PacificSource Medicare

Summary of Benefits 2019

MyCare 30 (HMO)

Yellowstone County

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Things to Know About PacificSource Medicare
MyCare 30 (HMO)

Who can join?

To join **PacificSource Medicare MyCare 30 (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 Montana: Yellowstone.

Which doctors, hospitals, and pharmacies can I use?

PacificSource Medicare MyCare 30 (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. Exceptions are emergencies, urgent care, and out-of-area dialysis services.

You can see our plan's **provider directory** on our website, www.Medicare.PacificSource.com/Search/Provider.

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

What do we cover?

- **Our plan members get <u>all</u> 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 <u>more</u> than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

Summary of Benefits:
January 1, 2019–December 31, 2019

This is a summary of drug and medical services and costs covered by PacificSource Medicare for the MyCare 30 (HMO) plan.

The benefit information provided is 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. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

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

Contact Us

Oct. 1 to Mar. 31: 7 days a week | 8 a.m. to 8 p.m. Local time
Apr. 1 to Sept. 30: Mon. to Fri. | 8 a.m. to 8 p.m. Local time
Toll-free: (888) 530-1428 | **TTY: (800) 735-2900** | **www.Medicare.PacificSource.com**

	MYCARE 30 (HMO)
	You Pay
Monthly Premium	
You must continue to pay your Medicare Part B premium.	**$0**
Medical Deductible	
	$250
Out-of-pocket Maximum	
Yearly limit on your out-of-pocket costs for medical and hospital care with in-network providers.	**$6,700**
Inpatient Hospital Care	
Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization is required, except in urgent or emergent situations.	**$360** per day for days 1–5 **$0** for days 6 and beyond
Outpatient Surgery	
Ambulatory surgical center **Outpatient hospital** Prior authorization is required for some services.	**$360** **$360**
Doctor's Office Visits	
Primary Care Physician (PCP)/Specialty Prior authorization may be required for surgery or treatment services.	PCP - **$0** Specialist - **$40** Not subject to annual deductible
Preventive Care	
For Medicare-approved preventive care. Examples include an annual physical exam, flu shots, and various cancer screenings.	**$0**
Emergency Care	
Waived if admitted to hospital within 72 hours	**$90** Not subject to annual deductible
Urgently Needed Services	
	$40 Not subject to annual deductible
Diagnostic Radiology Services (such as MRIs and CT scans)	
Prior authorization is required for advanced/complex, imaging such as: CT scan, MRI, PET scan, Nuclear Test.	CT Scan - **$300** MRI - **$400** PET Scan - **$400** Nuclear Test - **$300**
Diagnostic Tests and Procedures	
	$20 Not subject to annual deductible
Lab Services	
Prior authorization is required for genetic testing and analysis.	A1c and Protime Testing - **$0** Genetic Testing - **20%** All other Lab Services - **$40** Not subject to annual deductible
Outpatient X-rays	
	$20

	MYCARE 30 (HMO) You Pay
Therapeutic Radiology Services	
Prior authorization is required for some radiation services.	**20%**
Hearing Services	
Exam to diagnose and treat hearing and balance issues	**$40**
Routine hearing exam (up to one per year)	**$45**
TruHearing™ Flyte Hearing Aids **Flyte Advanced:** Per aid, up to two per year **Flyte Premium:** Per aid, up to two per year Routine hearing exam and hearing aid co-payments do not count toward out-of-pocket maximum.	 **$699** **$999** Routine hearing exams and hearing aids are not subject to annual deductible.
Dental Services	
For Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). Prior authorization is required for nonroutine dental care.	**$40**
Vision Services	
Medicare-covered eye exam to diagnose and treat glaucoma and diabetic retinopathy.	**$0**
Routine eye exam, one every two years	**$40**
Eyeglasses or contact lenses after cataract surgery *There is a limit to how much our plan will pay.*	**$0**
Reimbursement every 2 years for routine prescription eyeglasses or contact lenses.	**$200 reimbursement** Routine vision exams and vision hardware are not subject to annual deductible.
Mental Health Care	
Inpatient Services Prior authorization is required for inpatient mental health care, except in an emergency. 190-day lifetime limit for inpatient care not provided in a general hospital.	**$320** per day for days 1–5 **$0** for days 6 and beyond
Outpatient Services Per group or individual therapy visit	**$40** Not subject to annual deductible
Skilled Nursing Facility (SNF)	
Prior authorization is required. Limited up to 100 days per benefit period. No prior hospital stay is required.	**$0** per day for days 1–20 **$172** per day for days 21–100
Physical Therapy	
Prior authorization is required for services beyond the Medicare therapy cap limits.	**$40** Not subject to annual deductible
Ambulance	
Per one-way transport. Prior authorization is required for nonemergency transportation.	**Ground: $275** **Air: 20%** Not subject to annual deductible.

