

## Section 1

Introduction to the Summary of Benefits for  
**Providence Medicare Choice + RX (HMOPOS)**  
January 1, 2010 - December 31, 2010  
Portland Metro, Willamette Valley and Clark County

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Thank you for your interest in Providence Medicare Choice + RX (HMOPOS). Our plan is offered by PROVIDENCE HEALTH PLAN, a Medicare Advantage Health Maintenance Organization (HMO), with a point-of-service option (POS). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Providence Medicare Choice + RX (HMOPOS) and ask for the "Evidence of Coverage".

### **YOU HAVE CHOICES IN YOUR HEALTH CARE**

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Providence Medicare Choice + RX (HMOPOS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Providence Medicare Choice + RX (HMOPOS) at the number listed at the end of this introduction or 1-800-Medicare (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

### **HOW CAN I COMPARE MY OPTIONS?**

You can compare Providence Medicare Choice + RX (HMOPOS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

### **WHERE IS PROVIDENCE MEDICARE CHOICE + RX (HMOPOS) AVAILABLE?**

The service area for this plan includes: Clackamas, Columbia, Lane, Marion, Multnomah, Polk, Washington, Yamhill Counties, OR; and Clark County, WA. You must live in one of these areas to join the plan.

### **WHO IS ELIGIBLE TO JOIN PROVIDENCE MEDICARE CHOICE + RX (HMOPOS)?**

You can join Providence Medicare Choice + RX (HMOPOS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Providence Medicare Choice + RX (HMOPOS) unless they are members of our organization and have been since their dialysis began.

### **CAN I CHOOSE MY DOCTORS?**

Providence Medicare Choice + RX (HMOPOS) has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory or for an up-to-date list or visit us at [www.providence.org/healthplans](http://www.providence.org/healthplans). Our customer service number is listed at the end of this introduction.

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### **WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?**

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

### **DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?**

Providence Medicare Choice + RX (HMOPOS) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

### **WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?**

Providence Medicare Choice + RX (HMOPOS) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at [www.providence.org/php/medicarepharmacy](http://www.providence.org/php/medicarepharmacy). Our customer service number is listed at the end of this introduction.

### **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

Providence Medicare Choice + RX (HMOPOS) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at [www.providence.org/php/medicarepharmacy](http://www.providence.org/php/medicarepharmacy).

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

### **HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?**

You may be able to get extra help to pay for your prescription drug premiums and costs.

To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

### **WHAT ARE MY PROTECTIONS IN THIS PLAN?**

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Providence Medicare Choice + RX (HMOPOS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Acumentra Health 1-800-785-0411.

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### WHAT ARE MY PROTECTIONS IN THIS PLAN? Cont...

As a member of Providence Medicare Choice + RX (HMOPOS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Aumentra Health 1-800-785-0411.

### WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Providence Medicare Choice + RX (HMOPOS) for more details.

### WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Providence Medicare Choice + RX (HMOPOS) for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin alpha or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and infusion drugs** provided through DME.

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### PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on [www.medicare.gov](http://www.medicare.gov) and select “Compare Medicare Prescription Drug Plans” or “Compare Health Plans and Medigap Policies in Your Area” to compare the plan ratings for Medicare plans in your area. You can also call us directly at (800)-603-2340 to obtain a copy of the plan ratings for this plan. TTY users call (888)-244-6642.

Please call Providence Health Plan for more information about Providence Medicare Choice + RX (HMOPOS). Visit us at [www.providence.org/healthplans](http://www.providence.org/healthplans) or, call us: Customer Service Hours: Daily between 8 a.m. - 8 p.m. (Pacific).

Current members should call toll-free (800)-603-2340 for questions related to the Medicare Advantage Program.  
(TTY/TDD (888)-244-6642)

Prospective members should call toll-free (800)-457-6064 for questions related to the Medicare Advantage Program.  
(TTY/TDD (888)-244-6642)

Current members should call toll-free (800)-603-2340 for questions related to the Medicare Part D Prescription Drug program.  
(TTY/TDD (888)-244-6642)

Prospective members should call toll-free (800)-457-6064 for questions related to the Medicare Part D Prescription Drug program.  
(TTY/TDD (888)-244-6642)

For more information about Medicare, please call Medicare at 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit [www.medicare.gov](http://www.medicare.gov) on the web.

If you have special needs, this document may be available in other formats.

