

# 2017 PacificSource Medicare Advantage Plan Information

Thank you for your interest in applying for the PacificSource Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from PacificSource within 7 days of the application receipt.

## Enrollment Packet – click links below to view the information

Star Rating: [HMO](#) / [PPO](#)

[Apply Online](#)

Download Application: [Central OR](#) / [Coos & Curry](#) / [Lane County](#) / [PDX](#)

Summary of Benefits: [Essentials 2](#) / [Essentials RX 6](#) / [Essentials Choice Rx 14](#) / [Essentials RX 26](#) / [Explorer RX 4](#) / [Explorer RX 7](#) / [Explorer 8](#) / [MyCare Rx 22](#)

[Provider Directory](#)

[Formulary](#)

[Appeals and Grievance information](#)

[Low Income Subsidy](#)

[Multi-language Support](#)

### Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15<sup>th</sup> to December 7<sup>th</sup>. This will give you a January 1<sup>st</sup> effective date for your new plan.

### Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15<sup>th</sup> and December 7<sup>th</sup>. ***If they are signed prior to October 15<sup>th</sup> they will be returned to you with a new application.*** If they are received after December 7<sup>th</sup>, you will not be able to change plans until the next AEP for January of the following year.

### Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc...

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

**CDA Insurance LLC**

PO Box 26540

Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470

Secure File Upload: [Click here](#)

Email: [cs@cda-insurance.com](mailto:cs@cda-insurance.com)

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: <http://www.orhi.us>

Y0062\_MULTIPLAN\_CDA INSURANCE Oregon Accepted effective 7/31/2016



# Essentials Choice Rx 14 (HMO-POS) Summary of Benefits

Central Oregon, Eastern Oregon, and Mid-Columbia Gorge  
January 1, 2017 – December 31, 2017

This booklet gives you 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. This information is not a complete description of benefits. Contact the plan for more information. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

## **You have choices about how to get your Medicare benefits**

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)**).

## **Tips for comparing your Medicare choices**

This Summary of Benefits booklet gives you a summary of what **PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)** covers and what you pay.

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on [Medicare.gov](http://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 [Medicare.gov](http://Medicare.gov) or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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.

## **Sections in this booklet**

- Things to Know About **PacificSource Medicare Essentials Choice Rx 14 (HMO-POS)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

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

## Hours of Operation

- From October 1 to February 14, you can call us seven days a week from 8:00 a.m. to 8:00 p.m. Pacific time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Pacific time.

## Phone Numbers and Website

- If you are a member of this plan, call toll-free (888) 863-3637. TTY users call (800) 735-2900.
- If you are not a member of this plan, call toll-free (888) 863-3637. TTY users call (800) 735-2900.
- Our website: Medicare.PacificSource.com

## 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\*, Lake\*, Sherman, Wasco, and Wheeler.

\* denotes partial county

## 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. If you use the providers that are not in our network, the plan may not pay for these services. Out-of-network/non-contracted providers are under no obligation to treat PacificSource Community Health Plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

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 pharmacy directory at our website [Medicare.PacificSource.com/Search/Pharmacy](https://www.Medicare.PacificSource.com/Search/Pharmacy).

You can see our plan's provider directory at our website [Medicare.PacificSource.com/Search/Provider](https://www.Medicare.PacificSource.com/Search/Provider)

Or, call us and we will send you a copy of the provider and pharmacy directories.

## What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and more.

- **Our plan members get all 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 more 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, [Medicare.PacificSource.com/Search/Drug](http://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?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

## Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

### How much is the monthly premium?

\$127 per month. You must continue to pay your Medicare Part B premium.

### How much is the deductible?

This plan does not have a deductible on covered medical and hospital benefits. This plan does have a deductible of \$150 for Tier 3, 4, and 5 drugs.

### Is there any limit on how much I will pay for my covered services?

Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Your yearly limit(s) in this plan:

- \$5,500 for Medicare-covered services you receive from in-network providers.
- \$2,500 benefit limit for POS out-of-network services received.

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

## Is there a limit on how much the plan will pay?

Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

## Covered Medical and Hospital Benefits

### Inpatient Hospital Care

Our plan covers an unlimited number of days for an inpatient hospital stay.

**When in-network: Prior authorization is required, except in urgent or emergent situations.**

In-network:

- \$300 co-pay per day for days 1 through 6
- You pay nothing per day for days 7 and beyond

Out-of-network:

- 50% of the cost per stay. There is a limit to how much our plan will pay.

### Doctor's Office Visits

**No prior authorization required except as noted below. When in-network: Prior authorization may be required for surgery or treatment services. When in-network: Prior authorization is required for non-routine dental care.**

Primary care physician visit:

- In-network: \$20 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Specialist visit:

- In-network: \$40 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

### Preventive Care

- In-network: You pay nothing for Medicare-approved Preventive Care.
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Our plan covers many preventive services, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services

- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots. Vaccines received at your provider's office may incur an administration fee
- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Any additional preventive services approved by Medicare during the contract year will be covered.

## Emergency Care

\$75 co-pay

If you are admitted to the hospital within 72 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.