	MYCARE 30 (HMO) You Pay
Transportation	
	Not covered
Part B Drug Coverage	
Prior authorization is required for some drugs.	**20%**
Durable Medical Equipment (wheelchairs, oxygen, etc.)	
Prior authorization may be required for some durable medical equipment (DME).	**20%**
Foot Care (podiatry services)	
Foot exams and treatment if you have diabetic foot disease and/or meet certain conditions	**$40** Not subject to annual deductible
Medicare-covered Chiropractic Care	
Spinal manipulation to correct a subluxation	**$20** Not subject to annual deductible
Diabetes Supplies and Services	
Diabetes monitoring supplies, self-management training, and therapeutic shoes or inserts	Self-Management - **$0** All other benefits - **20%** Not subject to annual deductible.
Home Health Care	
	$0
Hospice	
Hospice is covered outside of our plan. Please contact us for more details.	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.
Outpatient Substance Abuse	
Group and individual therapy	**$40**
Prosthetic Devices (braces, artificial limbs, etc.)	
Prior authorization may be required.	**$0 internally implanted** **20% all other**
Renal Dialysis	
	20% Not subject to annual deductible.
Outpatient Rehabilitation	
Prior authorization is required for services beyond the Medicare therapy cap limits.	
Cardiac rehab services	**$35**
Pulmonary rehab services, per visit	**$30**
Occupational therapy, Speech and Language therapy, per visit	**$40** Not subject to annual deductible

Additional Benefits

	MYCARE 30 (HMO)
	You Pay
Fitness Programs (Silver&Fit® Exercise and Healthy Aging Program)	
Gym membership: **Home kits, up to two:**	**$0/year** **$0/year**
Office Visits for $0 Co-pay	
$0 co-pay for Primary Care Provider (PCP) office visits for new or existing conditions when included with an annual wellness visit or annual routine physical visit. This means there are no surprise office visit co-pays when you receive your annual wellness visit or annual routine physical.	**$0** when received in conjunction with annual wellness or annual routine physical exam with primary care provider
Dexa Scan	
Bone density diagnostic screenings	**$0**
Colonoscopy Diagnostic Screenings	
	$0
Chronic Care Management	
PCP or Specialist visit focusing on complex chronic care management services	**$0**
Transitional Care Management	
PCP or Specialist visit following discharge from an inpatient hospital setting	**$0**

Optional Benefits

You must pay an extra premium each month for these benefits.	MYCARE 30 (HMO) You Pay
Preventive Dental	
	$0 for the following: • Two annual cleanings (one every six months) • Two routine exams (one every six months) • Bitewing x-rays (one set every six months) • Full-mouth x-rays and/or panorex (one series every five calendar years)
Additional Monthly Premium	
	$21 per month. This premium is in addition to your monthly plan premium of $0.
Deductible	
	This package does not have a deductible.
Out-of-network Dental Services	
	We will cover 100% up to our maximum allowable charges for covered services. This maximum allowable is based on the 85th percentile of Usual, Customary, and Reasonable (UCR) charges. If your dentist is out of our network and the charges are more than the maximum allowable amount, you will have to pay for the excess charges.

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.

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal. This information is not a complete description of benefits. Call (888) 863-3637 or 711 for TTY users, for more information. Other pharmacies and providers are available in our network.