Providence
Medicare Advantage Plans

2025 Summary of Benefits

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

January 1, 2025 – December 31, 2025

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 are not just part of an insurance policy but part of a community of care, focused on your health and well-being. This Summary of Benefits is provided to help you make the right health care decisions. It is a short guide of what we would cover and what you would pay if you joined our Providence Medicare Align Group Plan + Rx 10/50/1000 (HMO). To be clear, this is not a complete breakdown of benefits, and will not list every service that we cover, nor every limitation or exclusion. Plans may offer supplemental benefits in addition to Part C 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 visiting **ProvidenceHealthAssurance.com/EOC** or by calling our Customer Service department at one of the numbers listed in the "Get in touch" section below.

Plan Overview

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

Not only do our plan members get all of the benefits covered by Original Medicare, they also get 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 / 1-800-855-7100)
- You can also visit us online at **ProvidenceHealthAssurance.com**

Helpful Resources

- Visit **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**, 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.

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

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 Surgical Center (ASC) Services[1]		$75 copayment for outpatient surgery at an Ambulatory Surgical Center
Doctor Visits	Primary Care Provider Visit	$15 copayment
	Specialist Visit	$20 copayment
Preventive Care (e.g., annual check-up, immunizations, flu shot)		You pay nothing
Emergency Care		$50 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived.
Urgently Needed Services		$25 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.

[1] Services may require prior authorization. See the Evidence of Coverage for more information.

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Benefits		In-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans)[1]	10% of the total cost
	Therapeutic Radiology Services[1]	10% of the total cost
	Outpatient X-rays	10% of the total cost
	Diagnostic Tests and Procedures[1]	$0 copayment
	Lab Services[1]	$0 copayment
Hearing Services	Medicare-Covered	$20 copayment
	Routine Exam	$0 copayment
	Hearing Aids	$699 copayment per Advanced hearing aid or $999 copayment per Premium hearing aid
Dental Services	Medicare-Covered[1]	$20 copayment
Vision Services	Medicare-Covered Exams/Screening	$20 copayment per exam $0 copayment for glaucoma screening
	Routine Exam	There is no coinsurance, or copayment for one routine vision exam (including refraction) per calendar year.
	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 Services	Inpatient Visit[1]	$100 copayment each day for days 1-5 and $0 copayment each day for days 6-90
	Outpatient Individual[1] and Group Therapy Visit[1]	$20 copayment

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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]	0% - 20% of the total cost (Insulin cost share up to $35 per month)
Wellness Program	$0 copayment for monthly gym membership with participating fitness clubs
Wig	There is no coinsurance, or copayment for one synthetic wig due to hair loss from chemotherapy

[1] Services may require prior authorization. See the Evidence of Coverage for more information.

Prescription Drug Benefits

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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 total yearly out-of-pocket costs reach $1,000. You may get your drugs at network retail pharmacies and mail-order pharmacies.

Preferred Retail and Mail-Order Cost Sharing			
	Up to 30 days	**Up to 60 days**	**Up to 100 days**
Tier 1 (Generic)	$10 copayment	$20 copayment	$30 copayment
Tier 2 (Brand)	50% of the total cost (Insulin cost share up to $35 per month)	50% of the total cost (Insulin cost share up to $70 per month)	50% of the total cost (Insulin cost share up to $105 per month)

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 your yearly out-of-pocket costs reach $1,000.

Out-Of-Network Cost Sharing			
	Up to 30 days	**Up to 60 days**	**Up to 100 days**
Tier 1 (Generic)	$10 copayment	Not covered	Not covered
Tier 2 (Brand)	50% of the total cost (Insulin cost share up to $35 per month)	Not covered	Not covered

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If you reside in a long-term care 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.

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 $1,000, the plan pays the full cost for your Part D covered drugs. You pay nothing.

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

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

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. For 2025, referrals are no longer required for in-network specialists visits and Medicare-covered services.