Providence
Medicare Advantage Plans

2023
Providence Medicare Advantage Plans Plan Change Form

Dear Providence Medicare Advantage Plans Member:

To make a change in the Medicare Advantage plan you have with Providence Medicare Advantage Plans, fill out the attached plan change form to make your choice. Check off the plan you want, and sign the form. Then mail the completed form back to us.

You can change health plans only at certain times during the year. From October 15 – December 7, you can join, switch or drop a Medicare health or drug plan for the following year. In addition, from January 1 – March 31, anyone enrolled in a Medicare Advantage Plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare Prescription Drug Plan). Generally, you can't make changes at other times except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug coverage.

If you select another plan and we receive your completed selection form by the end of any month, your new benefit plan will generally begin the first of the following month. Your monthly plan premium will be determined based on your plan selection as listed below. You may continue to see any Providence Medicare Advantage Plans primary care doctors and specialists.

Complete the attached form only if you wish to change plans.

To help you with your decision, we have also included 2023 Summary of Benefits for the available options online.

If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Thank you.

Providence Medicare Advantage Plans

Plan Change Form

DATE | LAST NAME | FIRST NAME | MI | MEMBER NUMBER

PERMANENT RESIDENCE STREET ADDRESS (DON'T ENTER A PO BOX) | PHONE NUMBER

CITY | COUNTY (OPTIONAL) | STATE | ZIP CODE

Mailing address, if different from your permanent address (PO Box allowed):

STREET ADDRESS

CITY | STATE | ZIP CODE

I want to transfer from my current plan to the plan I have selected below. I understand that if this form is received by the end of any month, my new plan will generally be effective the 1st of the following month. If this form is received during October 15 through December 7, the effective date will generally be the 1st of January.

Please check the appropriate box below:

☐ Providence Medicare Bridge + Rx (HMO-POS)

Monthly Premium Amount: $35

Out-of-Pocket Max:
+ In-Network: $4,900
+ Out-of-Network: $10,000 combined

Primary Care Provider visit:
+ In-Network: $0 copay
+ Out-of-Network: $25 copay

Specialist visit:
+ In-Network: $35 copay; $50 without referral
+ Out-of-Network: $50 copay

Inpatient Hospital Coverage:
+ In-Network: $325 copay per day for days 1-6; $0 copay per day for day 7 and beyond
+ Out-of-Network: 30% of the cost

Emergency Care: $90 copay

Ambulance: $250 copay one way

☐ Providence Medicare Extra + Rx (HMO)

Monthly Premium Amount: $173

Out-of-Pocket Max:
+ In-Network: $3,400

Primary Care Provider visit:
+ In-Network: $0 copay

Specialist visit:
+ In-Network: $20 copay

Inpatient Hospital Coverage:
+ In-Network: $250 copay per day for days 1-5; $0 copay per day for day 6 and beyond

Emergency Care: $70 copay

Ambulance: $250 copay one way

☐ Providence Medicare Focus Medical (HMO)

Monthly Premium Amount: $128

Out-of-Pocket Max:
+ In-Network: $3,400

Primary Care Provider visit:
+ In-Network: $0 copay

Specialist visit:
+ In-Network: $20 copay

Inpatient Hospital Coverage:
+ In-Network: $250 copay per day for days 1-5; $0 copay per day for day 6 and beyond

Emergency Care: $70 copay

Ambulance: $250 copay one way

☐ Providence Medicare Reverence (HMO-POS)

Monthly Premium Amount: $51

Out-of-Pocket Max:
+ In-Network: $4,500
+ Out-of-Network: $10,000 combined

Primary Care Provider visit:
+ In-Network: $15 copay
+ Out-of-Network: $25 copay

Specialist visit:
+ In-Network: $30 copay; $50 without referral
+ Out-of-Network: $50 copay

Inpatient Hospital Coverage:
+ In-Network: $300 copay per day for days 1-6; $0 copay per day for day 7 and beyond
+ Out-of-Network: 30% of the cost

Emergency Care: $90 copay

Ambulance: $250 copay one way

☐ Providence Medicare Choice + Rx (HMO-POS)

Monthly Premium Amount: $89

Out-of-Pocket Max:
+ In-Network: $4,500
+ Out-of-Network: $10,000 combined

Primary Care Provider visit:
+ In-Network: $15 copay
+ Out-of-Network: $25 copay

Specialist visit:
+ In-Network: $30 copay; $50 without referral
+ Out-of-Network: $50 copay

Inpatient Hospital Coverage:
+ In-Network: $300 copay per day for days 1-6; $0 copay per day for day 7 and beyond
+ Out-of-Network: 30% of the cost

Emergency Care: $90 copay

Ambulance: $250 copay one way

☐ Providence Medicare Timber + Rx (HMO)

Monthly Premium Amount: $0

Out-of-Pocket Max:
+ In-Network: $5,500

Primary Care Provider visit:
+ In-Network: $0 copay

Specialist visit:
+ In-Network: $40 copay

Inpatient Hospital Coverage:
+ In-Network: $450 copay per day for days 1-4; $0 copay per day for day 5 and beyond

Emergency Care: $90 copay

Ambulance: $250 copay one way

Optional Supplemental Dental Plan Change Form

Select <u>one</u> of the following options:

☐ **Drop:** I want to drop my current supplemental benefit election.

