Introduction to the
Summary of Benefits for
Providence Medicare Choice Group Plan + RX (10/50/1000)

Contract #H9047

January 1, 2008 - December 31, 2008
Portland Metro, Willamette Valley and Clark County

Thank you for your interest in Providence Medicare Choice Group Plan + RX. 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 Group Plan + RX 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 Group Plan + RX. 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 Group Plan + RX at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY 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 Group Plan + RX 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 GROUP PLAN+ RX AVAILABLE?

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

WHO IS ELIGIBLE TO JOIN PROVIDENCE MEDICARE CHOICE GROUP PLAN + RX?

You can join Providence Medicare Choice Group Plan + RX 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 not eligible to enroll in Providence Medicare Choice Group Plan + RX.

CAN I CHOOSE MY DOCTORS?

Providence Medicare Choice Group Plan + RX 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 for an up-to-date list or visit us at www.providence.org/healthplans. Our customer service number is listed at the end of this introduction.

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 Group Plan + RX 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 Group Plan + RX 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 current Pharmacy Network List or visit us at www.providence.org/healthplans. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Providence Medicare Choice Group Plan + RX uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, 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/healthplans.

If you are currently taking a drug that is not on our formulary or subject to additional requirement 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?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Providence Medicare Choice Group Plan + RX, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-Medicare (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

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 90 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 Group Plan + RX, 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.

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 Group Plan + RX for more details.

Please call Providence Health Plan for more information about this plan.

Visit us at www.providence.org/healthplans or, call us: 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).

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

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

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

Prospective members should call (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 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 Group Plan + RX**
IMPORTANT INFORMATION		
1 - Premium and Other Important Information	$96.40 monthly Medicare Part B premium. $135 yearly Medicare Part B deductible. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.	Your employer's retiree benefits plan pays your premium. Check with your retiree plan for any amount you may pay. $96.40 monthly Medicare Part B premium. **In and Out-of-Network** $3,500 out-of-pocket limit. Contact the plan for services that apply. 20% coinsurance for point of service benefit. Contact the plan for services that apply. Refer to page 19 for more information.
2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.) (See page 23-24 for additional information about Doctor and Hospital Choice.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-Network** Referral required for network hospitals and specialists (for certain benefits). You may have to pay a separate copay for certain doctor office visits.

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 Group Plan + RX**
INPATIENT CARE		
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services) (See page 23-24 for additional information about Inpatient Hospital Care.)	For each benefit period: Days 1 - 60: $1,024 deductible Days 61 - 90: $256 per day. Days 91 - 150: $512 per lifetime reserve day. Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. 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.	**General** Authorization rules may apply. Contact plan for details. **In-Network** $350 copay for each Medicare-covered hospital stay. $0 copay for additional hospital days No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Please Note: You pay 10% of the cost For hospital observation services.

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 Group Plan + RX**
INPATIENT CARE (Continued)		
4 - Inpatient Mental Health Care (See page 23-24 for additional information about Inpatient Mental Health Care.)	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day limit in a Psychiatric Hospital.	**General** Authorization rules may apply. Contact PBH/UBH at 1-800-711-4577. **In-Network** $350 copay for each Medicare-covered hospital stay. The maximum out of pocket limit is covered under Inpatient Hospital Care. You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility) (See page 23-24 for additional information about Skilled Nursing Facility.)	For each benefit period, after at least a 3-day covered hospital stay: Days 1 - 20: $0 per day. Days 21 - 100: $128 per day. 100 days for each benefit period. 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.	**General** Authorization rules may apply. Contact plan for details. **In-Network** For SNF stays: Days 1 - 21: $0 copay per day Days 22 - 100: $50 copay per day 100 days covered for each benefit period. No prior hospital stay is required.

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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 Group Plan + RX**
INPATIENT CARE (Continued)		
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.) (See page 23-24 for additional information about Home Health Care.)	$0 copay.	**In-Network** 10% of the cost for each Medicare-covered home health visit.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**In-Network** You must get care from a Medicare-certified hospice.
OUTPATIENT CARE		
8 - Doctor Office Visits (See page 23-24 for additional information about Doctor Office Visits.)	20% coinsurance. (1)(2)	**General** Refer to "34 - Physical Exams", for more information. **In-Network** $20 copay for each primary care doctor visit for Medicare-covered benefits. $20 copay for each specialist visit for Medicare-covered benefits.