## Urgently Needed Services

\$35 co-pay

## Diagnostic Tests, Lab and Radiology Services, and X-Rays

(Costs for these services may vary based on place of service)

Diagnostic radiology services (such as MRIs, CT scans):

- In-network: \$180-\$300 co-pay, depending on the service.
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

**When in-network: Prior authorization is required for Advanced/complex imaging such as: CT scan, MRI, PET Scan, Nuclear Test.**

Diagnostic tests and procedures:

- In-network: \$15 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Lab services:

- In-network: \$0-25 co-pay, depending on the service
  - Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.
- When in-network: Prior authorization is required for genetic testing and analysis.**

Outpatient x-rays:

- In-network: \$15 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Therapeutic radiology services (such as radiation treatment for cancer):

- In-network: 20% of the cost
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

**When in-network: Prior authorization is required for some radiation services.**

## Hearing Services

Exam to diagnose and treat hearing and balance issues:

- In-network: \$40 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Routine hearing exam (for up to 1 every year):

- In-network: \$45 co-pay
- Out-of-network: Not covered

Up to two TruHearing™ Flyte hearing aids per year. Benefit is limited to TruHearing Flyte 700 and Flyte 900 hearing aids. You must see a TruHearing provider to use this benefit.

- \$699 co-pay per aid for Flyte 700
- \$999 co-pay per aid for Flyte 900

Routine hearing exam and hearing aid copayments do not count towards out-of-pocket maximum.

## Dental Services

Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):

- In-network: \$40 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.  
**When in-network: Prior authorization is required for non-routine dental care.**

## Vision Services

Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):

- In-network: \$0
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Routine eye exam:

- In-network: \$40 co-pay. You are covered for up to 1 every two years.
- Out-of-network: 50% of the cost. There may be a limit to how often these services are covered.

There is a limit to how much our plan will pay from an out-of-network provider.

Eyeglasses or contact lenses after cataract surgery:

- In-network: You pay nothing
- Out-of-network: You pay nothing. There is a limit to how much our plan will pay.
- There is a limit to how much our plan will pay from an out-of-network provider.

Our plan pays up to \$200 every two years for routine prescription eyeglasses and/or contact lenses

## Mental Health Care

Inpatient visit:

In-network:

- \$265 co-pay per day for days 1 through 6
- You pay nothing per day for days 7 and beyond

Out-of-network:

- 50% of the cost per stay. There is a limit to how much our plan will pay.

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The 190-day limit does not apply to inpatient mental services provided in a general hospital. **When in-network: Prior authorization is required for inpatient mental health care, except in an emergency.**

Outpatient group therapy visit:

- In-network: \$40 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Outpatient individual therapy visit:

- In-network: \$40 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

**No prior authorization required for outpatient mental health care.**

## **Skilled Nursing Facility (SNF)**

**When in-network: Prior authorization is required. Limited up to 100 days per benefit period. No prior hospital stay is required.**

In-network:

- You pay nothing per day for days 1 through 20
- \$160 co-pay per day for days 21 through 100

Out-of-network: 50% of the cost per stay. There is a limit to how much our plan will pay.

## **Outpatient Rehabilitation**

Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):

- In-network: \$35 co-pay Pulmonary rehab services: \$30 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Occupational therapy visit:

- In-network: \$35 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Physical therapy and speech and language therapy visit.

- In-network: \$35 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

**When in-network: Prior authorization is required for services beyond the Medicare therapy cap limits.**

## **Ambulance**

**When in-network: Prior authorization is required for non-emergency transportation.**

\$295 co-pay



## Transportation

Not covered

## Foot Care (podiatry services)

Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:

- In-network: \$40 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

## Durable Medical Equipment (wheelchairs, oxygen, etc.)

**When in-network: Prior authorization may be required for some Durable Medical Equipment (DME).**

- In-network: 20% of the cost
- Out-of-network: 50% of the cost, depending on the equipment. There is a limit to how much our plan will pay.

## Wellness Programs

Silver&Fit® Exercise and Healthy Aging Program

\$50/year for gym membership; \$10/year for home kits

## Part B Drug Coverage

**When in-network: Prior authorization is required for some drugs. Contact the plan for more information.**

In-network: 20% of the cost

Out-of-network: 50% of the cost

# Prescription Drug Benefits

## Initial Coverage

You pay the following until your total yearly drug costs reach \$3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

This plan has a deductible of \$150 for Tier 3, 4 and 5 drugs.

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 non-preferred, mail-order, Long Term Care (LTC) or home infusion, and 30 or 90 days supply.

