



PacificSource Community Health Plans  
2965 NE Conners Avenue, Bend OR 97701  
541.385.5315 888.863.3637  
[Medicare.PacificSource.com](http://Medicare.PacificSource.com)

## **Addendum to the 2023 Evidence of Coverage, Annual Notice of Change, and Summary of Benefits**

**This is important information regarding changes to your 2023 coverage.**

This notice is regarding two cost-saving changes to 2023 Medicare Advantage benefits. These cost-saving benefit changes are part of the Inflation Reduction Act (IRA).

**Beginning April 1, 2023**, PacificSource Medicare members may pay less for certain drugs covered under Medicare Part B. If a drug had a price increase greater than the rate of inflation, your cost for those Part B drugs may be reduced.

**Beginning July 1, 2023**, you will pay **no more than** \$35 for a one-month supply of Part B insulin that is delivered through a pump covered under Medicare Part B as durable medical equipment.

You are **not** required to take any action in response to this document, but we recommend you keep this information for future reference. For more information regarding your benefits, the EOC can be found here: [www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com). If you have any questions, please call us at **888-863-3637** toll-free. TTY users should call **711**. We accept all relay calls. We are open:

- **Oct. 1 – Mar. 31:** 8:00 a.m. to 8:00 p.m. local time zone, seven days a week.
- **Apr. 1 – Sept. 30:** 8:00 a.m. to 8:00 p.m. local time zone, Monday – Friday.

Sincerely,

Customer Service  
PacificSource Community Health Plans

PacificSource Community Health Plans is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid).

PacificSource Community Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

PacificSource Community Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **888-863-3637**, TTY: **711**. Aceptamos todas las llamadas de retransmisión.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **888-863-3637**, TTY: **711**. 我們會接听所有的转接来电。



# Summary of Benefits 2023

## Essentials Rx 803 (HMO)

PERS Health Insurance Program (PHIP)

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



## 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: **Idaho:** Ada, Bannock, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Camas, Canyon, Elmore, Gem, Gooding, Jefferson, Jerome, Kootenai, Lincoln, Madison, Owyhee, Payette, Twin Falls, and Valley. **Montana:** Missoula and Yellowstone. **Oregon:** Clackamas, Coos, Crook, Curry, Deschutes, Douglas, Grant, Hood River, Jefferson, Klamath (97731, 97733, 97737, 97739), Lake (97638, 97641, 97735, 97739), Lane, Multnomah, Sherman, Wasco, Washington, Wheeler. **Washington:** Clark, Pierce, and Spokane.

## Which doctors, hospitals, and pharmacies can I use?

You can see our plan's **provider directory** on our website, [www.Medicare.PacificSource.com/Search/Provider](http://www.Medicare.PacificSource.com/Search/Provider). Our plan's **pharmacy directory** is also on our website, [www.Medicare.PacificSource.com/Search/Pharmacy](http://www.Medicare.PacificSource.com/Search/Pharmacy). If you would like a copy mailed to you, please call us.

## What prescription drugs are covered?

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](http://www.Medicare.PacificSource.com/Search/Drug).

If you would like a copy mailed to you, please call us.

## Summary of Benefits:

January 1, 2023–December 31, 2023



### This is a summary of costs for drug and medical services covered by PacificSource Medicare for the Essentials Rx 803 (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. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. 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](http://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](http://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