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>IMPORTANT INFORMATION</b>		
<p><b>1 - Premium and Other Important Information</b></p>	<p>In 2010 the monthly Part B Premium is \$110.50 and the yearly Part B deductible amount is \$155.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p><b>General</b> \$58 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p><b>In and Out-of-Network</b> \$3,400 out-of-pocket limit.</p> <p><b>In-Network</b> This limit includes only Medicare-covered services.</p> <p><b>Out-of-Network</b> This limit includes only Medicare-covered services.</p>
<p><b>2 - Doctor and Hospital Choice</b></p> <p>(Refer to Emergency - 15 and Urgently Needed Care - 16 for more information.)</p> <p>(See pages 27-28 for information about Doctor and Hospital Choice.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b> Referral required for network hospitals and specialists (for certain benefits).</p>

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### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>INPATIENT CARE</b>		
<p><b>3 - Inpatient Hospital Care</b> (includes Substance Abuse and Rehabilitation Services) (3)(4)</p> <p>(See pages 27-28 for information about Inpatient Hospital Care.)</p> <p>(See page 31 for information about hospital observation.)</p>	<p>In 2010 the amounts for each benefit period are:</p> <p>Days 1 - 60: \$1,100 deductible</p> <p>Days 61 - 90: \$275 per day</p> <p>Days 91 - 150: \$550 per lifetime reserve day</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><b>In-Network</b> \$450 copay for each Medicare-covered hospital stay.</p> <p>\$0 copay for additional hospital days.</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

(3) Authorization rules may apply.

(4) Contact plan for details.

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### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
INPATIENT CARE (Continued)		
<p><b>4 - Inpatient Mental Health Care</b> (3)(5)</p> <p>(See pages 27-28 for information about Inpatient Mental Health Care.)</p>	<p>Same deductible and copay as inpatient hospital care (See "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p><b>In-Network</b> \$450 copay for each Medicare-covered hospital stay.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p><b>5 - Skilled Nursing Facility</b> (in a Medicare-certified skilled nursing facility) (3)(4)</p> <p>(See pages 27-28 for information about Skilled Nursing Facility.)</p>	<p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <p>Days 1 - 20: \$0 per day</p> <p>Days 21 - 100: \$137.50 per day</p> <p>100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><b>In-Network</b> For SNF stays:</p> <p>Days 1 - 20: \$0 copay per day Days 21 - 100: \$50 copay per day</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p>

(3) Authorization rules may apply.

(4) Contact plan for details.

(5) Contact PBH/UBH at 1-800-711-4577.

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### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>INPATIENT CARE (Continued)</b>		
<p><b>6 - Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p> <p>(See pages 27-28 for information about Home Health Care.)</p>	<p>\$0 copay.</p>	<p><b>In-Network</b> 10% of the cost for each Medicare-covered home health visit.</p>
<p><b>7 - Hospice</b> (See page 31 for information about Hospice.)</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p><b>General</b> You must get care from a Medicare-certified hospice.</p>
<b>OUTPATIENT CARE</b>		
<p><b>8 - Doctor Office Visits</b> (See pages 27-28 for information about Doctor Office Visits.)</p>	<p>20% coinsurance. (1)(2)</p>	<p><b>General</b> See "33 - Physical Exams", for more information.</p> <p><b>In-Network</b> \$20 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$20 copay for each specialist visit for Medicare-covered benefits.</p> <p>Separate Office Visit cost sharing of \$20 or \$30 may apply.</p>

- (1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

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### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
OUTPATIENT CARE (Continued)		
<b>9 - Chiropractic Services</b>  (See pages 27-28 for information about Chiropractic Services.)	Routine care not covered.  20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. (1)(2)	<b>In-Network</b> \$20 copay for each Medicare-covered visit.  Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) If you get it from a chiropractor or other qualified providers.
<b>10 - Podiatry Services</b>  (See pages 27-28 for information about Podiatry Services.)	Routine care not covered.  20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. (1)(2)	<b>In-Network</b> \$20 copay for each Medicare-covered visit.  Medicare-covered podiatry benefits are for medically-necessary foot care.
<b>11 - Outpatient Mental Health Care (5)</b>  (See pages 27-28 for information about Outpatient Mental Health Care.)	45% coinsurance for most outpatient mental health services.	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$20 copay for each Medicare-covered individual or group therapy visit.
<b>12 - Outpatient Substance Abuse Care (5)</b>  (See pages 27-28 for information about Outpatient Substance Abuse Care.)	20% coinsurance. (1)(2)	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$20 copay for each Medicare-covered individual or group visits.

- (1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
- (5) Contact PBH/UBH at 1-800-711-4577.

