PacificSource Medicare

Explorer 6 (PPO) Summary of Benefits

Southwestern Idaho
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 Explorer 6 (PPO)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **PacificSource Medicare Explorer 6 (PPO)** 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 should call (800) 735-2900.

Sections in this booklet

- Things to Know About PacificSource Medicare Explorer 6 (PPO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

Things to Know About PacificSource Medicare Explorer 6 (PPO)

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. Mountain time.
- From February 15 to September 30, you can call us Monday through Friday, from 8:00 a.m. to 8:00 p.m. Mountain 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 Explorer 6 (PPO)**, 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 Idaho: Ada, Blaine, Boise, Camas, Canyon, Cassia, Elmore, Gem, Gooding, Jerome, Lincoln, Minidoka, Owyhee, Payette, Twin Falls, Valley, and Washington.

Which doctors and hospitals can I use?

PacificSource Medicare Explorer 6 (PPO) has a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. Out-of-network/non-contracted providers are under no obligation to treat PacificSource Community Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network 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 directory.

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.
- **PacificSource Medicare Explorer 6 (PPO)** covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does **not** cover Part D prescription drugs.

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

How much is the monthly premium?

$24 per month. You must continue to pay your Medicare Part B premium.

How much is the deductible?

This plan does not have a deductible.

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:

- $4,500 for Medicare-covered services you receive from in-network providers.
- $6,000 combined for Medicare-covered services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.

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.

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

Our plan covers an unlimited number of days for an inpatient hospital stay.
When in-network: Prior authorization is required, except in urgent or emergent situations.

In-network:

- $275 co-pay per day for days 1 through 7

You pay nothing per day for days 8 and beyond

Out-of-network:

- $375 co-pay per day for days 1 through 7

You pay nothing per day for days 8 and beyond

Doctor's Office Visits

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

Primary care physician visit:

- In-network: $15 co-pay
- Out-of-network: $25 co-pay

Specialist visit:

- In-network: $35 co-pay
- Out-of-network: $45 co-pay

Preventive Care

- In-network: You pay nothing for Medicare-approved Preventive Care.
- Out-of-network: 30% of the cost

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

Any additional preventive services approved by Medicare during the contract year will be covered.

Emergency Care

$75 co-pay

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

$35 co-pay

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

(Costs for these services may vary based on place of service)

Diagnostic radiology services (such as MRIs, CT scans):

- In-network: $125-$175 co-pay, depending on the service
- Out-of-network: 30% of the cost

When in-network: Prior authorization is required for advanced/complex imaging such as: CT scan, MRI, PET Scan, Nuclear Test.

Diagnostic tests and procedures:

- In-network: $15 co-pay
- Out-of-network: 30% of the cost

Lab services:

- In-network: $0-15 co-pay, depending on the service
- Out-of-network: 30% of the cost

When in-network: Prior authorization is required for genetic testing and analysis.

Outpatient x-rays:

- In-network: $15 co-pay
- Out-of-network: 30% of the cost

Therapeutic radiology services (such as radiation treatment for cancer):

- In-network: 20% of the cost
- Out-of-network: 30% of the cost

When in-network: Prior authorization is required for some radiation services.

Hearing Services

Exam to diagnose and treat hearing and balance issues:

- In-network: $35 co-pay
- Out-of-network: 30% of the cost

Routine hearing exam (for up to one every year):

- In-network: $45 co-pay
- Out-of-network: Not covered

Up to two TruHearing™ Flyte hearing aids per year. Benefit limited to TruHearing Flyte 700 and Flyte 900 hearing aids. Benefit is combined in-and-out-of-network. You must see a TruHearing provider to use this benefit.

- $699 co-pay per aid for Flyte 700
- $999 co-pay per aid for Flyte 900

Routine hearing exam and hearing aid copayments do not count towards out-of-pocket maximum.

Dental Services

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

- In-network: $35 co-pay
- Out-of-network: 30% of the cost

When in-network: 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):

- In-network: $0
- Out-of-network: 30% of the cost

Routine eye exam (for up to 1 every two years):

- In-network: $35 co-pay
- Out-of-network: 30% of the cost

Eyeglasses or contact lenses after cataract surgery:

- In-network: You pay nothing
- Out-of-network: You pay nothing

Our plan pays up to $200 every two years for routine prescription eyeglasses and/or contact lenses.

