



# **Summary of Benefits 2027**

## **PacificSource Medicare Valley Select Rx (HMO-POS)**

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# Things to know about PacificSource Medicare

## PacificSource Medicare Valley Select Rx (HMO-POS)



### Who can join?

To join **PacificSource Medicare Valley Select Rx (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**: Lane.

### Which doctors, hospitals, and pharmacies can I use?

Our **provider directory** is on our website, [Medicare.PacificSource.com/Search/Provider](https://www.Medicare.PacificSource.com/Search/Provider).

Our **pharmacy directory** is on our website, [Medicare.PacificSource.com/Search/Pharmacy](https://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, [Medicare.PacificSource.com/Search/Drug](https://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, 2027–December 31, 2027



### This is a summary of costs for drug and medical services covered by the PacificSource Medicare Valley Select Rx (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. For a complete list of services we cover, check the PacificSource Medicare Valley Select Rx (HMO-POS) plan Evidence of Coverage (EOC) on our website, [Medicare.PacificSource.com](https://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 [Medicare.gov](https://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 [Medicare.gov](https://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](mailto:MedicareCS@PacificSource.com)

Website: [Medicare.PacificSource.com](https://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                                                                             |                                 |
| <b>Monthly Premium</b>                                                                                                          |                                                                                     |                                 |
| You must continue to pay your Medicare Part B premium.                                                                          | \$49                                                                                |                                 |
| <b>Medical Deductible</b>                                                                                                       |                                                                                     |                                 |
|                                                                                                                                 | \$0                                                                                 |                                 |
| <b>Pharmacy Deductible</b>                                                                                                      |                                                                                     |                                 |
| Applies to Tier 3, 4, and 5 drugs. Deductible doesn't apply to covered insulin.                                                 | \$600                                                                               |                                 |
| <b>Out-of-pocket Maximum</b>                                                                                                    |                                                                                     |                                 |
| The most you pay during the calendar year for covered services.                                                                 | \$7,150                                                                             | There is no out-of-pocket limit |
| <b>Inpatient Hospital Care</b>                                                                                                  |                                                                                     |                                 |
| Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.                | \$495 per day for days 1–5<br>\$0 for days 6 and beyond                             | 50%                             |
| <b>Outpatient Surgery</b>                                                                                                       |                                                                                     |                                 |
| <b>Outpatient hospital or Ambulatory Surgical Center (ASC)</b> Prior authorization is required for some services.               | Hospital: \$450<br>ASC: \$400                                                       | 50%                             |
| <b>Doctor's Office Visits</b>                                                                                                   |                                                                                     |                                 |
| <b>Primary Care Provider (PCP) and Specialty Care</b><br>Prior authorization may be required for surgery or treatment services. | PCP: \$0<br>Specialist: \$45                                                        | 50%                             |
| <b>Preventive Care</b>                                                                                                          |                                                                                     |                                 |
| For Medicare-approved preventive care, including: an annual physical exam, flu shots, and various cancer screenings.            | \$0                                                                                 | 50%                             |
| <b>Emergency Care</b>                                                                                                           |                                                                                     |                                 |
| Copay waived if admitted to hospital within 72 hours.                                                                           | \$130                                                                               |                                 |
| <b>Urgently Needed Services</b>                                                                                                 |                                                                                     |                                 |
|                                                                                                                                 | \$50                                                                                |                                 |
| <b>Diagnostic Radiology Services</b>                                                                                            |                                                                                     |                                 |
| Prior authorization is required for advanced/complex, imaging such as: CT Scan, MRI, PET Scan, Nuclear Test.                    | CT Scan or Nuclear Test: \$375<br>MRI or PET Scan: \$450                            | 50%                             |
| <b>Diagnostic Tests and Procedures</b>                                                                                          |                                                                                     |                                 |
|                                                                                                                                 | \$45                                                                                | 50%                             |
| <b>Lab Services</b>                                                                                                             |                                                                                     |                                 |
| Prior authorization is required for genetic testing and analysis.                                                               | A1c and Protime Testing: \$0<br>Genetic Testing: 20%<br>All other Lab Services: \$0 | 50%                             |

