

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 503-574-8000 or 1-800-603-2340 (TTY: 711), 8am to 8pm (Pacific time), seven days a week.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.providencehealthassurance.com or call 503-574-8000 or 1-800-603-2340 (TTY: 711) to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- In addition to your monthly plan premium (including \$0 premium plans), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month. The Part B premium is covered for full-dual enrollees who are eligible for Providence Medicare Dual Plus (HMO SNP).
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2019.
- When selecting an HMO product, remember that except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- Our HMO-POS plans allow you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- Providence Medicare Dual Plus (HMO SNP) is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Providence Medicare Advantage Plans is an HMO, HMO-POS, and HMO SNP plan with Medicare and Oregon Health Plan contracts. Enrollment in Providence Medicare Advantage Plans depends on contract renewal. You must continue to pay your Medicare Part B premium.

Summary of Benefits

January 1, 2019 – December 31, 2019

Providence Medicare Enrich + RX (HMO)

This Plan is available in Linn and Benton counties.

2019

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.

This booklet gives you a summary of what **Providence Medicare Enrich + RX (HMO)** covers and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please refer to The "Evidence of Coverage." To obtain a copy of the EOC please contact customer service at 1-800-603-2340 or visit us online to request one at www.ProvidenceHealthAssurance.com/EOC.

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

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <http://medicare.gov> or get a copy 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.

THINGS TO KNOW ABOUT PROVIDENCE MEDICARE ENRICH + RX (HMO)

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific Time.

PROVIDENCE MEDICARE ENRICH + RX (HMO), PHONE NUMBERS AND WEBSITE

- If you are a member of this plan, call toll free 1-800-603-2340, TTY users call 711.
- If you are not a member of this plan, call toll free 1-800-457-6064, TTY users call 711.
- Our website: www.ProvidenceHealthAssurance.com
- Our plan members get all of the benefits covered by Original Medicare.
- Some of the extra benefits are outlined in this booklet.

WHO CAN JOIN

To join **Providence Medicare Enrich + RX (HMO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Oregon: Linn and Benton

You can see our plan's Provider and Pharmacy Directory at our website:

www.providencehealthassurance.com/providerdirectory or call us and we will send you a copy of the Provider and Pharmacy Directory. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.providencehealthassurance.com/formulary

Providence Medicare Enrich + RX (HMO)

Monthly Plan Premium	\$147 <i>In addition, you must continue to pay your Medicare Part B premium.</i>
Deductible	There is no medical deductible.
Maximum Out-of-pocket Responsibility	Your yearly limit for this plan \$5,000

SERVICES WITH A¹ MAY REQUIRE PRIOR AUTHORIZATION

SERVICES WITH A² MAY REQUIRE A REFERRAL FROM YOUR DOCTOR

Benefits		In-network
Inpatient Hospital Coverage¹		\$350 copay per day for days 1 through 5 You pay \$0 per day days 6 & beyond
Outpatient Hospital Coverage¹		\$275 copay outpatient surgery
Doctor Visits²	Primary Care Provider visit	\$15 copay
	Specialist visit	\$40 copay
Preventive Care		You pay nothing
Emergency Care		\$90 copay <i>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</i>
Urgently Needed Services		\$65 copay <i>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost of urgent care.</i>

Benefits		In-network
Diagnostic Services/Labs/ Imaging¹	Diagnostic radiology services (e.g. MRI, ultrasounds, CT Scans) ¹	20% of the cost
	Therapeutic radiology services ¹	20% of the cost
	Outpatient x-rays ¹	\$15 copay per day
	Diagnostic test and procedures ¹	20% of the cost
	Lab Services ¹	\$10 copay per day
Hearing Services²	Medicare-covered	\$40 copay
	Routine exam	\$45 copay
Dental Services²	Medicare-covered	\$40 copay
	Optional	Covered for additional Premium, see below
Vision Services	Medicare-covered	\$40 copay
	Routine exam	Allowance of up to \$45 per calendar year for a routine vision exam (including refraction).
	Routine eyeglasses or contact lenses	Allowance of up to \$200 per calendar year for any combination of routine prescription eyewear.
Mental Health Services¹	Inpatient Visit	\$225 copay per day for days 1-7. You pay nothing for days 8-190
	Outpatient individual and group therapy visit	\$40 copay
Skilled Nursing Facility¹		You pay nothing for days 1-20. \$160 copay for days 21-100
Physical therapy		\$40 copay
Ambulance¹		\$235 copay
Transportation		Not covered
Medicare Part B Drugs¹		20% of the cost

