

## Section 1



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

Contract #H9047

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

Thank you for your interest in Providence Medicare Extra Group Plan A + RX. 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 + 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 Extra Group Plan A + 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 Extra Group Plan A + 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 Extra Group Plan A + 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 EXTRA GROUP PLAN A + 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 areas to join the plan.

#### **WHO IS ELIGIBLE TO JOIN PROVIDENCE MEDICARE EXTRA GROUP PLAN A + RX?**

You can join Providence Medicare Extra Group Plan A + 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 generally not eligible to enroll in Providence Medicare Extra Group Plan A + RX 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 + RX 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.

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### **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.

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

Providence Medicare Extra Group Plan A + 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 Extra Group Plan A + 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](http://www.providence.org/healthplans). Our customer service number is listed at the end of this introduction.

Providence Health Plan has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

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

Providence Medicare Extra Group Plan A + 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/resources/healthplans/images/PME\\_DrugFormulary.pdf](http://www.providence.org/resources/healthplans/images/PME_DrugFormulary.pdf).

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 Extra Group Plan A + 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 Extra Group Plan A + 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.

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### **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 Extra Group Plan A + RX for more details.

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) and between 8 a.m. and 8 p.m. for questions about your prescription plan (Part D).

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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)

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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 + RX
<b>IMPORTANT INFORMATION</b>		
<p><b>1 - Premium and Other Important Information</b></p>	<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>
<p><b>2 - Doctor and Hospital Choice</b> (For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><b>In-Network</b></p> <p>You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p> <p>You may have to pay a separate copay for certain doctor office visits.</p>

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<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.</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>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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<b>Benefit Category</b>	<b>Original Medicare</b>	<b>Providence Medicare Extra Group Plan A + RX</b>
<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> Authorization rules may apply. 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</p> <p>Days 21 - 100: \$128 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>General</b> Prior authorization is required. Contact plan for details.</p> <p><b>In-Network</b> \$0 copay for SNF services.</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 + RX</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 + RX</b>
<b>OUTPATIENT CARE (Continued)</b>		
<b>10 - Podiatry Services</b>	20% coinsurance. (1)(2)  Routine care not covered.  20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	<b>In-Network</b> \$15 copay for each Medicare-covered visit.  Medicare-covered podiatry benefits are for medically-necessary foot care.
<b>11 - Outpatient Mental Health Care</b>	50% coinsurance for most outpatient mental health services.	<b>General</b> Authorization rules may apply. Contact PBH/UBH at 1-800-711-4577.  <b>In-Network</b> \$15 copay for each Medicare-covered individual or group therapy visit.
<b>12 - Outpatient Substance Abuse Care</b>	20% coinsurance. (1)(2)	<b>General</b> Authorization rules may apply. Contact PBH/UBH at 1-800-711-4577.  <b>In-Network</b> \$15 copay for each Medicare-covered individual or group visit.
<b>13 - Outpatient Services/Surgery</b>	20% coinsurance for the doctor. (1)(2)  20% of outpatient facility. (1)(2)	<b>General</b> Authorization rules may apply. Contact plan for details.  <b>In-Network</b> \$0 copay for each Medicare-covered ambulatory surgical center visit. \$0 copay for each Medicare-covered outpatient hospital facility visit.

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<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. <b>In-Network</b> \$50 copay for each Medicare-covered ambulance benefits.
<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>In-Network</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, \$0 for the urgent care visit.

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<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</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>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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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A + RX
<b>OUTPATIENT MEDICAL SERVICES AND SUPPLIES (Continued)</b>		
<p><b>21 – Diagnostic Tests, X-Rays, and Lab Services</b></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. 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>		
<p><b>22 – Bone Mass Measurement</b> (for people with Medicare who are at risk)</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>\$0 copay for Medicare-covered bone mass measurements.</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>Benefit Category</b>	<b>Original Medicare</b>	<b>Providence Medicare Extra Group Plan A + RX</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. Referral needed for other immunizations. 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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<b>26 – Pap Smears and Pelvic Exams</b> (for women with Medicare)	\$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)	<b>In-Network</b> \$0 copay for Medicare-covered Pap smears and pelvic exams. and <ul style="list-style-type: none"> <li>▪ up to 1 additional pap smear(s) and pelvic exam(s) every year.</li> </ul>
<b>27 – Prostate Cancer Screening Exams</b> (for men with Medicare age 50 and older)	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.	<b>In-Network</b> \$0 copay for Medicare-covered prostate cancer screening.
<b>28 – ESRD</b>	20% coinsurance for dialysis. (1)(2)	<b>General</b> Authorization rules may apply. Contact plan for details.  Out-of-area Renal Dialysis services do not require Authorization.  <b>In-Network</b> \$0 copay for in and out-of-area dialysis. \$15 copay for Nutrition Therapy for Renal Disease.  Refer to “29 – Prescription Drugs” for more information.

