

## Section 1



### Introduction to the Summary of Benefits for **Providence Medicare Extra Group Plan A**

Contract #H9047

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

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Thank you for your interest in Providence Medicare Extra Group Plan A. Our plan is offered by PROVIDENCE HEALTH PLAN, a Medicare Advantage Health Maintenance Organization (HMO). 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 Extra Group Plan A 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 Extra Group Plan A. 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 Extra Group Plan A 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 Extra Group Plan A 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 EXTRA GROUP PLAN A AVAILABLE?**

The service area for this plan includes: Benton, Clackamas, Columbia, Lane, Linn, 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 EXTRA GROUP PLAN A?**

You can join Providence Medicare Extra Group Plan A if you are entitled to Medicare Part A and enrolled to 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 Extra Group Plan A unless they are members of our organization and have been since their dialysis began.

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

Providence Medicare Extra Group Plan A has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part 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](http://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?**

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Providence Health Plan nor the Original Medicare Plan will pay for these services.

## Section 1

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

Providence Medicare Extra Group Plan A does cover Medicare Part B prescription drugs. Providence Medicare Extra Group Plan A does NOT cover Medicare Part D prescription drugs.

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

Outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact Providence Medicare Extra Group Plan A 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.

Please call Providence Health Plan for more information about this plan. Visit us at [www.providence.org/healthplans](http://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).

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)

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 Extra Group Plan A
<b>IMPORTANT INFORMATION</b>		
<b>1 - Premium and Other Important Information</b>	<p>\$96.40 monthly Medicare Part B premium.</p> <p>\$135 yearly Medicare Part B deductible.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>Your employer's retiree benefits plan pays your premium. Check with your retiree plan for any amount you may pay.</p> <p>\$96.40 monthly Medicare Part B premium.</p> <p><b>Out-of-Network</b> Unless otherwise noted, out-of-network services not covered.</p>
<b>2 - Doctor and Hospital Choice</b> (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b> You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits). You may have to pay a separate copay for certain doctor office visits.</p>

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### SUMMARY OF BENEFITS

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A
<b>INPATIENT CARE</b>		
<p><b>3 - Inpatient Hospital Care</b> (includes Substance Abuse and Rehabilitation Services)</p>	<p>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.</p>	<p><b>General</b> Authorization rules may apply. Contact plan for details.</p> <p><b>In-Network</b> \$250 for each Medicare-covered stay at a network hospital. \$0 copay for additional hospital days. There is a \$500 maximum out of pocket limit every year.  You are covered for unlimited days each benefit period.  Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</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 Extra Group Plan A
<b>INPATIENT CARE (Continued)</b>		
<b>4 - Inpatient Mental Health Care</b>	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above)</p> <p>190 day limit in a Psychiatric Hospital.</p>	<p><b>General</b> Prior authorization is required. Contact PBH/UBH at 1-800-711-4577.</p> <p><b>In-Network</b> \$250 for each Medicare-covered stay at a network hospital.</p> <p>The maximum out of pocket limit is covered under Inpatient Hospital Care.</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>
<b>5 - Skilled Nursing Facility</b> (in a Medicare-certified skilled nursing facility)	<p>For each benefit period, after at least a 3-day covered hospital stay:</p> <p>Days 1 - 20: \$0 per day. Days 21 - 100: \$128 per day. 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>General</b> Prior authorization is required. Contact plan for details.</p> <p><b>In-Network</b> \$0 copay for services received at a Skilled Nursing Facility.</p> <p>100 days covered for each benefit period.</p> <p>No prior hospital stay is required.</p>

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<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Providence Medicare Extra Group Plan A</b>
<b>INPATIENT CARE (Continued)</b>		
<b>6 - Home Health Care</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	<b>In-Network</b> \$0 copay for Medicare-covered home health visits.
<b>7 - Hospice</b>	You pay part of the cost for outpatient drugs and inpatient respite care.  You must get care from a Medicare-certified hospice.	<b>In-Network</b> You must get care from a Medicare-certified hospice.
<b>OUTPATIENT CARE</b>		
<b>8 - Doctor Office Visits</b>	20% coinsurance. (1)(2)	<b>General</b> Refer to "33 - Physical Exams", for more information.  \$15 for each primary care doctor visit for Medicare-covered benefits.  \$15 for each specialist visit for Medicare-covered benefits.
<b>9 - Chiropractic Services</b>	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)	<b>In-Network</b> \$15 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.

