PacificSource Medicare

Explorer 10 (PPO)

Eastern 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 Explorer 10 (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **PacificSource Medicare Explorer 10 (PPO)** 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 Explorer 10 (PPO)

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 Explorer 10 (PPO) 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 Explorer 10 (PPO)**, 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: Bannock, Bingham, Bonneville, Jefferson, and Madison.

Which doctors and hospitals can I use?

PacificSource Medicare Explorer 10 (PPO) has a network of doctors, hospitals, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

You can see our plan's provider directory at our website

www.Medicare.PacificSource.com/Tools/ProviderDirectory.aspx.

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

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.

PacificSource Medicare Explorer 10 (PPO) covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does **not** cover Part D prescription drugs.

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?	$49 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: • $3,400 for services you receive from in-network providers. • $3,400 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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.
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

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: $155 co-pay • Out-of-network: $155 co-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
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $35 co-pay • Out-of-network: 30% of the cost

Diabetes Supplies and Services	Diabetes monitoring supplies: • In-network: You pay nothing • Out-of-network: 30% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: 30% of the cost Therapeutic shoes or inserts: • In-network: You pay nothing • Out-of-network: 30% of the cost
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 Diagnostic tests and procedures: • In-network: $15 co-pay • Out-of-network: 30% of the cost Lab services: • In-network: $0-15 co-pay, depending on the service • Out-of-network: 30% of the cost Outpatient x-rays: • In-network: $15 co-pay • Out-of-network: 30% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 20% of the cost • Out-of-network: 30% of the cost
Doctor's Office Visits[1]	Primary care physician visit: • In-network: $15 co-pay • Out-of-network: $25 co-pay Specialist visit: • In-network: $35 co-pay • Out-of-network: $45 co-pay
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	• In-network: 30% of the cost • Out-of-network: 0-30% of the cost, depending on the equipment
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: $35 co-pay • Out-of-network: 30% of the cost
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $35 co-pay • Out-of-network: 30% of the cost Routine hearing exam (for up to 1 every year): • In-network: $35 co-pay • Out-of-network: 30% of the cost

Home Health Care[1]	• In-network: 20% of the cost • Out-of-network: 30% of the cost
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: o $250 co-pay per day for days 1 through 7 o You pay nothing per day for days 8 through 90 • Out-of-network: o $350 co-pay per day for days 1 through 7 o You pay nothing per day for days 8 through 90 Outpatient group therapy visit: • In-network: $40 co-pay • Out-of-network: 30% of the cost Outpatient individual therapy visit: • In-network: $40 co-pay • Out-of-network: 30% of the cost
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: $35 co-pay • Out-of-network: 30% of the cost Occupational therapy visit: • In-network: $35 co-pay • Out-of-network: 30% of the cost Physical therapy and speech and language therapy visit: • In-network: $35 co-pay • Out-of-network: 30% of the cost
Outpatient Substance Abuse	Group therapy visit: • In-network: $35 co-pay • Out-of-network: 30% of the cost Individual therapy visit: • In-network: $35 co-pay • Out-of-network: 30% of the cost
Outpatient Surgery[1]	Ambulatory surgical center: • In-network: $250 co-pay • Out-of-network: $350 co-pay Outpatient hospital: • In-network: $0-250 co-pay, depending on the service • Out-of-network: $0-350 co-pay, depending on the service
Over-the-Counter Items	Not Covered

Prosthetic Devices (braces, artificial limbs, etc.)[1]	Prosthetic devices: • In-network: 0-30% of the cost, depending on the device • Out-of-network: 0-30% of the cost, depending on the device Related medical supplies: • In-network: 0-30% of the cost, depending on the supply • Out-of-network: 0-30% of the cost, depending on the supply
Renal Dialysis	• In-network: 20% of the cost • Out-of-network: 30% of the cost
Transportation	Not covered
Urgently Needed Services	$35 co-pay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-35 co-pay, depending on the service • Out-of-network: 30% of the cost Routine eye exam (for up to 1 every two years): • In-network: $35 co-pay • Out-of-network: 30% of the cost Contact lenses: • In-network: $0 co-pay • Out-of-network: $0 co-pay 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 Our plan pays up to $100 every two years for eyewear from any provider.
Preventive Care	
	• In-network: You pay nothing • Out-of-network: 30% of the cost 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:
	  ○ $250 co-pay per day for days 1 through 7
	  ○ You pay nothing per day for days 8 through 90
	  ○ You pay nothing per day for days 91 and beyond
	• Out-of-network:
	  ○ $350 co-pay per day for days 1 through 7
	  ○ You pay nothing per day for days 8 and beyond

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:
	  ○ $40 co-pay per day for days 1 through 20
	  ○ $125 co-pay per day for days 21 through 100
	• Out-of-network:
	  ○ 30% of the cost per stay
	  ○ 30% of the cost per day for days 1 through 100

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 Other Part B drugs[1]: • In-network: 20% of the cost • Out-of-network: 30% of the cost Our plan does **not** cover Part D prescription drug.

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 $49 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 provider network may change at any time. You will receive notice when necessary.