Summary of Benefits:
Essentials Rx 803 (HMO)

PacificSource Medicare

Oregon | PERS

January 1, 2018–December 31, 2018

This is a summary of drug and health services covered by PacificSource Medicare Essentials Rx 803 (HMO). 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."

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 803 (HMO).**

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **PacificSource Medicare Essentials Rx 803 (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 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.

Sections in this booklet:

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.

Y0021_H3864_MED39_0817_CMS Accepted 08192017

Things to Know About PacificSource Medicare Essentials Rx 803 (HMO)

Hours of Operation

- From October 1 to February 14, you can call us 7 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

- Toll-free: (888) 863-3637
- TTY: (800) 735-2900
- www.Medicare.PacificSource.com

Who can join?

To join **PacificSource Medicare Essentials Rx 803 (HMO),** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be an eligible PERS retiree, and live in our service area. Our service area includes the following counties in Oregon: Coos, Crook, Curry, Deschutes, Grant, Hood River, Jefferson, Klamath*, Lake*, Lane, Sherman, Wasco, and Wheeler.

*Our service area includes these parts of counties in Oregon: Klamath (97731, 97733, 97737, 97739), Lake (97638, 97641, 97735, 97739).

Which doctors, hospitals, and pharmacies can I use?

PacificSource Medicare Essentials Rx 803 (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 must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

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

You can see our plan's pharmacy directory on our website, www.Medicare.PacificSource.com/Search/Pharmacy.

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 <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.

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, www.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.

Summary of Benefits

January 1, 2018–December 31, 2018

Monthly Premium, Deductible, and Limits on How Much You Pay

	IN-NETWORK
Monthly Premium	
You must continue to pay your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact PHIP or your employee group benefits plan administrator. Your total premium is set by PHIP and includes other benefits. Contact PHIP for more information.
Medical Deductible	
	This plan does not have a deductible for covered medical services.
Pharmacy Deductible	
	This plan does not have a deductible for prescription drugs.
Out-of-pocket Maximum	
	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 in this plan:** • **$3,400** 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.
Coverage Limits	
	Our plans have a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical and Hospital Benefits

	IN-NETWORK
Inpatient Hospital Care	**You Pay**
Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization is required, except in urgent or emergent situations.	**$125 co-pay** per day for days 1–4 **$0** for days 5 and beyond
Outpatient Surgery	
Prior authorization is required for some services.	**$125 co-pay** for ambulatory surgical center **$125 co-pay** for outpatient hospital
Doctor's Office Visits	
No prior authorization required except as noted below. Referrals for specialist services are not required. When in-network: • Prior authorization may be required for surgery or treatment services. • Prior authorization is required for nonroutine dental care.	**$15 co-pay** for primary care physician visit **$20 co-pay** for specialist visit

Covered Medical and Hospital Benefits

	IN-NETWORK
Preventive Care	**You Pay**
	$0 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, and 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	
	$50 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	
	$20 co-pay
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.	**10% of the cost**
Diagnostic Tests and Procedures	
	$0 co-pay

Covered Medical and Hospital Benefits

	IN-NETWORK
Lab Services	**You Pay**
Prior authorization is required for genetic testing and analysis.	**$0 co-pay**
Outpatient X-rays	
	10% of the cost
Therapeutic Radiology Services (such as radiation treatment for cancer)	
Prior authorization is required for some radiation services.	**10% of the cost**
Hearing Services	
	$15 co-pay per exam to diagnose and treat hearing and balance issues **$15 co-pay** per routine hearing exam (for up to one every year) Our plan pays up to $250 every two years for hearing aids.
Dental Services	
Prior authorization is required for nonroutine dental care.	**$15 co-pay** for Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).
Vision Services	
	$0 co-pay for Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including glaucoma screening) **$15 co-pay** for routine eye exam. You are covered for up to one every two years. **$0 co-pay** for eyeglasses or contact lenses after cataract surgery. There is a limit to how much our plan will pay. Our plan pays up to $100 every two years for routine prescription eyeglasses and/or contact lenses.

