

2024 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

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

[Apply Online](#)

Summary of Benefits: [MyCare Rx 40](#) / [MyCare Rx 34](#) / [MyCare Rx 30](#) / [Essentials Choice 2](#) / [Essentials Choice Rx 14](#) / [Essentials Rx 6](#) / [Essentials Rx 27](#) / [Essentials Rx 36](#) / [Essentials Rx 41](#) / [Essentials Rx 42](#) / [Explorer Rx 4](#) / [Explorer Rx 7](#) / [Explorer 8](#) / [Explorer Rx 11](#)

[Provider Directory](#)

[Pharmacy Directory](#)

[Formulary](#)

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 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. ***If they are signed prior to October 15th they will be returned to you with a new application.*** If they are received after December 7th, 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

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: <https://medicare-oregon.com/>

Y0062_MULTIPLAN_CDA INSURANCE Oregon 2024 (Pending)



Summary of Benefits 2024

Essentials Rx 6 (HMO)



Things to Know About PacificSource Medicare Essentials Rx 6 (HMO)



Who can join?

To join **PacificSource Medicare Essentials Rx 6 (HMO)**, 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 as well as North Klamath zip codes 97731, 97733, 97737, and 97739.

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, 2024–December 31, 2024



This is a summary of costs for drug and medical services covered by PacificSource Medicare for the Essentials Rx 6 (HMO) 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: 711. We accept all relay calls.

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

ESSENTIALS RX 6 (HMO)**You Pay****Monthly Premium**

You must continue to pay your Medicare Part B premium.

\$200

Medical Deductible

\$0

Pharmacy Deductible

\$0

Out-of-pocket Maximum

The most you pay during the calendar year for in-network covered services.

\$4,950

Inpatient Hospital Care

Our plan covers an unlimited number of days for an inpatient hospital stay. Notification from your provider is required upon admission.

\$275 per day for days 1–5
\$0 for days 6 and beyond

Outpatient Surgery**Outpatient hospital or Ambulatory Surgical Center**

Prior authorization is required for some services.

\$275

Doctor's Office Visits**Primary Care Physician (PCP)/Specialty**

Prior authorization may be required for surgery or treatment services.

PCP - **\$0**
Specialist - **\$15**

Preventive Care

For Medicare-approved preventive care. Examples include an annual physical exam, flu shots, and various cancer screenings.

\$0

Emergency Care

Copay waived if admitted to hospital within 72 hours. Includes Worldwide coverage.

\$120

Urgently Needed Services

Includes Worldwide coverage.

\$60

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 or Nuclear Test - **\$150**
MRI or PET Scan - **\$250**

Diagnostic Tests and Procedures

\$15

Lab Services

Prior authorization is required for genetic testing and analysis.

A1c and Protime Testing - **\$0**
Genetic Testing - **20%**
All other Lab Services - **\$25**

Outpatient X-rays

\$10

Therapeutic Radiology Services

Prior authorization is required for some radiation services.

20%

ESSENTIALS RX 6 (HMO)

You Pay

Hearing Services

Exam to diagnose and treat hearing and balance issues.

\$25

TruHearing™

Hearing Aids: Per aid (up to two per year).

Standard: **\$599**
Advanced: **\$799**
Premium: **\$999**

Routine hearing exam (up to one per year).

\$0

Dental Services (Medicare Covered)

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

\$25

Prior authorization is required for nonroutine dental care.

Dental Services

Routine dental services covered up to a combined \$500 annual maximum.

Coverage includes the following:

Preventive, Non-Routine, and Diagnostic Services:

- Exams
- Cleanings
- Brush Biopsy
- Topical Fluoride and Fluoride Varnish
- Bitewing x-rays, Full mouth x-ray, Conebeam, and/or Panorex, and Periapical x-rays (limited to dollar amount of a full mouth series)

Restorative, Extraction, Endodontics, Periodontics, and Prosthodontics Services, and Other Oral Maxillofacial Surgery:

- Pulpotomy: deciduous teeth only
- Tooth desensitization
- Pulp capping (direct)
- Oral Surgery (simple extractions)
- Crowns
- Core build up (tooth requires root canal therapy)
- Bone grafting (only covered at time of extraction or covered implant placement)
- Fillings
- Root planing/Perio Scaling
- Debridement
- Analgesia/Sedation: only with covered surgical procedures
- Inlays and Onlays
- Dentures and Denture Relines
- Bridges
- Implants
- Veneers
- Complicated Oral Surgery and Periodontic Surgery
- Root Canal Therapy

Preventive, Non-Routine, and Diagnostic Services: **\$0**

Restorative, Extraction, Endodontics, Periodontics, and Prosthodontics Services, and Other Oral Maxillofacial Surgery: **50%**

ESSENTIALS RX 6 (HMO)**You Pay****Vision Services**

Medicare-covered eye exam to diagnose and treat glaucoma and diabetic retinopathy

\$0

Routine eye exam, one every two years

\$0

Eyeglasses or contact lenses after cataract surgery. This is a limited benefit and only includes basic frames, lenses, or contact lenses.

