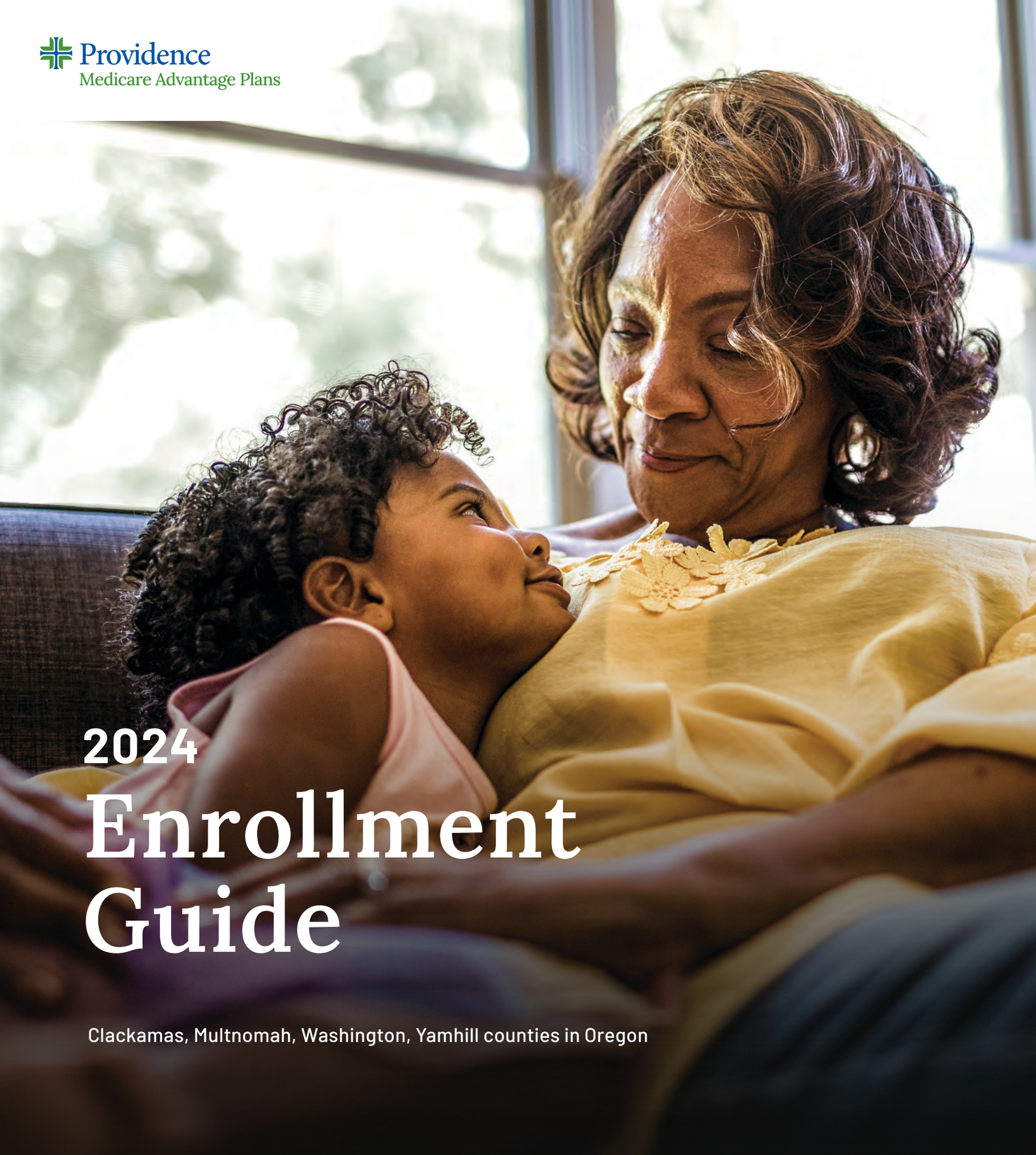
