PacificSource Medicare

Summary of Benefits 2019

Essentials Choice Rx 14 (HMO-POS)

Central Oregon, Eastern Oregon, and Mid-Columbia Gorge

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Things to Know About PacificSource Medicare
Essentials Choice Rx 14 (HMO-POS)

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-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?

- **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 Choice Rx 14 (HMO-POS) 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.

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Monthly Premium		
You must continue to pay your Medicare Part B premium.	**$116**	
Medical Deductible		
	$0	
Pharmacy Deductible		
For Tier 3, 4, and 5 drugs	**$175**	
Out-of-pocket Maximum		
Yearly limit on your out-of-pocket costs for medical and hospital care with in-network providers.	**$5,500**	NA
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.	**$295** per day for days 1–6 **$0** for days 7 and beyond	**50%**
Outpatient Surgery		
Ambulatory surgical center **Outpatient hospital** Prior authorization is required for some services.	**$295** **$295**	**50%** **50%**
Doctor's Office Visits		
Primary Care Physician (PCP)/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		
Waived if admitted to hospital within 72 hours	**$90**	**$90**
Urgently Needed Services		
	$40	**$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 - **$190** MRI - **$310** PET Scan - **$310** Nuclear Test - **$190**	**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 - **$20**	**50%**
Outpatient X-rays		
	$15	**50%**
Therapeutic Radiology Services		
Prior authorization is required for some radiation services.	**20%**	**50%**

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Hearing Services		
Exam to diagnose and treat hearing and balance issues	**$35**	**50%**
Routine hearing exam (up to one per year)	**$45**	**Not covered**
TruHearing™ Flyte Hearing Aids **Flyte Advanced:** Per aid, up to two per year **Flyte Premium:** Per aid, up to two per year Routine hearing exam and hearing aid co-payments do not count toward out-of-pocket maximum.	 **$699** **$999**	 **Not covered** **Not covered**
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.	**$35**	**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**	**$35**
Eyeglasses or contact lenses after cataract surgery *There is a limit to how much our plan will pay.*	**$0**	**$0**
Reimbursement every 2 years for routine prescription eyeglasses or contact lenses.	**$200 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.	**$275** per day for days 1–6 **$0** for days 7 and beyond	**50%**
Outpatient Services Per group or individual therapy visit	**$20**	**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 **$160** per day for days 21–100	**50%**
Physical Therapy		
Prior authorization is required for services beyond the Medicare therapy cap limits.	**$35**	**50%**
Ambulance		
Per one-way transport. Prior authorization is required for nonemergency transportation.	**$300**	**$300**
Transportation		
	Not covered	Not covered

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Part B Drug Coverage		
Prior authorization is required for some drugs.	**20%**	**50%**
Durable Medical Equipment (wheelchairs, oxygen, etc.)		
Prior authorization may be required for some durable medical equipment (DME).	**20%**	**50%**
Foot Care (podiatry services)		
Foot exams and treatment if you have diabetic foot disease and/or meet certain conditions	**$35**	**50%**
Medicare-covered Chiropractic Care		
Spinal manipulation to correct a subluxation	**20%**	**50%**
Diabetes Supplies and Services		
Diabetes monitoring supplies, self-management training, and therapeutic shoes or inserts	**$0**	**50%**
Home Health Care		
	$0	**50%**
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	**$35**	**50%**
Prosthetic Devices (braces, artificial limbs, etc.)		
Prior authorization may be required.	**$0 internally implanted** **20% all other**	**50%**
Renal Dialysis		
	20%	**50%**
Outpatient Rehabilitation		
Prior authorization is required for services beyond the Medicare therapy cap limits.		
Cardiac rehab services	**$35**	**50%**
Pulmonary rehab services, per visit	**$30**	**50%**
Occupational therapy, per visit	**$20**	**50%**
Speech and Language Therapy, per visit	**$35**	**50%**
Coverage Limits		
	Our plans have a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	**$2,500** benefit limit for elective (non-emergency) services with out-of-network providers

Prescription Drug Benefits

	ESSENTIALS CHOICE RX 14 (HMO-POS)	
Stage 1		
Pharmacy Deductible	**$0** on Tiers 1, 2, and 6 **$175** on Tiers 3, 4, and 5	
Stage 2	When the total drug costs[2] are between **$0** and **$3,820**, you pay[1]:	
Retail Pharmacy (30-day supply)*	**Preferred Pharmacy**	**Standard Pharmacy**
Tier 1 Preferred Generic	**$3**	**$8**
Tier 2 Generic	**$12**	**$17**
Tier 3 Preferred Brand	**$37**	**$47**
Tier 4 Non-preferred	**31%**	**33%**
Tier 5 Specialty Tier	**29%** (30-day supply only)	
Tier 6 Select Care	**$0**	**$0**
Stage 3	After total drug costs[2] reach **$3,820**, you pay[1]:	
Most Generic	**37%**	
Most Brand	**25%**	
Select Drugs in Tier 3 **All Drugs in Tier 6**	All Tier 6 drugs and a select group of Tier 3 drugs have additional coverage during Stage Three (coverage gap). Your cost will not increase from Stage Two to Stage Three. See the list of covered drugs to determine which drugs are included.	
Stage 4	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	Whichever is the larger amount: **5%** of the cost OR **$3.40** for generic drugs **$8.50** all other drugs	

Save with Mail Order: Receive a 90-day supply for the same cost as a 60-day supply for medications in Tiers 1, 2, 3 & 6, through CVS Caremark. Shipping is free and auto-refills are available.

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 standard, mail-order, Long Term Care (LTC) or home infusion, and 30-, 60-, or 90-day supply.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

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.

*A 60-day supply is available for 2 co-pays, and **a 90-day supply is available for 3 co-pays at retail prices.**

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Fitness Programs (Silver&Fit® Exercise and Healthy Aging Program)		
Gym membership: **Home kits, up to two:**	**$0/year** **$0/year**	**Not covered**
Alternative Care		
Acupuncture, naturopathy, and non-Medicare covered chiropractic care	**$20** (up to $450 combined benefit limit for these services per calendar year.)	**Not covered**
Over-the-counter Medications		
Reimbursement per year for purchase of over-the-counter (OTC) aspirin, calcium, and calcium-vitamin D combinations.	**$100 reimbursement**	
Office Visits for $0 Co-pay		
$0 co-pay for Primary Care Provider (PCP) office visits for new or existing conditions when included with an annual wellness visit or annual routine physical visit. This means there are no surprise office visit co-pays when you receive your annual wellness visit or annual routine physical.	**$0** when received in conjunction with annual wellness or annual routine physical exam with primary care provider	
Dexa Scan		
Bone density diagnostic screenings	**$0**	**50%**
Colonoscopy Diagnostic Screenings		
	$0	**50%**
Chronic Care Management		
PCP or Specialist visit focusing on complex chronic care management services	**$0**	**50%**
Transitional Care Management		
PCP or Specialist visit following discharge from an inpatient hospital setting	**$0**	**50%**

Optional Benefits

You must pay an extra premium each month for these benefits.	IN-NETWORK You Pay
Preventive Dental	
	$0 for the following: • 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. This premium is in addition to your monthly plan premium of $116.
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.

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.