\$0

Reimbursement every 2 years for routine prescription eyeglasses or contact lenses.

\$200 reimbursement**Mental Health Care****Inpatient Services**

Notification from your provider is required upon admission.

\$275 per day for days 1–5**\$0** for days 6 and beyond

190-day lifetime limit for inpatient care not provided in a general hospital.

Outpatient Services

Per group or individual therapy visit

\$20**Skilled Nursing Facility (SNF)**

Limited up to 100 days per benefit period. No prior hospital stay is required.

\$0 per day for days 1–20**\$203** per day for days 21–100**Physical Therapy****\$0****Ambulance**

Per one-way transport. Prior authorization is required for nonemergency transportation. Includes Worldwide coverage.

\$150**Transportation**

Not covered

Part B Drug Coverage

Prior authorization or step therapy is required for some drugs.

20%

Insulin covered up to a maximum of
\$35 per month supply

Prescription Drug Benefits



ESSENTIALS RX 6 (HMO)																	
Stage 1																	
Pharmacy Deductible	\$0																
Stage 2																	
When the total drug costs are between \$0 and \$5,030 , you pay:																	
Retail Pharmacy (30-day supply)	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #ccc; color: #333;">Preferred Pharmacy</th> <th style="background-color: #ccc; color: #333;">Standard Pharmacy</th> </tr> </thead> <tbody> <tr> <td style="background-color: #eee;">Tier 1 Preferred Generic</td> <td style="text-align: center;">\$3</td> </tr> <tr> <td style="background-color: #eee;">Tier 2 Generic</td> <td style="text-align: center;">\$12</td> </tr> <tr> <td style="background-color: #eee;">Tier 3 Preferred Brand</td> <td style="text-align: center;">\$42</td> </tr> <tr> <td style="background-color: #eee;">Tier 3 Insulin</td> <td style="text-align: center;">\$35</td> </tr> <tr> <td style="background-color: #eee;">Tier 4 Non-preferred</td> <td style="text-align: center;">31%</td> </tr> <tr> <td style="background-color: #eee;">Tier 5 Specialty Tier</td> <td style="text-align: center;">33% (30-day supply only)</td> </tr> <tr> <td style="background-color: #eee;">Tier 6 Select Care</td> <td style="text-align: center;">\$0</td> </tr> </tbody> </table>	Preferred Pharmacy	Standard Pharmacy	Tier 1 Preferred Generic	\$3	Tier 2 Generic	\$12	Tier 3 Preferred Brand	\$42	Tier 3 Insulin	\$35	Tier 4 Non-preferred	31%	Tier 5 Specialty Tier	33% (30-day supply only)	Tier 6 Select Care	\$0
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Tiers 1, 2, 3, 4, and 5	25%																
Covered Insulin	\$35																
Tier 6 Select Care	\$0																
See the list of covered drugs to determine which drugs are included.																	
Stage 4																	
After your out-of-pocket costs reach \$8,000 , the maximum you pay until the end of the calendar year is:																	
All Covered Drugs	\$0																

You won't pay more than \$35 per one-month supply of each covered insulin product regardless of the cost-sharing tier.



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.



Additional benefits not included above

	You Pay
Alternative Care	
Non-Medicare covered acupuncture, naturopathy, and non-Medicare covered chiropractic care. Combined total of 18 visits per calendar year	\$25
Meal Benefit	
Up to 2 meals per day for 7 days (total of 14 meals) after a recent inpatient stay in a hospital or nursing facility	\$0
Over-the-Counter (OTC) Drug Coverage	
OTC medications and/or health related items through NationsOTC	\$25 per Quarter
Silver&Fit® Healthy Aging and Exercise Program	
Including but not limited to the following options: <ul style="list-style-type: none">• A fitness center membership at participating exercise centers• A Home Fitness kit including options like a wearable fitness tracker or a strength kit• On-demand videos through the website and mobile app• Healthy Aging Coaching sessions by telephone• The Silver&Fit Connected™ tool for tracking your activity	\$0
Telehealth Services	
Care through phone or video for PCP visits, Specialist visits, Outpatient Rehabilitation services (Physical Therapy, Occupational Therapy, Speech Therapy), and Outpatient Mental Health Care. Please coordinate with your provider for these services.	Telehealth services are provided at the same cost share as an in-person visit.

PacificSource Community Health Plan is an HMO, HMO D-SNP, and PPO plan with a Medicare contract and a contract with Oregon Health Plan (Medicaid). Enrollment in PacificSource Medicare depends on contract renewal. 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. We accept all relay calls.