PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

2022 Summary of Benefits

Providence Medicare Bridge 2 + Rx (HMO-POS)

January 1, 2022 – December 31, 2022

This plan is available in **Columbia, Lane, Marion and Polk counties in Oregon and Clark County in Washington.**

When you join Providence

You're part of something bigger than an insurance policy. You're part of a community of care, focused on your health and well-being. To help you make the right health care decisions, we're providing this summary of benefits, a succinct guide that breaks down what we would cover and what you would pay if you joined our Providence Medicare Bridge 2 + Rx (HMO-POS) plan. To be clear, this summary of benefits is just that, a summary. It doesn't list every service that we cover nor every limitation or exclusion. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

For a complete list of services that we cover, please refer to the Evidence of Coverage (EOC). You can request a printed copy by visiting **ProvidenceHealthAssurance.com/EOC** or by calling our Customer Service department at one of the numbers listed in the "Get in touch" section below.

Plan overview

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.

Our plan members get all of the benefits covered by Original Medicare as well as some extra benefits outlined in this summary.

Who can join?

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes Columbia, Lane, Marion and Polk counties in Oregon and Clark County in Washington.

Get in touch

Questions? We're here to help seven days a week from 8 a.m. to 8 p.m. (Pacific Time).

+ If you're a member of this plan, call us toll-free at 1-800-603-2340 (TTY: 711)
+ If you're not a member of this plan, call us toll-free at 1-800-457-6064 (TTY: 711)
+ You can also visit us online at **ProvidenceHealthAssurance.com**

Helpful resources

+ Visit **ProvidenceHealthAssurance.com/findaprovider** to see our plan's Provider and Pharmacy Directory or to request a printed copy. You can also call us to have a printed copy mailed to you.
+ Want to see our plan's formulary (list of Part D prescription drugs), including any restrictions? Visit **ProvidenceHealthAssurance.com/Formulary**, or give us a call for a printed copy.
+ To learn more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, view it online at **www.Medicare.gov** or request a printed copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Providence Medicare Bridge 2 + Rx (HMO-POS)

Monthly Plan Premium	$40 In addition, you must continue to pay your Medicare Part B premium.	
Annual Medical Deductible	$0 There is no medical deductible for in- or out-of-network services.	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) for this plan:	
	In-network: $4,900	Out-of-network: $10,000 combined

Benefits		In-network	Out-of-network
Inpatient Hospital Coverage[1]		$325 copayment each day for days 1-6 and $0 copayment each day for day 7 and beyond	30% of the total cost per admission
Outpatient Hospital Coverage[1]		$375 copayment for outpatient surgery at a hospital facility	30% of the total cost
Ambulatory Surgery Center[1]		$250 copayment for outpatient surgery at an Ambulatory Surgery Center	30% of the total cost
Doctor Visits	Primary Care Provider Visit	$0 copayment	$25 copayment
	Specialist Visit[2]	$35 copayment $50 copayment no referral	$50 copayment
Preventive Care		You pay nothing	30% of the total cost
Emergency Care		$90 copayment If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.	
Urgently Needed Services		$50 copayment If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care.	

Out-of-network/non-contracted providers are under no obligation to treat Providence Medicare Advantage Plans members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

Providence Medicare Bridge 2 + Rx (HMO-POS)

