

2024 Summary of Benefits

Providence Medicare Sycamore + Rx (HMO)

January 1, 2024 – December 31, 2024

This plan is available in Orange County, California.

When You Join Providence

You are not just part of an insurance policy but part of a community of care, focused on your health and well-being. This Summary of Benefits is provided to help you make the right health care decisions. It is a short guide of what we would cover and what you would pay if you joined our Providence Medicare Sycamore + Rx (HMO). To be clear, this is not a complete breakdown of benefits, and will not list every service that we cover, nor every limitation or exclusion. Plans may offer supplemental benefits in addition to Part C 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](https://www.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 Health Assurance is an HMO, HMO-POS and HMO SNP with Medicare and Oregon Health Plan contracts. Enrollment in Providence Health Assurance depends on contract renewal.

Not only do our plan members get all of the benefits covered by Original Medicare, they also get 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 Orange County, California.

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](https://www.ProvidenceHealthAssurance.com)

Helpful Resources

- + Visit [ProvidenceHealthAssurance.com/findaprovider](https://www.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](https://www.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 Sycamore + Rx (HMO)

| | |
|--|---|
| Monthly Plan Premium | \$0 You must continue to pay your Medicare Part B premium. |
| Annual Medical Deductible | \$0 There is no medical deductible. |
| Maximum Out-of-Pocket Responsibility (does not include prescription drugs) | Your yearly limit(s) for this plan: |
| | In-network: \$400 |

| Benefits | | In-Network |
|--|-------------------------------|---|
| Inpatient Hospital Coverage ¹ | | \$0 copayment |
| Outpatient Hospital Coverage ¹ | | \$0 copayment for outpatient surgery at a hospital facility |
| Ambulatory Surgical Center (ASC) Services ¹ | | \$0 copayment for outpatient surgery at an Ambulatory Surgical Center |
| Doctor Visits | Primary Care Provider Visit | \$0 copayment |
| | Specialist Visit ² | \$0 copayment |
| Preventive Care (e.g., annual check-ups, immunizations, flu shots) | | You pay nothing |
| Emergency Care | | \$90 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived. |
| Urgently Needed Services | | \$0 copayment |

¹ Services may require prior authorization. See the Evidence of Coverage for more information.

² Services may require a referral from your doctor.

Providence Medicare Sycamore + Rx (HMO)

| Benefits | | In-Network |
|--|---|---|
| Diagnostic Services/ Labs/Imaging | Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans) ¹ | \$0 copayment |
| | Therapeutic Radiology Services ¹ | \$50 copayment |
| | Outpatient X-rays | \$0 copayment |
| | Diagnostic Tests and Procedures ¹ | \$0 copayment |
| | Lab Services ¹ | \$0 copayment |
| Hearing Services | Medicare-Covered ² | \$0 copayment |
| | Routine Exam | \$0 copayment |
| | Hearing Aids | \$399 copayment per Advanced hearing aid or \$699 copayment per Premium hearing aid |
| Dental Services | Medicare-Covered | \$0 copayment |
| | Other/Non-Medicare-Covered | \$3,100 allowance per calendar year for any dental services of your choosing |
| Vision Services | Medicare-Covered Exams ² /Screening | \$0 copayment per exam \$0 copayment for glaucoma screening |
| | Routine Exam | There is no coinsurance, or copayment for one routine vision exam (including refraction) per calendar year. |
| | Medicare-Covered Eyewear | \$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery |
| | Routine Eyeglasses or Contact Lenses | Allowance of up to \$250 per calendar year for any combination of routine prescription eyewear |
| Mental Health Services | Inpatient Visit ¹ | \$0 copayment |
| | Outpatient Individual ¹ and Group Therapy Visit ¹ | \$0 copayment |

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² Services may require a referral from your doctor.

Providence Medicare Sycamore + Rx (HMO)

| Benefits | In-Network |
|--|---|
| Skilled Nursing Facility (SNF) ¹ | \$0 copayment each day for days 1-20 and \$50 copayment each day for days 21-100 |
| Physical Therapy ¹ | \$0 copayment |
| Ambulance ¹ | \$50 copayment |
| Transportation | \$0 copayment for 60 one-way trips (max of 25 miles each) |
| Medicare Part B Drugs ¹ | 0% - 20% of the total cost (Insulin cost share up to \$35 per month) |
| Alternative Care (visit limits) | Chiropractic: \$0 copayment; 24 visits every calendar year Acupuncture: \$0 copayment; 24 visits every calendar year Naturopath: \$0 copayment; 20 visits every calendar year |
| Dental Care (combined benefit limit for Preventive & Comprehensive services) | \$3,100 allowance per calendar year for any dental services of your choosing |
| Meal Delivery Program (post-discharge only) | \$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization |
| Over-the-Counter Items | \$150 allowance every three months (retail card, catalog, online, mail, and telephonic ordering) |
| Personal Emergency Response System (PERS) | \$0 copayment |
| Wellness Program | \$0 copayment for monthly gym membership with participating fitness clubs |
| Wig | There is no coinsurance, or copayment for one synthetic wig due to hair loss from chemotherapy |

¹ Services may require prior authorization. See the Evidence of Coverage for more information.