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### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
OUTPATIENT CARE (continued)		
<b>13 - Outpatient Services/Surgery (4)</b>  (See pages 27-28 for information about Outpatient Services/Surgery.)	20% coinsurance for the doctor. (1)(2)  20% of outpatient facility charges. (1)(2)	<b>General</b> Authorization rules may apply.  <b>In-Network</b> \$150 copay for each Medicare-covered ambulatory surgical center visit.  \$150 copay for each Medicare-covered outpatient hospital facility visit.
<b>14 - Ambulance Services</b> (medically necessary ambulance services) (3)(4)	20% coinsurance. (1)(2)	<b>In and Out-of-Network</b> \$100 copay each way for Medicare-covered ambulance benefit.

- (1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
- (3) Authorization rules may apply.
- (4) Contact plan for details.

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### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
OUTPATIENT CARE (continued)		
<p><b>15 - Emergency Care</b> (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor.</p> <p>20% of facility charge, or a set copay per emergency room visit. (1)(2)</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p><b>General</b> \$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>
<p><b>16 - Urgently Needed Care</b> (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay. (1)(2)</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p><b>General</b> \$25 copay for Medicare-covered urgently needed care visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent care visit.</p>
<p><b>17 - Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p> <p>(See pages 27-28 for information about Outpatient Rehabilitation Services.)</p>	<p>20% coinsurance. (1)(2)</p>	<p><b>In-Network</b> \$20 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>

(1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

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### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>		
<p><b>18 - Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)</p> <p>(See pages 27-28 for information about Durable Medical Equipment.)</p>	20% coinsurance. (1)(2)	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 15% of the cost for Medicare-covered items.</p>
<p><b>19 - Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.) (4)</p> <p>(See pages 27-28 for information about Prosthetic Devices.)</p>	20% coinsurance. (1)(2)	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> 15% of the cost for Medicare-covered items.</p>
<p><b>20 - Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, screening tests and self-management training)</p> <p>(See pages 27-28 for information about Diabetes Self-Monitoring Training and Supplies.)</p>	<p>20% coinsurance. (1)(2)</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>In-Network</b> \$20 copay for each Diabetes self-monitoring training.</p> <p>\$20 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p>

- (1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*
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- (4) Contact plan for details.

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Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES (Continued)		
<p><b>21 - Diagnostic Tests, X-Rays, and Lab Services</b></p> <p>(See pages 27-28 for information about Diagnostic Tests, X-Rays, and Lab Services.) (4)</p>	<p>20% coinsurance for diagnostic tests and x-rays. (1)(2)</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>• \$0 copay for Medicare-covered lab service.</li> <li>• \$0 copay for Medicare-covered diagnostic procedures and tests.</li> <li>• 10% of the cost for Medicare-covered X-rays.</li> <li>• 10% of the cost for Medicare-covered diagnostic radiology services.</li> <li>• 10% of the cost for Medicare-covered therapeutic radiology services.</li> </ul> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p>

- (1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
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Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>PREVENTIVE SERVICES</b>		
<p><b>22 - Bone Mass Measurement</b> (for people with Medicare who are at risk)</p> <p>(See pages 27-28 for information about Bone Mass Measurement.)</p>	<p>20% coinsurance. (1)(2)</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p><b>In-Network</b></p> <p>\$10 copay for Medicare-covered bone mass measurement.</p> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p>
<p><b>23 - Colorectal Screening Exams</b> (for people with Medicare age 50 and older)</p> <p>(See pages 27-28 and 31 for information about Colorectal Screening Exams.)</p>	<p>20% coinsurance. (1)(2)</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p><b>In-Network</b></p> <p>\$10 copay for Medicare-covered colorectal screenings.</p> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p>
<p><b>24 - Immunizations</b> (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine) (3)(4)</p> <p>(See pages 27-28 for information about Immunizations.)</p>	<p>\$0 copay for Flu and Pneumonia vaccines.</p> <p>20% coinsurance for Hepatitis B vaccine. (1)(2)</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for the Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p> <p>Referral needed for other immunizations.</p>

- (1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
- (3) Authorization rules may apply.
- (4) Contact plan for details.

