PacificSource Medicare

Summary of Benefits 2021

Essentials Choice Rx 14 (HMO-POS)

Central Oregon, Eastern Oregon, and Mid-Columbia Gorge

Y0021_H3864_MED36_0820_M Accepted 08232020

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, Klamath (97731, 97733, 97737, 97739), Sherman, Wasco, and Wheeler.

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 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. 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

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Monthly Premium		
You must continue to pay your Medicare Part B premium.	**$99**	
Medical Deductible		
	$0	
Pharmacy Deductible		
For Tier 3, 4, and 5 drugs	**$100**	
Out-of-pocket Maximum		
The most you pay during the calendar year for covered services.	**$5,500**	N/A
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.	**$295** per day for days 1–6 **$0** for days 7 and beyond	**50%**
Outpatient Surgery		
Ambulatory surgical center or Outpatient hospital Prior authorization is required for some services.	**$295**	**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		
Copay 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 - **$225** MRI - **$310** PET Scan - **$310** Nuclear Test - **$225**	**50%**
Diagnostic Tests and Procedures		
	$15	**50%**

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
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%**
Hearing Services		
Exam to diagnose and treat hearing and balance issues	**$35**	**50%**
Routine hearing exam (up to one per year)	**$0**	**Not covered**
TruHearing™ Flyte Hearing Aids		
Flyte Advanced: Per aid, up to two per year	**$699**	**Not covered**
Flyte Premium: Per aid, up to two per year	**$999**	**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%**
Optional Preventive Dental Services		
This plan covers preventive services, such as cleanings, routine exams, and X-rays from any dentist who accepts our payment as payment in full.	**$29** monthly premium (in addition to your monthly plan premium of $99)	
Optional Comprehensive Dental Services		
This plan offers all the benefits of preventive dental with the addition of coverage for Class II and Class III services. Examples of Class II services are fillings and simple extractions. Class III are major services, such as complex oral surgery, crowns, bridges, and dentures.	**$50** monthly premium (in addition to your monthly plan premium of $99)	

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
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**	**$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. Notification from your provider is required upon admission. 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	**$30**	**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 **$184** 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.	**$300**	**$300**
Transportation		
	Not covered	Not covered
Part B Drug Coverage		
Prior authorization is required for some drugs.	**20%**	**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 **$100** on Tiers 3, 4, and 5	
Stage 2	When the total drug costs are between **$0** and **$4,130**, you pay:	
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	**31%** (30-day supply only)	
Tier 6 Select Care	**$0**	**$0**
Stage 3	After total drug costs reach **$4,130**, you pay:	
Tiers 1, 2, 3, 4, and 5	**25%**	
Tier 6 Select Care	All Tier 6 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 reach **$6,550,** the maximum you pay until the end of the calendar year is:	
All Covered Drugs	Whichever is the larger amount: **5%** of the cost OR **$3.70** for generic drugs **$9.20** all other drugs	

Save even more 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 (our preferred mail-order pharmacy).

Other benefits of our mail order service:

- Free shipping
- Auto-refills available
- $0 copay for Preferred Generic (Tier 1) drugs.

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.

Optional Benefits

You must pay an extra premium each month for these benefits.

With either dental option, members can see any licensed dentist in the United States

For all our dental plans, 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.

	You Pay
Comprehensive Dental	
Monthly Premium	**$50**
Deductible	**$100** (applies to Class II and Class III services only)
Coverage Limits	**$1,000** annual benefit limit for covered services
Diagnostic Services (Preventive Class I)	**$0**
Restorative & Extraction Services (Basic Class II)	**20%**
Endodontics, periodontics, etc. (Major Class III)	**50%**

	You Pay
Preventive Dental	
Monthly Premium	**$29**
• 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)	**$0**

PacificSource Community Health Plans is an HMO/PPO plan with a Medicare contract. 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