PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

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

Section I

Introduction to the Summary of Benefits for
Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
January 1, 2017 – December 31, 2017
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; Clark County in Washington

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This booklet gives you 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. To get a complete list of services we cover, please refer to the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan, such as **Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://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 http://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.

Sections in this booklet

- Things to Know About **Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

For additional information, call us at 1-800-603-2340. TTY users call 711.

Section I – Introduction to Summary of Benefits

Things to Know About Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)

Hours of Operation
You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time.

Providence Medicare Align Group + RX 10/50/1000 (HMO) Phone Numbers and Website
If you are a member of this plan, call toll-free 1-800-603-2340. TTY users call 711.
If you are not a member of this plan, call toll-free 1-800-457-6064. TTY users call 711.
Our website: www.ProvidenceHealthAssurance.com

Who can join?
To join **Providence Medicare Align Group Plan + RX 10/50/1000 (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 the following counties in Oregon: Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Linn, Marion, Multnomah, Polk, Washington, Wheeler, Yamhill; and Clark County in Washington.

Which doctors, hospitals, and pharmacies can I use?
Providence Medicare Align Group Plan + RX 10/50/1000 (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's Provider and Pharmacy Directory at our website (www.ProvidenceHealthAssurance.com/providerdirectory).
Or, call us and we will send you a copy of the Provider and Pharmacy Directory.

What do we cover?
- **Our plan members get *all* of the benefits covered by Original Medicare.**
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

Section I – Introduction to Summary of Benefits

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.ProvidenceHealthAssurance.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?
Our plan groups each medication into one of two "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Providence Health Assurance for details.

Section II – Summary of Benefits

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
How much is the monthly premium?	Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $1,500 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
Inpatient Hospital coverage[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: $100 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond Benefit periods begin the day you go into a hospital or skilled nursing facility and end when you haven't received any inpatient hospital care or skilled nursing facility care for 60 days in a row.
Doctor's Visits *(Primary and Specialists)*[2]	Primary care physician visit: In-network: $15 copay Specialist visit: In-network: $20 copay If your doctor provides additional services, a separate cost-sharing amount may apply.
Preventive Care	In-network: You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual routine physical exam • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
Preventive Care Continued	• Diabetes screening • Diabetes self-management training • Health and wellness education programs* • HIV screening • Immunizations • Medical nutrition therapy • Obesity screening and counseling to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care* • "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered. If your doctor provides additional services, a separate cost-sharing amount may apply. *Please refer to the benefit sections below for further description of benefits.
Emergency Care	$50 copay Worldwide Coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
Urgent Care	$25 copay Worldwide Coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.
Diagnostic Services/Labs/Imaging[1]	Diagnostic radiology services (such as MRIs, ultrasounds, CT scans): In-network: You pay 10% of the cost Diagnostic tests and procedures: In-network: You pay nothing Lab services: In-network: You pay nothing Outpatient x-rays: In-network: You pay 10% of the cost Therapeutic radiology services (such as radiation treatment for cancer): In-network: You pay 10% of the cost If your doctor provides additional services, a separate cost-sharing amount may apply.
Hearing Services[2]	Exam to diagnose and treat hearing and balance issues: In-network: $20 copay Hearing aids are <u>not</u> covered.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
Dental Services[2]	Limited dental services (this does not include services in connection with routine care, treatment, filling, removal, or replacement of teeth): In-network: $20 copay Medicare-covered dental includes surgery of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease, or services that would be covered if provided by a medical provider. Only Medicare-covered dental services are covered under this plan.
Vision Services[2]	Exam to diagnose and treat diseases and conditions of the eye: In-network: $20 copay Medicare-covered Preventive glaucoma screening In-network: You pay nothing Medicare-covered Eyeglasses or contact lenses after cataract surgery: In-network: You pay nothing Routine eye exam (for up to 1 every year): In-network: $15 copay Routine eyeglasses or contact lenses: In-network: Routine basic lenses, including glass or plastic, single vision, lined bifocal, lined trifocal, or lenticular prescription lens are covered in full. There is a $100 benefit limit for routine eyeglass frames or contacts every two calendar years. Routine Vision Services are administered by VSP at 1-800-877-7195.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
Mental Health Services[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-network: $100 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 Outpatient individual and group therapy visit: In-network: $20 copay Mental Health Services is administered by Optum at 1-800-711-4577
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. In-network: You pay nothing Benefit periods begin the day you go into a hospital or skilled nursing facility and end when you haven’t received any inpatient hospital care or skilled nursing facility care for 60 days in a row.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
Rehabilitation Services[1]	Occupational therapy visit: In-network: $20 copay Physical therapy and Speech and Language therapy visit: In-network: $20 copay
Ambulance[1]	$50 copay This copay applies to each way of a Medicare-covered or medically approved ambulance transport You pay a $25 copay for each authorized one-way transport from an out-of-network facility to an in-network facility.
Transportation	Not covered
Foot Care *(podiatry services)*[2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: In-network: $20 copay
Medical Equipment/Supplies[1]	Durable medical equipment and supplies: In-network: 20% of the cost Prosthetic devices: In-network: 20% of the cost Diabetic supplies such as monitoring supplies and therapeutic shoes or inserts: In-network: You pay nothing All in-network durable medical equipment (DME), such as therapeutic shoes or inserts, must be provided by Providence Home Services or other network provider

