

2022 Summary of Benefits

Providence Medicare Align Group Plan + Rx 10/50/1000 (HMO)

January 1, 2022 – December 31, 2022

This plan is available in Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Linn, Marion, Multnomah, Polk, Washington, Wheeler and Yamhill counties in Oregon and Clark, Snohomish and Spokane counties in Washington.

When you join Providence

You're part of something bigger than an insurance policy. You're part of a community of care, focused on your health and well-being. To help you make the right health care decisions, we're providing this summary of benefits, a succinct guide that breaks down what we would cover and what you would pay if you joined our Providence Medicare Align Group Plan + Rx 10/50/1000 (HMO) plan. To be clear, this summary of benefits is just that, a summary. It doesn't list every service that we cover nor every limitation or exclusion. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

For a complete list of services that we cover, please refer to the Evidence of Coverage (EOC). You can request a printed copy by calling our Customer Service department at one of the numbers listed in the "Get in touch" section below.

Plan overview

Providence Medicare Advantage Plans is an HMO, HMO-POS and HMO SNP with Medicare and Oregon Health Plan contracts. Enrollment in Providence Medicare Advantage Plans depends on contract renewal.

Our plan members get all of the benefits covered by Original Medicare as well as some extra benefits outlined in this summary.

Who can join?

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Linn, Marion, Multnomah, Polk, Washington, Wheeler and Yamhill counties in Oregon and Clark, Snohomish and Spokane counties in Washington.

Get in touch

Questions? We're here to help seven days a week from 8 a.m. to 8 p.m. (Pacific Time).

- + If you're a member of this plan, call us toll-free at 1-800-603-2340 (TTY: 711)
- + If you're not a member of this plan, call us toll-free at 1-800-457-6064 (TTY: 711)
- + You can also visit us online at [ProvidenceHealthAssurance.com](https://www.ProvidenceHealthAssurance.com)

Helpful resources

- + Visit [ProvidenceHealthAssurance.com/findaprovider](https://www.ProvidenceHealthAssurance.com/findaprovider) to see our plan's Provider and Pharmacy Directory or to request a printed copy. You can also call us to have a printed copy mailed to you.
- + Want to see our plan's formulary (list of Part D prescription drugs), including any restrictions? Visit [ProvidenceHealthAssurance.com/Formulary](https://www.ProvidenceHealthAssurance.com/Formulary), or give us a call for a printed copy.
- + To learn more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, view it online at www.Medicare.gov or request a printed copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Providence Medicare Align Group Plan + Rx 10/50/1000 (HMO)

Monthly Plan Premium	<p>Your coverage is provided through a contract with your employer or former employer or union.</p> <p>Please contact the employer or union's benefits administrator for information about your plan premium.</p> <p>In addition, you must continue to pay your Medicare Part B premium.</p>
Annual Medical Deductible	<p>\$0</p> <p>There is no medical deductible for in- or out-of-network services.</p>
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	<p>Your yearly limit(s) for this plan:</p> <p>In-network: \$1,500</p>

Benefits		In-network
Inpatient Hospital Coverage ¹		\$100 copayment each day for days 1-5 and \$0 copayment each day for day 6 and beyond
Outpatient Hospital Coverage ¹		\$75 copayment for outpatient surgery at a hospital facility
Ambulatory Surgery Center ¹		\$75 copayment for outpatient surgery at an Ambulatory Surgery Center
Doctor Visits	Primary Care Provider Visit	\$15 copayment
	Specialist Visit ²	\$20 copayment
Preventive Care		You pay nothing
Emergency Care		<p>\$50 copayment</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</p>
Urgently Needed Services		<p>\$25 copayment</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care.</p>

¹ Services may require prior authorization.

² Services may require a referral from your doctor.

Providence Medicare Align Group Plan + Rx 10/50/1000 (HMO)

Benefits		In-network
Diagnostic Services/ Labs/Imaging¹	Diagnostic Radiology Services (e.g. MRI, ultrasounds, CT scans) ¹	10% of the total cost
	Therapeutic Radiology Services	10% of the total cost
	Outpatient X-rays	10% of the total cost
	Diagnostic Tests and Procedures ¹	\$0 copayment
	Lab Services	\$0 copayment
Hearing Services	Medicare-Covered ²	\$20 copayment
	Routine Exam	\$0 copayment
	Hearing Aids	\$699 copayment per Advanced hearing aid or a \$999 copayment per Premium hearing aid
Dental Services²	Medicare-Covered	\$20 copayment
Vision Services	Medicare-Covered Exams ² /Screening	\$20 copayment per exam \$0 copayment for glaucoma screening
	Routine Exam	Allowance of up to \$60 per calendar year for a routine vision exam (including refraction)
	Medicare-Covered Eyewear	\$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery
	Routine Eyeglasses or Contact Lenses	Allowance of up to \$300 per calendar year for any combination of routine prescription eyewear
Mental Health Services¹	Inpatient Visit	\$100 copayment each day for days 1-5 and \$0 copayment each day for days 6-90
	Outpatient Individual and Group Therapy Visit	\$20 copayment