## Standard Retail Cost-Sharing

<b>Tier</b>	<b>1-month supply</b>	<b>2-month supply</b>	<b>3-month supply</b>
Tier 1 (Preferred Generic)	\$7 co-pay	\$14 co-pay	\$21 co-pay
Tier 2 (Generic)	\$17 co-pay	\$34 co-pay	\$51 co-pay
Tier 3 (Preferred Brand)	\$47 co-pay	\$94 co-pay	\$141 co-pay
Tier 4 (Non-Preferred Drugs)	\$100 co-pay	\$200 co-pay	\$300 co-pay
Tier 5 (Specialty Tier)	30% of the cost	Not Offered	Not Offered
Tier 6 (Select Care Drugs)	\$0	\$0	\$0

## Preferred Retail Cost-Sharing

<b>Tier</b>	<b>1-month supply</b>	<b>2-month supply</b>	<b>3-month supply</b>
Tier 1 (Preferred Generic)	\$2 co-pay	\$4 co-pay	\$6 co-pay
Tier 2 (Generic)	\$12 co-pay	\$24 co-pay	\$36 co-pay
Tier 3 (Preferred Brand)	\$37 co-pay	\$74 co-pay	\$111 co-pay
Tier 4 (Non-Preferred Drugs)	\$90 co-pay	\$180 co-pay	\$270 co-pay
Tier 5 (Specialty Tier)	30% of the cost	Not Offered	Not Offered
Tier 6 (Select Care Drugs)	\$0	\$0	\$0

## Standard Mail Order Cost-Sharing

Tier	1-month supply	2-month supply	3-month supply
Tier 1 (Preferred Generic)	\$7 co-pay	\$14 co-pay	\$21 co-pay
Tier 2 (Generic)	\$17 co-pay	\$34 co-pay	\$51 co-pay
Tier 3 (Preferred Brand)	\$47 co-pay	\$94 co-pay	\$141 co-pay
Tier 4 (Non-Preferred Drugs)	\$100 co-pay	\$200 co-pay	\$300 co-pay
Tier 5 (Specialty Tier)	30% of the cost	Not Offered	Not Offered
Tier 6 (Select Care Drugs)	\$0	\$0	\$0

## Preferred Mail Order Cost-Sharing

Tier	1-month supply	2-month supply	3-month supply
Tier 1 (Preferred Generic)	\$2 co-pay	\$4 co-pay	\$6 co-pay
Tier 2 (Generic)	\$12 co-pay	\$24 co-pay	\$36 co-pay
Tier 3 (Preferred Brand)	\$37 co-pay	\$74 co-pay	\$111 co-pay
Tier 4 (Non-Preferred Drugs)	\$90 co-pay	\$180 co-pay	\$270 co-pay
Tier 5 (Specialty Tier)	30% of the cost	Not Offered	Not Offered
Tier 6 (Select Care Drugs)	\$0	\$0	\$0

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

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

## Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,700.

After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total \$4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier.

All Tier 6 drugs and a select group of Tier 3 and 4 drugs have additional coverage in the Coverage Gap. Your cost will not increase from the Initial Coverage co-pay. See the list of covered drugs to determine which drugs are included.

## Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,950, you pay the greater of:

- 5% of the cost, or
- \$3.30 co-pay for generic (including brand drugs treated as generic) and a \$8.25 co-pay for all other drugs.

## Other covered medical benefits

### Acupuncture

Not covered

### Chiropractic Care

Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):

- In-network: \$20 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

### Diabetes Supplies and Services

Diabetes monitoring supplies:

- In-network: You pay nothing
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Diabetes self-management training:

- In-network: You pay nothing
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Therapeutic shoes or inserts:

- In-network: You pay nothing
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

### Home Health Care

**When in-network: Prior authorization is required.**

- In-network: You pay nothing
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

### Hospice

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. Hospice is covered outside of our plan. Please contact us for more details.

## Outpatient Substance Abuse

Group therapy visit:

- In-network: \$40 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Individual therapy visit:

- In-network: \$40 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

## Outpatient Surgery

**When in-network: Prior authorization is required for some services.**

Ambulatory surgical center:

- In-network: \$300 co-pay
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

Outpatient hospital:

- In-network: \$300 co-pay, depending on the service
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

## Over-the-Counter Items

Not Covered

## Prosthetic Devices (braces, artificial limbs, etc.)

**When in-network: Prior authorization is required.**

- In-network: 0%-20% of the cost, depending on the device
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

## Renal Dialysis

- In-network: 20% of the cost
- Out-of-network: 50% of the cost. There is a limit to how much our plan will pay.

## Optional Benefits (you must pay an extra premium each month for these benefits)

**Package 1: Preventive Dental** benefits include: Preventive Dental

**How much is the monthly premium?** Additional \$28 per month. You must keep paying your Medicare Part B premium and your \$127 monthly plan premium.

**How much is the deductible?** This package does not have a deductible.

**Is there any limit on how much the plan will pay?** No. There is no limit to how much our plan will pay for benefits in this package.

PacificSource Community Health Plans is an HMO/HMO-POS/PPO Plan with a Medicare contract. Enrollment in PacificSource Medicare depends on contract renewal. Limitations, co-payments, and restrictions may apply. Benefits, premium, and co-payments/co-insurance may change on January 1 of each year. The formulary, pharmacy network, and provider network may change at any time. You will receive notice when necessary. The Silver&Fit® Program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). All programs and services may not be available in all areas. Silver&Fit® is a registered trademark of ASH and used with permission herein. TruHearing™ is a registered trademark of TruHearing, Inc.