PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

2021 Summary of Benefits

Providence Medicare Align Group Plan + Rx (HMO), an Oregon Public Employees Retirement System (PERS) employer group plan, offered by Providence Health Assurance

January 1, 2021 – December 31, 2021

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.

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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 (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.

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/PHIP** or 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**

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/PHIP**, 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 (HMO)

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.
Deductible	$0 There is no medical deductible for in- or out-of-network services.
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 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		$50 copayment If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services		$25 copayment If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care.

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

Providence Medicare Align Group Plan + Rx (HMO)

Benefits		In-network
Diagnostic Services/ Labs/Imaging[1]	Diagnostic Radiology Services (e.g. MRI, ultrasounds, CT scans)	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	$0 copayment
	Lab Services	$0 copayment
Hearing Services	Medicare-Covered[2]	$20 copayment
	Routine Exam	$45 copayment
	Hearing Aids	$699 copayment per Advanced hearing aid or a $999 copayment per Premium hearing aid
Dental Services[2]	Medicare-Covered	$20 copayment
Vision Services	Medicare-Covered Exams[2]/Screening	$20 copayment per exam $0 copayment for glaucoma screening
	Routine Exam	$15 copayment for one exam per calendar year with a qualified licensed provider
	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 $100 every two calendar years for any combination of routine prescription eyewear
Mental Health Services[1]	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

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[2] Services may require a referral from your doctor.

Providence Medicare Align Group Plan + Rx (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
Medicare-Covered Foot Care (podiatry services)[2]		$20 copayment
Medical Equipment and Supplies[1]	Durable Medical Equipment and Supplies	20% of the total cost
	Prosthetic Devices	20% of the total cost
	Diabetic Supplies	$0 copayment
	Diabetic Therapeutic Shoes or Inserts	0% of the total cost
Wellness Program		$0 copayment for monthly gym membership with contracted 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 (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 $6,550. You may get your drugs at retail pharmacies and mail-order pharmacies.		
Retail and Mail-Order Cost Sharing			
	Up to 31 days	**Up to 62 days**	**Up to 93 days**
Tier 1 (Preferred Generic)	**Retail and Mail:** $8 copayment	**Retail and Mail:** $16 copayment	**Retail:** $24 copayment **Mail:** $16 copayment
Tier 2 (Generic)	**Retail and Mail:** $15 copayment	**Retail and Mail:** $30 copayment	**Retail:** $45 copayment **Mail:** $30 copayment
Tier 3 (Preferred Brand Name)	**Retail and Mail:** 40% up to $250 max.	**Retail and Mail:** 40% up to $500 max.	**Retail and Mail:** 40% up to $750 max.
Tier 4 (Non-Preferred Drug)	**Retail and Mail:** 40% up to $250 max.	**Retail and Mail:** 40% up to $500 max.	**Retail and Mail:** 40% up to $750 max.
Tier 5 (Specialty)	**Retail and Mail:** 40% up to $250 max.	Not offered	Not offered
Tier 6 ($0 Part D Vaccines)	**Retail and Mail:** $0 copayment	Not applicable	Not applicable

Prescription Drug Benefits

Providence Medicare Align Group Plan + Rx (HMO)

Out-of-Network Cost Sharing			
	Up to 31 days	**Up to 62 days**	**Up to 93 days**
Tier 1 (Preferred Generic)	$8 copayment plus any difference in the cost if you were to have used a standard pharmacy	Not offered	Not offered
Tier 2 (Generic)	$15 copayment plus any difference in the cost if you were to have used a standard pharmacy	Not offered	Not offered
Tier 3 (Preferred Brand Name)	40% of the cost plus any difference in the cost if you were to have used a standard pharmacy up to a maximum of $250	Not offered	Not offered
Tier 4 (Non-Preferred Drug)			
Tier 5 (Specialty)			
Tier 6 ($0 Part D Vaccines)	$0 copayment	Not offered	Not offered

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.

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)	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay $0 for the remainder of the calendar year.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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