PacificSource Medicare

Summary of Benefits 2026

MyCare Choice 30 (HMO-POS)

Y0021_H3864_MED59_0825_M Accepted 08242025

Things to Know About PacificSource Medicare

MyCare Choice 30 (HMO-POS)

Who can join?

To join **PacificSource Medicare MyCare Choice 30 (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:** Bonner and Kootenai. **Montana:** Yellowstone. **Oregon:** Clackamas, Multnomah, and Washington.

Which doctors and hospitals can I use?

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

If you would like a copy 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 MyCare Choice 30 (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 MyCare Choice 30 (HMO-POS) 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.	**$15**	
Medical Deductible		
	$0	
Out-of-pocket Maximum		
The most you pay during the calendar year for covered services.	**$4,950** 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.	**$425** per day for days 1–5 **$0** for days 6 and beyond	**30%**
Outpatient Surgery		
Outpatient hospital or Ambulatory Surgical Center Prior authorization is required for some services.	**$400**	**30%**
Doctor's Office Visits		
Primary Care Provider (PCP)/Specialty Prior authorization may be required for surgery or treatment services.	**$0**	**$45**
Preventive Care		
For Medicare-approved preventive care, including: 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.	**$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: **$190** MRI or PET Scan: **$310**	**30%**
Diagnostic Tests and Procedures		
	$20	**30%**

	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: **$0**	**30%**
Outpatient X-rays		
	$15	**30%**
Therapeutic Radiology Services		
Prior authorization is required for some radiation services.	**20%**	**30%**
Hearing Services		
Exam to diagnose and treat hearing and balance issues.	**$30**	**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)		
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.	**$30**	**30%**
Dental Services (Supplemental)		
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: • 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 and tooth desensitization • Oral and periodontic surgery • Debridement • Pulpotomy and pulp capping • Bridges, implants, and bone grafting • Root canal therapy and root planing/perio scaling • Dentures and denture relines	**$0**	**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 calendar year 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.	**$420** per day for days 1–5 **$0** for days 6 and beyond	**30%**
Outpatient Services Per group or individual therapy visit	**$0**	**30%**
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	**30%**
Physical Therapy		
Prior authorization required after 10 visits.	**$0**	**$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.	**$0**
Over-the-Counter (OTC) Drug Coverage	
OTC medications and/or health related items through **NationsOTC**	**$50 per Quarter**
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.