CDA Insurance LLC

Please return signed applications via one of the following methods:

EMAIL: secure email link (Ctrl+Click)
tiffany@lowinsure.com

FAX: 1-541-284-2994

MAIL: CDA Insurance LLC
P.O. Box 26540
Eugene, OR 97402

CONTACT: **Tiffany Jackson**, independent agent, with any questions or concerns.
Email: tiffany@lowinsure.com or phone: 1-541-434-9613

If using the Annual Enrollment Period, please return between October 15th and December 7th for a January 1st effective date.

All other enrollments will be processed for the first of the month following receipt of the application. A valid Enrollment Period is required by CMS.

PACIFICSOURCE MEDICARE ADVANTAGE PLAN DOCUMENTS:

Benefit Summaries
MyCare Rx 40 HMO | MyCare Choice 30 HMO-POS | Essentials Choice 3 HMO-POS |
Essentials Choice Rx 14 HMO-POS | Essentials Rx 6 HMO | Essentials Choice Rx 36 HMO-POS
Explorer Rx 4 PPO | Explorer 6 PPO | Essentials Rx 41 HMO

Application
Available 10-15-2025 please email if you would like one to be sent out.

Links
Provider Search
Star ratings HMO Star ratings PPO
Pharmacy search
Formulary search

TPMO disclaimer: CDA Insurance LLC may not offer every plan available in your area. Currently represented in the Medicare Advantage market are all plans available from: 9 insurance companies in the state of Oregon, 9 in the state of Washington, 4 in the state of Idaho, and 3 in the state of Texas. Any information provided is limited to those plans we do offer in your area. For a breakdown by county, please visit our websites: Oregon, Washington, Idaho, Texas Please contact Medicare.gov, 1-800-MEDICARE , or your local SHIP to obtain information on all of your options.

PacificSource Medicare

Summary of Benefits 2026

Explorer Rx 4 (PPO)

Y0021_H4754_MED41_0825_M Accepted 08242025

Things to Know About PacificSource Medicare
Explorer Rx 4 (PPO)

Who can join?

To join **PacificSource Medicare Explorer Rx 4 (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area, which is Lane County in **Oregon.**

Which doctors, hospitals, and pharmacies can I use?

Our **provider directory** on our website, www.Medicare.PacificSource.com/Search/Provider.

Our **pharmacy directory** is also on our website, www.Medicare.PacificSource.com/Search/Pharmacy.

What prescription drugs are covered?

Our **formulary** (list of Part D prescription drugs), and any restrictions is on our website, www.Medicare.PacificSource.com/Search/Drug.

If you would like a provider directory, pharmacy directory, or formulary mailed to you, please contact us.

Summary of Benefits:
January 1, 2026–December 31, 2026

This is a summary of costs for drug and medical services covered by PacificSource Medicare for the Explorer Rx 4 (PPO) 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. For a complete list of services we cover, check the Explorer Rx 4 (PPO) plan Evidence of Coverage (EOC) on our website, www.Medicare.PacificSource.com or get a copy by contacting us.

If you want to compare our plans with other Medicare health plans, use the Medicare Plan Finder on www.Medicare.gov or ask the other plans for their Summary of Benefits booklets.

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

Email: MedicareCS@PacificSource.com

Website: www.Medicare.PacificSource.com

Call toll-free: 888-530-1428 | TTY: 711. We accept all relay calls.

- October 1 to March 31: 7 days a week | 8 a.m. to 8 p.m. local time
- April 1 to September 30: Monday through Friday | 8 a.m. to 8 p.m. local time

