PacificSource Medicare

Summary of Benefits 2022

Explorer 16 (PPO)

Missoula, Montana

Y0021_H4754_MED648_0821_M Accepted 08232021

Things to Know About PacificSource Medicare
Explorer 16 (PPO)

Who can join?

To join **PacificSource Medicare Explorer 16 (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes Missoula County in Montana.

Which doctors and hospitals can I use?

You can see our plan's **provider directory** on our website, www.Medicare.PacificSource.com/Search/Provider.

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

Summary of Benefits:
January 1, 2022–December 31, 2022

This is a summary of costs for drug and medical services covered by PacificSource Medicare for the Explorer 16 (PPO) 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. 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

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Monthly Premium		
You must continue to pay your Medicare Part B premium.	**$0**	
Medical Deductible		
	$0	
Out-of-pocket Maximum		
The most you pay during the calendar year for covered services.	**$5,900** Annual limit for Medicare-covered services you receive from in-network providers	**$10,000** Annual limit for Medicare-covered services you receive from both in-network and out-of-network providers combined.
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. Notification from your provider is required upon admission.	**$285** per day for days 1–7 **$0** for days 8 and beyond	**50%**
Outpatient Surgery		
Ambulatory surgical center or Outpatient hospital Prior authorization is required for some services.	**$285**	**50%**
Doctor's Office Visits		
Primary/Specialty Prior authorization may be required for surgery or treatment services.	PCP - **$10** Specialist - **$35**	**50%**
Preventive Care		
For Medicare-approved preventive care. Examples include an annual physical exam, flu shots, and various cancer screenings.	**$0**	**50%**
Emergency Care		
Copay waived if admitted to hospital within 72 hours. Includes Worldwide coverage.	**$90**	
Urgently Needed Services		
Includes Worldwide coverage.	**$40**	
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 - **$190** MRI or PET Scan - **$310**	**50%**
Diagnostic Tests and Procedures		
	$15	**50%**
Lab Services		
Prior authorization is required for genetic testing and analysis.	A1c and Protime Testing - **$0** Genetic Testing - **20%** All other Lab Services - **$15**	**50%**

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Outpatient X-rays		
	$15	**50%**
Therapeutic Radiology Services		
Prior authorization is required for some radiation services.	**20%**	**50%**
Hearing Services		
Exam to diagnose and treat hearing and balance issues.	**$35**	**50%**
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**	**50%**
Dental Services (Routine)		
Routine dental services covered up to a combined $500 annual maximum. Coverage includes the following: **Preventive Services:** • Routine Exam - 1 per calendar year • Cleaning - 1 per calendar year • Bitewing x-ray - 1 per calendar year • Full mouth x-ray, Conebeam, and/or Panorex - 1 per 5 years **Restorative & Extraction Services:** • Pulpotomy: deciduous teeth only • Tooth desensitization • Pulp capping (direct) • Oral Surgery (simple extractions) • Stainless steel crowns • Core build up (tooth requires root canal therapy) • Bone grafting (only covered at time of extraction or implant placement) • Fillings - 1 every 2 calendar years • Root planing/Perio Scaling - 1 every 2 calendar years per quad • Debridement - 1 every 3 years not within 3 years of other prophy • Analgesia/Sedation: only with surgical procedures	Preventive Services: **$0** Restorative & Extraction Services: **30%**	

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Optional Supplemental Comprehensive Dental Plan		
This plan can be purchased for an additional monthly premium and offers all the benefits included under Dental Services (Routine), plus more. This plan 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 - 2 per calendar year • Bitewing x-rays - 2 per calendar year • Full mouth x-ray, Conebeam, and/or Panorex - 1 per 5 years • Fluoride or Fluoride Varnish - 4 per calendar year • And more <u>Restorative & Extraction Services:</u> • Fillings - 1 per 2 calendar years • Simple surgery • Stainless steel crowns • Removal of damaged tissue (debridement) - 1 per 3 years • And more <u>Endodontics, Periodontics, Prosthodontics, Other Oral/Maxillofacial Surgery:</u> • Crowns, inlays, onlays, dentures, or bridges - 1 per 5 years • Root canal therapy - 1 per 3 years per tooth • Implants - 1 per tooth per lifetime • Veneers • Complex surgery • And more	Monthly premium: **$57** (in addition to your monthly plan premium of $0) **$1,000** annual benefit limit for combined services Preventive Services: **$0** Restorative & Extraction Services: **20%** Endodontics, Periodontics, Prosthodontics, Other Oral/ Maxillofacial Surgery: **50%**	
Vision Services		
Medicare-covered eye exam to diagnose and treat glaucoma and diabetic retinopathy.	**$0**	**50%**
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**	

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Mental Health Care		
Inpatient Services Prior authorization is required except in an emergency. Notification from your provider is required upon admission. 190-day lifetime limit for inpatient care not provided in a general hospital.	**$230** per day for days 1–7 **$0** for days 8 and beyond	**50%**
Outpatient Services Per group or individual therapy visit	**$25**	**50%**
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 **$188** per day for days 21–100	**50%**
Physical Therapy		
Prior authorization is required for services beyond $3,000 for physical therapy and speech therapy combined.	**$35**	**50%**
Ambulance		
Per one-way transport. Prior authorization is required for nonemergency transportation. Includes Worldwide coverage.	**Ground: $250** **Air: 20%**	
Transportation		
	Not covered	
Part B Drug Coverage		
Prior authorization or step therapy is required for some drugs.	**20%**	**50%**

Additional Benefits and Programs not included above

	You Pay
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**
Rewards and Incentives	
When you complete one or more of the activities listed in the calendar year, you will receive a gift card redeemable at a variety of popular retailers. Limit one reward per eligible activity completed in the calendar year.	• Routine physical or annual wellness visit: **$50** • Mammogram: **$25** • Diabetic A1c (blood glucose test): **First test: $15; Second test: $25** • Diabetic eye exam: **$25** • Flu Shot: **$10** • Dexa Scan: **$20** • Colonoscopy or Fit kit: **$20**
Silver&Fit® Healthy Aging and Exercise Program	
Includes 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. • 8,000+ 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. Available for in-network providers only.	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. Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. 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