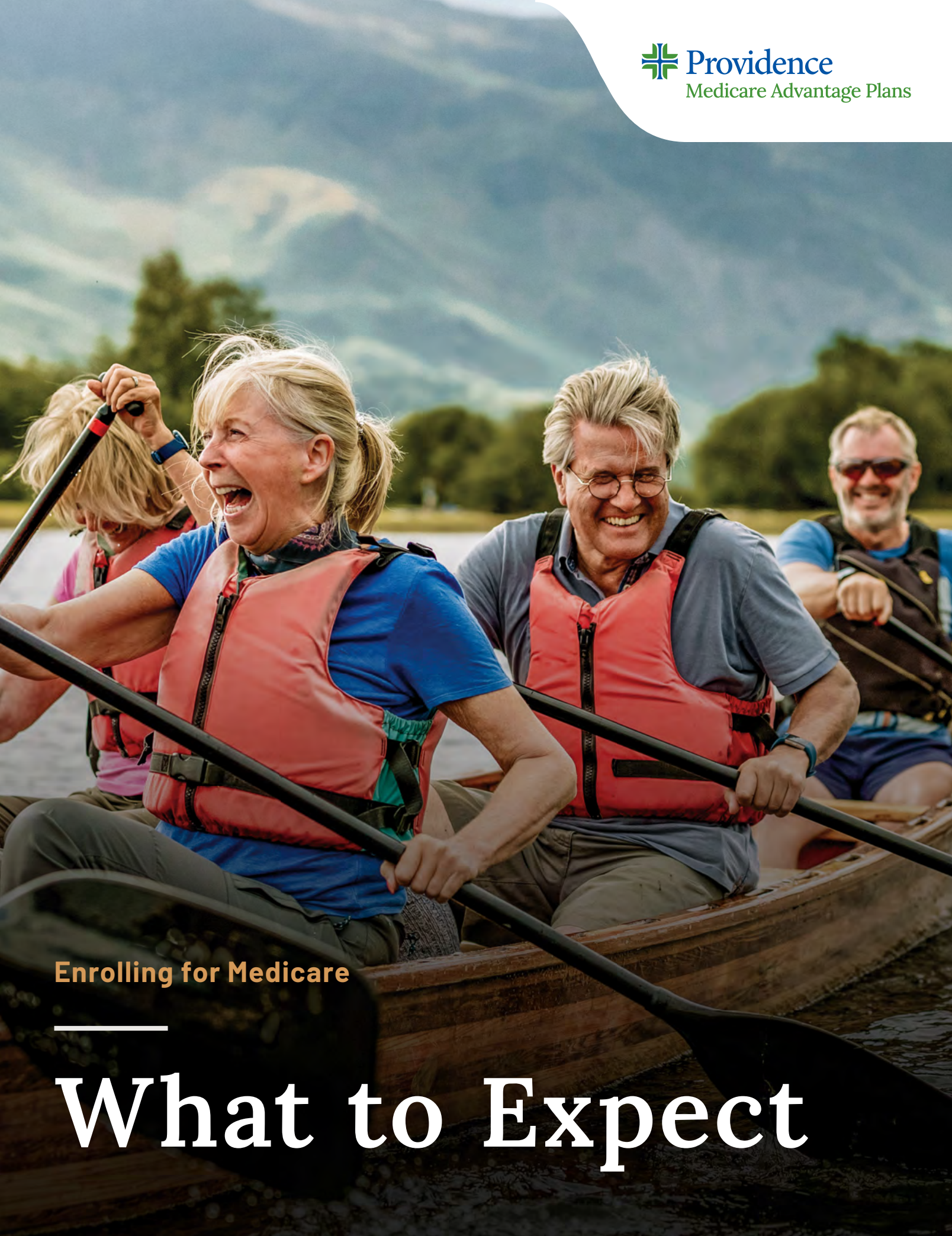
Providence
Medicare Advantage Plans