(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 Group Plan + RX**
OUTPATIENT CARE (Continued)		
9 - Chiropractic Services (See page 23-24 for additional information about Chiropractic Services.)	20% coinsurance. Routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractor or other qualified provider. (1)(2)	**In-Network** $20 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.
10 – Podiatry Services (See page 23-24 for additional information about Podiatry Services.)	20% coinsurance. (1)(2) Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $20 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.
11 – Outpatient Mental Health Care (See page 23-24 for additional information about Outpatient Mental Health Care.)	50% coinsurance for most outpatient mental health services.	**General** Authorization rules may apply. Contact PBH/UBH at 1-800-711-4577. **In-Network** $20 copay for each Medicare-covered individual or group therapy visit.
12 - Outpatient Substance Abuse Care (See page 23-24 for additional information about Outpatient Substance Abuse Care.)	20% coinsurance. (1)(2)	**General** Authorization rules may apply. Contact PBH/UBH at 1-800-711-4577. **In-Network** $20 copay for each Medicare-covered individual or group therapy visit.

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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 Group Plan + RX
OUTPATIENT CARE (continued)		
13 - Outpatient Services/Surgery (See page 23-24 for additional information about Outpatient Services/Surgery.)	20% coinsurance for the doctor. (1)(2) 20% of outpatient facility. (1)(2)	**General** Authorization rules may apply. **In-Network** $100 copay for each Medicare-covered ambulatory surgical center visit. $100 copay for each Medicare-covered outpatient hospital facility visit.
14 – 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.	20% coinsurance. (1)(2)	**In-Network** You pay 10% of the cost for some Part B services. Contact plan for details.
15 - Ambulance Services (medically necessary ambulance services)	20% coinsurance. (1)(2)	**In-Network** $50 copay for each Medicare-covered ambulance benefit.

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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 Group Plan + RX**
OUTPATIENT CARE (continued)		
16 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor. 20% of facility charge, or a set copay per emergency room visit. (1)(2) 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. NOT covered outside the U.S. except under limited circumstances.	**In-Network** $50 copay for each Medicare-covered emergency room visit. **Out-of-Network** Worldwide coverage. **In and Out-of-Network** If you are admitted to the hospital within 24 hour(s) for the same condition, you pay $0 for the emergency room visit.
17 – Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay. (1)(2) NOT covered outside the U.S. except under limited circumstances.	**General** $25 for each Medicare-covered urgently needed care visit. **Out-of-Network** Worldwide coverage. **In and Out-of-Network** If you are admitted to the hospital within 24 hour(s) for the same condition, $0 for the urgent care visit.
18 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy) (See page 23-24 for additional information about Outpatient Rehabilitation Services.)	20% coinsurance. (1)(2)	**In-Network** $20 copay for Medicare-covered Occupational Therapy visits. $20 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.

(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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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 Group Plan + RX**
OUTPATIENT CARE (continued)		
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
19 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.) (See page 23-24 for additional information about Durable Medical Equipment.)	20% coinsurance. (1)(2)	**General** Authorization rules may apply. Contact the plan for details. **In-Network** 10% of the cost for Medicare-covered items.
20 – Prosthetic Devices (includes braces, artificial limbs and eyes, etc.) (See page 23-24 for additional information about Prosthetic Devices.)	20% coinsurance. (1)(2)	**General** Authorization rules may apply. Contact the plan for details. **In-Network** 10% of the cost for Medicare-covered items.
21 – Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets, and self-management training) (See page 23-24 for additional information about Diabetes Self-Monitoring Training and Supplies.)	20% coinsurance. (1)(2)	**In-Network** $20 copay for Diabetes self-monitoring training. $20 copay for Nutrition Therapy for Diabetes. $0 copay for Diabetes supplies.

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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 Group Plan + RX**
OUTPATIENT MEDICAL SERVICES AND SUPPLIES (Continued)		
22 – Diagnostic Tests, X-Rays, and Lab Services (See page 23-24 for additional information about Diagnostic Tests, X-Rays, and Lab Services.)	20% coinsurance for diagnostic tests and x-rays. (1)(2) $0 copay for Medicare-covered lab services. 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.	**General** Authorization rules may apply. Contact the plan for details. **In-Network** ▪ $0 copay for Medicare-covered lab service. ▪ $0 copay for Medicare-covered diagnostic procedures and tests. ▪ 10% of the cost for Medicare-covered X-rays. ▪ 10% of the cost for each Medicare-covered diagnostic radiology services. ▪ 10% of the cost for each Medicare-covered therapeutic radiology services.
PREVENTIVE SERVICES		
23 – Bone Mass Measurement (for people with Medicare who are at risk) (See page 23-24 for additional information about Bone Mass Measurement.)	20% coinsurance. (1)(2) Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	**In-Network** $10 copay for Medicare-covered bone mass measurement.