|                                                                                                                                                                                                                                                                                                                                                                                                                                      | IN-NETWORK                 | OUT-OF-NETWORK |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                      | You pay                    |                |
| <b>Outpatient X-rays</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>\$15</b>                | <b>50%</b>     |
| <b>Therapeutic Radiology Services</b>                                                                                                                                                                                                                                                                                                                                                                                                |                            |                |
| Prior authorization is required for some radiation services.                                                                                                                                                                                                                                                                                                                                                                         | <b>20%</b>                 | <b>50%</b>     |
| <b>Hearing Services</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                |
| Exam to diagnose and treat hearing and balance issues.                                                                                                                                                                                                                                                                                                                                                                               | <b>\$25</b>                | <b>50%</b>     |
| <b>TruHearing™</b>                                                                                                                                                                                                                                                                                                                                                                                                                   | Standard: <b>\$599</b>     |                |
| Up to two TruHearing-branded hearing aids every year (one per ear, per year).                                                                                                                                                                                                                                                                                                                                                        | Advanced: <b>\$799</b>     |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                      | Premium: <b>\$999</b>      |                |
| Routine hearing exam (one per year).                                                                                                                                                                                                                                                                                                                                                                                                 | <b>\$0</b>                 |                |
| <b>Medicare Dental Services</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                            |                |
| 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.                                                                                                                                                                                                                                                      | <b>\$40</b>                | <b>50%</b>     |
| <b>Preventive &amp; Comprehensive Dental Services</b>                                                                                                                                                                                                                                                                                                                                                                                |                            |                |
| These additional dental services are covered by your plan up to a <b>\$1,000</b> annual maximum. Service limits and restrictions may apply.                                                                                                                                                                                                                                                                                          |                            |                |
| <b>Preventive, Non-Routine, and Diagnostic Services:</b>                                                                                                                                                                                                                                                                                                                                                                             | <b>\$0</b>                 |                |
| <ul style="list-style-type: none"> <li>• Routine and problem-focused exams</li> <li>• Cleanings</li> <li>• Brush biopsy</li> <li>• Topical fluoride and fluoride varnish</li> <li>• Bitewing x-rays, full mouth x-rays, and periapical x-rays</li> </ul>                                                                                                                                                                             |                            |                |
| <b>Restorative, Endodontics, Periodontics, Prosthodontics, Oral Maxillofacial Surgery and Adjunctive General Services:</b>                                                                                                                                                                                                                                                                                                           | <b>50%</b>                 |                |
| <ul style="list-style-type: none"> <li>• Core build up, fillings, and crowns</li> <li>• Inlays, onlays, and veneers</li> <li>• Analgesia/sedation and tooth desensitization</li> <li>• Oral surgery, periodontic surgery, and debridement</li> <li>• Pulpotomy and pulp capping</li> <li>• Bridges and bone grafting</li> <li>• Root canal therapy and root planing/perio scaling</li> <li>• Dentures and denture relines</li> </ul> |                            |                |
| <b>Vision Services</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                            |                |
| Medicare-covered eye exam to diagnose and treat glaucoma and diabetic retinopathy.                                                                                                                                                                                                                                                                                                                                                   | <b>\$0</b>                 | <b>50%</b>     |
| Routine eye exam, one every calendar year.                                                                                                                                                                                                                                                                                                                                                                                           | <b>\$0</b>                 |                |
| Eyeglasses or contact lenses after cataract surgery. This is a limited benefit and only includes basic frames, lenses, or contact lenses.                                                                                                                                                                                                                                                                                            | <b>\$0</b>                 |                |
| Reimbursement every two calendar years for routine prescription eyeglasses or contact lenses.                                                                                                                                                                                                                                                                                                                                        | <b>\$135 reimbursement</b> |                |

|                                                                                                                                          | IN-NETWORK                                                                                                          | OUT-OF-NETWORK                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
|                                                                                                                                          | You pay                                                                                                             |                                                                                                   |
| Mental Health Care                                                                                                                       |                                                                                                                     |                                                                                                   |
| Inpatient Services<br>190-day lifetime limit for inpatient care not provided in a general hospital. Prior authorization may be required. | \$475 per day for days 1–4<br>\$0 for days 5 and beyond                                                             | 50%                                                                                               |
| Outpatient Services<br>Per group or individual therapy visit                                                                             | \$40                                                                                                                | 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<br>\$221 per day for days 21–100                                                          | 50%                                                                                               |
| Physical Therapy                                                                                                                         |                                                                                                                     |                                                                                                   |
| Prior authorization required after 10 visits.                                                                                            | \$40                                                                                                                | 50%                                                                                               |
| Ambulance                                                                                                                                |                                                                                                                     |                                                                                                   |
| Per one-way transport. Prior authorization is required for non-emergency transportation.                                                 | \$350                                                                                                               |                                                                                                   |
| Transportation                                                                                                                           |                                                                                                                     |                                                                                                   |
|                                                                                                                                          | Not covered                                                                                                         |                                                                                                   |
| Part B Drug Coverage                                                                                                                     |                                                                                                                     |                                                                                                   |
| Prior authorization or step therapy is required for some drugs.<br><br>You pay no more than \$35 per one-month supply of Part B insulin. | Up to 20%                                                                                                           | 50%                                                                                               |
| Coverage Limits                                                                                                                          |                                                                                                                     |                                                                                                   |
|                                                                                                                                          | Our plans have a coverage limit every year for certain in-network benefits. Contact us for the services that apply. | \$3,000<br><br>Benefit limit for elective (non-emergency) services with out-of-network providers. |