Benefits		In-network	Out-of-network
Diagnostic Services/ Labs/Imaging[1]	Diagnostic Radiology Services (e.g. MRI, ultrasounds, CT scans)[1]	20% of the total cost	30% of the total cost
	Therapeutic Radiology Services	20% of the total cost	30% of the total cost
	Outpatient X-rays	$10 copayment per day	30% of the total cost
	Diagnostic Tests and Procedures[1]	20% of the total cost	30% of the total cost
	Lab Services	$0 copayment	30% of the total cost
Hearing Services	Medicare-Covered[2]	$35 copayment	30% of the total cost
	Routine Exam	$0 copayment	Not covered
	Hearing Aids	$699 copayment per Advanced hearing aid or a $999 copayment per Premium hearing aid	Not covered
Dental Services	Medicare-Covered[2]	$35 copayment	30% of the total cost
	Embedded Preventive	$15 copayment Includes exams, cleanings, X-rays; limits apply	Not covered
	Optional	Covered for additional premium; see last page of this summary	
Vision Services	Medicare-Covered Exams/Screening[2]	$35 copayment per exam $0 copayment for glaucoma screening	30% of the total cost per exam 30% of the total cost for glaucoma screening
	Routine Exam	Allowance of up to $75 per calendar year for a routine vision exam (including refraction)	
	Medicare-Covered Eyewear	20% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	30% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery
	Routine Eyeglasses or Contact Lenses	Allowance of up to $150 per calendar year for any combination of routine prescription eyewear	

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

Providence Medicare Bridge 2 + Rx (HMO-POS)

Benefits		In-network	Out-of-network
Mental Health Services[1]	Inpatient Visit	$300 copayment each day for days 1-5 and $0 copayment each day for days 6-90	30% of the total cost per admission
	Outpatient Individual and Group Therapy Visit	$35 copayment	30% of the total cost
Skilled Nursing Facility (SNF)[1]		$0 copayment each day for days 1-20 and $160 copayment each day for days 21-100	30% of the total cost for each benefit period (days 1-100)
Physical Therapy[1]		$35 copayment	30% of the total cost
Ambulance[1]		$250 copayment	
Transportation		Not covered	
Medicare Part B Drugs[1]		20% of the total cost	30% of the total cost
Alternative Care (combined benefit limit for chiropractic, acupuncture & naturopath services)		Chiropractic: $20 copayment Naturopath and Acupuncture Specialist: $35 copayment $500 plan maximum	Not covered
Meal Delivery Program (post-discharge only)		$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization	Not covered
Over-the-Counter Items		$50 allowance per quarter (catalog, online, mail, and telephonic ordering)	Not covered
Personal Emergency Response System (PERS)		$0 copayment	Not covered
Wellness Program		$0 copayment for monthly gym membership with participating fitness clubs	Not covered

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

Prescription Drug Benefits

Providence Medicare Bridge 2 + Rx (HMO-POS)

Prescription Drug Deductible	
Yearly Deductible (Applies to all tiers)	There is no prescription drug deductible for this plan.

Initial Coverage	You pay the following until your total yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Preferred Retail and Mail-Order Cost Sharing			
	Up to 30 days	**Up to 60 days**	**Up to 90 days**
Tier 1 (Preferred Generic)	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Generic)	$10 copayment ($10 copayment for Select Insulins)	$10 copayment ($10 copayment for Select Insulins)	$10 copayment ($10 copayment for Select Insulins)
Tier 3 (Preferred Brand)	$47 copayment ($35 copayment for Select Insulins)	$94 copayment ($35 copayment for Select Insulins)	$141 copayment ($35 copayment for Select Insulins)
Tier 4 (Non-Preferred Drug)	$100 copayment	$200 copayment	$300 copayment
Tier 5 (Specialty)	33% of the total cost	Not covered	Not covered
Tier 6 ($0 Part D Vaccines)	$0 copayment	Not covered	Not covered
The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then, the insulin must be covered under Part B and will not be eligible for the Part D copays.			

