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

Annual Notice of Changes for 2022

You are currently enrolled as a member of Providence Medicare Flex Group Plan + Rx (HMO-POS). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **The PERS Health Insurance Program (PHIP) Annual Plan Change period is October 1 to November 15. These changes will be effective January 1, 2022.**
- **Medicare plans not offered by PHIP have an annual enrollment period from October 15 until December 7 to make changes to your coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket

costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Sections 1.3 and 1.4 for information about our *Provider and Pharmacy Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you want to **keep** your Providence Medicare Flex Group Plan + Rx (HMO-POS) plan with PHIP, you don't need to do anything. You will stay enrolled in the Providence Medicare Flex Group Plan + Rx (HMO-POS).
- If you decide a different PHIP plan will better meet your needs, you can switch to another PHIP plan between October 1 and November 15. If you enroll in a new PHIP plan, your coverage will begin on January 1, 2022.
- The information below is for general Medicare enrollment; contact the PERS Health Insurance Program for details regarding their enrollment and Plan Change guidelines.

- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change to a different PHIP Plan during the PHIP Plan Change period of October 1 through November 15, 2021, contact PHIP or go online at www.pershealth.com for more information. The following information is for general Medicare enrollment; contact PHIP for details regarding their enrollment and Plan Change guidelines.
   - To change to a plan outside of PHIP, join a plan between **October 15** and **December 7, 2021**.
   - If you don't join another plan by **December 7, 2021**, you stay in Providence Medicare Flex Group Plan + Rx (HMO-POS) plan with PHIP.
   - If you join another plan by **December 7, 2021**, your new coverage will start on **January 1, 2022.**

Additional Resources

- This Plan, Providence Medicare Flex Group Plan + Rx (HMO-POS), is a PERS Health Insurance Program (PHIP) employer group plan. Disenrolling from the Providence Medicare Flex Group Plan + Rx (HMO-POS) will disenroll you from PHIP. If you would like to make a change, you may call PHIP to discuss your options at 1-800-768-7377 or local 503-224-7377 (TTY users call 711) from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday. If you leave PHIP you may not be able to rejoin at a later date.
- This information is available in a different format, including large print and braille.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Providence Medicare Flex Group Plan + Rx (HMO-POS)

- 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.
- When this booklet says "we," "us," or "our," it means Providence Health Assurance. When it says "plan" or "our plan," it means Providence Medicare Flex Group Plan + Rx (HMO-POS).

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Providence Medicare Flex Group Plan + Rx (HMO-POS) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.ProvidenceHealthAssurance.com/PHIP. You may also call Providence Health Assurance Customer Service to ask us to mail you an *Evidence of Coverage*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower depending upon your circumstances. See Section 1.1 for details.	Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2021.	Premium amounts are changing starting January 1, 2022. Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2022.
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$3,000 when using your in-network benefit $3,000 when using your Point-of-Service (POS) benefit	$3,000 when using your in-network benefit $3,000 when using your Point-of-Service (POS) benefit
Doctor office visits	Primary care visits in-network: $20 copayment per visit Primary care visits when using your POS benefit: $30 copayment per visit Specialist visits in-network: $25 copayment per visit Specialist visits when using your POS benefit: $35 copayment per visit	Primary care visits in-network: $20 copayment per visit Primary care visits when using your POS benefit: $30 copayment per visit Specialist visits in-network: $25 copayment per visit Specialist visits when using your POS benefit: $35 copayment per visit

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	Hospital stays in-network: $125 copayment each day for days 1-4 and there is no coinsurance, copayment, or deductible each day for day 5 and beyond for Medicare-covered inpatient hospital care Hospital stays when using your POS benefit: 20% of the total cost per stay for Medicare-covered inpatient hospital care	Hospital stays in-network: $125 copayment each day for days 1-4 and there is no coinsurance, copayment, or deductible each day for day 5 and beyond for Medicare-covered inpatient hospital care Hospital stays when using your POS benefit: 20% of the total cost per stay for Medicare-covered inpatient hospital care
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: Up to an $8 copayment at a preferred network pharmacy or up to an $8 copayment at a network pharmacy • Drug Tier 2: Up to a $15 copayment at a preferred network pharmacy or up to a $15 copayment at a network pharmacy	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: Up to an $8 copayment at a preferred network pharmacy or up to an $8 copayment at a network pharmacy • Drug Tier 2: Up to a $15 copayment at a preferred network pharmacy or up to a $15 copayment at a network pharmacy