2024 Enrollment Guide

Clackamas, Multnomah, Washington, Yamhill counties in Oregon

Providence
Medicare Advantage Plans



Enrolling for Medicare

What to Expect

Providence
Medicare Advantage Plans

Medicare made easy.

Your health is personal. Your plan should be, too.

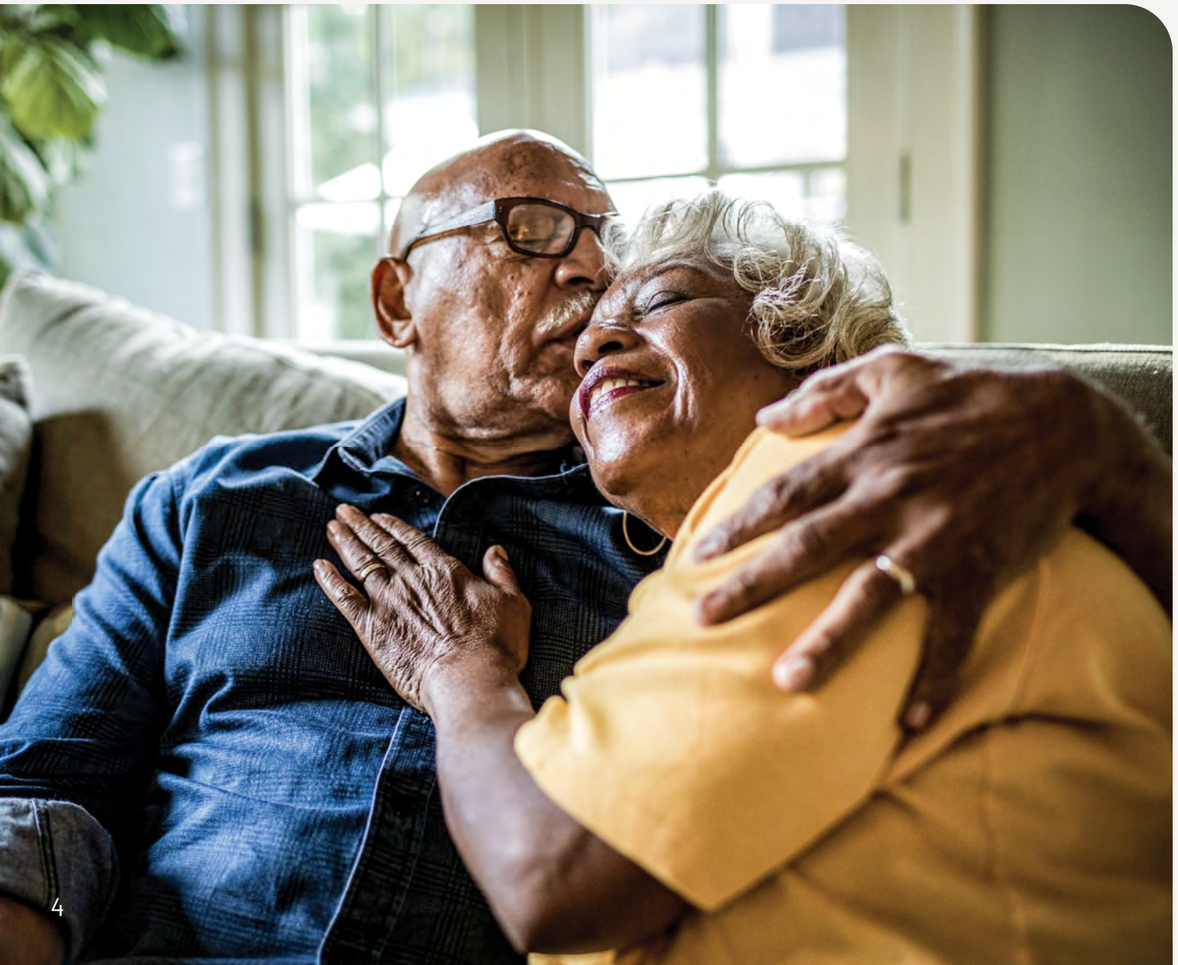
For more than 160 years, Providence has set the health and well-being standard for the community. Our commitment to caring for the whole self — mind, body, and spirit — is rooted in the idea that the healthier each of us are, the healthier we all are.

Medicare 101

Getting Started

Medicare can be hard to understand, but we're here to help.

This guide will tell you about your options for Medicare and help you choose the best one for you. You can't enroll for a Medicare Advantage plan unless you're already enrolled in Original Medicare.



Original Medicare

Original Medicare is basic health coverage from the government. It has two parts: Part A and Part B.

Part A

Hospital insurance

- Inpatient hospital services
- Skilled nursing facility care
- Hospice care
- Home healthcare

You won't have to pay for Part A if you or your spouse paid Medicare taxes for at least 10 years.