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
PREVENTIVE SERVICES (Continued)		
<p><b>25 - Mammograms (Annual Screening)</b> (for women with Medicare age 40 and older)</p> <p>(See pages 27-28 for information about Mammograms.)</p>	<p>20% coinsurance. (1)(2)</p> <p>No referral needed.</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p><b>In-Network</b></p> <p>\$10 copay for Medicare-covered screening mammograms.</p> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p>
<p><b>26 - Pap Smears and Pelvic Exams</b> (for women with Medicare)</p> <p>(See pages 27-28 for information about Pap Smears and Pelvic Exams.)</p>	<p>\$0 copay for Pap smears.</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk. (2)</p> <p>20% coinsurance for Pelvic Exams. (2)</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered pap smears and pelvic exams.</p> <ul style="list-style-type: none"> <li>• Up to 1 additional pap smear(s) and pelvic exam(s) every year.</li> </ul> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p>
<p><b>27 - Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)</p> <p>(See pages 27-28 for information about Prostate Cancer Screening Exams.)</p>	<p>20% coinsurance for digital rectal exam. (2)</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><b>In-Network</b></p> <p>\$0 copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p>

(1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<p><b>28 – End-Stage Renal Disease</b></p> <p>(Refer to “29 - Prescription Drugs” and see page 31 for information about Prescription Drugs.) (4)</p>	<p>20% coinsurance for renal dialysis. (1)(2)</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><b>General</b> Authorization rules may apply.</p> <p>Out-of-area Renal Dialysis services do not require authorization.</p> <p><b>In-Network</b> 10% of the cost for in and out-of-area renal dialysis.</p> <p>\$20 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

- (1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
- (4) Contact plan for details.

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<p><b>29 - Prescription Drugs</b></p> <p>(See pages 31-33 for information about Prescription Drugs.) (3)(4)</p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b> 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p><b>Drugs Covered under Medicare Part D</b></p> <p><b>General</b> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at <a href="http://www.providence.org/php/medicarepharmacy">www.providence.org/php/medicarepharmacy</a> on the web.</p> <p>Different out-of-pocket costs may apply for people who:</p> <ul style="list-style-type: none"> <li>• have limited incomes,</li> <li>• live in long term care facilities, or</li> <li>• have access to Indian/Tribal/Urban (Indian Health Service).</li> </ul> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). 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).</p>

(3) Authorization rules may apply.

(4) Contact plan for details.

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>29 - Prescription Drugs (Continued)</b>		<p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Providence Medicare Choice + RX (HMOPOS) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to the special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on <a href="http://www.Medicare.gov">www.Medicare.gov</a>.</p> <p>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.</p>

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>29 - Prescription Drugs (Continued)</b>		<p>You pay \$0 the first time you fill a prescription for certain drugs. These drugs will be listed as “free first fill” on the plan’s website, formulary, printed materials, and on the Medicare Prescription Drug Plan Finder on <a href="http://www.Medicare.gov">www.Medicare.gov</a>.</p> <p>If you request a tier exception in this plan, you will pay Specialty cost sharing.</p> <p><b>In-Network</b> \$0 deductible.</p> <p><b>Initial Coverage</b> You pay the following until total yearly drug costs reach \$2,830:</p> <p><b>Retail Pharmacy</b> Generic</p> <ul style="list-style-type: none"> <li>• \$6 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy.</li> <li>• \$18 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy.</li> <li>• \$9 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy.</li> <li>• \$27 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>29 - Prescription Drugs (Continued)</b>		<p><b>Brand</b></p> <ul style="list-style-type: none"> <li>• \$45 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy.</li> <li>• \$135 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy.</li> <li>• \$45 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy.</li> <li>• \$135 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Specialty</b></p> <ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy.</li> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy.</li> </ul> <p><b>Long Term Care Pharmacy</b></p> <p><b>Generic</b></p> <ul style="list-style-type: none"> <li>• \$9 copay for a one-month (34-day) supply of drugs in this tier.</li> </ul> <p><b>Brand</b></p> <ul style="list-style-type: none"> <li>• \$45 copay for a one-month (34-day) supply of drugs in this tier.</li> </ul> <p><b>Specialty</b></p> <ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (34-day) supply of drugs in this tier.</li> </ul>

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>29 - Prescription Drugs (Continued)</b>		<p><b>Mail Order</b></p> <p>Generic</p> <ul style="list-style-type: none"> <li>• \$6 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.</li> <li>• \$18 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.</li> <li>• \$9 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.</li> <li>• \$27 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.</li> </ul> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Brand</p> <ul style="list-style-type: none"> <li>• \$45 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.</li> <li>• \$135 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.</li> <li>• \$45 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.</li> <li>• \$135 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.</li> </ul>

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>29 - Prescription Drugs (Continued)</b>		<p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p><b>Specialty</b></p> <ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.</li> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.</li> </ul> <p><b>Coverage Gap</b> After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p><b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> <li>• \$2.50 copay for generic (including brand drugs treated as generic) \$6.30 copay for all other drugs or 5% coinsurance.</li> </ul>