Cost	2021 (this year)	2022 (next year)
	• Drug Tier 3: 40% of the total cost up to a maximum of $250 per prescription at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 per prescription at a network pharmacy	• Drug Tier 3: 40% of the total cost up to a maximum of $250 per prescription at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 per prescription at a network pharmacy
	• Drug Tier 4: 40% of the total cost up to a maximum of $250 per prescription at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 per prescription at a network pharmacy	• Drug Tier 4: 40% of the total cost up to a maximum of $250 per prescription at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 per prescription at a network pharmacy
	• Drug Tier 5: 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy	• Drug Tier 5: 40% of the total cost up to a maximum of $250 at a preferred network pharmacy or 40% of the total cost up to a maximum of $250 at a network pharmacy
	• Drug Tier 6: $0 copayment at a preferred network pharmacy or $0 copayment at a network pharmacy	• Drug Tier 6: $0 copayment at a preferred network pharmacy or $0 copayment at a network pharmacy

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2021.	Premium amounts are changing starting January 1, 2022. Your total premium is set by PHIP. Please contact PHIP for premium amounts for 2022.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an extra Part D amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,000 In-Network $3,000 Out-of-Network	$3,000 In-Network $3,000 Out-of-Network Once you have paid $3,000 out-of-pocket for covered services from in-network or out-of-network providers, you will pay nothing for your covered services for the rest of the calendar year. There is no change for the upcoming benefit year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.ProvidenceHealthAssurance.com/PHIP. You may also call Providence Health Assurance Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2022 *Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.ProvidenceHealthAssurance.com/PHIP. You may also call Providence Health Assurance Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2022 *Provider and Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Fitness benefit	**In-Network** The Silver&Fit® Healthy Aging and Exercise Program is offered to eligible Medicare Advantage beneficiaries. The following choices are available to you at no cost: You can select one fitness center membership, one Stay Fit Kit, and one Home Fitness Kit each benefit year. **Out-of-Network** Out-of-network services are not covered for the fitness benefit.	**In-Network** The Silver&Fit® Healthy Aging and Exercise Program is offered to eligible Medicare Advantage beneficiaries. The following choices are available to you at no cost: You can select one fitness center membership and one Home Fitness Kit each benefit year. You also have access to the Premium Fitness Network for an additional cost per month. **Out-of-Network** Out-of-network services are not covered for the fitness benefit.

Cost	2021 (this year)	2022 (next year)
Health and wellness classes	**In-Network** Health and wellness includes educational classes on the topics of weight management, stress reduction, fall prevention, pain education, osteoporosis, yoga, childbirth, smoking cessation, progressive disorders, and nutrition offered at participating Providence facilities. You have an allowance of $500 for health and wellness classes. **Out-of-Network** Out-of-network services are not covered for health and wellness classes.	**In-Network** Health and wellness includes educational classes on the topics of weight management, stress reduction, fall prevention, pain education, urinary incontinence-pelvic floor, osteoporosis, yoga, smoking cessation, progressive disorders and nutrition. You may access classes offered virtually through participating facilities. You have an unlimited allowance for health and wellness classes. **Out-of-Network** Out-of-network services are not covered for health and wellness classes.

Cost	2021 (this year)	2022 (next year)
Hearing aids	**In-Network** This benefit is administered by TruHearing You pay a $699 copayment per Advanced hearing aid or a $999 copayment per Premium hearing aid. You pay an additional $50 for rechargeable style hearing aids. Hearing Aid purchases include: • 3 provider visits within first year of hearing aid purchase • 45-day trial period • 3-year extended warranty • 48 batteries per aid for non-rechargeable models **Out-of-Network** Out-of-network services are not covered for hearing aids.	**In-Network** This benefit is administered by TruHearing You pay a $399 copayment per Advanced hearing aid or a $699 copayment per Premium hearing aid. You pay an additional $0 for rechargeable style hearing aids. Hearing Aid purchases include: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models **Out-of-Network** Out-of-network services are not covered for hearing aids.
Opioid treatment program services	**In-Network** You pay a $20 copayment in primary care setting and a $25 copayment in specialty care setting for each Medicare-covered opioid treatment program services visit.	**In-Network** There is no coinsurance, copayment, or deductible for services with an Opioid treatment provider enrolled with Medicare. You pay a $20 copayment in primary care setting and you pay a $25 copayment in specialty care setting for each Medicare-covered opioid treatment program services visit.