(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.

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 Group Plan + RX**
PREVENTIVE SERVICES (Continued)		
24 – Colorectal Screening Exams (for people with Medicare age 50 and older) (See page 23-24 for additional information about Colorectal Screening Exams.)	20% coinsurance. (1)(2) Covered when you are high risk or when you are age 50 and older.	**In-Network** $10 copay for Medicare-covered colorectal screenings.
25 – Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine) (See page 23-24 for additional information about Immunizations.)	$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccine. (1)(2) You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	**In-Network** $0 copay for Flu and Pneumonia vaccines. $0 copay for the Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. Immunizations covered under Medicare Part D are excluded from this plan. Contact plan for details.
26 – Mammograms (Annual Screening) (for women with Medicare age 40 and older) (See page 23-24 for additional information about Mammograms.)	20% coinsurance. (1)(2) No referral needed. 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.	**In-Network** $10 copay for Medicare-covered screening mammograms.

(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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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 Group Plan + RX**
PREVENTIVE SERVICES (Continued)		
27 – Pap Smears and Pelvic Exams (for women with Medicare) (See page 23-24 for additional information about Pap Smears and Pelvic Exams.)	$0 copay for Pap smears. Covered once every 2 years. Covered once a year for women with Medicare at high risk. (2) 20% coinsurance for Pelvic Exams. (2)	**In-Network** $0 copay for Medicare-covered Pap smears and pelvic exams. and ▪ up to 1 additional pap smear(s) and pelvic exam(s) every year.
28 – Prostate Cancer Screening Exams (for men with Medicare age 50 and older) (See page 23-24 for additional information about Prostate Cancer Screening Exams.)	20% coinsurance for digital rectal exam. (2) $0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	**In-Network** $0 copay for Medicare-covered prostate cancer screening.
29 – ESRD	20% coinsurance for dialysis. (1)(2)	**General** Authorization rules may apply. Contact plan for details. Out-of-area Renal Dialysis services do not require Authorization. **In-Network** 10% of the cost for in and out-of-area dialysis. $20 copay for Nutrition Therapy for Renal Disease. Refer to "30 – Prescription Drugs" and page 22 for more information.

(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 Group Plan + RX**
30 – Prescription Drugs Refer to page 22 and page 24 for more information.	Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)	**Drugs covered under Medicare Part B** **General** $10 copay for Part B-covered drugs (not including Part B-covered chemotherapy drugs). $10 copay for Part B-covered chemotherapy drugs. **Drugs Covered under Medicare Part D** **General** This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.providence.org/resources/health plans/images/PME_DrugFormulary.pdf on the web. Different out-of-pocket costs may apply for people who ▪ have limited incomes, ▪ live in long term care facilities, or ▪ have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage. This means that you will pay the same 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).

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 Group Plan + RX**
30 - Prescription Drugs (Continued)		**Generic drugs:** $10 copay for up to a 30-day supply purchased at a participating retail pharmacy. One copayment applies for each 30-day supply. **Brand name drugs:** 50% coinsurance for each 30-day supply purchased at a participating retail pharmacy. **Compounded prescription drugs:** 50% coinsurance for each 30-day supply purchased at a participating retail pharmacy. There is a $1,000 annual out-of-pocket maximum for covered prescriptions. Once that is met, covered prescriptions are covered at no cost to you. You must go to certain pharmacies for a very limited number of drugs, due to the special handling requirements of these drugs. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.Medicare.gov. If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.

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 Group Plan + RX**
30 - Prescription Drugs (Continued)		You may receive drugs from an In-Network Preferred Pharmacy for a three-month (90 day) supply. You may receive drugs from an In-Network Non-Preferred Pharmacy for a three-month (90 day) supply. Covered Part D drugs are available at out of network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. In addition to paying the copay/co-insurances listed, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of network pharmacy charged for your prescriptions. You may receive drugs from an in-network or participating Mail Order Pharmacy for a three-month (90 day) supply. Certain prescription drugs will have maximum quantity limits. Contact plan for details. Your provider must get prior authorization from Providence Medicare Choice Group Plan + RX for certain prescription drugs. Contact plan for details.