¹ Services may require prior authorization.

² Services may require a referral from your doctor.

Providence Medicare Align Group Plan + Rx 10/50/1000 (HMO)

Benefits	In-network
Skilled Nursing Facility (SNF) ¹	\$0 copayment each day for days 1-100
Physical Therapy ¹	\$20 copayment
Ambulance ¹	\$50 copayment
Transportation	Not covered
Medicare Part B Drugs ¹	20% of the total cost
Wellness Program	\$0 copayment for monthly gym membership with participating fitness clubs

¹ Services may require prior authorization.

² Services may require a referral from your doctor.

Prescription Drug Benefits

Providence Medicare Align Group Plan + Rx 10/50/1000 (HMO)

Prescription Drug Deductible	
Yearly Deductible (Applies to all tiers)	There is no prescription drug deductible for this plan.

Initial Coverage	You pay the following until your yearly out-of-pocket costs reach \$7,050. You may get your drugs at retail pharmacies and mail-order pharmacies.
------------------	---

Preferred Retail and Mail-Order Cost Sharing			
	Up to 30 days	Up to 60 days	Up to 90 days
Tier 1 (Generic)	\$10 copayment	\$20 copayment	\$30 copayment
Tier 2 (Brand Name)	50% of the total cost	50% of the total cost	50% of the total cost

Out-of-Network	Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Providence Medicare Align Group Plan + Rx 10/50/1000 (HMO).
Out-of-Network Initial Coverage	You will be reimbursed up to the plan's cost of the drugs minus the following for drugs purchased out-of-network until yearly out-of-pocket costs reach \$7,050.

Out-of-Network Cost Sharing			
	Up to 30 days	Up to 60 days	Up to 90 days
Tier 1 (Generic)	\$10 copayment	Not covered	Not covered
Tier 2 (Brand Name)	50% of the total cost	Not covered	Not covered

If you reside in a long-term facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. You may get drugs from a standard in-network pharmacy, but may pay more than you pay at a preferred in-network pharmacy. There is a \$1,000 annual out-of-pocket maximum for covered prescriptions. Once that is met, covered prescriptions are covered at no cost to you.

Prescription Drug Benefits

Providence Medicare Align Group Plan + Rx 10/50/1000 (HMO)

Coverage Gap (Applies to all tiers)	Because there is no coverage gap for the plan, this payment stage does not apply to you.
Catastrophic Coverage (Applies to all tiers, both in-network and out-of-network pharmacies)	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$7,050, you pay the greater of: 5% of the cost or \$3.95 copayment for generic (including brand drugs treated as generic) and a \$9.85 copayment for all other drugs.

The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445 (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-603-2340 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-603-2340 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-603-2340 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-603-2340 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-603-2340 (TTY: 711) 번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-603-2340 (телетайп: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-603-2340 (TTY: 711).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-603-2340 (телетайп: 711).

Mon-Khmer, Cambodian: ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 1-800-603-2340 (TTY: 711)។

Japanese: 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-603-2340 (TTY:711)まで、お電話にてご連絡ください。

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-603-2340 (መስማት ለተሳናቸው: 711)።

Cushite (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-603-2340 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-603-2340 (رقم هاتف الصم والبكم: (TTY: 711).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-603-2340 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-603-2340 (TTY: 711).

Laotian: ໂປດຊາບ: ຖ້າ ວ່າ ທ່ານ ອ້າ າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອດ້ າພາສາ, ໂດຍບໍ່ເສັຽ ງຄ່ າ, ແມ່ນ ນມພັ ອມໃຫ້ ທ່ານ. ໂທຮ 1-800-603-2340 (TTY: 711).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-603-2340 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-603-2340 (ATS: 711).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-603-2340 (TTY: 711)

Persian:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیرید.
فراهم می باشد. با 1-800-603-2340 (TTY: 711)