# Prescription drug benefits



| PACIFICSOURCE MEDICARE VALLEY SELECT RX (HMO-POS)                                                                |                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <b>Stage 1</b>                                                                                                   |                                                                                                                    |
| <b>Pharmacy Deductible</b>                                                                                       | <b>\$0</b> on Tiers 1 and 2<br><b>\$600</b> on Tiers 3, 4, and 5<br>(Deductible does not apply to covered insulin) |
| <b>Stage 2</b>                                                                                                   |                                                                                                                    |
| When your out-of-pocket costs are between <b>\$0</b> and <b>\$2,400</b> , you pay:                               |                                                                                                                    |
| <b>Retail Pharmacy</b>                                                                                           | <b>30-day supply</b>                                                                                               |
| <b>Tier 1</b> Preferred Generic                                                                                  | <b>\$0</b>                                                                                                         |
| <b>Tier 2</b> Generic                                                                                            | <b>\$6</b>                                                                                                         |
| <b>Tier 3</b> Preferred Brand                                                                                    | <b>20%</b>                                                                                                         |
| <b>Tier 3</b> Insulin                                                                                            | <b>20% up to \$35</b>                                                                                              |
| <b>Tier 4</b> Non-preferred                                                                                      | <b>29%</b>                                                                                                         |
| <b>Tier 4</b> Insulin                                                                                            | <b>25% up to \$35</b>                                                                                              |
| <b>Tier 5</b> Specialty Tier                                                                                     | <b>26%</b> (maximum 30-day supply)                                                                                 |
| <b>Tier 5</b> Insulin                                                                                            | <b>25% up to \$35</b> (maximum 30-day supply)                                                                      |
| <b>Stage 3</b>                                                                                                   |                                                                                                                    |
| After your out-of-pocket costs reach <b>\$2,400</b> , the maximum you pay until the end of the calendar year is: |                                                                                                                    |
| <b>All Covered Drugs</b>                                                                                         | <b>\$0</b>                                                                                                         |

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](https://www.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

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

# This plan also includes

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | You pay                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <b>Alternative Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                         |
| Non-Medicare covered acupuncture, naturopathy, and non-Medicare covered chiropractic care. Combined total of 12 visits per calendar year.                                                                                                                                                                                                                                                                                                                          | <b>\$25</b>                                                                                                             |
| <b>Over-the-Counter (OTC) Drug Coverage</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                         |
| OTC medications and/or health related items through NationsOTC.                                                                                                                                                                                                                                                                                                                                                                                                    | <b>\$20</b> per quarter                                                                                                 |
| <b>Fitness Benefit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                         |
| Benefits offered through <b>One Pass™</b> include: <ul style="list-style-type: none"> <li>• A nationwide network of gyms and fitness locations</li> <li>• Live, digital fitness classes and on-demand workouts</li> <li>• Three at-home fitness kits.</li> <li>• 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</li> </ul> | <b>\$0</b>                                                                                                              |
| <b>Telehealth Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                         |
| Access <b>Teladoc®</b> for convenient virtual care.<br>Care by phone or video with Teladoc and other in-network providers. Availability varies by provider and region. Please coordinate telehealth services with your provider. Some limitations apply.                                                                                                                                                                                                           | Telehealth services are provided at the same cost share as an in-person visit.                                          |
| <b>Worldwide Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         |
| Emergency care, urgent care, and emergency transportation received outside of the United States are subject to a \$25,000 annual maximum plan coverage limit.                                                                                                                                                                                                                                                                                                      | <b>\$130</b> copay for emergency and urgent care visits.<br><br><b>\$350</b> per one way emergency transportation trip. |

PacificSource Community Health Plans is an HMO and HMO D-SNP 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.

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.

PacificSource Medicare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Free language assistance services for people whose primary language is not English, and free aids and services for people with disabilities, are available, including interpreters and information in other formats. If you need any of these services, please call 888-863-3637, TTY 711.