(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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<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Providence Medicare Extra Group Plan A</b>
<b>OUTPATIENT CARE (Continued)</b>		
<b>10 - Podiatry Services</b>	<p>20% coinsurance. (1)(2)</p> <p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p><b>In-Network</b></p> <p>\$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
<b>11 - Outpatient Mental Health Care</b>	<p>50% coinsurance for most outpatient mental health services.</p>	<p><b>General</b></p> <p>Authorization rules may apply. Contact PBH/UBH at 1-800-711-4577.</p> <p><b>In-Network</b></p> <p>\$15 copay for each Medicare-covered individual or group therapy visit.</p>
<b>12 - Outpatient Substance Abuse Care</b>	<p>20% coinsurance. (1)(2)</p>	<p><b>General</b></p> <p>Authorization rules may apply. Contact PBH/UBH at 1-800-711-4577.</p> <p><b>In-Network</b></p> <p>\$15 copay for each Medicare-covered individual or group visit.</p>
<b>13 - Outpatient Services/Surgery</b>	<p>20% coinsurance for the doctor. (1)(2)</p> <p>20% of outpatient facility. (1)(2)</p>	<p><b>General</b></p> <p>Authorization rules may apply. Contact plan for details.</p> <p><b>In-Network</b></p> <p>\$0 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p>

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<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Providence Medicare Extra Group Plan A</b>
<b>OUTPATIENT CARE (Continued)</b>		
<b>14 - Ambulance Services</b> (medically necessary ambulance services)	20% coinsurance. (1)(2)	<b>General</b> Authorization rules may apply. Contact plan for details. \$50 copay for each Medicare-covered ambulance benefit.
<b>15 – Emergency Care</b> (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.	<b>General</b> \$50 copay for each Medicare-covered emergency room visit. <b>Out-of-Network</b> Worldwide coverage. <b>In and Out-of-Network</b> If you are admitted to the hospital within 24 hour(s) for the same condition, you pay \$0 for the emergency room visit.
<b>16 – Urgently Needed Care</b> (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.	<b>General</b> \$25 for each Medicare-covered urgently needed care visit. <b>Out-of-Network</b> Worldwide coverage. <b>In and Out-of-Network</b> If you are admitted to the hospital within 24 hour(s) for the same condition, you pay \$0 for the urgent care visit.

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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A
<b>OUTPATIENT CARE (continued)</b>		
<b>17 – Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance. (1)(2)	<b>In-Network</b> \$15 copay for Medicare-covered Occupational Therapy visits.  \$15 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</b>		
<b>18 – Durable Medical Equipment</b> (includes wheelchairs, oxygen, etc.)	20% coinsurance. (1)(2)	<b>General</b> Authorization rules may apply. Contact plan for details.  <b>In-Network</b> \$0 copay for Medicare-covered items.
<b>19 – Prosthetic Devices</b> (includes braces, artificial limbs and eyes, etc.)	20% coinsurance. (1)(2)	<b>General</b> Authorization rules may apply. Contact plan for details.  <b>In-Network</b> \$0 copay for Medicare-covered items.
<b>20 – Diabetes Self-Monitoring Training and Supplies</b> (includes coverage for glucose monitors, test strips, lancets, and self-management training)	20% coinsurance. (1)(2)	<b>In-Network</b> \$15 copay for each Diabetes self-monitoring training.  \$15 copay for Nutrition Therapy for Diabetes.  \$0 copay for Diabetes supplies.

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<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Providence Medicare Extra Group Plan A</b>
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES (continued)</b>		
<b>21 – Diagnostic Tests, X-Rays, and Lab Services</b>	<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. Contact plan for details.</p> <p><b>In-Network</b></p> <ul style="list-style-type: none"> <li>▪ 0% of the cost for Medicare-covered lab service.</li> <li>▪ 0% of the cost for Medicare-covered diagnostic procedures and tests.</li> <li>▪ 0% of the cost for Medicare-covered X-rays.</li> <li>▪ 0% of the cost for each Medicare-covered diagnostic radiology services.</li> <li>▪ 0% of the cost for each Medicare-covered therapeutic radiology services.</li> </ul>
<b>PREVENTIVE SERVICES</b>		
<b>22 – Bone Mass Measurement</b> (for people with Medicare who are at risk)	<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>\$0 copay for Medicare-covered bone mass measurements.</p>

