PROVIDENCE
Medicare Advantage Plans

A division of Providence Health Assurance

Summary of Benefits

January 1, 2019 – December 31, 2019

Providence Medicare Harbor + RX (HMO)

This plan is available in Snohomish and King Counties in Washington State

2019

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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 Harbor + 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 HARBOR + RX (HMO)

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

PROVIDENCE MEDICARE FOCUS MEDICAL (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 HARBOR + 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 Washington: Snohomish and King

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 Harbor + RX (HMO)

Monthly Plan Premium	$0 In addition, you must continue to pay your Medicare Part B premium.
Deductible	There is no medical deductible for in or out-of-network services.
Maximum Out-of-pocket Responsibility	Your yearly limit(s) in this plan
	$6,700

SERVICES WITH A[1] MAY REQUIRE PRIOR AUTHORIZATION
SERVICES WITH A[2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR

Benefits		**In-network**
Inpatient Hospital Coverage[1]		$450 copay per day for days 1-4 You pay $0 per day days 5-90
Outpatient Hospital Coverage[1]		$385 copay outpatient surgery
Doctor Visits[2]	Primary	$15 copay
	Specialist	$50 copay
Preventive Care		You pay nothing
Emergency Care		$90 copay *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		$65 copay *If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost of urgent care.*

Benefits		In-network
Diagnostic Services/Labs/ Imaging[1]	Diagnostic radiology services	20% of the cost
	Diagnostic test and procedures	20% of the cost
	Lab Services	$15 copay per day
	Outpatient x-rays	$15 copay per day
	Therapeutic radiology services	20% of the cost
Hearing Services[2]	Medicare-covered	$50 copay
	Routine exam	$45 copay
Dental Services[2]	Medicare-covered	$50 copay
	Optional	Covered for additional premium, see below
Vision Services	Medicare-covered	$50 copay
	Routine exam	Allowance of up to $30 per calendar year for a routine vision exam (including refraction)
	Routine eyeglasses or contact lenses	Allowance of up to $75 every two calendar years for any combination of routine prescription eyewear.
Mental Health Services[1]	Inpatient visit	$320 copay per day for days 1-5. You pay nothing for days 6-190.
	Outpatient individual and group therapy visit	$40 copay
Skilled Nursing Facility[1]		You pay nothing for days 1- 20 $172 copay per day for days 21-100
Physical therapy		$40 copay
Ambulance[1]		$270 copay
Transportation		Not covered
Medicare Part B Drugs[1]		20% of the cost

Providence Medicare Harbor + 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. *You may get your drugs at network retail pharmacies and mail order pharmacies*.		
	Preferred Retail and Mail Order Cost-Sharing		
	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$20 copay	$24 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)	27% of the cost	Not offered	Not offered
	Standard Retail Cost-Sharing		
Tier 1 (Preferred Generic)	$16 copay	$32 copay	$48 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)	27% of the cost	Not offered	Not offered
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. Your yearly deductible for Part D (pharmacy) coverage is $290. You must pay this amount before the cost shares above apply. ***Note:*** *The Deductible is waived for Generic Tiers (Tiers 1 & 2).*			
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 benefits[1]* *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[2]*		
Option 1: Basic Dental *Benefits include: Preventive Dental Comprehensive Dental*		
Monthly premium[1]	Additional $35.50 per month. *You must keep paying your Medicare Part B and monthly plan premium.*	
Benefits	In-network	Out-of-network
Deductible[1]	$50	$150
Annual Benefit Maximum[1,2]	$1000 per year	
Diagnostic and Preventive Care[1,2]	You pay 0%	You pay 20%
Basic Care[1,2]	You pay 50%	You pay 60% • 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 premium[1]	Additional $49.60 per month. *You must keep paying your Medicare Part B and monthly plan premium.*	
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% • Fillings (Silver) • Fillings (Composite)
Major Restorative Care[1]	You pay 50%	You pay 60%