Part B

Medical insurance

- Outpatient services
- Doctor visits
- Outpatient lab tests and x-rays
- And more

Part B costs money, and how much you pay depends on your income. The money is usually taken out of your Social Security or Railroad Retirement Board check.

What's not covered?

Original Medicare pays for a lot of medical costs, but not all of them. You will still have to pay for about 20% of your medical costs out of your own pocket.

Original Medicare doesn't cover services like:

- Rx drugs
- Dental
- Vision
- Hearing aids
- Alternative Care

Providence Medicare Advantage Plans can help you pay for more of your medical costs. This can give you peace of mind knowing that you're covered.

Extending Coverage. Controlling Costs.

Additional Medicare Coverage

A lot of people who have Original Medicare also get extra coverage. This can help them pay for things like doctor visits, hospital stays, and prescription drugs.

Extra coverage comes in three forms:

- Medicare Advantage (Part C)
- Prescription Drug Coverage (Part D)
- Medicare Supplement (Medigap)

If you think you might need extra Medicare coverage, Providence has a plan that can help. We have many different plans to choose from, so you can find one that fits your needs.

Part C

Medicare Advantage

Providence Medicare Advantage Plans include Parts A, B, and sometimes Part D (Prescription Drug Coverage). They also offer extra benefits and services that Original Medicare doesn't cover, such as:

- Eyeglasses
- Hearing coverage
- Wellness programs

Original Medicare doesn't have a limit on how much you have to pay out of your own pocket. Providence Medicare Advantage Plans do have an out-of-pocket maximum, which can help you save money.

If you enroll for a Part C plan, you will also continue to pay your Part B premium.

Part D

Prescription Drug Coverage

Original Medicare doesn't pay for prescription drugs. Private insurance companies offer plans to help pay for the cost of prescription drugs. These plans can help you save money on your prescription drugs like:

- Brand-name drugs
- Generic drugs

If you don't enroll for Part D coverage when you enroll for Original Medicare, you will have to pay a late enrollment penalty. This penalty is added to your monthly Part D premium for as long as you have Part D coverage.

Lower income people may qualify for a program called Extra Help to lower your prescription drug costs and sometimes the plans monthly premium.