Prescription Drug Benefits
Providence Medicare Bridge 2 + Rx (HMO-POS)

Standard Retail Cost Sharing			
	Up to 30 days	**Up to 60 days**	**Up to 90 days**
Tier 1 (Preferred Generic)	$16 copayment	$32 copayment	$48 copayment
Tier 2 (Generic)	$20 copayment ($20 copayment for Select Insulins)	$40 copayment ($40 copayment for Select Insulins)	$60 copayment ($60 copayment for Select Insulins)
Tier 3 (Preferred Brand)	$47 copayment ($35 copayment for Select Insulins)	$94 copayment ($70 copayment for Select Insulins)	$141 copayment ($105 copayment for Select Insulins)
Tier 4 (Non-Preferred Drug)	$100 copayment	$200 copayment	$300 copayment
Tier 5 (Specialty)	33% of the total cost	Not covered	Not covered
Tier 6 ($0 Part D Vaccines)	$0 copayment	Not covered	Not covered
The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then, the insulin must be covered under Part B and will not be eligible for the Part D copays.			

If you reside in a long-term facility, you pay the same as at a standard retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. You may get drugs from a standard in-network pharmacy, but may pay more than you pay at a preferred in-network pharmacy.

Coverage Gap (Applies to all tiers)	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for the drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430. After you enter the coverage gap, you pay $10-$35 per month for Select Insulins, 25% of the plan’s cost for the covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.
The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then, the insulin must be covered under Part B and will not be eligible for the Part D copays.	

Prescription Drug Benefits

Providence Medicare Bridge 2 + Rx (HMO-POS)

Catastrophic Coverage (Applies to all tiers)	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: 5% of the cost or $3.95 copayment for generic (including brand drugs treated as generic) and a $9.85 copayment for all other drugs.

The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Optional Supplemental Dental
Providence Medicare Bridge 2 + Rx (HMO-POS)

Please Note:

Optional Benefits: You must pay an extra premium each month for these benefits.
Cost Sharing: While you can see any dentist, our in-network providers have agreed to accept a contracted rate for the services they provide. This means cost sharing will be lower if you see an in-network provider.

Option 1: Basic Dental Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $32.50 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-network**	**Out-of-network**
Deductible	$50	$150
Annual Benefit Maximum	$1,000 every year	
Diagnostic and Preventive Care*	$0 copayment	You pay 20%
Basic Care*	You pay 50%	You pay 60%
Major Restorative Care*	You pay 50%	You pay 60%

Option 2: Enhanced Dental Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $45.10 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-network**	**Out-of-network**
Deductible	$50	$150
Annual Benefit Maximum	$1,500 every year	
Diagnostic and Preventive Care*	$0 copayment	You pay 20%
Basic Care*	You pay 50%	You pay 60%
Major Restorative Care*	You pay 50%	You pay 60%

*Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members must use a Medicare contracted provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

PROVIDENCE
Medicare Advantage Plans

A division of Providence Health Assurance

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800- 603-2340. All other members can call 503-574-7500 or 1-800-878-4445 (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-603-2340 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-603-2340 (TTY: 711).

Chinese: 注意：如果您使用繁體中文, 您可以免費獲得語言援助服務. 請致電 1-800-603- 2340 (TTY: 711）

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-603-2340 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-603-2340 (TTY: 711) 번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-603-2340 (телетайп: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-603-2340 (TTY: 711).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-603-2340 (телетайп: 711).

Mon-Khmer, Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-603-2340 (TTY: 711)។

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます.1-800-603-2340 （TTY:711）まで、お電話にてご連絡ください.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-603-2340 (መስማት ለተሳናቸው: 711).

Cushite (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-603-2340 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-603-2340 (رقم هاتف الصم والبكم: (TTY: 711).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-603-2340 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-603-2340 (TTY: 711).

Laotian: ໂປດຊາບ: ຖ້ າອ່ າ ທ່ ານເວ້ ົ າພາສາ ລາວ, ການບ ໍ ລິການຊ ່ ວຍເຫ ຼ ອດ້ ານພາສາ, ໂດຍ ່ ບເສ ັ ຽ ຄ ່ າ, ແມ ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ ່ ານ. ໂທຣ 1-800-603-2340 (TTY: 711).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-603-2340 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-603-2340 (ATS: 711).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-603-2340 (TTY: 711)

Persian:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-603-2340 (TTY: 711) تماس بگیرید.