☐ **Add or Replace:** I want to select a new supplemental dental benefit from the list below.

☐ **Basic:** $32.50 will be added to your medical premium.

☐ **Enhanced:** $45.10 will be added to your medical premium.

OFFICE USE ONLY

NAME OF STAFF MEMBER/AGENT/BROKER (IF ASSISTED IN ENROLLMENT)	PLAN ID #	EFFECTIVE DATE OF COVERAGE
		____/____/____

☐ ICEP/IEP ☐ AEP ☐ SEP (type): _____ ☐ Not Eligible _____ ____/____/____ DATE

PBP	TRAN. CODE	PREMIUMS	GROUP #	CONTRACT #

Your Plan Premium

You can pay your monthly plan premium (including any late enrollment penalty you have or may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board Check each month.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office or call 1-800-MEDICARE (1-800-633-4227), 24 hours per day, 7 days per week. TTY/TDD users should call 1-877-486-2048.

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium for this benefit. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare does not cover.

If you don't select a payment option, you will receive a bill each month.

Please select a premium payment option:

☐ **Receive a monthly bill**

Once you receive your first bill, you can choose a different payment option:

+ You can pay by credit/debit card or checking/savings account: One-time or recurring payments can be made via your myProvidence account at myProvidence.com or through the Providence website at Providence.org/premiumpay.
+ You can pay by phone: Self Service is available 24 hours a day, 7 days a week, at 1-844-791-1468. (TTY users should call 711.)

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. You may receive an invoice for the first few months before the withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Providence Medicare Advantage Plans at 1-800-603-2340 (TTY users should call 711) if you need information in an accessible format or language other than English. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

SIGNATURE **TODAY'S DATE** __ __ / __ __ / __ __

If you are the authorized representative, you must sign above and provide the following information:

NAME

ADDRESS

CITY COUNTY (OPTIONAL) STATE ZIP CODE

PHONE NUMBER RELATIONSHIP TO ENROLLEE

Submission Options

Mail pages to:
Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

Scan and fax pages to:
503-574-8653

Scan and email pages to:
provMedicare@providence.org

AGENT USE ONLY

AGENT NAME DATE __ __ / __ __ / __ __

NPN # REQUESTED DATE OF COVERAGE __ __ / __ __ / __ __

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am leaving employer or union coverage on (insert date): ___ ___/___ ___/___ ___
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date): ___ ___/___ ___/___ ___
- ☐ I am enrolling during the Annual Enrollment Period (October 15-December 7).
- ☐ I am enrolling during a Special Enrollment Period (insert special enrollment being used): _____
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) (January 1-March 31).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): ___ ___/___ ___/___ ___
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date): ___ ___/___ ___/___ ___
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into the facility on (insert date): ___ ___/___ ___/___ ___ I moved/will move out of the facility on (insert date): ___ ___/___ ___/___ ___
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): ___ ___/___ ___/___ ___
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date): ___ ___/___ ___/___ ___
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, State or local government entity.)
  One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
  Name of disaster impacted by:

  _____

  Eligibility Period that was missed due to the disaster: (for example, the initial enrollment period, annual enrollment period, open enrollment period, or a special enrollment period).

  _____
- ☐ I was impacted by a significant network change with my current plan and was notified on (insert date): ___ ___/___ ___/___ ___

If none of these statements applies to you or you're not sure, please contact Providence Medicare Advantage Plans at 1-800-603-2340 or 503-574-8000 (TTY users should call 711) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

Race/Ethnicity Questionnaire

The following questions are optional. Your responses will help us to better serve all communities.

Which of the following describes your racial or ethnic identity? Please check all that apply.

Hispanic and Latino/a/x

- ☐ Hispanic or Latino/a/x Central American
- ☐ Hispanic or Latino/a/x Mexican
- ☐ Hispanic or Latino/a/x South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian or Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other

- ☐ Other
- ☐ I don't know.
- ☐ I don't want to answer.

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European/Slavic
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ **Yes** (please specify): _____
- ☐ **No:** I do not have just one primary racial or ethnic identity.
- ☐ **No:** I identify as Biracial or Multiracial.
- ☐ **N/A:** I only checked one category above.
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

What is your preferred spoken language?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other

What is your preferred written language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Simplified Chinese
- ☐ Russian
- ☐ Other
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

Gender

- ☐ Male
- ☐ Female
- ☐ Other

How do you identify?

- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Non-binary
- ☐ Other