PacificSource Medicare

Summary of Benefits 2020

Essentials Rx 803 (HMO)

Oregon and Washington PERS

Y0021_H3864_MED39_0819_M Accepted 09022019

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 areas includes the following counties in Oregon: Clackamas, Coos, Crook, Curry, Deschutes, Grant, Hood River, Jefferson, Klamath (97731, 97733, 97737, 97739), Lake (97638, 97641, 97735, 97739), Lane, Multnomah, Sherman, Wasco, Washington, Wheeler. Our service area includes the following county in Washington: Clark.

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, 2020–December 31, 2020

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.

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: (800) 735-2900

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 803 (HMO)
	You Pay
Monthly Premium	
You must continue to pay your Medicare Part B premium.	Your total premium is set by the PERS Health Insurance Program (PHIP). Please contact PHIP for more information.
Medical Deductible	
	$0
Pharmacy Deductible	
For all covered drugs.	**$0**
Out-of-pocket Maximum	
The most you pay during the calendar year for in-network covered services.	**$3,400**
Inpatient Hospital Care	
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.	**$125** per day for days 1–4 **$0** for days 5 and beyond
Outpatient Surgery	
Ambulatory surgical center or Outpatient hospital Prior authorization is required for some services.	**$125**
Doctor's Office Visits	
Primary Care Physician (PCP)/Specialty Prior authorization may be required for surgery or treatment services.	PCP - **$15** Specialist - **$20**
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	**$50**
Urgently Needed Services	
	$20
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%**
Diagnostic Tests and Procedures	
	$0
Lab Services	
Prior authorization is required for genetic testing and analysis.	**$0**
Outpatient X-rays	
	10%
Therapeutic Radiology Services	
Prior authorization is required for some radiation services.	**10%**

	ESSENTIALS RX 803 (HMO)
	You Pay
Hearing Services	
Exam to diagnose and treat hearing and balance issues	**$15**
Routine hearing exam (up to one per year)	**$45**
TruHearing™ Flyte Hearing Aids **Flyte Advanced:** Per aid, up to two per year **Flyte Premium:** Per aid, up to two per year	 **$699** **$999**
Dental Services	
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.	**$15**
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.	**$100 reimbursement**
Mental Health Care	
Inpatient Services Prior authorization is required for inpatient mental health care, except in an emergency. 190-day lifetime limit for inpatient care not provided in a general hospital.	**$125** per day for days 1–4 **$0** for days 5 and beyond
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.	**$50**
Transportation	
	Not covered
Part B Drug Coverage	
Prior authorization is required for some drugs.	**20%**

Prescription Drug Benefits

	ESSENTIALS RX 803 (HMO)	
Initial Coverage	When the total drug costs are between **$0** and **$4,020**, you pay:	
Retail Pharmacy	**1 to 31-Day Supply**	**32 to 93-Day Supply**
Tier 1 Preferred Generic	40% of the cost, up to a $250 max	
Tier 2 Generic	40% of the cost, up to a $250 max	
Tier 3 Preferred Brand	40% of the cost, up to a $250 max	40% of the cost, up to a $750 max
Tier 4 Non-preferred	40% of the cost, up to a $250 max	**Generic:** 40% of the cost, up to a $250 max **Brand:** 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 Care	40% of the cost, up to a $250 max	
Coverage Gap	After total drug costs reach **$4,020**, you pay:	
	All covered drugs have the same cost-share as in initial coverage	
Catastrophic Coverage	After your out-of-pocket costs reach **$6,350,** the maximum you pay until the end of the calendar year is:	
All Covered Drugs	You pay $0	

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 Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal. Other pharmacies and providers are available in our network.