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>29 - Prescription Drugs (Continued)</b>		<p><b>Out-of-Network</b> 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 Choice + RX (HMOPOS).</p> <p><b>Out-of-Network Initial Coverage</b> You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830:</p> <p>Generic</p> <ul style="list-style-type: none"> <li>• \$9 copay for a one-month (30-day) supply of drugs in this tier.</li> </ul> <p>Brand</p> <ul style="list-style-type: none"> <li>• \$45 copay for a one-month (30-day) supply of drugs in this tier.</li> </ul> <p>Specialty</p> <ul style="list-style-type: none"> <li>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier.</li> </ul>

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<b>29 - Prescription Drugs (Continued)</b>		<p><b>Out-of-Network Coverage Gap</b></p> <p>After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Providence Medicare Choice + RX (HMOPOS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Providence Medicare Choice + RX (HMOPOS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p><b>Out-of-Network Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:            \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or 5% coinsurance.</p>

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<p><b>30 - Dental Services</b></p> <p>(See pages 27-28 for information about Dental Services.) (4)</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> In general, preventive dental benefits (such as cleaning) not covered. \$20 copay for Medicare-covered dental benefits.</p>
<p><b>31 - Hearing Services</b></p> <p>(See pages 27-28 for information about Hearing Services.) (4)</p>	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams. (1)(2)</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b> In general, routine hearing exams and hearing aids not covered.</p> <p>\$20 copay for Medicare-covered diagnostic hearing exams.</p>
<p><b>32 - Vision Services</b></p> <p>(See pages 27-28 for information about Vision Services) (4)</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. (1)(2)</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><b>General</b> Authorization rules may apply.</p> <p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>• 10% of the cost for one pair of eyeglasses or contact lenses after each cataract surgery.</li> <li>• \$20 copay for exams to diagnose and treat diseases and conditions of the eye.</li> <li>• \$20 copay for up to 1 routine eye exam(s) every two years.</li> </ul>

- (1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*
- (2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.
- (4) Contact plan for details.

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<p><b>33 - Physical Exams</b></p> <p>(See pages 27-28 for information about Physical Exams.)</p>	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. (1)(2)</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><b>In-Network</b></p> <p>\$20 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$20 copay for Medicare-covered benefits.</p>
<p><b>34 - Health/Wellness Education</b></p> <p>(See page 34 for information about Health/Wellness Education.)</p>	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p>	<p><b>In-Network</b></p> <p>This plan covers the following health/wellness education benefits.</p> <ul style="list-style-type: none"> <li>• Written health education materials, including Newsletters</li> <li>• Nutritional Training</li> <li>• Additional Smoking Cessation</li> <li>• Nursing Hotline</li> <li>• Other Wellness Benefits</li> </ul> <p>\$0 to \$15 copay for each Medicare-covered smoking cessation counseling session.</p>
<p><b>Transportation</b> (Routine)</p>	<p>Not covered.</p>	<p><b>In-Network</b></p> <p>This plan does not cover routine transportation.</p>
<p><b>Acupuncture</b></p>	<p>Not covered.</p>	<p><b>In-Network</b></p> <p>This plan does not cover acupuncture.</p>

(1) Each year, you pay a total of one \$135 deductible. *NOTE: The Medicare Part B deductible may change each year.*

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<p><b>Point of Service</b></p> <p>(See pages 29-30 for information about Point of Service.) (4)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>General</b></p> <p>Authorization rules may apply.</p> <p>20% of the cost per hospital stay.</p> <p>20% of the cost per Inpatient Psychiatric Hospital stay.</p> <p>20% of the cost for each SNF stay.</p> <p>\$30 copay for doctor office visits.</p> <p>Point of Service coverage is available for the following benefits:</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Care</li> <li>• Inpatient Mental Health Care</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Home Health Care</li> <li>• Doctor Office Visits</li> <li>• Chiropractic Services</li> <li>• Podiatry Services</li> <li>• Outpatient Mental Health Care</li> <li>• Outpatient Substance Abuse Care</li> <li>• Outpatient Services/Surgery</li> <li>• Outpatient Rehabilitation Services</li> <li>• Durable Medical Equipment</li> <li>• Prosthetic Devices</li> <li>• Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</li> <li>• Diagnostic Tests, X-Rays, Lab Services and Radiology Services</li> <li>• Bone Mass Measurement</li> <li>• Colorectal Screening Exam</li> <li>• Immunizations</li> <li>• Mammograms (Annual Screenings)</li> <li>• Pap Smears and Pelvic Exams</li> <li>• Prostate Cancer Screening Exams</li> </ul>

(4) Contact plan for details.