Mental Health Care

Inpatient visit:
In-network:

- $225 co-pay per day for days 1 through 7
- You pay nothing per day for days 8 and beyond

Out-of-network:

- $325 co-pay per day for days 1 through 7
- You pay nothing per day for days 8 and beyond

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The 190-day limit does not apply to inpatient mental services provided in a general hospital. **When in-network: Prior authorization is required for inpatient mental health care, except in an emergency.**

Outpatient group therapy visit:
- In-network: $40 co-pay
- Out-of-network: 30% of the cost

Outpatient individual therapy visit:
- In-network: $40 co-pay
- Out-of-network: 30% of the cost

Skilled Nursing Facility (SNF)

When in-network: Prior authorization is required. Limited up to 100 days per benefit period. No prior hospital stay is required.

In-network:
- $0 co-pay per day for days 1 through 20
- $150 co-pay per day for days 21 through 100

Out-of-network:
- 30% of the cost per day for days 1 through 100

Outpatient Rehabilitation

Cardiac (heart) rehab services (for a maximum of two one-hour sessions per day for up to 36 sessions up to 36 weeks):

- In-network: $35 co-pay
- Out-of-network: 30% of the cost

Pulmonary rehab services:
- In-network $30 co-pay
- Out-of-network: 30% of the cost

Occupational therapy visit:
- In-network: $35 co-pay
- Out-of-network: 30% of the cost

Physical therapy and speech and language therapy visit.
In-network: $35 co-pay

Out-of-network: 30% of the cost

When in-network: Prior authorization is required for services beyond the Medicare therapy cap limits.

Ambulance

When in-network: Prior authorization is required for non-emergency transportation.

- In-network: $200 co-pay
- Out-of-network: $200 co-pay

Transportation

Not covered

Foot Care (podiatry services)

Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:

- In-network: $35 co-pay
- Out-of-network: 30% of the cost

Durable Medical Equipment (wheelchairs, oxygen, etc.)

When in-network: Prior authorization may be required for some Durable Medical Equipment (DME).

- In-network: 20% of the cost
- Out-of-network: 40% of the cost

Wellness Programs

Silver&Fit® Exercise and Healthy Aging Program

$50/year for gym membership; $10/year for home kits up to two

Part B Drug Coverage

When in-network: Prior authorization is required for some drugs. Contact the plan for more information.

- In-network: 20% of the cost
- Out-of-network: 30% of the cost

Prescription Drug Benefits

The plan does **not** cover Part D drugs.

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):

- In-network: 20% of the cost
- Out-of-network: 30% of the cost

Diabetes Supplies and Services

Diabetes monitoring supplies:
- In-network: You pay nothing
- Out-of-network: 30% of the cost

Diabetes self-management training:
- In-network: You pay nothing
- Out-of-network: 30% of the cost

Therapeutic shoes or inserts:
- In-network: You pay nothing
- Out-of-network: 30% of the cost

Home Health Care

When in-network: Prior authorization is required.

- In-network: You pay nothing
- Out-of-network: 30% of the cost

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

Group therapy visit:
- In-network: $35 co-pay
- Out-of-network: 30% of the cost

Individual therapy visit:
- In-network: $35 co-pay
- Out-of-network: 30% of the cost

Outpatient Surgery

When in-network: Prior authorization is required for some services.
Ambulatory surgical center:
- In-network: $275 co-pay
- Out-of-network: $350 co-pay

Outpatient hospital:
- In-network: $275 co-pay
- Out-of-network: $350 co-pay

Over-the-Counter Items

Not Covered

Prosthetic Devices (braces, artificial limbs, etc.)

When in-network: Prior authorization is required.

- In-network: 0%-20% of the cost, depending on the device
- Out-of-network: 30% of the cost

Renal Dialysis

- In-network: 20% of the cost
- Out-of-network: 30% 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 $22 per month. You must keep paying your Medicare Part B premium and your $24 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 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. TruHearing® is a registered trademark of TruHearing, Inc.