Summary of Benefits:
Essentials Choice Rx 14 (HMO-POS)

PacificSource Medicare

Central Oregon, Eastern Oregon, and Mid-Columbia Gorge

January 1, 2018–December 31, 2018

This is a summary of drug and health services covered by PacificSource Medicare Essentials Choice Rx 14 (HMO-POS). 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 Choice Rx 14 (HMO-POS).**

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)** 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 Essentials Choice Rx 14 (HMO-POS)

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 Choice Rx 14 (HMO-POS),** 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 Oregon: Crook, Deschutes, Grant, Hood River, Jefferson, Sherman, Wasco, and Wheeler.

Which doctors, hospitals, and pharmacies can I use?

PacificSource Medicare Essentials Choice Rx 14 (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. You also have the option to receive care for covered services from Medicare participating providers who are not in our network. If you use an out out-of-network provider, your share of the costs for your covered services may be higher. 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

Monthly Premium

You must continue to pay your Medicare Part B premium.

$125 per month

Medical Deductible

This plan does not have a deductible for covered medical services.

Pharmacy Deductible

$150 for Tier 3, 4, and 5 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:

- **$5,500** 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 an annual coverage limit for certain in-network benefits. Contact us for information about which in-network benefits have an annual coverage limit.
- **$2,500** benefit limit for elective (non-emergency) services with out-of-network providers

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Care	**You Pay**	**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.	**$400 co-pay** per day for days 1–4 **$0** for days 5 and beyond	**50% of the cost** per stay
Outpatient Surgery		
Prior authorization is required for some services.	**$400 co-pay** for ambulatory surgical center **$400 co-pay** for outpatient hospital	**50% of the cost** for ambulatory surgical center **50% of the cost** 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.	**$10 co-pay** for primary care physician visit **$35 co-pay** for specialist visit	**50% of the cost** for primary care physician visit **50% of the cost** for specialist visit

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Preventive Care	**You Pay**	**You Pay**
	$0 for Medicare-approved Preventive Care	**50% of the cost** 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		
	$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.	
Urgently Needed Services		
	$40 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.	**$190–$310 co-pay,** depending on the service	**50% of the cost**

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Tests and Procedures	**You Pay**	**You Pay**
	$15 co-pay	**50% of the cost**
Lab Services		
Prior authorization is required for genetic testing and analysis.	**$0–$20 co-pay**, depending on the service	**50% of the cost**
Outpatient X-rays		
	$15 co-pay	**50% of the cost**
Therapeutic Radiology Services (such as radiation treatment for cancer)		
Prior authorization is required for some radiation services.	**20% of the cost**	**50% of the cost**
Hearing Services		
	$35 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.	**50% of the cost** per exam to diagnose and treat hearing and balance issues Routine hearing exams and hearing aids are not covered.

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Dental Services	**You Pay**	**You Pay**
Prior authorization is required for nonroutine dental care.	**$35 co-pay** for Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	**50% of the cost** 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) **$35 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 routine prescription eyeglasses and/or contact lenses.	**50% of the cost** for Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including glaucoma screening) **50% of the cost** 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 routine prescription eyeglasses and/or contact lenses.
Mental Health Care		
Prior authorization is required for inpatient mental health care, except in an emergency.	**Inpatient Services:** • **$400 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:** • **$20 co-pay** per group therapy visit • **$20 co-pay** per individual therapy visit	**Inpatient Services:** **50% of the cost** 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:** • **50% of the cost** per group therapy visit • **50% of the cost** per individual therapy visit

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility (SNF)	**You Pay**	**You Pay**
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 **$160 co-pay** per day for days 21–100	**50% of the cost** per stay
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 **$20 co-pay** for occupational therapy per visit **$35 co-pay** for physical therapy and speech and language therapy per visit	**50% of the cost** for cardiac (heart) rehab services (for a maximum of two one-hour sessions per day for up to 36 sessions up to 36 weeks) **50% of the cost** for pulmonary rehab services **50% of the cost** for occupational therapy per visit **50% of the cost** for physical therapy and speech and language therapy visit
Ambulance		
Prior authorization is required for non-emergency transportation.	**$300 co-pay** per one-way transport	**$300 co-pay** per one-way transport
Transportation		
	Not covered	Not covered
Part B Drug Coverage		
Prior authorization is required for some drugs. Contact the plan for more information.	**20% of the cost**	**50% of the cost**
Durable Medical Equipment (wheelchairs, oxygen, etc.)		
Prior authorization may be required for some durable medical equipment (DME).	**20% of the cost**	**50% of the cost**
Foot Care (podiatry services)		
	$35 co-pay for foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	**50% of the cost** for foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions

Covered Medical and Hospital Benefits		
	IN-NETWORK	**OUT-OF-NETWORK**
Wellness Programs	**You Pay**	**You Pay**
	Silver&Fit® Exercise and Healthy Aging Program: • **$50/year** for gym membership • **$10/year** for home kits up to two	Not covered

Prescription Drug Benefits

IN-NETWORK
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.

