PacificSource Medicare

Summary of Benefits 2024

Essentials Rx 41 (HMO)

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Things to Know About PacificSource Medicare
Essentials Rx 41 (HMO)

Who can join?
To join **PacificSource Medicare Essentials Rx 41 (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 Lane county in Oregon.

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.

Our plan's **pharmacy directory** is also on our website, 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.

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

Summary of Benefits:
January 1, 2024–December 31, 2024

This is a summary of costs for drug and medical services covered by PacificSource Medicare for the Essentials Rx 41 (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.

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

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

	ESSENTIALS RX 41 (HMO)
	You Pay
Monthly Premium	
You must continue to pay your Medicare Part B premium.	**$70**
Medical Deductible	
	$0
Pharmacy Deductible	
	$0
Out-of-pocket Maximum	
The most you pay during the calendar year for in-network covered services.	**$5,500**
Inpatient Hospital Care	
Our plan covers an unlimited number of days for an inpatient hospital stay. Notification from your provider is required upon admission.	**$360** per day for days 1–5 **$0** for days 6 and beyond
Outpatient Surgery	
Outpatient hospital or Ambulatory Surgical Center Prior authorization is required for some services.	**$360**
Doctor's Office Visits	
Primary Care Physician (PCP)/Specialty Prior authorization may be required for surgery or treatment services.	PCP - **$10** Specialist - **$35**
Preventive Care	
For Medicare-approved preventive care. Examples include an annual physical exam, flu shots, and various cancer screenings.	**$0**
Emergency Care	
Copay waived if admitted to hospital within 72 hours. Includes Worldwide coverage.	**$120**
Urgently Needed Services	
Includes Worldwide coverage.	**$60**
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 or Nuclear Test - **$225** MRI or PET Scan - **$310**
Diagnostic Tests and Procedures	
	$15
Lab Services	
Prior authorization is required for genetic testing and analysis.	A1c and Protime Testing - **$0** Genetic Testing - **20%** All other Lab Services - **$15**
Outpatient X-rays	
	$15
Therapeutic Radiology Services	
Prior authorization is required for some radiation services.	**20%**

	ESSENTIALS RX 41 (HMO)
	You Pay
Hearing Services	
Exam to diagnose and treat hearing and balance issues.	**$35**
TruHearing™ Hearing Aids: Per aid (up to two per year).	Standard: **$599** Advanced: **$799** Premium: **$999**
Routine hearing exam (up to one per year).	**$0**
Dental Services (Medicare Covered)	
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.	**$35**
Optional Supplemental Preventive Dental Plan	
This plan can be purchased for an additional monthly premium. It cannot be combined with other dental benefits. With this plan you can see any licensed dentist in the United States. Coverage includes: • Routine Exams • Cleanings • Bitewing x-rays, Full mouth x-ray, Conebeam, and/or Panorex • Fluoride or Fluoride Varnish • Brush Biopsy	Monthly premium: **$42** (in addition to your monthly plan premium of $70) Preventive Services: **$0**
Optional Supplemental Comprehensive Dental Plan	
This plan can be purchased for an additional monthly premium. It cannot be combined with other dental benefits. With this plan you can see any licensed dentist in the United States. Coverage includes: <u>Preventive Services:</u> • Routine Exams • Cleanings • Bitewing x-rays, Full mouth x-ray, Conebeam, and/or Panorex • Fluoride or Fluoride Varnish • Brush Biopsy <u>Restorative & Extraction Services:</u> • Fillings • Simple surgery • Removal of damaged tissue (debridement) • And more <u>Endodontics, Periodontics, Prosthodontics, Other Oral/Maxillofacial Surgery:</u> • Crowns, inlays, onlays, dentures, or bridges • Root canal therapy • Implants • Veneers • Complex surgery • And more	Monthly premium: **$63** (in addition to your monthly plan premium of $70) **$2,000** annual benefit limit for combined services Preventive Services: **$0** Restorative & Extraction Services: **20%** Endodontics, Periodontics, Prosthodontics, Other Oral/ Maxillofacial Surgery: **50%**