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 Group Plan + RX**
31 – Dental Services (See page 23-24 for additional information about Dental Services.)	Preventive dental services (such as cleaning) not covered.	**General** Authorization rules may apply. Contact plan for details. **In-Network** In general, preventive dental benefits (such as cleaning) not covered. $20 copay for Medicare-covered dental benefits.
32 – Hearing Services (See page 23-24 for additional information about Hearing Services.)	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams. (1)(2)	**General** Authorization rules may apply. Contact plan for details. **In-Network** In general, routine hearing exams and hearing aids not covered. $20 copay for each diagnostic hearing exam. Referral required.
33 – Vision Services (See page 23-24 for additional information about Vision Services)	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. (1)(2) Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-Network** ▪ 10% of the cost for one pair of eyeglasses or contact lenses after each cataract surgery. ▪ $20 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye. Referral required. ▪ $20 copay for up to 1 routine eye exam(s) every two years.

(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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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 Group Plan + RX**
34 – Physical Exams (See page 23-24 for additional information about Physical Exams.)	20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage. (1)(2) When you get Medicare Part B, you can get a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.	**In-Network** $20 copay for routine exams. Limited to 1 exam(s) every year. $20 copay for Medicare-covered benefits.
Health/Wellness Education	Not covered.	**In-Network and Out-of-Network** This plan covers health/wellness education benefits. ▪ Written health education materials, including Newsletters ▪ Nutritional Training ▪ Smoking Cessation ▪ Nursing Hotline ▪ Other Wellness Benefits Copays may apply for these benefits.

(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.

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 Group Plan + RX**
Point of Service (See page 23-24 for additional information about Point of Service.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**General** Authorization rules may apply. Contact plan for details. 20% of the cost per hospital stay. 20% of the cost per Inpatient Psychiatric Hospital stay. Point of Service coverage is available at 20% for the following benefits: ▪ Inpatient Hospital Care ▪ Inpatient Mental Health Care ▪ Skilled Nursing Facility ▪ Home Health Care ▪ Doctor Office Visits ▪ Chiropractic Services ▪ Podiatry Services ▪ Outpatient Mental Health Care ▪ Outpatient Substance Abuse Care ▪ Outpatient Services/Surgery ▪ Ambulance Services ▪ Outpatient Rehabilitation Services ▪ Durable Medical Equipment ▪ Prosthetic Devices ▪ Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies ▪ Procedures, Tests, Labs and Radiology Services ▪ Bone Mass Measurement ▪ Colorectal Screening Exam

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 Group Plan + RX**
Point of Service (Continued) (See page 23-24 for additional information about Point of Service.)		▪ Immunizations ▪ Mammograms (Annual Screenings) ▪ Pap Smears and Pelvic Exams ▪ Prostate Cancer Screening Exams ▪ Dental Services ▪ Hearing Services ▪ Vision Services ▪ Physical Exams ▪ Health/Wellness Education ▪ Comprehensive Outpatient Rehabilitation Facility (CORF) ▪ Partial Hospitalization ▪ Other Health Care ▪ Professional Services ▪ Cardiac Rehabilitation Services ▪ Outpatient Blood ▪ Nutrition Therapy for Diabetes and Renal Disease

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 5)

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

30 – Prescription Drugs (continued from page 15)

Drugs covered under Medicare Part B (Original Medicare)

The following outpatient prescription drugs may be covered under Medicare Part B. Some Part B drugs may require authorization. Contact plan for details. This may include, but is not limited to, the following types of drugs. Contact Providence Medicare Choice Group Plan + RX for more details. If Part B medications are received in the Providence Network your cost share will be 10% coinsurance. If you decide to use your point of service option your cost share will be 20% coinsurance.

- 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. Please refer to the coverage information under Home Health Care for Women with Osteoporosis.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

SUMMARY OF BENEFITS

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

Point of Service **(Continued from page 20)**

What is Point of Service?

Point of Service is an additional option for using your Providence Medicare Choice Group Plan + RX 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.

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 $3,500 for in-network and out-of-network services combined.

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

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Doctor Office Visits
- Chiropractic Services
- Podiatry Services
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care
- Outpatient Services/Surgery
- Outpatient Rehabilitation
- Durable Medical Equipment
- Prosthetic Devices
- 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
- Physical Exams

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 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.

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 refer to pages 20 through 21 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 Group Plan + RX 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.
- High Tech Radiology: MRI, CT, PET, and Nuclear Cardiology. Contact authorizing agent: American Imaging Management (AIM) at 1-800-920-1250.
- Non-emergency procedures, including lumbar spinal surgeries and bariatric surgery.
- Durable Medical Equipment (DME) and prosthetic devices that cost more than $500.
- All Mental Health/Chemical Dependency services. Contact authorizing agent: PBH 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, TMJ.
- Organ and bone marrow transplants (including pre-transplant evaluations and HLA typing).
- Uvulectomy, uvulopalatophyaryngoplasty (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.

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.

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 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

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