(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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Benefit Category	Original Medicare	Providence Medicare Extra Group Plan A + RX
<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><b>Drugs covered under Medicare Part B</b></p> <p><b>General</b> 0% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).</p> <p>0% of the cost for Part B-covered chemotherapy 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/resources/health_plans/images/PME_DrugFormulary.pdf">www.providence.org/resources/health_plans/images/PME_DrugFormulary.pdf</a> on the web. 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. 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).</p>

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<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 Extra Group Plan A + RX for certain drugs.</p> <p>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 <a href="http://www.Medicare.gov">www.Medicare.gov</a>.</p> <p>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.</p>

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<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 + RX
<p><b>29 –Prescription Drugs (Continued)</b></p>		<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><b>In-Network</b> \$0 deductible.</p> <p><b>Initial Coverage</b> You pay the following until total yearly drug costs reach \$2,510:</p> <p><b>Retail Pharmacy</b> Generic</p> <ul style="list-style-type: none"> <li>▪ \$7 copay for a one-month (30-day) supply of drugs from a preferred pharmacy</li> <li>▪ \$21 copay for a three-month (90-day) supply of drugs from a preferred pharmacy</li> <li>▪ \$7 copay for a one-month (30-day) supply of drugs from a non-preferred pharmacy</li> <li>▪ \$21 copay for a three-month (90-day) supply of drugs from a non-preferred 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 Extra Group Plan A + RX
<b>29 –Prescription Drugs (Continued)</b>		<p>Brand</p> <ul style="list-style-type: none"> <li>▪ \$38 copay for a one-month (30-day) supply of drugs from a preferred pharmacy</li> <li>▪ \$114 copay for a three-month (90-day) supply of drugs from a preferred pharmacy</li> <li>▪ \$38 copay for a one-month (30-day) supply of drugs from a non-preferred pharmacy</li> <li>▪ \$114 copay for a three-month (90-day) supply of drugs from a non-preferred pharmacy</li> </ul> <p>Specialty</p> <ul style="list-style-type: none"> <li>▪ 33% coinsurance for a one-month (30-day) supply of drugs from a preferred pharmacy</li> <li>▪ 33% coinsurance for a one-month (30-day) supply of drugs from a non-preferred pharmacy</li> </ul> <p><b>Long Term Care Pharmacy</b></p> <p>Generic</p> <ul style="list-style-type: none"> <li>▪ \$7 copay for a one-month (34-day) supply of drugs</li> </ul> <p>Brand</p> <ul style="list-style-type: none"> <li>▪ \$38 copay for a one-month (34-day) supply of drugs</li> </ul> <p>Specialty</p> <ul style="list-style-type: none"> <li>▪ 33% coinsurance for a one-month (34-day) supply of drugs</li> </ul>

## Section 2

<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 + RX</b>
<b>29 –Prescription Drugs (Continued)</b>		<p><b>Mail Order</b></p> <p>Generic</p> <ul style="list-style-type: none"> <li>▪ \$7 copay for a one-month (30-day) supply of drugs from a preferred mail order pharmacy.</li> <li>▪ \$21 copay for a three-month (90-day) supply of drugs from a preferred mail order pharmacy.</li> <li>▪ \$7 copay for a one-month (30-day) supply of drugs from a non-preferred mail order pharmacy.</li> <li>▪ \$21 copay for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</li> </ul> <p>Brand</p> <ul style="list-style-type: none"> <li>▪ \$38 copay for a one-month (30-day) supply of drugs from a preferred mail order pharmacy.</li> <li>▪ \$114 copay for a three-month (90-day) supply of drugs from a preferred mail order pharmacy.</li> <li>▪ \$38 copay for a one-month (30-day) supply of drugs from a non-preferred mail order pharmacy.</li> <li>▪ \$114 copay for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</li> </ul>