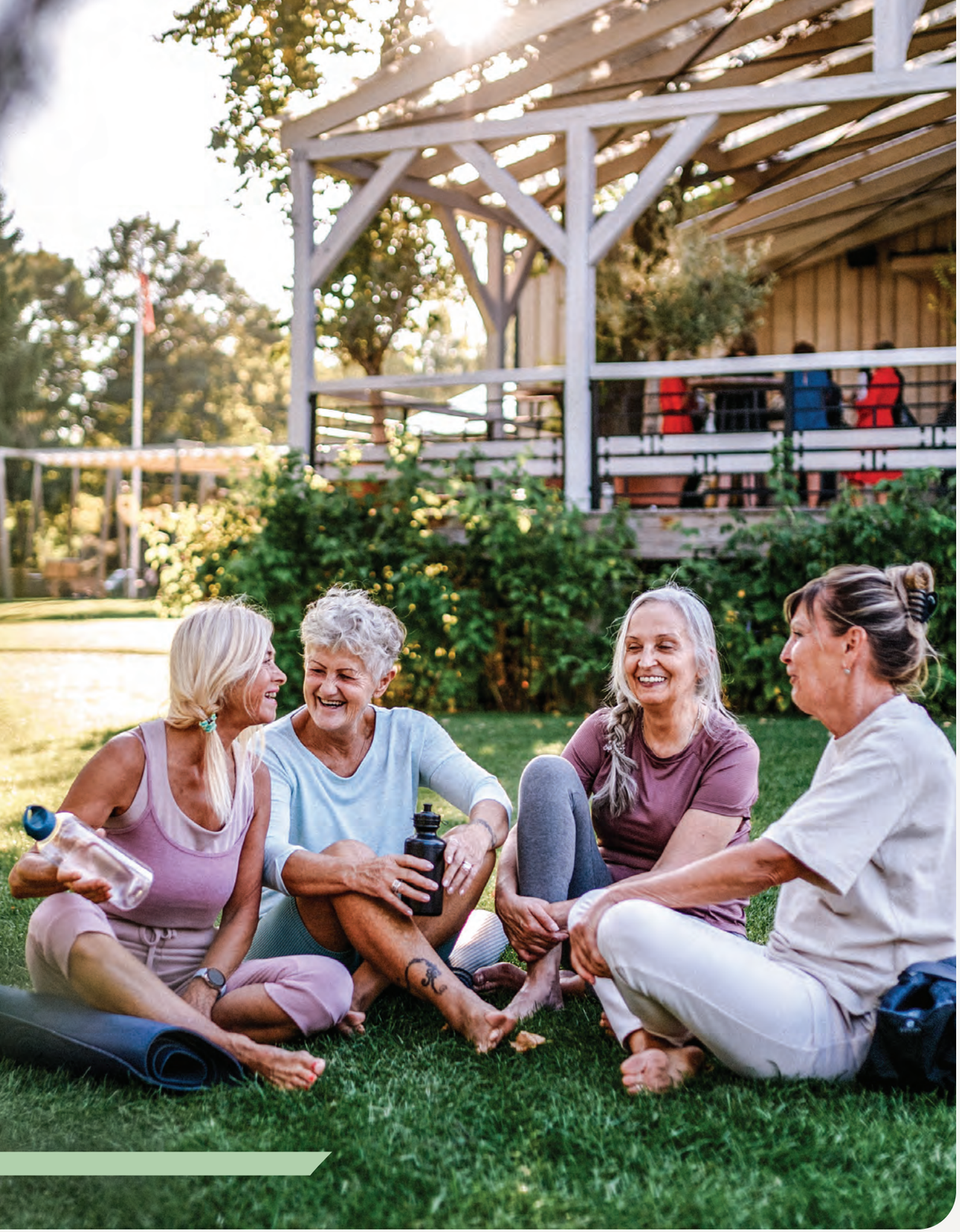
Medigap

Medicare Supplement Plans*

Medicare Supplement plans are designed to help pay for the costs of Original Medicare that you have to pay out of your own pocket.

Medicare Supplement plans charge you a set amount each month, instead of paying for each service as you use it. With this coverage, you can go to any doctor or specialist who accepts Medicare, anywhere in the country, without a referral.

*Medicare Supplement does not cover prescription drugs, so you will need to pair it with a Medicare Part D plan. Additionally, Medicare Supplement cannot be combined with a Medicare Advantage plan (Part C).



Original Medicare

Who's Eligible?

To get Medicare Parts A and B, you must be a U.S. citizen or have been a permanent legal resident for at least 5 years. You must also be 65 years old or older.

If you're under age 65, you can get Medicare if you:

- Are permanently disabled and have been getting disability benefits for at least 24 months.
- Have end-stage renal disease (ESRD).
- Have Lou Gehrig's disease (ALS).

Enrolling in Medicare at age 65

If you are collecting Social Security or a Railroad Retirement Pension, you will be automatically enrolled into Medicare Parts A and B.

If you are not collecting Social Security or a Railroad Retirement Pension, you will need to apply for Medicare Parts A and B.

- Apply on the Social Security website: **SSA.gov/Benefits/Medicare**
- Visit your local Social Security office
- Call Social Security at **1-800-772-1213 (TTY users can call 1-800-325-0778)** or the Railroad Retirement Board (if you worked there) at **1-877-772-5772**.

> To speak with a Providence Medicare Advantage expert, call **1-833-949-0263 (TTY: 711)** or explore and sign up online at **ProvidenceTrueHealth.com/Guides**.

One plan. Many advantages.

Providence Medicare Advantage Plans

In addition to having many different plans to choose from, our plans also come with many health and fitness benefits that can help you save money and reach your health goals.

Medicare Star Ratings

Every year, Medicare rates health plans on a scale of 1 to 5 stars. These star ratings, given by the Centers for Medicare and Medicaid Services (CMS), help you compare different plans.

We always aim for the highest rating possible. You can see our current star rating in the folder at the back of this enrollment kit.

myProvidence

You can manage your healthcare online 24/7. You can see your claims history, benefit information, and more. It's secure and convenient.

Hearing Coverage

You can get your hearing checked once a year at no cost to you. If you need hearing aids, you can get up to two of them each year.