Covered Medical and Hospital Benefits

	IN-NETWORK
Mental Health Care	**You Pay**
Prior authorization is required for inpatient mental health care, except in an emergency.	**Inpatient Services:** • **$125 co-pay** per day for days 1–4 • **$0** for days 5 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. **Outpatient Services:** • **$15 co-pay** per group therapy visit • **$15 co-pay** per individual therapy visit
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
Outpatient Rehabilitation	
Prior authorization is required for services beyond the Medicare therapy cap limits.	**$0 co-pay** for cardiac (heart) rehab services (for a maximum of two one-hour sessions per day for up to 36 sessions up to 36 weeks) **$0 co-pay** for pulmonary rehab services **$20 co-pay** for occupational therapy per visit **$20 co-pay** for physical therapy and speech and language therapy per visit
Ambulance	
Prior authorization is required for non-emergency transportation.	**$50 co-pay** per one-way transport
Transportation	
	Not covered
Part B Drug Coverage	
Prior authorization is required for some drugs. Contact the plan for more information.	**20% of the cost**
Durable Medical Equipment (wheelchairs, oxygen, etc.)	
Prior authorization may be required for some durable medical equipment (DME).	**20% of the cost**

Covered Medical and Hospital Benefits	
	IN-NETWORK
Foot Care (podiatry services)	**You Pay**
	$15 co-pay for foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions
Wellness Programs	
	Silver&Fit® Exercise and Healthy Aging Program: • **$50/year** for gym membership • **$10/year** for home kits up to two

Prescription Drug Benefits

Initial Coverage

You pay the following until your total yearly drug costs reach $3,750. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

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 days supply.

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.

Standard Retail Cost Sharing			
Tier	**1-month supply**	**2-month supply**	**3-month supply**
Tier 1 (Preferred Generic)	40% of the cost for up to 93-day supply, up to a $250 max		
Tier 2 (Generic)	40% of the cost for up to 93-day supply, up to a $250 max		
Tier 3 (Preferred Brand)	40% for 31-day supply up to a $250 max	40% for 32 to 93-day supply, up to a $750 max	
Tier 4 (Non-preferred Drugs)	40% for 31-day supply up to a $250 max	40% for 32 to 93-day supply, up to a $750 max	
Tier 5 (Specialty Tier)	40% for 31-day supply up to a $250 max	*32-day to 93-day supply not available*	
Tier 6 (Select Care Drugs)	40% of the cost for up to 93-day supply, up to a $250 max		

Standard Mail-Order Cost Sharing			
Tier	**1-month supply**	**2-month supply**	**3-month supply**
Tier 1 (Preferred Generic)	40% of the cost for up to 93-day supply, up to a $250 max		
Tier 2 (Generic)	40% of the cost for up to 93-day supply, up to a $250 max		
Tier 3 (Preferred Brand)	40% for 31-day supply up to a $250 max	40% for 32 to 93-day supply, up to a $750 max	
Tier 4 (Non-preferred Drugs)	40% for 31-day supply up to a $250 max	40% for 32 to 93-day supply, up to a $750 max	
Tier 5 (Specialty Tier)	40% for 31-day supply up to a $250 max	*32-day to 93-day supply not available*	
Tier 6 (Select Care Drugs)	40% of the cost for up to 93-day supply, up to a $250 max		

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750.

After you enter the coverage gap, all covered drugs have the same cost-share as in initial coverage.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay $0.

Other Covered Medical Benefits

	IN-NETWORK
Medicare-covered Chiropractic Care	**You Pay**
	$15 co-pay for manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position)
Diabetes Supplies and Services	
	$0 co-pay for diabetes monitoring supplies
	$0 co-pay for diabetes self-management training
	$0 co-pay for therapeutic shoes or inserts
Home Health Care	
	$0 co-pay
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	
	$15 co-pay for group therapy per visit
	$15 co-pay for individual therapy per visit
Over-the-counter Items	
	Not covered
Prosthetic Devices (braces, artificial limbs, etc.)	
Prior authorization is required.	**$0 co-pay**
Renal Dialysis	
	$0 co-pay

PacificSource Community Health Plans is an HMO/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. TruHearing™ is a registered trademark of TruHearing, Inc.