## Section 2

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

Benefit Category	Original Medicare	Providence Medicare Choice + RX (HMOPOS)
<p><b>Point of Service (Continued)</b></p> <p>(See pages 29-30 for information about Point of Service.)</p>		<ul style="list-style-type: none"> <li>• Dental Services</li> <li>• Hearing Services</li> <li>• Vision Services</li> <li>• Physical Exams</li> <li>• Health/Wellness Education</li> <li>• Comprehensive Outpatient Rehabilitation Facility (CORF)</li> <li>• Partial Hospitalization</li> <li>• Other Health Care Professional Services</li> <li>• Diagnostic Radiological Services</li> <li>• Therapeutic Radiological Services</li> <li>• Outpatient X-Rays</li> <li>• Cardiac Rehabilitation Services</li> <li>• Outpatient Blood</li> <li>• Nutrition Therapy for Diabetes and Renal Disease</li> </ul>

## Section 3

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

#### Point of Service (Continued)

##### **What is Point of Service?**

Point of Service is an additional option for using your Providence Medicare Choice + RX (HMOPOS) benefits. For a higher cost share you will be able to use facilities and providers that are out of the Providence network (out-of-network providers). This includes services that you may want to use while out of the service area.

**You pay \$30 for doctor office visits when using your Point of Service option\*.**

##### **What will my cost share be with the Point of Service option?**

If you decide to use your Point of Service option your cost share will be 20% coinsurance. Excess charges may apply\*. The out-of-pocket maximum is \$3,400 combined for in-network and out-of-network services.

**You pay 20% for the following Medicare-covered services.**

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Chiropractic Services
- Podiatry Services
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care
- Outpatient Services/Surgery
- Outpatient Rehabilitation
- Durable Medical Equipment
- Prosthetic Devices
- CORF
- Other Health Care Professional Services
- Diagnostic Radiological Services
- Therapeutic Radiological Services
- Cardiac Rehabilitation Services
- Diabetes Self-Monitoring Training and Supplies
- Diagnostic Tests, X-Rays, and Lab Services
- Bone Mass Measurement
- Colorectal Screening Exams
- Immunizations
- Mammograms (Annual Screening)
- Pap Smears and Pelvic Exams
- Prostate Cancer Screening Exams
- Dental Services
- Hearing Services
- Vision Services
- Health and Wellness
- Partial Hospitalization
- Outpatient X-Rays
- Outpatient Blood
- Nutrition Therapy for Diabetes and Renal Disease
- Outpatient pulmonary rehabilitation

##### **Do I need referrals for the Point of Service option?**

No. A referral is not required if you use your Point of Service option. This means you can see an Out-of-Network or an In-Network provider without a referral. Keep in mind that you will be responsible for a 20% coinsurance for the above listed items and/or \$30 copay for doctor office visits whenever you use Point of Service unless it is deemed Urgent/Emergent.

\* If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

## Section 3

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

#### Point of Service (Continued)

##### **Are my benefits different with the Point of Service option?**

Please see pages 27 and 28 for the list of benefits you may receive under Point of Service. Keep in mind that although your cost share is different, the benefits themselves are the same. For example: Since Providence Medicare Choice + RX (HMOPOS) does not cover most dental services under In-Network they would not be covered under your Point of Service option either.

##### **Will some services require a Prior Authorization?**

Yes. To receive coverage, the following services require prior authorization.

- All Inpatient Hospital admissions.
- All Skilled Nursing Facility (SNF) admissions.
- All Inpatient Rehabilitation Facility admissions.
- Some Part B drugs. Contact plan for details.
- Some outpatient surgeries. Contact plan for details.
- Outpatient cardiac rehabilitation.
- Outpatient pulmonary rehabilitation.
- High Tech Radiology: MRI, MRA, SPECT, CTA, CT, PET, and Nuclear Cardiology. Contact authorizing agent: American Imaging Management (AIM) at 1-800-920-1250.
- Non-emergency procedures, including cervical, thoracic, lumbar spinal surgeries and bariatric surgery.
- Durable Medical Equipment (DME) and prosthetic devices that cost more than \$1,500.
- All Mental Health/Chemical Dependency services. Contact authorizing agent: PBH/UBH at 1-800-711-4577.

