Providence Medicare Dual Plus (HMO D-SNP) offered by Providence Health Assurance

Annual Notice of Changes for 2022

You are currently enrolled as a member of Providence Medicare Dual Plus (HMO D-SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?

- What about the hospitals or other providers you use?
- Look in Sections 1.3 and 1.4 for information about our *Provider and Pharmacy Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2021, you will be enrolled in Providence Medicare Dual Plus (HMO D-SNP).
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 3.2, page 12 to learn more about your choices.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Providence Medicare Dual Plus (HMO D-SNP).
- If you join another plan between **October 15** and **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Customer Service number at 503-574-8000 or 1-800-603-2340 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m. (Pacific Time), seven days a week.
- This information is available in a different format, including large print and braille.

- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Providence Medicare Dual Plus (HMO D-SNP)

- Providence Medicare Advantage Plans is an HMO, HMO-POS and HMO SNP with Medicare and Oregon Health Plan contracts. Enrollment in Providence Medicare Advantage Plans depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Providence Health Assurance. When it says "plan" or "our plan," it means Providence Medicare Dual Plus (HMO D-SNP).

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Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Providence Medicare Dual Plus (HMO D-SNP) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.ProvidenceHealthAssurance.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*. If you are eligible for Medicare cost-sharing assistance under Oregon Health Plan (Medicaid), you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Deductible	$0 or $203	In 2021 the deductible was $0 or $203. This amount may change for 2022.
Doctor office visits	Primary care visits: 0% or 20% of the total cost per visit Specialist visits: 0% or 20% of the total cost per visit	Primary care visits: 0% or 20% of the total cost per visit Specialist visits: 0% or 20% of the total cost per visit

Cost	2021 (this year)	2022 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	The amounts for each benefit period are $0 or: • $1,484 deductible; • $0 copayment for days 1-60; • $371 copayment each day for days 61-90; • $742 copayment each day for days 91-150; • $0 copayment each day for day 151 and beyond.	These are 2021 cost-sharing amounts and may change for 2022. Providence Medicare Dual Plus (HMO D-SNP) will provide updated rates as soon as they are released. In 2021, the amounts for each benefit period were $0 or: • $1,484 deductible; • $0 copayment for days 1-60; • $371 copayment each day for days 61-90; • $742 copayment each day for days 91-150; • $0 copayment each day for day 151 and beyond.
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment during the Initial Coverage Stage: • For generic drugs, you pay either a $0, $1.30 or $3.70 copayment per prescription • For all other drugs, you pay either a $0, $4.00 or $9.20 copayment per prescription	Deductible: $0 Copayment during the Initial Coverage Stage: • For generic drugs, you pay either a $0, $1.35 or $3.95 copayment per prescription • For all other drugs, you pay either a $0, $4.00 or $9.85 copayment per prescription

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$3,400 If you are eligible for Medicare cost-sharing assistance under Oregon Health Plan (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$3,400 If you are eligible for Medicare cost-sharing assistance under Oregon Health Plan (Medicaid), you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

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Table of Contents

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Oregon Health Plan (Medicaid).	$0	$0 There is no change for the upcoming benefit year.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2021 (this year)	2022 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Oregon Health Plan (Medicaid), very few members ever reach this out-of-pocket maximum.** If you are eligible for Oregon Health Plan (Medicaid) assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400	$3,400 Once you have paid $3,400 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year. There is no change for the upcoming benefit year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.ProvidenceHealthAssurance.com/findaprovider. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2022 *Provider and Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated *Provider and Pharmacy Directory* is located on our website at www.ProvidenceHealthAssurance.com/findaprovider. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*. **Please review the 2022 *Provider and Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.* A copy of the *Evidence of Coverage* is located on our website at www.ProvidenceHealthAssurance.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage.*

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Dental services (embedded routine preventive)	You pay a $0 copayment for each preventive dental services exam (2 dental exams per calendar year including a maximum of one comprehensive evaluation per 36 months).	You pay a $0 copayment for each preventive dental services exam (2 dental exams per calendar year including a maximum of one comprehensive evaluation per 36 months and one limited oral evaluation per 12 months).
	You pay a $0 copayment for 1 bitewing x-ray per calendar year or one diagnostic x-ray every 5 years.	You pay a $0 copayment for any combination of bitewing x-rays, 2 per calendar year or one diagnostic x-ray, for a total of 2.

