Summary of Benefits:
MyCare™ 30 (HMO)

PacificSource Medicare

Yellowstone County

January 1, 2018–December 31, 2018

This is a summary of drug and health services covered by PacificSource Medicare MyCare 30 (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 MyCare 30 (HMO).**

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **PacificSource Medicare MyCare 30 (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.

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Things to Know About PacificSource Medicare MyCare 30 (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 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 and hospitals 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 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.

PacificSource Medicare MyCare 30 (HMO) covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does not cover Part D prescription drugs.

Summary of Benefits

January 1, 2018–December 31, 2018

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

	MYCARE 30 (HMO)
Monthly Premium	
You must continue to pay your Medicare Part B premium.	**$5 per month**
Medical Deductible	
	This plan does not have a deductible for covered medical services.
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:** • **$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.
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

	MYCARE 30 (HMO)
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.	**$360 co-pay** per day for days 1–5 **$0** for days 6 and beyond
Outpatient Surgery	
Prior authorization is required for some services.	• **$360 co-pay for ambulatory surgical center** • **$360 co-pay for outpatient hospital**
Doctor's Office Visits	
No prior authorization required except as noted below. Prior authorization is required for nonroutine dental care.	**$10 co-pay** for primary care physician visit **$40 co-pay** for specialist visit **This service does not apply to the deductible.**

Covered Medical and Hospital Benefits

	MYCARE 30 (HMO)
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. **Preventive services do not apply to the deductible.**
Emergency Care	
	$80 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. **This service does not apply to the deductible.**
Urgently Needed Services	
	$40 co-pay **This service does not apply to the deductible.**

Covered Medical and Hospital Benefits

	MYCARE 30 (HMO)
Diagnostic Radiology Services (such as MRIs and CT scans)	**You Pay**
Prior authorization is required for advanced/complex imaging such as: CT scan, MRI, PET scan, Nuclear Test.	**20% of the cost**
Diagnostic Tests and Procedures	
	$20 co-pay **This service does not apply to the deductible.**
Lab Services	
Prior authorization is required for genetic testing and analysis.	**$0–$40 co-pay**, depending on the service **This service does not apply to the deductible.**
Outpatient X-rays	
	$20 co-pay
Therapeutic Radiology Services (such as radiation treatment for cancer)	
Prior authorization is required for some radiation services.	**20% of the cost**
Hearing Services	
	• **$40 co-pay** per exam to diagnose and treat hearing and balance issues • **$45 co-pay** per routine hearing exam (for up to one every year) • Up to two TruHearing™ Flyte hearing aids per year. Benefit is limited to TruHearing Flyte Advanced and Flyte Premium hearing aids. You must see a TruHearing provider to use this benefit. • **$699 co-pay** per aid for Flyte Advanced • **$999 co-pay** per aid for Flyte Premium Routine hearing exam and hearing aid co-payments do not count toward out-of-pocket maximum. **Routine hearing exams and hearing aids do not apply to the deductible.**
Dental Services	
Prior authorization is required for nonroutine dental care.	**$40 co-pay** for Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).

Covered Medical and Hospital Benefits

	MYCARE 30 (HMO)
Vision Services	**You Pay**
	• **$40 co-pay** for Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including glaucoma screening). • **$40 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 $200 every two years for eyeglasses and/or contact lenses. **Routine vision exams and vision hardware do not apply to the deductible.**
Mental Health Care	
Prior authorization is required for inpatient mental health care, except in an emergency.	**Inpatient Services:** • **$320 co-pay** per day for days 1–5 • **$0** for days 6 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:** • **$40 co-pay** per group therapy visit • **$40 co-pay** per individual therapy visit **Outpatient services do not apply to the 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 **$167 co-pay** per day for days 21–100
Outpatient Rehabilitation	
Prior authorization is required for services beyond the Medicare therapy cap limits.	• **$35 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) • **$30 co-pay** for pulmonary rehab services • **$40 co-pay** for occupational therapy per visit • **$40 co-pay** for physical therapy and speech and language therapy per visit **Occupational, physical and speech therapy do not apply to the deductible.**
Ambulance	
Prior authorization is required for non-emergency transportation.	• **$250** for ground ambulance per one-way transport • **20% of the cost** for air ambulance per one-way transport **This service does not apply to the deductible.**

Covered Medical and Hospital Benefits

	MYCARE 30 (HMO)
Transportation	**You Pay**
	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**
Foot Care (podiatry services)	
	$40 co-pay for foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions **This service does not apply to the deductible.**
Wellness Programs	
	Silver&Fit® Exercise and Healthy Aging Program: • **$50/year** for gym membership • **$10/year** for home kits up to two **This service does not apply to the deductible.**
Prescription Drug Benefits	
	This plan does **not** cover Part D drugs.

Other Covered Medical Benefits

	MYCARE 30 (HMO)
Medicare-covered Chiropractic Care	**You Pay**
	$20 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) **This service does not apply to the deductible.**
Diabetes Supplies and Services	
	• **20% of the cost for diabetes monitoring supplies** • **20% of the cost for diabetes self-management training** • **20% of the cost for therapeutic shoes or inserts** **This service does not apply to the deductible.**

Other Covered Medical Benefits	
	MYCARE 30 (HMO)
Home Health Care	**You Pay**
	$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	
	• **$40 co-pay for group therapy per visit** • **$40 co-pay for individual therapy per visit**
Over-the-counter Items	
	Not covered
Prosthetic Devices (braces, artificial limbs, etc.)	
Prior authorization is required.	**20% of the cost**
Renal Dialysis	
	20% of the cost **This service does not apply to the deductible.**

Optional Benefits

You must pay an extra premium each month for these benefits.

Package 1: Preventive Dental	**You Pay**
	Preventive Dental covers: • 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	
	$24 per month. You must keep paying your Medicare Part B premium and your monthly plan premium of $5.
Deductible	
	This package does not have a deductible.

Out-of-network Dental Services	You Pay
	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.

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.