



Summary of Benefits 2021

Essentials Rx 803 (HMO)

PERS Health Insurance Program (PHIP)



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, 2021–December 31, 2021



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. Notification from your provider is required upon admission.

\$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%

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

Routine hearing exam (up to one per year)

\$45**TruHearing™ Flyte Hearing Aids**

Flyte Advanced: Per aid, up to two per year

\$699

Flyte Premium: Per aid, up to two per year

\$999**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.

\$100 reimbursement**Mental Health Care****Inpatient Services**

Prior authorization is required for inpatient mental health care, 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.

\$50

ESSENTIALS RX 803 (HMO)

You Pay

Transportation

Not covered

Part B Drug Coverage

Prior authorization 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 Care Drugs and Vaccines	\$0		

Catastrophic Coverage

After your out-of-pocket costs reach **\$6,550**, 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, 2 & 6, 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 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.

Accessibility help: For assistance reading this document, please call us at (888) 863-3637; TTY 711