	ESSENTIALS RX 41 (HMO)
	You Pay
Vision Services	
Medicare-covered eye exam to diagnose and treat glaucoma and diabetic retinopathy.	**$0**
Routine eye exam, one every two years.	**$35**
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 Notification from your provider is required upon admission. 190-day lifetime limit for inpatient care not provided in a general hospital.	**$330** per day for days 1–5 **$0** for days 6 and beyond
Outpatient Services Per group or individual therapy visit	**$30**
Skilled Nursing Facility (SNF)	
Limited up to 100 days per benefit period. No prior hospital stay is required.	**$0** per day for days 1–20 **$203** per day for days 21–100
Physical Therapy	
	$35
Ambulance	
Per one-way transport. Prior authorization is required for nonemergency transportation. Includes Worldwide coverage.	**$300**
Transportation	
	Not covered
Part B Drug Coverage	
Prior authorization or step therapy is required for some drugs.	**20%** Insulin covered up to a maximum of **$35** per month supply

Prescription Drug Benefits

	ESSENTIALS RX 41 (HMO)	
Stage 1		
Pharmacy Deductible	**$0**	
Stage 2	When the total drug costs are between **$0** and **$5,030**, you pay:	
Retail Pharmacy (30-day supply)	**Preferred Pharmacy**	**Standard Pharmacy**
Tier 1 Preferred Generic	**$3**	**$8**
Tier 2 Generic	**$12**	**$17**
Tier 3 Preferred Brand	**$42**	**$47**
Tier 3 Insulin	**$35**	
Tier 4 Non-preferred	**31%**	**33%**
Tier 5 Specialty Tier	**33%** (30-day supply only)	
Tier 6 Select Care	**$0**	**$0**
Stage 3	After total drug costs reach **$5,030**, you pay:	
Tiers 1, 2, 3, 4, and 5	**25%**	
Covered Insulin	**$35**	
Tier 6 Select Care	**$0** See the list of covered drugs to determine which drugs are included.	
Stage 4	After your out-of-pocket costs reach **$8,000,** the maximum you pay until the end of the calendar year is:	
All Covered Drugs	**$0**	

You won't pay more than $35 per one-month supply of each covered insulin product regardless of the cost-sharing tier.

Save even more with Mail-Order:

Receive a 90-day supply for the same cost as a 60-day supply for medications in Tiers 1, 2, 3 & 6, through CVS Caremark (our preferred mail-order pharmacy).

Other benefits of our Mail-Order service:

- Free shipping
- Auto-refills available
- $0 copay for Preferred Generic (Tier 1) drugs.

Cost-sharing may differ relative to the pharmacy's status as preferred or standard, mail-order, Long Term Care (LTC) or home infusion, and 30-, 60-, or 90-day supply.

Additional Benefits not included above

	You Pay
Alternative Care	
Non-Medicare covered acupuncture, naturopathy, and non-Medicare covered chiropractic care. Combined total of 12 visits per calendar year.	**$25**
Meal Benefit	
Up to 2 meals per day for 7 days (total of 14 meals) after a recent inpatient stay in a hospital or nursing facility.	**$0**
Over-the-Counter (OTC) Drug Coverage	
Aspirin, Calcium, and Calcium-Vitamin D combinations	**$100 annual reimbursement**
Silver&Fit® Healthy Aging and Exercise Program	
Including but not limited to the folllowing options: • A fitness center membership at participating exercise centers • A Home Fitness kit including options like a wearable fitness tracker or a strength kit • On-demand videos through the website and mobile app • Healthy Aging Coaching sessions by telephone • The Silver&Fit Connected™ tool for tracking your activity	**$0**
Telehealth Services	
Care through phone or video for PCP visits, Specialist visits, Outpatient Rehabilitation services (Physical Therapy, Occupational Therapy, Speech Therapy), and Outpatient Mental Health Care. Please coordinate with your provider for these services.	Telehealth services are provided at the same cost share as an in-person visit.

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.