PacificSource Medicare

Summary of Benefits 2025

Essentials Choice 2 (HMO-POS)

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Things to Know About PacificSource Medicare

Essentials Choice 2 (HMO-POS)

Who can join?

To join **PacificSource Medicare Essentials Choice 2 (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 (97731, 97733, 97737, & 97739), Lane, Sherman, Wasco, and Wheeler.

Which doctors and hospitals can I use?

You can see our plan's **provider directory** on our website, www.Medicare.PacificSource.com/Search/Provider.

If you would like a copy mailed to you, please call us.

Summary of Benefits:

January 1, 2025–December 31, 2025

This is a summary of costs for drug and medical services covered by PacificSource Medicare for the Essentials Choice 2 (HMO-POS) 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. 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

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Monthly Premium		
You must continue to pay your Medicare Part B premium.	**$0**	
Medical Deductible		
	$0	
Out-of-pocket Maximum		
The most you pay during the calendar year for covered services.	**$5,950** Annual limit for Medicare-covered services you receive from in-network providers	**$8,950** Annual limit for Medicare-covered services you receive from both in-network and out-of-network providers combined.
Inpatient Hospital Care		
Our plan covers an unlimited number of days for an inpatient hospital stay.	**$425** per day for days 1–7 **$0** for days 8 and beyond	**30%**
Outpatient Surgery		
Outpatient hospital or Ambulatory Surgical Center Prior authorization is required for some services.	**$425**	**30%**
Doctor's Office Visits		
Primary/Specialty Prior authorization may be required for surgery or treatment services.	**$10**	**$45**
Preventive Care		
For Medicare-approved preventive care. Examples include an annual physical exam, flu shots, and various cancer screenings.	**$0**	**30%**
Emergency Care		
Copay waived if admitted to hospital within 72 hours. Includes Worldwide coverage.	**$120**	
Urgently Needed Services		
Includes Worldwide coverage.	**$55**	
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 - **$300** MRI or PET Scan - **$400**	**30%**
Diagnostic Tests and Procedures		
	$15	**30%**
Lab Services		
Prior authorization is required for genetic testing and analysis.	A1c and Protime Testing - **$0** Genetic Testing - **20%** All other Lab Services - **$0**	**30%**
Outpatient X-rays		
	$15	**30%**

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Therapeutic Radiology Services		
Prior authorization is required for some radiation services.	**20%**	**30%**
Hearing Services		
Exam to diagnose and treat hearing and balance issues.	**$40**	**30%**
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). Prior authorization is required for nonroutine dental care.	**$40**	**30%**
Dental Services		
Routine dental services covered up to a combined $1,000 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, Endodontics, Periodontics, Prosthodontics, Implant Services, Oral Maxillofacial Surgery and Adjunctive General Services:** • 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, Endodontics, Periodontics, Prosthodontics, Implant Services, Oral Maxillofacial Surgery and Adjunctive General Services: **50%**	

	IN-NETWORK	OUT-OF-NETWORK
	You Pay	
Vision Services		
Medicare-covered eye exam to diagnose and treat glaucoma and diabetic retinopathy.	**$0**	**30%**
Routine eye exam, one every calendar year	**$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 two calendar 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.	**$230** per day for days 1–5 **$0** for days 6 and beyond	**30%**
Outpatient Services Per group or individual therapy visit	**$10**	**30%**
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	**30%**
Physical Therapy		
	$10	**$45**
Ambulance		
Per one-way transport. Prior authorization is required for nonemergency transportation. Includes Worldwide coverage.	**$300**	
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	**30%** Insulin covered up to a maximum of **$35** per month supply
Coverage Limits		
	Our plans have a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	**Unlimited** benefit limit for elective (non-emergency) services with out-of-network providers.

This Plan Also Includes

	You Pay
Alternative Care	
Non-Medicare covered acupuncture, naturopathy, and non-Medicare covered chiropractic care. Combined total of 24 visits per calendar year.	**$10**
Over-the-Counter (OTC) Drug Coverage	
OTC medications and/or health related items through NationsOTC	**$50 per Quarter**
Fitness Benefit	
Offered through One Pass, benefits include: • Access to a nationwide network of gyms and fitness locations • Live, digital fitness classes and on-demand workouts • Online brain training to help improve memory and focus • Groups, clubs and social events near you	**$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.

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