This plan has a deductible of $150 for Tier 3, 4, and 5 drugs.

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)	$8 co-pay	$16 co-pay	$24 co-pay
Tier 2 (Generic)	$17 co-pay	$34 co-pay	$51 co-pay
Tier 3 (Preferred Brand)	$47 co-pay	$94 co-pay	$141 co-pay
Tier 4 (Non-preferred Drugs)	33% of the cost	33% of the cost	33% of the cost
Tier 5 (Specialty Tier)	30% of the cost	Not offered	Not offered
Tier 6 (Select Care Drugs)	$0 co-pay	$0 co-pay	$0 co-pay

Preferred Retail Cost Sharing			
Tier	**1-month supply**	**2-month supply**	**3-month supply**
Tier 1 (Preferred Generic)	$3 co-pay	$6 co-pay	$9 co-pay
Tier 2 (Generic)	$12 co-pay	$24 co-pay	$36 co-pay
Tier 3 (Preferred Brand)	$37 co-pay	$74 co-pay	$111 co-pay
Tier 4 (Non-preferred Drugs)	31% of the cost	31% of the cost	31% of the cost
Tier 5 (Specialty Tier)	30% of the cost	Not offered	Not offered
Tier 6 (Select Care Drugs)	$0 co-pay	$0 co-pay	$0 co-pay

Standard Mail-Order Cost Sharing			
Tier	**1-month supply**	**2-month supply**	**3-month supply**
Tier 1 (Preferred Generic)	$8 co-pay	$16 co-pay	$24 co-pay
Tier 2 (Generic)	$17 co-pay	$34 co-pay	$51 co-pay
Tier 3 (Preferred Brand)	$47 co-pay	$94 co-pay	$141 co-pay
Tier 4 (Non-preferred Drugs)	33% of the cost	33% of the cost	33% of the cost
Tier 5 (Specialty Tier)	30% of the cost	Not offered	Not offered
Tier 6 (Select Care Drugs)	$0 co-pay	$0 co-pay	$0 co-pay

Preferred Mail-Order Cost Sharing			
Tier	**1-month supply**	**2-month supply**	**3-month supply**
Tier 1 (Preferred Generic)	$3 co-pay	$6 co-pay	$9 co-pay
Tier 2 (Generic)	$12 co-pay	$24 co-pay	$36 co-pay
Tier 3 (Preferred Brand)	$37 co-pay	$74 co-pay	$111 co-pay
Tier 4 (Non-preferred Drugs)	31% of the cost	31% of the cost	31% of the cost
Tier 5 (Specialty Tier)	30% of the cost	Not offered	Not offered
Tier 6 (Select Care Drugs)	$0 co-pay	$0 co-pay	$0 co-pay

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. 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, you pay 35% of the plan's cost for covered brand-name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.

All Tier 6 drugs and a select group of Tier 3 drugs have additional coverage in the coverage gap. Your cost will not increase from the initial coverage co-pay. See the list of covered drugs to determine which drugs are included.

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 the greater of:

- **5% of the cost**, or
- **$3.35 co-pay** for generic (including brand drugs treated as generic) and an **$8.35 co-pay** for all other drugs.

Other Covered Medical Benefits		
	IN-NETWORK	**OUT-OF-NETWORK**
Medicare-covered Chiropractic Care	**You Pay**	**You Pay**
	20% of the cost for manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position)	**50% of the cost** 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	**50% of the cost** for diabetes monitoring supplies
	$0 co-pay for diabetes self-management training	**50% of the cost** for diabetes self-management training
	$0 co-pay for therapeutic shoes or inserts	**50% of the cost** for therapeutic shoes or inserts

Other Covered Medical Benefits		
	IN-NETWORK	**OUT-OF-NETWORK**
Home Health Care	**You Pay**	**You Pay**
	$0 co-pay	**50% of the cost**
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.	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		
	$35 co-pay for group therapy per visit **$35 co-pay** for individual therapy per visit	**50% of the cost** for group therapy per visit **50% of the cost** for individual therapy per visit
Over-the-counter Items		
	Not covered	Not covered
Prosthetic Devices (braces, artificial limbs, etc.)		
Prior authorization is required.	**20% of the cost**	**50% of the cost**
Renal Dialysis		
	20% of the cost	**50% of the cost**

Optional Benefits

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

	IN-NETWORK
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	
	$28 per month. You must keep paying your Medicare Part B premium and your monthly plan premium of $125.
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.

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.