##### **The following services are excluded as point of service benefits. They must be provided by in-network providers and do require prior authorization:**

- Miscellaneous cosmetic, reconstructive, nasal, oral/dental/orthognathic procedures.
- Organ and bone marrow transplants (including pre-transplant evaluations and HLA typing).
- Uvulectomy, uvulopalatopharyngoplasty (UPPP), laser-assisted uvulopalatoplasty (LAUP).
- Services and procedures without specific CPT codes (unlisted services and procedures).
- Procedures/surgeries/treatment that may be considered experimental or investigational.
- Genetic testing/cytogenetic studies/counseling.
- CT colonography.

*Call or fax to request prior authorization.*

**503.574.6400**

**800.638.0449**

**Fax 503.574.6464**

**Fax 800.989.7479**

***Authorization does not guarantee benefits or payment. Benefits are based on eligibility at the time the service is rendered and are subject to any applicable contract terms.***

## Section 3

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

#### **3 - Inpatient Hospital Care (continued from page 6)**

You pay 10% of the cost for outpatient hospital observation.

#### **7 - Hospice (continued from page 8)**

Who pays for my Hospice Care if I'm in a Medicare Advantage Plan like Providence Medicare Advantage Plans?

All Medicare-covered services you get while in hospice care are covered under Original Medicare, even if you are in a Medicare Advantage Plan. However, Providence Medicare Advantage Plans will continue to cover you for any extra services not covered by Original Medicare (like vision benefits), including Part D drugs not related to your terminal hospice related diagnosis. If you choose to stay in your Medicare Advantage Plan while getting hospice care, you must continue to pay your plan's monthly premium.

#### **24 - Colorectal Screening Exams (continued from page 14)**

You may be charged an office visit copay and/or a separate outpatient services/surgery copay.

#### **29 - Prescription Drugs (continued from page 17)**

Drugs covered under Medicare Part B (Original Medicare)

Some Part B drugs may require authorization. You pay 10% of the cost for Part B-covered drugs. Contact plan for details. If you decide to use your point of service option your cost share will be 20% coinsurance.

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs.

- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service, (medications administered in your providers office) for example, chemotherapy regimens.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Erythropoietin (Epoetin alpha or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Inhalation and infusion:** Drugs provided through DME.
- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.

## Section 3

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

#### **Using your Providence Medicare Advantage Plans Identification Card at your pharmacy**

When filling prescriptions at your pharmacy make sure that you use your Providence Medicare Advantage Plans Identification Card. Ask the pharmacy to process the prescription claim to us. This is the best way to make sure that your prescription out-of-pocket expenses are tracked. Please remember that you will never pay more than what the drug costs.

#### **Other Physician Services**

Other physician services include services such as: Allergy Serum Administration, Chemotherapy Administration, Injection Administration, Infusion Therapy. This list is just an example, contact plan for details.

In-Network you pay 10% of the cost for some Part B services.

Out-of-Network you pay 20% of the cost.

#### **29 - Prescription Drugs (continued from page 17)**

Half tablet

Providence Medicare Advantage Plans will inform you at your pharmacy about select half-tablet opportunities. When selected appropriately, half-tab prescriptions are almost half the cost of the full-tablet equivalent. Depending on where you are in your prescription benefit (For example: initial coverage, coverage gap or catastrophic) taking half-tablets could result in savings on your pharmacy co-payment or coinsurance.

If for any reason you think tablet splitting is not an option for you, simply tell your physician or pharmacist that you do not wish to participate.

#### **29 - Prescription Drugs (continued from page 17)**

Preferred Network Pharmacies (Network Differential):

Preferred pharmacies and Participating pharmacies are pharmacies in the Providence Medicare Advantage Plans network where Providence Medicare Advantage Plans has negotiated a lower price for covered prescription drugs. However, you may pay more for a 90-day supply at a participating pharmacy than you would pay at a preferred pharmacy.

If you purchase a 90-day supply at a participating pharmacy, a charge in addition to your copayment or coinsurance will be assessed. This charge is the negotiated price difference between preferred and participating reimbursement rates.

If you purchase a 90-day supply at a preferred pharmacy no additional charge will be applied. You will always be charged the lowest copayment or coinsurance amount by using a preferred pharmacy.

You may go to either of these types of pharmacies to receive your covered prescription drugs.

## Section 3

### SUMMARY OF BENEFITS

**If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.**

#### **29 - Prescription Drugs (continued from page 17)**

Drugs covered under Medicare Part D - Free First Fill.

The prescription drugs listed below are eligible for a Free First Fill. This allows you to get a free supply the first time you fill one of these generic alternatives/equivalents.

