PacificSource Medicare

Essentials Choice Rx 24 (HMO-POS)

Southwestern Idaho

Summary of Benefits

January 1, 2016 – December 31, 2016

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. 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 24 (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **PacificSource Medicare Essentials Choice Rx 24 (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 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.

Sections in this booklet:

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.

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Things to Know About PacificSource Medicare Essentials Choice Rx 24 (HMO-POS)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Mountain time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Mountain time.

PacificSource Medicare Essentials Choice Rx 24 (HMO-POS) 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: www.Medicare.PacificSource.com

Who can join?

To join **PacificSource Medicare Essentials Choice Rx 24 (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 Idaho: Ada, Blaine, Boise, Camas, Canyon, Elmore, Gooding, Jerome, Lincoln, Owyhee, Twin Falls, and Valley.

Which doctors, hospitals, and pharmacies can I use?

PacificSource Medicare Essentials Choice Rx 24 (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network.

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 at our website www.Medicare.PacificSource.com/Tools/ProviderDirectory.aspx.

You can see our plan's pharmacy directory at our website www.Medicare.PacificSource.com/Tools/PharmacySearch.aspx.

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, www.Medicare.PacificSource.com/Tools/DrugSearch.aspx.

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.

Summary of Benefits

January 1, 2016 – December 31, 2016

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

How much is the monthly premium?	$65 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
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: • $5,000 for services you receive from in-network providers. 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 benefits from any provider. Contact us for services that apply.

Covered Medical and Hospital Benefits

Note:

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

Outpatient Care and Services

Acupuncture	Not covered
Ambulance[1]	• In-network: $200 co-pay • Out-of-network: $200 copay. There is a limit to how much our plan will pay.
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: 30% of the cost. There is a limit to how much our plan will pay.
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $30 co-pay • Out-of-network: 30% 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: 30% 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: 30% 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: 30% of the cost. There is a limit to how much our plan will pay.
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for these services may vary based on place of service)[1]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: 20% of the cost • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Diagnostic tests and procedures: • In-network: $15 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Lab services: • In-network: $0-15 co-pay, depending on the service • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Outpatient x-rays: • In-network: $15 co-pay • Out-of-network: 30% 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: 30% of the cost. There is a limit to how much our plan will pay.
Doctor's Office Visits[1]	Primary care physician visit: • In-network: You pay nothing • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Specialist visit: • In-network: $30 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay.
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	• In-network: 20% of the cost • Out-of-network: 0-30% of the cost, depending on the equipment. There is a limit to how much our plan will pay.
Emergency Care	$75 co-pay If you are immediately admitted to the hospital, 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.

Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $30 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay.
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $30 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Routine hearing exam: • In-network: $30 co-pay. You are covered for up to 1 every year. • Out-of-network: 30% of the cost. There may be a limit to how often these services are covered.
Home Health Care[1]	• In-network: You pay nothing • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay.

Mental Health Care[1]	Inpatient visit:
	Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.
	
	Our plan covers 90 days for an inpatient hospital stay.
	
	Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.
	
	• In-network:
	  ○ $225 co-pay per day for days 1 through 6
	  ○ You pay nothing per day for days 7 through 90
	• Out-of-network:
	  ○ 30% of the cost per stay. There is a limit to how much our plan will pay.
	
	Outpatient group therapy visit:
	• In-network: $30 co-pay
	• Out-of-network: 30% of the cost. There is a limit to how much our plan will pay.
	
	Outpatient individual therapy visit:
	• In-network: $30 co-pay
	• Out-of-network: 30% of the cost. There is a limit to how much our plan will pay.

Outpatient Rehabilitation[1]	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: $30 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Occupational therapy visit: • In-network: $30 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay.

	Physical therapy and speech and language therapy visit: • In-network: $30 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay.
Outpatient Substance Abuse	Group therapy visit: • In-network: $30 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Individual therapy visit: • In-network: $30 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay.
Outpatient Surgery[1]	Ambulatory surgical center: • In-network: $100 co-pay • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Outpatient hospital: • In-network: $0-225 co-pay, depending on the service • Out-of-network: 30% 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.)[1]	Prosthetic devices: • In-network: 0-20% of the cost, depending on the device • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Related medical supplies: • In-network: 0-20% of the cost, depending on the supply • Out-of-network: 30% 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: 30% of the cost. There is a limit to how much our plan will pay.
Transportation	Not covered
Urgently Needed Services	$30 co-pay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-30 co-pay, depending on the service • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Routine eye exam: • In-network: $30 co-pay. You are covered for up to 1 every two years. • Out-of-network: 30% 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. Contact lenses: • In-network: $0 co-pay • Out-of-network: $0 co-pay

Vision Services	Eyeglasses (frames and lenses): • In-network: $0 co-pay • Out-of-network: $0 co-pay Eyeglass frames: • In-network: $0 co-pay • Out-of-network: $0 co-pay Eyeglass lenses: • In-network: $0 co-pay • Out-of-network: $0 co-pay 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. Our plan pays up to $100 every two years for eyewear from an in-network provider. There is a limit to how much our plan will pay from an out-of-network provider.
Preventive Care	
	• In-network: You pay nothing • Out-of-network: 30% 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 • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
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.

