



Summary of Benefits 2027

PacificSource Medicare Idaho Basic (HMO-POS)



Things to know about PacificSource Medicare

PacificSource Medicare Idaho Basic (HMO-POS)



Who can join?

To join **PacificSource Medicare Idaho Basic (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 **Idaho**: Ada, Canyon, Elmore, Gooding, Jerome, Payette, Twin Falls, and Valley.

Which doctors and hospitals can I use?

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

If you would like a copy 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 Idaho Basic (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 Idaho Basic (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

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	
Monthly Premium		
You must continue to pay your Medicare Part B premium.	\$0	
Part B Premium Reduction		
This plan offers a \$60 give back every month in your Social Security check.		
Medical Deductible		
	\$0	
Out-of-pocket Maximum		
The most you pay during the calendar year for covered services.	\$7,150	There is no out-of-pocket limit
Inpatient Hospital Care		
Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	\$550 per day for days 1–5 \$0 for days 6 and beyond	50%
Outpatient Surgery		
Outpatient hospital or Ambulatory Surgical Center (ASC) Prior authorization is required for some services.	Hospital: \$425 ASC: \$350	50%
Doctor's Office Visits		
Primary Care Provider (PCP) and Specialty Care Prior authorization may be required for surgery or treatment services.	PCP: \$0 Specialist: \$45	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.	\$130	
Urgently Needed Services		
	\$50	
Diagnostic Radiology Services		
Prior authorization is required for advanced/complex, imaging such as: CT Scan, MRI, PET Scan, Nuclear Test.	20%	50%
Diagnostic Tests and Procedures		
	\$15	50%
Lab Services		
Prior authorization is required for genetic testing and analysis.	A1c and Protime Testing: \$0 Genetic Testing: 20% All other Lab Services: \$0	50%

	IN-NETWORK	OUT-OF-NETWORK
	You pay	
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.	\$20	50%
TruHearing™	Standard: \$599 Advanced: \$799 Premium: \$999	
Up to two TruHearing-branded hearing aids every year (one per ear, per year).		
Routine hearing exam (one per year).	\$0	
Medicare Dental Services		
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%
Preventive & Comprehensive Dental Services		
These additional dental services are covered by your plan up to a \$1,000 annual maximum. Service limits and restrictions may apply.		
Preventive, Non-Routine, and Diagnostic Services:	\$0	
• Routine and problem-focused exams • Cleanings and brush biopsy • Topical fluoride and fluoride varnish • Bitewing x-rays, full mouth x-rays, and periapical x-rays		
Restorative, Endodontics, Periodontics, Prosthodontics, Oral Maxillofacial Surgery and Adjunctive General Services:	50%	
• Core build up, fillings, and crowns • Inlays, onlays, and veneers • Analgesia/sedation and tooth desensitization • Oral surgery, periodontic surgery, and debridement • Pulpotomy and pulp capping • Bridges and bone grafting • Root canal therapy and root planing/perio scaling • Dentures and denture relines		
Vision Services		
Medicare-covered eye exam to diagnose and treat glaucoma and diabetic retinopathy.	\$0	50%
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 calendar year for routine prescription eyeglasses or contact lenses.	\$200 reimbursement	

	IN-NETWORK	OUT-OF-NETWORK
	You pay	
Mental Health Care		
Inpatient Services 190-day lifetime limit for inpatient care not provided in a general hospital.	\$550 per day for days 1–4 \$0 for days 5 and beyond	50%
Outpatient Services Per group or individual therapy visit	\$25	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 \$221 per day for days 21–100	50%
Physical Therapy		
Prior authorization required after 10 visits.	\$25	50%
Ambulance		
Per one-way transport. Prior authorization is required for non-emergency transportation.	\$400	
Transportation		
	Not covered	
Part B Drug Coverage		
Prior authorization or step therapy is required for some drugs. 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 Benefit limit for elective (non-emergency) services from out-of-network providers.

This plan also includes



	You pay
Fitness Benefit	
Benefits offered through One Pass™ include: • A nationwide network of gyms and fitness locations. • Live, digital fitness classes and on-demand workouts. • Three at-home fitness kits • 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	
Access Teladoc® for convenient virtual care. 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.

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 providers and pharmacies 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.