PacificSource Medicare

Summary of Benefits 2019

Essentials Rx 803 (HMO)

Oregon and Washington PERS

Y0021_H3864_MED39_0918

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 area includes the following counties in Washington: Clark and Oregon: Coos, Crook, Curry, Deschutes, Grant, Hood River, Jefferson, Klamath*, Lake*, Lane, Sherman, Wasco, Wheeler, Clackamas, Multnomah, and Washington.

*Our service area includes these parts of counties in Oregon: Klamath (97731, 97733, 97737, 97739), Lake (97638, 97641, 97735, 97739).

Which doctors, hospitals, and pharmacies can I use?

PacificSource Medicare Essentials Rx 803 (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. 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?

- **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?

The amount you pay depends on the drug's tier, the pharmacy, and which benefit stage you have reached. See your formulary to locate which tier your drug is on. See the Prescription Drug Benefits page of this document for more detail on the benefit stages: initial coverage, coverage gap, and catastrophic coverage.

Summary of Benefits:
January 1, 2019–December 31, 2019

This is a summary of drug and medical services and costs 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. 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.

	ESSENTIALS RX 803 (HMO)
	You Pay
Monthly Premium	
You must continue to pay your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact PERS Health Insurance Program (PHIP) or your employee group benefits plan administrator. Your total premium is set by PHIP and includes other benefits. Contact PHIP for more information.
Medical Deductible	
	$0
Pharmacy Deductible	
For all covered drugs	**$0**
Out-of-pocket Maximum	
Yearly limit on your out-of-pocket costs for medical and hospital care with in-network providers.	**$3,400**
Inpatient Hospital Care	
Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization is required, except in urgent or emergent situations.	**$125** per day for days 1–4 **$0** for days 5 and beyond
Outpatient Surgery	
Ambulatory surgical center **Outpatient hospital** Prior authorization is required for some services.	**$125** **$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	
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**

	ESSENTIALS RX 803 (HMO)
	You Pay
Outpatient X-rays	
	10%
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)	**$15**
Hearing Aids Reimbursement every two years for hearing aids. Hearing aids discounts also available.	**$250 reimbursement**
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 *There is a limit to how much our plan will pay.*	**$0**
Reimbursement every two 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 the Medicare therapy cap limits.	**$20**
Ambulance	
Per one-way transport. Prior authorization is required for nonemergency transportation.	**$50**
Transportation	
	Not covered

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	You Pay
Part B Drug Coverage	
Prior authorization is required for some drugs.	**20%**
Durable Medical Equipment (wheelchairs, oxygen, etc.)	
Prior authorization may be required for some durable medical equipment (DME).	**20%**
Foot Care (podiatry services)	
Foot exams and treatment if you have diabetic foot disease and/or meet certain conditions	**$15**
Medicare-covered Chiropractic Care	
Spinal manipulation to correct a subluxation	**$15**
Diabetes Supplies and Services	
Diabetes monitoring supplies, self-management training, and therapeutic shoes or inserts	**$0**
Home Health Care	
	$0
Hospice	
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.
Outpatient Substance Abuse	
Group and individual therapy	**$15**
Prosthetic Devices (braces, artificial limbs, etc.)	
Prior authorization may be required.	**$0**
Renal Dialysis	
	$0
Outpatient Rehabilitation	
Prior authorization is required for services beyond the Medicare therapy cap limits.	
Cardiac rehab services Maximum of two one-hour sessions per day for up to 36 sessions up to 36 weeks	**$0**
Pulmonary rehab services	**$0**
Occupational therapy, per visit	**$20**
Speech and language therapy, per visit	**$20**
Fitness Programs (Silver&Fit® Exercise and Healthy Aging Program)	
Gym membership: **Home kits, up to two:**	**$0/year** **$0/year**

Prescription Drug Benefits

	ESSENTIALS RX 803 (HMO)	
Initial Coverage	When the total drug costs[2] are between **$0** and **$3,820**, you pay[1]:	
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**	**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[2] reach **$3,820**, you pay[1]:	
	All covered drugs have the same cost-share as in initial coverage.	
Catastrophic Coverage	After your out-of-pocket costs[3] reach **$5,100,** the maximum you pay[1] 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.

[1] If you're receiving Extra Help (low-income subsidy), your prescription drug deductible and co-pays may be lower.
[2] Total drug costs: what you and others on your behalf pay, and what PacificSource Medicare pays for your prescriptions.
[3] Out-of-pocket costs: everything you and others have paid on your behalf during stages one, two, and three.

Contact Us

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
Toll-free: (888) 530-1428 | **TTY: (800) 735-2900** | **www.Medicare.PacificSource.com**

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.

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal. This information is not a complete description of benefits. Call (888) 863-3637 or 711 for TTY users, for more information. Other pharmacies and providers are available in our network.