost. **Prior authorization is required for non-emergency transportation.**

Transportation

Not covered

Foot Care (podiatry services)

Foot exams and treatment, if you have diabetes-related nerve damage and/or meet certain conditions: 20% of the cost

Durable Medical Equipment (wheelchairs, oxygen, etc.)

20% of the cost. **Prior authorization may be required for some Durable Medical Equipment (DME).**

Wellness Programs

Not covered

Part B Drug Coverage

20% of the cost. **Prior authorization is required for some drugs. Contact the plan for more information.**

Prescription Drug Benefits

Initial Coverage

You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

This plan has a deductible of $400 for Tier 3, 4, and 5 drugs.

You may get your drugs at network retail pharmacies and mail order pharmacies. Cost-sharing may differ relative to the pharmacy's status as preferred or non-preferred, mail-order, Long Term Care (LTC) or home infusion, and 30- or 90-day supply.

Standard Retail Cost-Sharing

Tier	1-month supply	2-month supply	3-month supply
Tier 1 (Preferred Generic)	$6 co-pay	$12 co-pay	$18 co-pay
Tier 2 (Generic)	$20 co-pay	$40 co-pay	$60 co-pay
Tier 3 (Preferred Brand)	$47 co-pay	$94 co-pay	$141 co-pay
Tier 4 (Non-Preferred Drugs)	$100 co-pay	$200 co-pay	$300 co-pay
Tier 5 (Specialty Tier)	25% of the cost	Not Offered	Not Offered
Tier 6 (Select Care Drugs)	$0	$0	$0

Preferred Retail Cost-Sharing

Tier	1-month supply	2-month supply	3-month supply
Tier 1 (Preferred Generic)	$1 co-pay	$2 co-pay	$3 co-pay
Tier 2 (Generic)	$15 co-pay	$30 co-pay	$45 co-pay
Tier 3 (Preferred Brand)	$37 co-pay	$74 co-pay	$111 co-pay
Tier 4 (Non-Preferred Drugs)	$90 co-pay	$180 co-pay	$270 co-pay
Tier 5 (Specialty Tier)	25% of the cost	Not Offered	Not Offered
Tier 6 (Select Care Drugs)	$0	$0	$0

Standard Mail Order Cost-Sharing

Tier	1-month supply	2-month supply	3-month supply
Tier 1 (Preferred Generic)	$6 co-pay	$12 co-pay	$18 co-pay
Tier 2 (Generic)	$20 co-pay	$40 co-pay	$60 co-pay
Tier 3 (Preferred Brand)	$47 co-pay	$94 co-pay	$141 co-pay
Tier 4 (Non-Preferred Drugs)	$100 co-pay	$200 co-pay	$300 co-pay
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If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700.

After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of:

- 5% of the cost, or
- $3.30 co-pay for generic (including brand drugs treated as generic) and a $8.25 co-pay for all other drugs. If you have Low Income Copay Subsidies you will have varying out-of-pocket expenses.

Other covered medical benefits

Acupuncture

Not covered

Chiropractic Care

Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): 20% of the cost

Diabetes Supplies and Services

20% of the cost

Home Health Care

You pay nothing. **Prior authorization is required.**

Hospice

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

Outpatient Substance Abuse

20% of the cost

Outpatient Surgery

Ambulatory surgical center: 20% of the cost

Outpatient hospital: 20% of the cost

Prior authorization is required for some services.

Over-the-Counter Items

Not Covered

Prosthetic Devices (braces, artificial limbs, etc.)

Prosthetic devices: 20%

Related medical supplies: 20% of the cost

Prior authorization is required.

Renal Dialysis

20% of the cost

Optional Benefits (you must pay an extra premium each month for these benefits)

Package 1: Preventive Dental benefits include: Preventive Dental

How much is the monthly premium? Additional $28 per month. You must keep paying your Medicare Part B premium and your $122 monthly plan premium.

How much is the deductible? This package does not have a deductible.

Is there any limit on how much the plan will pay? No. There is no limit to how much our plan will pay for benefits in this package.

PacificSource Community Health Plans is an HMO/HMO-POS/PPO Plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal. Limitations, co-payments, and restrictions may apply. Benefits, premium, and co-payments/co-insurance may change on January 1 of each year. The formulary, pharmacy network, and provider network may change at any time. You will receive notice when necessary. The Silver&Fit® Program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). All programs and services may not be available in all areas. Silver&Fit® is a registered trademark of ASH and used with permission herein. .