Generic Drug Name	Category Reference
Alendronate Sodium	Osteoporosis
Atenolol	High Blood Pressure/Heart Medications
Atenolol/Chlorthalidone	High Blood Pressure/Heart Medications Combination Medications
Benazepril HCL	High Blood Pressure/Heart Medications
Benazepril/Hydrochlorothiazide	High Blood Pressure/Heart Medications Combination Medications
Carvedilol	High Blood Pressure/Heart Medications
Citalopram HBR	Anxiety/Depression
Enalapril Maleate	High Blood Pressure/Heart Medications
Enalapril/ Hydrochlorothiazide	High Blood Pressure/Heart Medications Combination Medications
Fosinopril Sodium	High Blood Pressure/Heart Medications
Fosinopril/ Hydrochlorothiazide	High Blood Pressure/Heart Medications Combination Medications
Glimepiride	Diabetes
Glipizide	Diabetes
Glipizide ER	Diabetes
Glyburide	Diabetes
Glyburide, Micronized	Diabetes
Lisinopril	High Blood Pressure/Heart Medications
Lisinopril/ Hydrochlorothiazide	High Blood Pressure/Heart Medications Combination Medications
Meloxicam	Arthritis/Inflammatory Pain
Metformin HCL	Diabetes
Metformin HCL ER	Diabetes
Metoprolol Succinate	High Blood Pressure/Heart Medications
Metoprolol Tartrate	High Blood Pressure/Heart Medications
Omeprazole	Stomach Acid Suppression/Heartburn
Sertraline HCL	Anxiety/Depression
Simvastatin	Cholesterol

## Section 3

*The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Providence Medicare Advantage Plans grievance process.*

The following is a list of other value added services available to members of Providence Medicare Advantage Plans. Show your member identification card and receive discounts with any of these providers. Discounts vary by provider. You may contact the plan for help with locating a provider in your area.

### **ChooseHealthy™**

Access discounts for acupuncture, chiropractic care, massage therapy and dietitian services. ChooseHealthy™ is a national affinity discount program that provides a network of providers offering 25 percent off their usual and customary fees or lowest membership rate. This program is not a covered benefit under your medical health plan, but is a member extra value service. Contact plan for details.

ChooseHealthy is a product of American Specialty Health Networks, Inc. and Healthyroads, Inc., subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy is a trademark of ASH.

### **Health and Fitness Classes**

Stay healthy and achieve wellness! Receive discounts on classes to help you lose weight, stop smoking, be a better parent or just have fun! Contact plan for details.

### **Hearing Aid Discounts**

Providence Medicare Advantage Plans has partnered with several hearing aid providers to offer discounts to our members. Contact plan for details.

### **LifeBalance: Recreational Activities & Event Discounts**

As a member of Providence Health Plan, you have access to discounts on recreational and cultural activities and events in Oregon, Washington and Alaska. From health clubs, professional instructors, retail stores, to guide services, tour operators, performance venues, museums, theaters, massage therapists and much more.

### **Providence RN: Medical Advice Line**

Do you need guidance on how to treat a specific health problem? Not sure if you need to see a doctor? Providence RN Medical Advice Line is a free telephone medical advice line available to members of Providence Health Plan. Members may call 503-574-6520 or 1-800-700-0481, TTY 1-800-735-2900 (Oregon Relay for TTY).

### **Binyon's**

You have access to discounts on eyeglasses through Binyon's locations in Oregon and SW Washington. This is not a covered benefit under your medical health plan, but is a member extra value service.

### **Other Vision Discounts**

Discounts are available on Laser Vision Correction (LASIK) through TruVision and on contact lenses. These programs are not a covered benefit under your medical health plan, but are value added services. Contact plan for details.

### **Our mission**

As people of Providence, we reveal God's love for all, especially the poor and the vulnerable, through our compassionate service.

### **Our core values**

The Providence mission is carried out by employees, physicians, volunteers and other care providers whose service reflects our five core values: compassion, justice, respect, excellence and stewardship.

Providence Medicare Advantage Plans Service Team

P.O. Box 5548

Portland, OR 97228-5548

If you have any questions about this plan's benefits or costs, please contact Providence Health Plan at 1-800-603-2340 (for current members) and 1-800-457-6064 (for prospective members).  
TTY line for the hearing impaired at 503-574-8702 or 1-888-244-6642.

Customer Service assistance is available Monday through Friday, between 8 a.m. and 5 p.m. for questions about your medical plan (Part C) and between 8 a.m. and 8 p.m. for questions about your prescription plan (Part D).

[www.providence.org/healthplans](http://www.providence.org/healthplans)



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