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<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Providence Medicare Extra Group Plan A</b>
<b>PREVENTIVE SERVICES (Continued)</b>		
<b>23 – Colorectal Screening Exams</b> (for people with Medicare age 50 and older)	20% coinsurance. (1)(2)  Covered when you are high risk or when you are age 50 and older.	<b>In-Network</b> \$0 copay for Medicare-covered colorectal screenings.
<b>24 – Immunizations</b> (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	\$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.	<b>In-Network</b> \$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.
<b>25 – Mammograms (Annual Screening)</b> (for women with Medicare age 40 and older)	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.	<b>In-Network</b> \$0 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		
<p><b>If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.</b></p>		
Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A
<b>PREVENTIVE SERVICES (Continued)</b>		
<p><b>26 – Pap Smears and Pelvic Exams</b> (for women with Medicare)</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> <p>and</p> <ul style="list-style-type: none"> <li>▪ up to 1 additional pap smear(s) and pelvic exam(s) every year.</li> </ul>
<p><b>27 – Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)</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><b>28 – ESRD</b></p>	<p>20% coinsurance for dialysis. (1)(2)</p>	<p><b>General</b></p> <p>Authorization rules may apply. Contact plan for details.</p> <p>Out-of-area Renal Dialysis services do not require Authorization.</p> <p><b>In-Network</b></p> <p>\$0 copay for in and out-of-area dialysis.</p> <p>\$15 copay for Nutrition Therapy for Renal Disease.</p> <p>Refer to “29 – Prescription Drugs” for more information.</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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<b>SUMMARY OF BENEFITS</b>		
<b>If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.</b>		
<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Providence Medicare Extra Group Plan A</b>
<p><b>29 – Prescription Drugs</b></p> <p>Refer to page 16 for more information.</p>	<p>Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)</p>	<p>You may have prescription drug coverage from your employer's retiree benefits plan. If not, you pay 100% for most prescription drugs.</p> <p><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b> Most drugs not covered.</p> <p>\$0 copay for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>\$0 copay for Part B-covered chemotherapy drugs.</p> <p><b>Drugs Covered under Medicare Part D</b></p> <p>This plan does not offer prescription drug coverage.</p>
<p><b>30 – Dental Services</b></p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p><b>General</b> Authorization rules may apply. Contact plan for details.</p> <p><b>In-Network</b> In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$15 copay for each Medicare-covered dental benefit.</p>

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<b>SUMMARY OF BENEFITS</b>		
<b>If you have any questions about this plan's benefits or costs, please contact Providence Health Plan.</b>		
<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Providence Medicare Extra Group Plan A</b>
<b>31 – Hearing Services</b>	<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. Contact plan for details.</p> <p><b>In-Network</b> In general, routine hearing exams and hearing aids not covered.</p> <ul style="list-style-type: none"> <li>▪ \$15 copay for each diagnostic hearing exam. Referral required.</li> </ul>
<b>32 – Vision Services</b>	<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>In-Network</b></p> <ul style="list-style-type: none"> <li>▪ \$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.</li> <li>▪ \$15 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye. Referral required.</li> <li>▪ \$15 copay for up to 1 routine eye exam(s) every two years.</li> </ul> <p><b>General</b> Authorization rules may apply. Contact the plan for details.</p>
<b>33 – Physical Exams</b>	<p>20% coinsurance for one exam within the first 6 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 6 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><b>In-Network</b> \$15 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$15 copay for Medicare-covered 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 Extra Group Plan A
<b>Health/Wellness Education</b>	Not covered.	<b>In-Network</b> This plan covers health/wellness education benefits. <ul style="list-style-type: none"><li>▪ Written health education materials, including Newsletters</li><li>▪ Nutritional Training</li><li>▪ Smoking Cessation</li><li>▪ Nursing Hotline</li><li>▪ Other Wellness Benefits</li></ul> Copays may apply for these benefits.

## 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 14)**

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 Extra Group Plan A for more details. You pay 0% of the cost for Part B-covered 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. 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.

## **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).

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