Providence Medicare Enrich + RX (HMO) Prescription Drug Benefits

Initial Coverage	After you pay your yearly deductible you pay the following until your total yearly drug costs reach \$3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. <i>You may get your drugs at network retail pharmacies and mail order pharmacies.</i>		
	Preferred Retail and Mail Order Cost-Sharing		
	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic)	\$7 copay	\$14 copay	\$16.80 copay
Tier 2 (Generic)	\$15 copay	\$30 copay	\$36 copay
Tier 3 (Preferred Brand)	\$47 copay	\$94 copay	\$112.80 copay
Tier 4 (Non-preferred Drug)	\$100 copay	\$200 copay	\$240 copay
Tier 5 (Specialty)	28% of the cost	Not offered	Not offered
	Standard Retail Cost-Sharing		
Tier 1 (Preferred Generic)	\$14 copay	\$28 copay	\$42 copay
Tier 2 (Generic)	\$20 copay	\$40 copay	\$60 copay
Tier 3 (Preferred Brand)	\$47 copay	\$94 copay	\$141 copay
Tier 4 (Non-preferred Drug)	\$100 copay	\$200 copay	\$300 copay
Tier 5 (Specialty)	28% of the cost	Not offered	Not offered
<p>If you reside in a long-term care facility, you pay the same as at a 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.</p> <p>Your yearly deductible for Part D (pharmacy) coverage is \$260. You must pay this amount before the cost shares above apply.</p> <p>Note: <i>The Deductible is waived for Generic Tiers (Tiers 1 & 2).</i></p>			
Coverage Gap	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 \$3,820. After you enter the coverage gap, you pay 25% of the plan’s cost for the covered brand name drugs and 37% of the plan’s cost for covered generic drugs until your costs total \$5,100, which is the end of the coverage gap. Not everyone will enter the coverage gap.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,100, you pay the greater of: 5% of the cost or \$3.40 copay for generic (including brand drugs treated as generic) and an \$8.50 copay for all other drugs.		

This information is not a complete description of benefits. Call 1-800-603-2340, TTY users call 711 for more information.

OPTIONAL SUPPLEMENTAL DENTAL

Please note:

Optional Benefits: You must pay an extra premium each month for these benefits¹

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 provider²

Option 1: Basic Dental

Benefits include: Preventive Dental Comprehensive Dental

Monthly premium¹	Additional \$33.70 per month. <i>You must keep paying your Medicare Part B and monthly plan premium.</i>	
Benefits	In-network	Out-of-network
Deductible ¹	\$50	\$150
Annual Benefit Maximum ^{1,2}	\$1,000 per year	
Diagnostic and Preventive Care ^{1,2}	You pay 0%	You pay 20%
Basic Care ^{1,2}	You pay 50%	You pay 60% <ul style="list-style-type: none"> • Fillings (Silver) • Fillings (Composite)
Major Restorative Care ^{1,2}	You pay 50%	You pay 60%

Option 2: Enhanced Dental

Benefits include: Preventive Dental Comprehensive Dental

Monthly premium¹	Additional \$46.50 per month. <i>You must keep paying your Medicare Part B and monthly plan premium.</i>	
Benefits	In-network	Out-of-network
Deductible ¹	\$50	\$150
Annual Benefit Maximum ^{1,2}	\$1,500 per year	
Diagnostic and Preventive Care ^{1,2}	You pay 0%	You pay 20%
Basic Care ^{1,2}	You pay 50%	You pay 60% <ul style="list-style-type: none"> • Fillings (Silver) • Fillings (Composite)
Major Restorative Care ¹	You pay 50%	You pay 60%