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
Wellness Programs *(e.g., fitness)*	$500 annual benefit for health and wellness classes offered at participating Providence facilities. In-network: You pay nothing The fitness/gym benefit includes free monthly membership at contracted gyms, orientation to the facility, and classes. Additionally, you can receive an at home fitness kit from our contracted vendors. In-network: You pay nothing
Medicare Part B Drugs[1]	For Part B drugs such as chemotherapy drugs: In-network: 20% of the cost Other Part B drugs: In-network: 20% of the cost A separate cost-sharing may apply for the administration of Part B medications.
Chiropractic Care[2]	Manual Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). In-network: $20 copay Benefit is limited to Medicare-covered chiropractic services.
Home Health Care[1]	In-network: You pay nothing All in-network home health care and services must be provided and arranged through Providence Home Services or other network provider.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. Original Medicare pays for your care once hospice begins. We may coordinate benefits with Original Medicare for any non-hospice related care provided plan rules are followed.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
Outpatient Substance Abuse[1]	Individual and group therapy visit: In-network: $20 copay Outpatient Substance Abuse Care is administered by Optum at 1-800-711-4577.
Outpatient Surgery[1]	Ambulatory surgical center: In-network: $75 copay Outpatient hospital: In-network: $75 copay
Renal Dialysis[1]	Medicare-covered renal dialysis treatment: In-network: You pay nothing Medicare-covered kidney disease education: In-network: You pay nothing

Section II – Summary of Benefits

PRESCRIPTION DRUG BENEFITS	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
How much do I pay?	**Drugs covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.ProvidenceHealthAssurance.com on the web. Different out-of-pocket costs may apply for people who -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Providence Medicare Align Group Plan + RX 10/50/1000 (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

PRESCRIPTION DRUG BENEFITS	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
How much do I pay? - Continued	If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. The plan charges a minimum cost sharing amount for certain low-cost drugs. If you request a formulary exception for a drug and Providence Medicare Align Group Plan + RX 10/50/1000 (HMO) approves the exception, you will pay the applicable generic or brand copay for that drug. You may get drugs from a standard in-network pharmacy, but may pay more than you pay at a preferred in-network pharmacy. **In-Network** $0 deductible. **Initial Coverage** You pay the following until total yearly out-of-pocket costs reach $4,950: **Retail Pharmacy** Tier 1: Generic • $10 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy. • $20 copay for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy. • $30 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy. • $10 copay for a one-month (30-day) supply of drugs in this tier from a standard pharmacy. • $20 copay for a two-month (60-day) supply of drugs in this tier from a standard pharmacy. • $30 copay for a three-month (90-day) supply of drugs in this tier from a standard pharmacy. Tier 2: Brand • 50% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy. • 50% coinsurance for a two-month (60-day) supply of drugs in this tier from a preferred pharmacy. • 50% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy.

PRESCRIPTION DRUG BENEFITS	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
How much do I pay? - Continued	• 50% coinsurance for a one-month (30-day) supply of drugs in this tier from a standard pharmacy. • 50% coinsurance for a two-month (60-day) supply of drugs in this tier from a standard pharmacy. • 50% coinsurance for a three-month (90-day) supply of drugs in this tier from a standard pharmacy. **Long Term Care Pharmacy** Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed. Tier 1: Generic • $10 copay for a one-month (34-day) supply of drugs in this tier. Tier 2: Brand • 50% coinsurance for a one-month (34-day) supply of drugs in this tier. **Mail Order** Tier 1: Generic • $10 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $20 copay for a two-month (60-day) supply of drugs in this tier from a preferred mail order pharmacy. • $30 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $10 copay for a one-month (30-day) supply of drugs in this tier from a standard mail order pharmacy. • $20 copay for a two-month (60-day) supply of drugs in this tier from a standard mail order pharmacy. • $30 copay for a three-month (90-day) supply of drugs in this tier from a standard mail order pharmacy.

PRESCRIPTION DRUG BENEFITS	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
How much do I pay? - Continued	Tier 2: Brand • 50% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • 50% coinsurance for a two-month (60-day) supply of drugs in this tier from a preferred mail order pharmacy. • 50% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • 50% coinsurance for a one-month (30-day) supply of drugs in this tier from a standard mail order pharmacy. • 50% coinsurance for a two-month (60-day) supply of drugs in this tier from a standard mail order pharmacy. • 50% coinsurance for a three-month (90-day) supply of drugs in this tier from a standard mail order 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. **Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,950, you pay the greater of: • 5% coinsurance, or • $3.30 copay for generic (including brand drugs treated as generic) and $8.25 copay for all other drugs. **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).

Section II – Summary of Benefits

PRESCRIPTION DRUG BENEFITS	
	Providence Medicare Align Group Plan + RX 10/50/1000 (HMO)
How much do I pay? - Continued	**Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly out-of-pocket costs reach $4,950: Tier 1: Generic • $10 copay for a one-month (30-day) supply of drugs in this tier. Tier 2: Brand • 50% coinsurance for a one-month (30-day) supply of drugs in this tier. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. **Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,950, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $3.30 copay for generic (including brand drugs treated as generic) and $8.25 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.