SUMMIT
HEALTH

Summit Health Medicare Advantage

2022 Summary of Benefits

H2765_1099H276522A_M

2022 Summary of Benefits

This is a summary of drug and health services covered by Summit Health Medicare Advantage plans for January 1, 2022 – December 31, 2022.

Summit Health Plan, Inc. is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the “Evidence of Coverage”.

To join a Summit Medicare Advantage 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 the following counties in Oregon: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler.

If you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

This document is available in other formats such as large print or Spanish.

For more information, please call us at 844-827-2355 (TTY Users should call 711) or visit us at yoursummithealth.com. From October 1 to March 31, with the exceptions of Christmas Day and Thanksgiving Day, you can call us 7 days a week from 7:00 a.m. to 8:00 p.m. Pacific Time. From April 1 to September 30, you can call us Monday through Friday from 7:00 a.m. to 8:00 p.m. Pacific Time.

Medical benefits

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

	Summit Health Core (HMO-POS) H2765-001		Summit Health Value + Rx (HMO) H2765-002		Summit Health Standard + Rx (HMO-POS) H2765-003		Summit Health Premier + Rx (HMO-POS) H2765-004	
Monthly Premium	$22		$69		$99		$140	
Medical Deductible	$0		$0		$0		$0	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Maximum out-of-pocket responsibility *(Does not include prescription drugs)*	$4,000	$4,000	$6,650	N/A	$5,100	$8,000	$4,000	$7,750
Inpatient hospital coverage *(Copay per day 1-5)* *(Authorization rules may apply)*	$350	30%	$370	Not covered	$350	50%	$315	30%
Outpatient hospital coverage (Observation) *(Authorization rules may apply)*	$350	30%	$370	Not covered	$350	50%	$315	30%
Ambulatory surgical center *(Authorization rules may apply)*	$350	30%	$370	Not covered	$350	50%	$315	30%
Outpatient surgery *(Authorization rules may apply)*	$350	30%	$370	Not covered	$350	50%	$315	30%
Doctor Visits **Primary care provider** *(PCP)*	$10	30%	$10	Not covered	$10	50%	$10	30%
Specialists *(Referral rules may apply)*	$35	30%	$40	Not covered	$35	50%	$35	30%
Preventive care	$0	30%	$0	Not covered	$0	50%	$0	30%
Emergency care	$90		$90		$90		$90	
Urgently needed services	$35		$50		$35		$35	

Medical benefits *(continued)*

	Summit Health Core (HMO-POS) H2765-001		Summit Health Value + Rx (HMO) H2765-002		Summit Health Standard + Rx (HMO-POS) H2765-003		Summit Health Premier + Rx (HMO-POS) H2765-004	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*	*In-network*	*Out-of-network*	*In-network*	*Out-of-network*
Diagnostic services/labs/imaging *(Authorization rules may apply)*								
Diagnostic radiology services *(e.g. MRIs, CT scans)*	20%	30%	20%	Not covered	20%	50%	20%	30%
Lab services	$0	30%	$0	Not covered	$5	50%	$5	30%
Outpatient x-rays	20%	30%	20%	Not covered	20%	50%	20%	30%
Hearing services								
Exams to diagnose and treat hearing and balance issues *(Referral rules may apply)*	$35	30%	$40	Not covered	$35	50%	$35	30%
Routine hearing exam for hearing aids	$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered
Hearing aids *(Copay per each aid)*	$699 - $999	Not covered	$699 - $999	Not covered	$699 - $999	Not covered	$699 - $999	Not covered
Dental services								
Medicare-covered *(Referral rules may apply)*	$35	30%	$40	Not covered	$35	50%	$35	30%
Preventive and comprehensive dental *(Total $500 allowance is combined for in and out of network services)*	$0 preventive $500 allowance	$500 allowance	$0 preventive $500 allowance	$500 allowance	$0 preventive $500 allowance	$500 allowance	$0 preventive $500 allowance	$500 allowance