Cost	2021 (this year)	2022 (next year)
Other health care professionals (e.g., nurse practitioner; physician assistant)	**In-Network** You pay a $20 copayment in primary care setting and a $25 copayment in specialty care setting for each Medicare-covered visit.	**In-Network** You pay a $0-$20 copayment in primary care setting and a $25 copayment in specialty care setting for each Medicare-covered visit.
Routine hearing services	**In-Network** This benefit is administered by TruHearing You pay a $45 copayment for each routine hearing exam. Routine hearing aid fitting/evaluation visits are not covered. **Out-of-Network** Out-of-network services are not covered for routine hearing services.	**In-Network** This benefit is administered by TruHearing There is no coinsurance, copayment, or deductible for each routine hearing exam. There is no coinsurance, copayment, or deductible for routine hearing aid fitting/evaluation visits. **Out-of-Network** Out-of-network services are not covered for routine hearing services.
Routine vision care	**In-Network and Out-of-Network** You have an allowance up to $100 every two calendar years for a combination of routine prescription contacts, routine prescription lenses, routine vision frames, and/or upgrades, such as tinting.	**In-Network and Out-of-Network** You have an allowance up to $200 every two calendar years for a combination of routine prescription contacts, routine prescription lenses, routine vision frames, and/or upgrades, such as tinting.
Telehealth	**In-Network** You pay a $20 copayment in primary care setting and a $25 copayment in specialty care setting for additional Medicare-covered telehealth services.	**In-Network** You pay a $0-$20 copayment in primary care setting and a $25 copayment in specialty care setting for additional Medicare-covered telehealth services.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Providence Health Assurance Customer Service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Providence Health Assurance Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you had an approved formulary exception during the previous year, a new request may need to be submitted for the current year. To see if you need a new formulary exception request, you may call Providence Health Assurance Customer Service.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Providence Health Assurance Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.ProvidenceHealthAssurance.com/PHIP. You may also call Providence Health Assurance Customer Service to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	**Tier 1 Preferred Generic:** You pay up to an $8 copayment for each prescription filled, up to a 31-day supply from a retail or mail-order pharmacy. You pay up to a $16 copayment for each prescription filled, up to a 62-day supply from a retail or mail-order pharmacy. You pay up to a $24 copayment for each prescription filled, up to a 93-day supply from a retail pharmacy and a $16 copayment for up to a 93-day supply from a mail-order pharmacy.	**Tier 1 Preferred Generic:** You pay up to an $8 copayment for each prescription filled, up to a 31-day supply from a retail or mail-order pharmacy. You pay up to a $16 copayment for each prescription filled, up to a 62-day supply from a retail or mail-order pharmacy. You pay up to a $24 copayment for each prescription filled, up to a 93-day supply from a retail pharmacy and a $16 copayment for up to a 93-day supply from a mail-order pharmacy.

Stage	2021 (this year)	2022 (next year)
	Tier 2 Generic: You pay up to a $15 copayment for each prescription filled, up to a 31-day supply from a retail or mail-order pharmacy. You pay up to a $30 copayment for each prescription filled, up to a 62-day supply from a retail or mail-order pharmacy. You pay up to a $45 copayment for each prescription filled, up to a 93-day supply from a retail pharmacy and a $30 copayment for up to a 93-day supply from a mail-order pharmacy.	**Tier 2 Generic:** You pay up to a $15 copayment for each prescription filled, up to a 31-day supply from a retail or mail-order pharmacy. You pay up to a $30 copayment for each prescription filled, up to a 62-day supply from a retail or mail-order pharmacy. You pay up to a $45 copayment for each prescription filled, up to a 93-day supply from a retail pharmacy and a $30 copayment for up to a 93-day supply from a mail-order pharmacy.
	Tier 3 Preferred Brand Name: You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply from a retail or mail-order pharmacy. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 62-day supply from a retail or mail-order pharmacy. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 93-day supply from a retail or mail-order pharmacy.	**Tier 3 Preferred Brand:** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply from a retail or mail-order pharmacy. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 62-day supply from a retail or mail-order pharmacy. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 93-day supply from a retail or mail-order pharmacy.

