



Summary of Benefits 2022

MyCare 30 (HMO)

Yellowstone County



Things to Know About PacificSource Medicare MyCare 30 (HMO)



Who can join?

To join **PacificSource Medicare MyCare 30 (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes Yellowstone County in Montana.

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, 2022–December 31, 2022



This is a summary of costs for drug and medical services covered by PacificSource Medicare for the MyCare 30 (HMO) 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: (800) 735-2900

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

		MYCARE 30 (HMO)
		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 in-network covered services.		\$3,500
Inpatient Hospital Care		
Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required depending on the procedure, except in urgent or emergent situations. Notification from your provider is required upon admission.		\$295 per day for days 1–5 \$0 for days 6 and beyond
Outpatient Surgery		
Ambulatory surgical center or Outpatient hospital Prior authorization is required for some services.		\$295
Doctor's Office Visits		
Primary Care Physician (PCP)/Specialty Prior authorization may be required for surgery or treatment services.		\$0
Preventive Care		
For Medicare-approved preventive care. Examples include an annual physical exam, flu shots, and various cancer screenings.		\$0
Emergency Care		
Copay waived if admitted to hospital within 72 hours. Includes Worldwide coverage.		\$90
Urgently Needed Services		
Includes Worldwide coverage.		\$40
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
Diagnostic Tests and Procedures		
		\$20
Lab Services		
Prior authorization is required for genetic testing and analysis.		A1c and Prottime Testing - \$0 Genetic Testing - 20% All other Lab Services - \$20
Outpatient X-rays		
		\$20
Therapeutic Radiology Services		
Prior authorization is required for some radiation services.		20%

MYCARE 30 (HMO)**You Pay****Hearing Services**

Exam to diagnose and treat hearing and balance issues.

\$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).

\$30

Prior authorization is required for nonroutine dental care.

Dental Services (Routine)

Routine dental services covered up to a combined \$500 annual maximum.

Coverage includes the following:

Preventive Services:

- Routine Exam - 1 per calendar year
- Cleaning - 1 per calendar year
- Bitewing x-ray - 1 per calendar year
- Full mouth x-ray, Conebeam, and/or Panorex - 1 per 5 years

Restorative & Extraction Services:

- Pulpotomy: deciduous teeth only
- Tooth desensitization
- Pulp capping (direct)
- Oral Surgery (simple extractions)
- Stainless steel crowns
- Core build up (tooth requires root canal therapy)
- Bone grafting (only covered at time of extraction or implant placement)
- Fillings - 1 every 2 calendar years
- Root planing/Perio Scaling - 1 every 2 calendar years per quad
- Debridement - 1 every 3 years not within 3 years of other prophylaxis
- Analgesia/Sedation: only with surgical procedures

Preventive Services: **\$0**Restorative & Extraction Services:
30%

MYCARE 30 (HMO)**You Pay****Optional Supplemental Comprehensive Dental Plan**

This plan can be purchased for an additional monthly premium and offers all the benefits included under Dental Services (Routine), plus more. This plan cannot be combined with other dental benefits. With this plan you can see any licensed dentist in the United States. Coverage includes:

Preventive Services:

- Routine Exams - 2 per calendar year
- Bitewing x-rays - 2 per calendar year
- Full mouth x-ray, Conebeam, and/or Panorex - 1 per 5 years
- Fluoride or Fluoride Varnish - 4 per calendar year
- And more

Restorative & Extraction Services:

- Fillings - 1 per 2 calendar years
- Simple surgery
- Stainless steel crowns
- Removal of damaged tissue (debridement) - 1 per 3 years
- And more

Endodontics, Periodontics, Prosthodontics, Other Oral/Maxillofacial Surgery:

- Crowns, inlays, onlays, dentures, or bridges - 1 per 5 years
- Root canal therapy - 1 per 3 years per tooth
- Implants - 1 per tooth per lifetime
- Veneers
- Complex surgery
- And more

Monthly premium: **\$57** (in addition to your monthly plan premium of \$0)

\$1,000 annual benefit limit for combined services

Preventive Services: **\$0**

Restorative & Extraction Services: **20%**

Endodontics, Periodontics, Prosthodontics, Other Oral/Maxillofacial Surgery: **50%**

Vision Services

Medicare-covered eye exam to diagnose and treat glaucoma and diabetic retinopathy.

\$0

Routine eye exam, one every two years.

\$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 2 years for routine prescription eyeglasses or contact lenses.

\$200 reimbursement**Mental Health Care****Inpatient Services**

Prior authorization is required except in an emergency. Notification from your provider is required upon admission.

\$295 per day for days 1–5**\$0** for days 6 and beyond

190-day lifetime limit for inpatient care not provided in a general hospital.

Outpatient Services

Per group or individual therapy visit

\$0

MYCARE 30 (HMO)**You Pay****Skilled Nursing Facility (SNF)**

Prior authorization is required. Limited up to 100 days per benefit period. No prior hospital stay is required.

\$0 per day for days 1–20
\$188 per day for days 21–100

Physical Therapy

Prior authorization is required for services beyond \$3,000 for physical therapy and speech therapy combined.

\$0

Ambulance

Per one-way transport. Prior authorization is required for nonemergency transportation. Includes Worldwide coverage.

Ground: \$275

Air: 20%

Transportation

Not covered

Part B Drug Coverage

Prior authorization or step therapy is required for some drugs.

20%

Additional Benefits and Programs not included above



	You Pay
Meal Benefit	
Up to 2 meals per day for 7 days (total of 14 meals) after a recent inpatient stay in a hospital or nursing facility.	\$0
Over-the-Counter (OTC) Drug Coverage	
Aspirin, Calcium, and Calcium-Vitamin D combinations	\$100 annual reimbursement
Rewards and Incentives	
When you complete one or more of the activities listed in the calendar year, you will receive a gift card redeemable at a variety of popular retailers. Limit one reward per eligible activity completed in the calendar year.	<ul style="list-style-type: none"> • Routine physical or annual wellness visit: \$50 • Mammogram: \$25 • Diabetic A1c (blood glucose test): First test: \$15; Second test: \$25 • Diabetic eye exam: \$25 • Flu Shot: \$10 • DEXA Scan: \$20 • Colonoscopy or Fit kit: \$20
Silver&Fit® Healthy Aging and Exercise Program	
Includes the following options: <ul style="list-style-type: none"> • A fitness center membership at participating exercise centers, • A Home Fitness kit including options like a wearable fitness tracker or a strength kit. • 8,000+ on-demand videos through the website and mobile app, • Healthy Aging Coaching sessions by telephone, • The Silver&Fit Connected™ tool for tracking your activity 	\$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.	Telehealth services are provided at the same cost share as an in-person visit.

PacificSource Community Health Plan 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. 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