Cost	2021 (this year)	2022 (next year)
Fitness benefit	The Silver&Fit® Healthy Aging and Exercise Program is offered to eligible Medicare Advantage beneficiaries. The following choices are available to you at no cost: You can select one fitness center membership, one Stay Fit Kit and one Home Fitness Kit each benefit year.	The Silver&Fit® Healthy Aging and Exercise Program is offered to eligible Medicare Advantage beneficiaries. The following choices are available to you at no cost: You can select one fitness center membership and one Home Fitness Kit each benefit year.
Health and wellness classes	Health and wellness includes educational classes on weight management, stress reduction, fall prevention, pain education, osteoporosis, yoga, childbirth, smoking cessation, progressive disorders, and nutrition offered at participating Providence facilities. You have an allowance of $500 for health and wellness classes.	Health and wellness includes educational classes on the topics of weight management, stress reduction, fall prevention, pain education, urinary incontinence-pelvic floor, osteoporosis, yoga, smoking cessation, progressive disorders and nutrition. You may access classes offered virtually through participating facilities. You have an unlimited allowance for health and wellness classes.
Meal delivery program (non-Medicare-covered)	Meal delivery program is not covered.	You pay a $0 copayment for non-Medicare-covered meal delivery program. (two meals per day for 14 days (total of 28 meals), immediately following each inpatient hospitalization). There is no plan coverage limit.

Cost	2021 (this year)	2022 (next year)
Over-the-counter (OTC) items	You receive a credit of $190 every 3 months. You can purchase products from a catalog via phone, web, mobile app, or mail through Firstline Essentials+. Unused credit amounts carry over to the next quarterly period and expire on 12/31 of each year.	You receive a credit of $204 every 3 months. You can purchase products at approved retail locations with a pre-loaded retail card or from a catalog via phone, web, or mail through Medline. Unused credit amounts carry over to the next quarterly period and expire on 12/31 of each year.
Personal Emergency Response System (PERS)	Personal Emergency Response System (PERS) services are not covered.	There is no coinsurance, copayment, or deductible for Personal Emergency Response System (PERS) services.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) or call Customer Service.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you had an approved formulary exception during the previous year, a new request may need to be submitted for the current year. To see if you need a new formulary exception request, you may call Customer Service.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and didn't receive this insert with this packet, please call Customer Service and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage		
During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.	For generic drugs, you pay either a $0, $1.30 or $3.70 copayment per prescription.	For generic drugs, you pay either a $0, $1.35 or $3.95 copayment per prescription.
For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*.	For all other drugs, you pay either a $0, $4.00 or $9.20 copayment per prescription.	For all other drugs, you pay either a $0, $4.00 or $9.85 copayment per prescription.
	Once you have paid $6,550 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	Once you have paid $7,050 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2021 (this year)	2022 (next year)
Medicare Part B prescription drugs - Step Therapy requirement.	There is no step therapy requirement for Medicare Part B prescription drugs.	Medicare Part B prescription drugs may be subject to a step therapy requirement. Refer to the 2022 *Evidence of Coverage* for additional information.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Providence Medicare Dual Plus (HMO D-SNP)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Providence Medicare Dual Plus (HMO D-SNP).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Providence Health Assurance offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Providence Medicare Dual Plus (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Providence Medicare Dual Plus (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - *– or –* Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 4 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2022.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year.

If you enrolled in a Medicare Advantage plan for January 1, 2022, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare

prescription drug coverage) between January 1 and March 31, 2022. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA).

SHIBA is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIBA counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIBA at 1-800-722-4134 (TTY 711). You can learn more about SHIBA by visiting their website (www.healthcare.oregon.gov/shiba).

For questions about your Oregon Health Plan (Medicaid) benefits, contact Oregon Health Plan (Medicaid) at 1-800-273-0557, Monday – Friday, 8 a.m. to 5 p.m. TTY users should call 711. Ask how joining another plan or returning to Original Medicare affects how you get your Oregon Health Plan (Medicaid) coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Oregon Health Plan (Medicaid), you are already enrolled in "Extra Help," also called the Low Income Subsidy. "Extra Help" pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about "Extra Help", call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Oregon AIDS Drug Assistance Program, call CAREAssist. For information on eligibility

criteria, covered drugs, or how to enroll in the program, please call CAREAssist at 971-673-0144 or 1-800-805-2313 (TTY 711).

SECTION 7 Questions?

Section 7.1 – Getting Help from Providence Medicare Dual Plus (HMO D-SNP)

Questions? We're here to help. Please call Customer Service at 503-574-8000 or 1-800-603-2340. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m. (Pacific Time), seven days a week. Calls to these numbers are free.

Read your 2022 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2022. For details, look in the 2022 *Evidence of Coverage* for Providence Medicare Dual Plus (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.ProvidenceHealthAssurance.com. You may also call Customer Service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.ProvidenceHealthAssurance.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider and Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare.)

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 7.3 – Getting Help from Oregon Health Plan (Medicaid)

To get information from Oregon Health Plan (Medicaid) you can call Oregon Health Plan (Medicaid) at 1-800-273-0557. TTY users should call 711.