PROVIDENCE
Medicare Advantage Plans

A division of Providence Health Assurance

2022 Summary of Benefits

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

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 Flex Group Plan + Rx (HMO-POS) 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 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/PHIP**

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 Flex Group Plan + Rx (HMO-POS)

<table>
<tr><td>Monthly Plan Premium</td><td colspan="2">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.</td></tr>
<tr><td>Annual Medical Deductible</td><td colspan="2">$0
There is no medical deductible for in- or out-of-network services.</td></tr>
<tr><td rowspan="2">Maximum Out-of-Pocket Responsibility (does not include prescription drugs)</td><td colspan="2">Your yearly limit(s) for this plan:</td></tr>
<tr><td>In-network: $3,000</td><td>Out-of-network: $3,000 combined</td></tr>
</table>

<table>
<tr><th colspan="2">Benefits</th><th>In-network</th><th>Out-of-network</th></tr>
<tr><td colspan="2">Inpatient Hospital Coverage[1]</td><td>$125 copayment each day for days 1-4 and $0 copayment each day for day 5 and beyond</td><td>20% of the total cost per stay</td></tr>
<tr><td colspan="2">Outpatient Hospital Coverage[1]</td><td>$150 copayment for outpatient surgery at a hospital facility</td><td>20% of the total cost</td></tr>
<tr><td colspan="2">Ambulatory Surgery Center[1]</td><td>$150 copayment for outpatient surgery at an Ambulatory Surgery Center</td><td>20% of the total cost</td></tr>
<tr><td rowspan="2">Doctor Visits</td><td>Primary Care Provider Visit</td><td>$20 copayment</td><td>$30 copayment</td></tr>
<tr><td>Specialist Visit[2]</td><td>$25 copayment
$35 copayment no referral</td><td>$35 copayment</td></tr>
<tr><td colspan="2">Preventive Care</td><td colspan="2">You pay nothing</td></tr>
<tr><td colspan="2">Emergency Care</td><td colspan="2">$65 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.</td></tr>
</table>

Out-of-network/non-contracted providers are under no obligation to treat Providence Medicare Advantage Plans 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.

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

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

Benefits		In-network	Out-of-network
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.	
Diagnostic Services/ Labs/Imaging[1]	Diagnostic Radiology Services (e.g. MRI, ultrasounds, CT scans)[1]	10% of the total cost	20% of the total cost
	Therapeutic Radiology Services	10% of the total cost	20% of the total cost
	Outpatient X-rays	10% of the total cost	20% of the total cost
	Diagnostic Tests and Procedures[1]	$0 copayment	20% of the total cost
	Lab Services	$0 copayment	20% of the total cost
Hearing Services	Medicare-Covered[2]	$25 copayment	$35 copayment
	Routine Exam	$0 copayment	Not covered
	Hearing Aids	$399 copayment per Advanced hearing aid or a $699 copayment per Premium hearing aid	Not covered
Dental Services[2]	Medicare-Covered	$25 copayment	$35 copayment
Vision Services	Medicare-Covered Exams/Screening[2]	$25 copayment per exam $0 copayment for glaucoma screening	$35 copayment per exam $0 copayment for glaucoma screening
	Routine Exam	$20 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	20% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery
	Routine Eyeglasses or Contact Lenses	Allowance of up to $200 every two calendar years for any combination of routine prescription eyewear	

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

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

Benefits		In-network	Out-of-network
Mental Health Services[1]	Inpatient Visit	$125 copayment each day for days 1-4 and $0 copayment each day for days 5-90	20% of the total cost per stay
	Outpatient Individual and Group Therapy Visit	$25 copayment	$35 copayment
Skilled Nursing Facility (SNF)[1]		$0 copayment each day for days 1-20 and $50 copayment each day for days 21-100	20% of the total cost for each benefit period (days 1-100)
Physical Therapy[1]		$25 copayment	$35 copayment
Ambulance[1]		$50 copayment	
Transportation		Not covered	
Medicare Part B drugs[1]		20% of the total cost	20% of the total cost
Medicare-Covered Foot Care (podiatry services)[2]		$25 copayment	$35 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	20% of the total cost
	Diabetic Therapeutic Shoes or Inserts	$0 copayment	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 Flex Group Plan + Rx (HMO-POS)

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.		
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:** Up to an $8 copayment	**Retail and Mail:** Up to a $16 copayment	**Retail:** Up to a $24 copayment **Mail:** Up to a $16 copayment
Tier 2 (Generic)	**Retail and Mail:** Up to a $15 copayment	**Retail and Mail:** Up to a $30 copayment	**Retail:** Up to a $45 copayment **Mail:** Up to a $30 copayment
Tier 3 (Preferred Brand)	**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 Flex Group Plan + Rx (HMO-POS)

Out-of-Network Cost Sharing			
	Up to 31 days	**Up to 62 days**	**Up to 93 days**
Tier 1 (Preferred Generic)	Up to an $8 copayment plus any difference in the cost if you were to have used a standard pharmacy	Not offered	Not offered
Tier 2 (Generic)	Up to a $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)	40% of the total 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 $7,050, you pay $0 for the remainder of the calendar year.

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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 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 ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ 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: ຖ້ າວ່ າ ທ່ ານເວົ້ າພາສາ ລາວ, ການບໍລິການຊ່ ວຍເຫຼ ອດ້ ານພາສາ, ໂດຍບໍ່ເສັ ຽຄ່ າ, ແມ່ ນມພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 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 فراهم می باشد. با (TTY: 711) 1-800-603-2340 تماس بگیرید.