**Toll-free: 888-530-1428 | TTY: 711. We accept all relay calls.**

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

**[www.Medicare.PacificSource.com](http://www.Medicare.PacificSource.com)**

<b>ESSENTIALS RX 803 (HMO)</b>	
<b>You Pay</b>	
<b>Monthly Premium</b>	
You must continue to pay your Medicare Part B premium.	Your premium is set by the PERS Health Insurance Program (PHIP). Please contact PHIP for more information.
<b>Medical Deductible</b>	
	<b>\$0</b>
<b>Pharmacy Deductible</b>	
For all covered drugs.	<b>\$0</b>
<b>Out-of-pocket Maximum</b>	
The most you pay during the calendar year for in-network covered services.	<b>\$3,400</b>
<b>Inpatient Hospital Care</b>	
Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required depending on the procedure, except in urgent or emergent situations. Notification from your provider is required upon admission.	<b>\$125</b> per day for days 1–4 <b>\$0</b> for days 5 and beyond
<b>Outpatient Surgery</b>	
<b>Outpatient Hospital or Ambulatory Surgical Center</b> Prior authorization is required for some services.	<b>\$125</b>
<b>Doctor's Office Visits</b>	
<b>Primary Care Physician (PCP)/Specialty</b> Prior authorization may be required for surgery or treatment services.	PCP - <b>\$15</b> Specialist - <b>\$20</b>
<b>Preventive Care</b>	
For Medicare-approved preventive care. Examples include an annual physical exam, flu shots, and various cancer screenings.	<b>\$0</b>
<b>Emergency Care</b>	
Copay waived if admitted to hospital within 72 hours. Includes Worldwide coverage	<b>\$50</b>
<b>Urgently Needed Services</b>	
Includes Worldwide coverage.	<b>\$20</b>
<b>Diagnostic Radiology Services (such as MRIs and CT scans)</b>	
Prior authorization is required for advanced/complex, imaging such as: CT scan, MRI, PET scan, Nuclear Test.	<b>10%</b>
<b>Diagnostic Tests and Procedures</b>	
	<b>\$0</b>
<b>Lab Services</b>	
Prior authorization is required for genetic testing and analysis.	<b>\$0</b>
<b>Outpatient X-rays</b>	
	<b>10%</b>

**ESSENTIALS RX 803 (HMO)****You Pay****Therapeutic Radiology Services**

Prior authorization is required for some radiation services.

**10%****Hearing Services**

Exam to diagnose and treat hearing and balance issues

**\$15****TruHearing™ Hearing Aids**

**Advanced:** Per aid (up to two per year)

**\$399**

**Premium:** Per aid (up to two per year)

**\$699**

Routine hearing exam (up to one per year)

**\$0****Dental Services**

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

**\$15**

Prior authorization is required for nonroutine dental care.

**Vision Services**

Medicare-covered eye exam to diagnose and treat glaucoma and diabetic retinopathy.

**\$0**

Routine eye exam, one every two years.

**\$15**

Eyeglasses or contact lenses after cataract surgery. This is a limited benefit and only includes basic frames, lenses, or contact lenses.

**\$0**

Reimbursement every 2 years for routine prescription eyeglasses or contact lenses.

**\$200 reimbursement****Mental Health Care****Inpatient Services**

Prior authorization is required except in an emergency. Notification from your provider is required upon admission.

**\$125** per day for days 1–4**\$0** for days 5 and beyond

190-day lifetime limit for inpatient care not provided in a general hospital.

**Outpatient Services**

Per group or individual therapy visit

**\$15****Skilled Nursing Facility (SNF)**

Prior authorization is required. Limited up to 100 days per benefit period. No prior hospital stay is required.

**\$0****Physical Therapy**

Prior authorization is required for services beyond \$3,000 for physical therapy and speech therapy combined.

**\$20****Ambulance**

Per one-way transport. Prior authorization is required for nonemergency transportation. Includes Worldwide coverage.

**\$50****Transportation**

Not covered

**Part B Drug Coverage**

Prior authorization or step therapy is required for some drugs.

**20%**

# Prescription Drug Benefits



	ESSENTIALS RX 803 (HMO)		
Initial Coverage			
Retail Pharmacy	1 to 31-Day Supply	32 to 62-Day Supply	63 to 93-Day Supply
Tier 1 Preferred Generic	\$8	\$16	\$24
Tier 2 Generic	\$15	\$30	\$45
Tier 3 Preferred Brand	40% of the cost, up to a \$250 max	40% of the cost, up to a \$500 max	40% of the cost, up to a \$750 max
Tier 4 Non-preferred	40% of the cost, up to a \$250 max	40% of the cost, up to a \$500 max	40% of the cost, up to a \$750 max
Tier 5 Specialty Tier	40% of the cost, up to a \$250 max	32 to 93-Day supply not available	
Tier 6 Select Vaccines	\$0		
Catastrophic Coverage	After your out-of-pocket costs reach <b>\$7,400</b> , the maximum you pay until the end of the calendar year is:		
All Covered Drugs	You pay \$0		



## Save even more with Mail Order:

Receive a 93-day supply for the same cost as a 62-day supply for medications in Tiers 1 and 2, through CVS Caremark (our preferred mail-order pharmacy).

You may get your drugs at network retail pharmacies and mail order pharmacies.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get up to 3 fills from an out-of-network pharmacy but will need to pay the full cost of the prescription and then submit for reimbursement.

We do not cover prescription drugs purchased outside of the United States and its territories.

PacificSource Community Health Plan is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). Enrollment in PacificSource Medicare depends on contract renewal. Other pharmacies and providers are available in our network.

Accessibility help: For assistance reading this document, please call us at 888-863-3637, TTY: 711. We accept all relay calls.