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Monthly Premium		
You must continue to pay your Medicare Part B premium.	**$157**	
Medical Deductible		
	$0	
Pharmacy Deductible		
Applies to Tier 3, 4, and 5 drugs. Deductible doesn't apply to covered insulin.	**$499**	
Out-of-pocket Maximum		
The most you pay during the calendar year for covered services.	**$6,700** From in-network providers	**$8,950** From in-network and out-of-network providers combined
Inpatient Hospital Care		
Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	**$450** per day for days 1–6 **$0** for days 7 and beyond	**50%**
Outpatient Surgery		
Outpatient hospital or Ambulatory Surgical Center Prior authorization is required for some services.	**$450**	**50%**
Doctor's Office Visits		
Primary Care Provider (PCP)/Specialty Prior authorization may be required for surgery or treatment services.	PCP: **$15** Specialist: **$40**	**50%**
Preventive Care		
For Medicare-approved preventive care, including: an annual physical exam, flu shots, and various cancer screenings.	**$0**	**50%**
Emergency Care		
Copay waived if admitted to hospital within 72 hours. Includes Worldwide coverage.	**$120**	
Urgently Needed Services		
Includes Worldwide coverage.	**$50**	
Diagnostic Radiology Services		
Prior authorization is required for advanced/complex, imaging such as: CT Scan, MRI, PET Scan, Nuclear Test.	CT Scan or Nuclear Test: **$350** MRI or PET Scan: **$400**	**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: **$15**	**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.	**$30**	**50%**
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)		
This does not include services in connection with care, treatment, filling, removal, or replacement of teeth. Prior authorization is required for Medicare-covered dental care.	**$35**	**50%**
Dental Services (Supplemental)		
These additional dental services are covered by your plan up to a **$500** annual maximum. Service limits and restrictions may apply.		
Preventive, Non-Routine, and Diagnostic Services: • Routine and problem-focused exams • Cleanings • Brush biopsy • Topical fluoride and fluoride varnish • Bitewing x-rays, full mouth x-rays, and periapical x-rays	**$0**	
Restorative, Endodontics, Periodontics, Prosthodontics, Implant Services, Oral Maxillofacial Surgery, and Adjunctive General Services: • Core build up • Fillings and crowns • Inlays, onlays, and veneers • Analgesia/sedation • Tooth desensitization • Oral and periodontic surgery • Debridement • Pulpotomy and pulp capping • Bridges and implants • Bone grafting • Root canal therapy and root planing/perio scaling • Dentures and denture relines	**50%**	

	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**	
Reimbursement every two years for routine prescription eyeglasses or contact lenses.	**$200 reimbursement**	
Mental Health Care		
Inpatient Services 190-day lifetime limit for inpatient care not provided in a general hospital. Prior authorization may be required.	**$330** per day for days 1–5 **$0** for days 6 and beyond	**50%**
Outpatient Services Per group or individual therapy visit	**$30**	**50%**
Skilled Nursing Facility (SNF)		
Limited up to 100 days per benefit period. No prior hospital stay is required. Prior authorization is required.	**$0** per day for days 1–20 **$203** per day for days 21–100	**50%**
Physical Therapy		
Prior authorization needed after 10 visits.	**$35**	**50%**
Ambulance		
Per one-way transport. Prior authorization is required for nonemergency transportation. Includes Worldwide coverage.	**$275**	
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	**50%** Insulin covered up to a maximum of **$35** per month supply

Prescription Drug Benefits

	EXPLORER RX 4 (PPO)
Stage 1	
Pharmacy Deductible	**$0** on Tiers 1 and 2 **$499** on Tiers 3, 4, and 5 (Deductible does not apply to covered insulin)
Stage 2	When your out-of-pocket costs are between **$0** and **$2,100**, you pay:
Retail Pharmacy	**30-day supply**
Tier 1 Preferred Generic	**$0**
Tier 2 Generic	**$6**
Tier 3 Preferred Brand	**20%**
Tier 3 Insulin	**20% up to $35**
Tier 4 Non-preferred	**25%**
Tier 5 Specialty Tier	**27%** (maxium 30-day supply)
Stage 3	After your out-of-pocket costs reach **$2,100,** 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. Most adult Part D vaccines are covered at no cost to you.

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** To learn more about this payment option, please contact us at 888-863-3637 or visit Medicare.gov.

Save even more with CVS Caremark Mail-Order

Filling your prescriptions through CVS Caremark Mail-Order can save you time and money.

The benefits of CVS Mail-Order include:

- Free shipping
- Auto-refills available
- Ability to order refills and check refill status online
- 15% coinsurance for Tier 3 drugs
- Up to a 90-day supply for the same cost as a 30-day supply of Tier 2 drugs and Tier 3 Insulin

Cost-sharing may differ relative to the pharmacy's status as retail, mail-order, Lon Term Care (LTC), or home infusion and day supply.

This Plan Also Includes

	You Pay
Alternative Care	
Non-Medicare covered acupuncture, naturopathy, and non-Medicare covered chiropractic care. Combined total of 12 visits per calendar year.	**$25**
Over-the-Counter (OTC) Drug Coverage	
Aspirin, Calcium, and Calcium-Vitamin D combinations	**$100 annual reimbursement**
Fitness Benefit	
Benefits offered through **One Pass™** include: • A nationwide network of gyms and fitness locations • Live, digital fitness classes and on-demand workouts • Online brain health subscription through CogniFit which includes an initial cognitive test, complete brain workout, and a brain training program with regular reassessment of progress	**$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. Available for in-network providers only.	Telehealth services are provided at the same cost share as an in-person visit.

PacificSource Community Health Plans 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. 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.

For help reading this document, please call us at 888-863-3637, TTY: 711. We accept all relay calls.