² Services may require a referral from your doctor.

Prescription Drug Benefits

Providence Medicare Sycamore + Rx (HMO)

| 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 \$5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at retail pharmacies and mail-order pharmacies. | | |
| Preferred Retail and Mail-Order Cost Sharing | | | |
| | Up to 30 days | Up to 60 days | Up to 100 days |
| Tier 1 (Preferred Generic) | \$0 copayment | \$0 copayment | \$0 copayment |
| Tier 2 (Generic) | \$0 copayment | \$0 copayment | \$0 copayment |
| Tier 3 (Preferred Brand) | \$37 copayment (\$35 copayment for Insulin) | \$74 copayment (\$35 copayment for Insulin) | \$74 copayment (\$35 copayment for Insulin) |
| Tier 4 (Non-Preferred Drug) | \$100 copayment | \$200 copayment | \$300 copayment |
| Tier 5 (Specialty) | 33% of the total cost | Not Covered | Not Covered |

Prescription Drug Benefits

Providence Medicare Sycamore + Rx (HMO)

| Standard Retail Cost Sharing | | | |
|------------------------------|--|--|--|
| | Up to 30 days | Up to 60 days | Up to 100 days |
| Tier 1 (Preferred Generic) | \$16 copayment | \$32 copayment | \$48 copayment |
| Tier 2 (Generic) | \$20 copayment | \$40 copayment | \$60 copayment |
| Tier 3 (Preferred Brand) | \$37 copayment (\$35 copayment for Insulin) | \$74 copayment (\$70 copayment for Insulin) | \$111 copayment (\$105 copayment for Insulin) |
| Tier 4 (Non-Preferred Drug) | \$100 copayment | \$200 copayment | \$300 copayment |
| Tier 5 (Specialty) | 33% of the total cost | Not Covered | Not Covered |

If you reside in a long-term care 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) | <p>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 \$5,030.</p> <p>After you enter the coverage gap, you pay your Tier 1 cost-share for Tier 1 (Preferred Generic) drugs, Tier 2 cost-share for Tier 2 (Generic) drugs, no more than \$35 per month for insulins, 25% of the plan's cost for the covered brand name drugs, and 25% of the plan's cost for other covered generic drugs until your costs total \$8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> |
|--|--|

| Preferred Retail and Mail-Order Cost Sharing | | | |
|--|---|---|---|
| | Up to 30 days | Up to 60 days | Up to 100 days |
| Tier 1 (Preferred Generic) | \$0 copayment | \$0 copayment | \$0 copayment |
| Tier 2 (Generic) | \$0 copayment | \$0 copayment | \$0 copayment |
| Tier 3 (Preferred Brand) | 25% of the total cost (\$35 copayment for Insulin) | 25% of the total cost (\$35 copayment for Insulin) | 25% of the total cost (\$35 copayment for Insulin) |
| Tier 4 (Non-Preferred Drug) | 25% of the total cost | 25% of the total cost | 25% of the total cost |
| Tier 5 (Specialty) | 25% of the total cost | Not covered | Not covered |

Prescription Drug Benefits

Providence Medicare Sycamore + Rx (HMO)

| Standard Retail Cost Sharing | | | |
|--|---|--|---|
| Tier 1 (Preferred Generic) | \$16 copayment | \$32 copayment | \$48 copayment |
| Tier 2 (Generic) | \$20 copayment | \$40 copayment | \$60 copayment |
| Tier 3 (Preferred Brand) | 25% of the total cost (\$35 copayment for Insulin) | 25% of the total cost (\$70 copayment for Insulin) | 25% of the total cost (\$105 copayment for Insulin) |
| Tier 4 (Non-Preferred Drug) | 25% of the total cost | 25% of the total cost | 25% of the total cost |
| Tier 5 (Specialty) | 25% of the total cost | Not covered | Not covered |
| 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 \$8,000, the plan pays the full cost for your Part D covered drugs. You pay nothing. | | |

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

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Important Message About What You Pay for Insulin - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-603-2340 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-603-2340 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-603-2340 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-603-2340 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-603-2340 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-603-2340 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-603-2340 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-603-2340 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-603-2340 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-603-2340 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-603-2340 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-603-2340 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-603-2340 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-603-2340 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-603-2340 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-603-2340 (TTY: 711)にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。