## Section 2

<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 + RX</b>
<b>29 –Prescription Drugs (Continued)</b>		<p>Specialty</p> <ul style="list-style-type: none"> <li>▪ 33% coinsurance for a one-month (30-day) supply of drugs from a preferred mail order pharmacy.</li> <li>▪ 33% coinsurance for a one-month (30-day) supply of drugs from a non-preferred mail order pharmacy.</li> </ul> <p><b>Coverage Gap</b> After your total yearly drug costs reach \$2,510, you pay 100% until your yearly out-of-pocket drug costs reach \$4,050.</p> <p><b>Catastrophic Coverage</b> After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> <li>▪ \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs,</li> </ul> <p>or</p> <ul style="list-style-type: none"> <li>▪ 5% coinsurance.</li> </ul>

## Section 2

<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 + RX</b>
<b>29 –Prescription Drugs (Continued)</b>		<p><b>Out-of-Network</b></p> <p>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 pay more than the copay if you get your drugs at an out-of-network pharmacy.</p> <p><b>Out-of-Network Initial Coverage</b></p> <p>You pay the following until total yearly drug costs reach \$2,510:</p> <p>Generic</p> <ul style="list-style-type: none"> <li>▪ \$7 copay for a one-month (30-day) supply of drugs</li> </ul> <p>Brand</p> <ul style="list-style-type: none"> <li>▪ \$38 copay for a one-month (30-day) supply of drugs</li> </ul> <p>Specialty</p> <ul style="list-style-type: none"> <li>▪ 33% coinsurance for a one-month (30-day) supply of drugs</li> </ul> <p><b>Out-of-Network Catastrophic Coverage</b></p> <p>After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> <li>▪ \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs,</li> </ul> <p>or</p> <ul style="list-style-type: none"> <li>▪ 5% coinsurance.</li> </ul>

## Section 2

<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 + RX</b>
<b>30 – Dental Services</b>	Preventive dental services (such as cleaning) not covered.	<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. \$15 copay for each Medicare-covered dental benefit.</p>
<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> <p>\$15 copay for each diagnostic hearing exam. Referral required.</p>
<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>

(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		
<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 + RX
<b>ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER) Continued</b>		
<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.                      Limited to 1 exam(s) every year.                      \$15 copay for Medicare-covered benefits.</p>
<b>Health/Wellness Education</b>	Not covered.	<p><b>In-Network</b>                      This plan covers health/wellness education benefits.</p> <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> <p>Copays may apply for these benefits.</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 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 Plan 1 + RX 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.

#### **29 – Prescription Drugs (continued from page 14)**

Half tablet

Providence Medicare 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.

## 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)**

Preferred Network Pharmacies (Network Differential):

Preferred pharmacies and Participating pharmacies are pharmacies in the Providence Medicare Plans network where Providence Medicare 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 14)**

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 30-day supply the first time you fill one of these generic alternatives/equivalents.

Generic Drug Name	Category Reference
Benazepril HCL	High Blood Pressure/Heart Medications ACE Inhibitors/Angiotension Receptor Blockers
Benazepril HCL/Hydrochlorothiazide	High Blood Pressure/Heart Medications Combination Medications
Citalopram	Anxiety/Depression
Enalapril Maleate	High Blood Pressure/Heart Medications ACE Inhibitors/Angiotension Receptor Blockers
Enalapril Maleate/ Hydrochlorothiazide	High Blood Pressure/Heart Medications ACE Inhibitors/Angiotension Receptor Blockers
Fexofenadine	Allergies
Flunisolide	Allergies
Fluticasone	Allergies
Fosinopril Sodium	High Blood Pressure/Heart Medications ACE Inhibitors/Angiotension Receptor Blockers
Fosinopril Sodium/ Hydrochlorothiazide	High Blood Pressure/Heart Medications ACE Inhibitors/Angiotension Receptor Blockers
Lisinopril	High Blood Pressure/Heart Medications ACE Inhibitors/Angiotension Receptor Blockers
Lisinopril/ Hydrochlorothiazide	High Blood Pressure/Heart Medications ACE Inhibitors/Angiotension Receptor Blockers
Meloxicam	Arthritis/Inflammatory Pain
Metformin HCl	Diabetes
Omeprazole	Stomach Acid Suppression
Sertraline HCl	Anxiety/Depression
Simvastatin	Cholesterol

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