Stage	2021 (this year)	2022 (next year)
	Tier 4 Non-Preferred Drug: You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply from a retail or mail-order pharmacy. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 62-day supply from a retail or mail-order pharmacy. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 93-day supply from a retail or mail-order pharmacy.	**Tier 4 Non-Preferred Drug:** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply from a retail or mail-order pharmacy. You pay 40% of the total cost up to a maximum of $500 for each prescription filled, up to a 62-day supply from a retail or mail-order pharmacy. You pay 40% of the total cost up to a maximum of $750 for each prescription filled, up to a 93-day supply from a retail or mail-order pharmacy.
	Tier 5 Specialty: You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply.	**Tier 5 Specialty:** You pay 40% of the total cost up to a maximum of $250 for each prescription filled, up to a 31-day supply.
	Tier 6 $0 Part D Vaccines: You pay a $0 copayment for each prescription filled, up to a 31-day supply.	**Tier 6 $0 Part D Vaccines:** You pay a $0 copayment for each prescription filled, up to a 31-day supply.
	Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Once you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2021 (this year)	2022 (next year)
Medicare Part B prescription drugs - Step Therapy requirement.	There is no step therapy requirement for Medicare Part B prescription drugs.	Medicare Part B prescription drugs may be subject to a step therapy requirement. Refer to the 2022 *Evidence of Coverage* for additional information.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Providence Medicare Flex Group Plan + Rx (HMO-POS)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan offered by the PERS Health Insurance Program by November 15 or change to a Medicare Plan not offered by PHIP or to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2022.

Section 3.2 – If you want to change plans

The Providence Medicare Flex Group Plan + Rx (HMO-POS) plan is sponsored by PHIP. Disenrolling from the Providence Medicare Flex Group Plan + Rx (HMO-POS) will disenroll you from PHIP.

If you would like to make a change, you may call PHIP to discuss your options at 1-800-768-7377 or local 503-224-7377 (TTY users call 711) from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday. If you leave the PERS Health Insurance Plan, you may not be able to return to the PHIP at a later date.

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can change to a different PHIP plan.
- You can join a different Medicare health plan timely,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Providence Health Assurance offers other Medicare health plans These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- You can change to a different PHIP plan offered by Providence Health Assurance or another PHIP health plan. You will need to decide between October 1 and November 15.
- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Providence Medicare Flex Group Plan + Rx (HMO-POS).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Providence Medicare Flex Group Plan + Rx (HMO-POS).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Providence Health Assurance Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different PHIP health plan for next year, you can do it from October 1 through November 15. The change will take effect on January 1, 2022. Please see below if you would like to change to a Medicare plan not offered by PHIP or to Original Medicare.

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA). In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (also SHIBA).

SHIBA is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIBA counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIBA in Oregon at 1-800-722-4134 (TTY 711). You can call SHIBA in Washington at 1-800-562-6900 (TTY 360-586-0241). You can learn more about SHIBA by visiting their website (www.healthcare.oregon.gov/shiba or www.insurance.wa.gov/shiba).

OREGON:
SHIBA
Oregon Insurance Division
P.O. Box 14480
Salem, OR 97309

WASHINGTON:
SHIBA
Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through CAREAssist in Oregon or Early Intervention Program (EIP) in Washington. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call CAREAssist at 971-673-0144 or 1-800-805-2313 (TTY 711) or EIP at 1-877-376-9316.

SECTION 7 Questions?

Section 7.1 – Getting Help from Providence Medicare Flex Group Plan + Rx (HMO-POS)

Questions? We're here to help. Please call Providence Health Assurance Customer Service at 503-574-8000 or 1-800-603-2340. (TTY only, call 711). We are available for phone calls 8 a.m. to 8 p.m. (Pacific Time), seven days a week. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for Providence Medicare Flex Group Plan + Rx (HMO-POS). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at

www.ProvidenceHealthAssurance.com/PHIP. You may also call Providence Health Assurance Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.ProvidenceHealthAssurance.com/PHIP. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare.)

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or 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.

How to contact PERS Health Insurance Program (PHIP) Customer Service

For assistance with plan premiums, changes, updating your name, address, and phone numbers, please call or write to PHIP Customer Service.

Method	PERS Health Insurance Program (PHIP) Customer Service – Contact Information
CALL	**1-800-768-7377** Calls to this number are free. Customer Service is available from 7:30 a.m. to 5:30 p.m., Pacific Time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. This number is available 24 hours a day, seven days a week.
FAX	503-765-3452 or 1-888-393-2943
WRITE	**PERS Health Insurance Program (PHIP)** P.O. Box 40187 Portland, OR 97240-0187 persinfo@pershealth.com
WEBSITE	www.pershealth.com