Medical benefits *(continued)*

	Summit Health Core (HMO-POS) H2765-001		Summit Health Value + Rx (HMO) H2765-002		Summit Health Standard + Rx (HMO-POS) H2765-003		Summit Health Premier + Rx (HMO-POS) H2765-004	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*	*In-network*	*Out-of-network*	*In-network*	*Out-of-network*
Vision services								
Medical vision services *(Medicare-covered)* *(Referral rules may apply)*	$35	30%	$40	Not covered	$35	50%	$35	30%
Routine vision services *(Annual exam & glasses every 2 years)*	$0	50%	$0	50%	$0	50%	$0	50%
Additional services								
Mental health services	$35	30%	$40	Not covered	$35	50%	$35	30%
Skilled nursing facility *(SNF)* *(Copay per day 21-100)* *(Authorization rules may apply)*	$150	30%	$170	Not covered	$165	50%	$160	30%
Physical therapy *(Authorization rules may apply)*	$35	30%	$40	Not covered	$35	50%	$35	30%
Ambulance *(Authorization rules may apply)*	$250		$300		$300		$250	
Transportation	Not covered		Not covered		Not covered		Not covered	
Medicare Part B Drugs *(Authorization rules may apply)*	20%	30%	20%	Not covered	20%	50%	20%	30%
Durable medical equipment *(DME)*	20%	30%	20%	Not covered	20%	50%	20%	30%
Diabetic monitoring supplies *(Authorization rules may apply)*	$0-20%	30%	$0-20%	Not covered	$0-20%	50%	$0-20%	30%

Pharmacy benefits

	Summit Health Core (HMO-POS) H2765-001	Summit Health Value + Rx (HMO) H2765-002		Summit Health Standard + Rx (HMO-POS) H2765-003		Summit Health Premier + Rx (HMO-POS) H2765-004	
Outpatient prescription drugs							
Prescription drug deductible	This plan does not include Part D prescription drug coverage.	$250 (waived on tiers 1, 2, & 7)		$200 (waived on tiers 1, 2, & 7)		$150 (waived on tiers 1, 2, & 7)	
Initial coverage Stage		30-day supply	90-day supply	30-day supply	90-day supply	30-day supply	90-day supply
Tier 1 *(Preferred generic)*		$4	$12	$4	$12	$4	$12
Tier 2 *(Generic)*		$10	$30	$10	$30	$10	$30
Tier 3 *(Preferred brand)*		$45	$135	$45	$135	$45	$135
Tier 4 *(Non-preferred brand)*		$100	$300	$100	$300	$100	$300
Tier 5 *(Preferred specialty tier)*		23%	N/A	24%	N/A	25%	N/A
Tier 6 *(Specialty tier)*		28%	N/A	29%	N/A	30%	N/A
Tier 7 *(Vaccine)*		$0	N/A	$0	N/A	$0	N/A

You begin in the deductible stage when you fill your first prescription of the year. During this stage, you pay the full cost of your drugs until you have paid the Part D deductible (waived on Tier 1, Tier 2 and Tier 7) for your drugs. Cost sharing amounts are the same when received from network retail, mail-order, and home infusion pharmacies as well as if you reside in a long-term care facility. You may get up; to a 31-day supply of drugs from an out-of-network pharmacy, but you will pay more than you pay at a network pharmacy. Cost sharing changes when you enter another stage of the Part D benefit.

During the coverage gap stage, you pay 25% of the cost for generic or brand name drugs. During the catastrophic coverage stage, you pay the greater of 5% or $3.95 copay for generic drugs and $9.85 copay for all other drugs.

For more information on the different stages, please access your Evidence of Coverage online at yoursummithealth.com or contact Pharmacy Customer Service at 844-827-2355, 7 am to 8 pm Pacific Time, seven days a week from October 1 through March 31, with the exceptions of Christmas Day and Thanksgiving Day. (After March 31, your call will be handled by our automated phone systems Saturdays, Sundays, and holidays.)

Optional Supplemental Benefits

You must pay an extra premium each month for these benefits.

Summit Health Extra Care	
Premium	**$5 per month**
Included Services: • Routine chiropractic services • Acupuncture • Alternative therapies (naturopathic services)	Our plan pays up to $500 every year. You pay 50% of the billed cost for these services until the plan maximum of $500 for all services combined is met, then you pay 100% of the cost

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

844-827-2355 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Summit Health Plan
Attention: Appeal Unit
P.O. Box 820070
Portland, OR 97282
Fax: 855-466-7208

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

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

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@yoursummithealth.com

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION: si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با تماس بگیرید. (TTY: 711) 1-877-605-3229

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

YourSummitHealth.com

0581 (08/20)

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

SUMMIT
HEALTH

YourSummitHealth.com

REV2-0518 (08/21)