Inpatient Care

Inpatient Hospital Care[1]	Our plan covers an unlimited number of days for an inpatient hospital stay.
	• In-network:
	  ○ $225 co-pay per day for days 1 through 6
	  ○ You pay nothing per day for days 7 through 90
	  ○ You pay nothing per day for days 91 and beyond
	• Out-of-network:
	  ○ 30% of the cost per stay. There is a limit to how much our plan will pay.

Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.

Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF.
	• In-network:
	  ○ You pay nothing per day for days 1 through 20
	  ○ $150 co-pay per day for days 21 through 100
	• Out-of-network:
	  ○ 30% of the cost per stay

Prescription Drug Benefits

How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • In-network: 20% of the cost • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay. Other Part B drugs[1]: • In-network: 20% of the cost • Out-of-network: 30% of the cost. There is a limit to how much our plan will pay.

Initial Coverage

You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$5 co-pay	$15 co-pay
Tier 2 (Generic)	$17 co-pay	$51 co-pay
Tier 3 (Preferred Brand)	$47 co-pay	$141 co-pay
Tier 4 (Non-Preferred Brand)	$100 co-pay	$300 co-pay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered
Tier 6 (Select Care Drugs)	$0	$0

Preferred Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Generic)	$12 co-pay	$36 co-pay
Tier 3 (Preferred Brand)	$37 co-pay	$111 co-pay
Tier 4 (Non-Preferred Brand)	$90 co-pay	$270 co-pay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered
Tier 6 (Select Care Drugs)	$0	$0

Standard Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$5 co-pay	$15 co-pay
Tier 2 (Generic)	$17 co-pay	$51 co-pay
Tier 3 (Preferred Brand)	$47 co-pay	$141 co-pay
Tier 4 (Non-Preferred Brand)	$100 co-pay	$300 co-pay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered
Tier 6 (Select Care Drugs)	$0	$0

Preferred Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Generic)	$12 co-pay	$36 co-pay
Tier 3 (Preferred Brand)	$37 co-pay	$111 co-pay
Tier 4 (Non-Preferred Brand)	$90 co-pay	$270 co-pay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered
Tier 6 (Select Care Drugs)	$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 $3,310.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, 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. See the chart that follows to find out how much it will cost you.

Standard Retail Cost-Sharing

Tier	Drugs Covered	One-month supply	Three-month supply
Tier 3 (Preferred Brand)	Some	$47 co-pay	$141 co-pay
Tier 4 (Non-Preferred Brand)	Some	$100 co-pay	$300 co-pay
Tier 6 (Select Care Drugs)	All	$0	$0

Preferred Retail Cost-Sharing

Tier	Drugs Covered	One-month supply	Three-month supply
Tier 3 (Preferred Brand)	Some	$37 co-pay	$111 co-pay
Tier 4 (Non-Preferred Brand)	Some	$90 co-pay	$270 co-pay
Tier 6 (Select Care Drugs)	All	$0	$0

Standard Mail Order Cost-Sharing

Tier	Drugs Covered	One-month supply	Three-month supply
Tier 3 (Preferred Brand)	Some	$47 co-pay	$141 co-pay
Tier 4 (Non-Preferred Brand)	Some	$100 co-pay	$300 co-pay
Tier 6 (Select Care Drugs)	All	$0	$0

Preferred Mail Order Cost-Sharing

Tier	Drugs Covered	One-month supply	Three-month supply
Tier 3 (Preferred Brand)	Some	$37 co-pay	$111 co-pay
Tier 4 (Non-Preferred Brand)	Some	$90 co-pay	$270 co-pay
Tier 6 (Select Care Drugs)	All	$0	$0

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of:

- 5% of the cost, or
- $2.95 co-pay for generic (including brand drugs treated as generic) and a $7.40 co-payment for all other drugs.

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 $24 per month. You must keep paying your Medicare Part B premium and your $65 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/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. Other Physicians/Providers are available in our network.