Behavioral Health

If you ever need help, your plan has options. We work with doctors and other providers (like licensed therapists, psychologists, and psychiatrists) to make sure you get the care you need.

Post-discharge meals

After you leave an inpatient stay at the hospital, Mom's Meals will give you two meals a day for 14 days. Included in your plan.

Personal Emergency Response System

You can get help 24/7 by pressing a button. A professional will help you and come to you if needed. Included in your plan.

Vision Coverage

No matter which plan you choose, you will get an annual eye exam and $250 to spend on glasses and/or contact lenses.

$0 Rx Deductible and Copays

All plans have a $0 Rx deductible and let you get generic drugs for $0. Get a 100-day supply of your medications at a reduced cost at mail order and retail pharmacies.

Over-The-Counter

You can get money to buy over-the-counter health and wellness items every quarter. This is available on some plans.

Fitness Membership

All plans include a fitness program through One Pass™. You will get access to a premium network of gyms, plus the ability to use more than one gym at a time. Virtual classes are also available.

Frequently Asked

Questions

Are my medications covered?

A list of covered prescriptions can be found in a prescription drug formulary. This formulary is available online at: **ProvidenceTrueHealth.com/FormularyGuide**.

If you want a printed copy of the formulary, you can ask for one to be mailed to you by visiting the link above or calling the number below.

Formularies are only available for Part D prescription drug plans.

Where do I find a provider?

You can find a doctor or pharmacy by using our online directory at **ProvidenceTrueHealth.com/ProviderGuide**.

If you want a printed copy of the directory to be mailed to you, you can call the number below or visit the link above.

Who can I call for help?

We are always here to help. Call us at **1-833-949-0263** (TTY: 711) 8 a.m. to 8 p.m. (Pacific Time) seven days a week (Oct. 1 - Dec. 7) and Monday - Friday (Dec. 8 - Sept. 30).

Providence Medicare Advantage Plans

How to Enroll

There are many ways to enroll for Providence Medicare Advantage Plans. Choose the way that is easiest for you. We are excited to have you join the Providence community.

- Enroll online with our secure enrollment form **ProvidenceTrueHealth.com/EnrollGuide**.
- Enroll by phone by contacting the Providence Medicare Advantage Plans Sales Team at **1-833-949-0263 (TTY: 711)**. Service is available between 8 a.m. to 8 p.m. (Pacific Time), seven days a week (Oct. 1 – Dec. 7), Monday – Friday (Dec. 8 – Sept. 30).
- Enroll one-on-one by scheduling a meeting with a local agent.
- Enroll via mail or fax by completing an enrollment form and sending to:
  Providence Medicare Advantage Plans
  P.O. Box 5548
  Portland, OR 97228-5548
  Fax: 503-574-8653

After you enroll, you will get a letter in the mail saying that we received your request.

- Medicare's annual enrollment period is October 15 – December 7.
- Individuals must have both Part A and Part B to enroll.

What to Expect

After Enrolling

ID card and welcome guide

You will get your member ID card and welcome guide in the mail 7-10 days after we tell you that you are enrolled. The welcome guide has important information about how to use your plan, where to get care, and what your benefits are. If your plan includes flex dental or over-the-counter benefits, your Flexible Benefit Card will come in a separate envelope.

Confirmation and Rx subsidy

After you fill out and send in your enrollment form, you will get a Confirmation of Enrollment letter that says when your coverage starts. If you have a plan with prescription drug coverage and you qualify for extra help, you will get another letter that tells you how much your premium will be and what your prescription drug costs will be.

Within your first 90 days

Within 3 months of enrollment, your Care Management team will send you a health survey, called the Health Risk Assessment, in the mail. This will help us understand your health goals and give you easy access to quality care.

If you want to talk to us sooner, need help finding care, or want to talk to a nurse directly, call **503-574-7247 (TTY: 711)** from 8 a.m. to 5 p.m. (Pacific Time), Monday to Friday.

Once we tell you that you are enrolled, you can stop paying for any Medigap or supplemental insurance that you have.

If you were on a different Medicare Advantage plan or Medicare Cost plan when you enrolled:

- Your old plan will be canceled automatically.
- You don't need to tell your old insurance company. Medicare will take care of it when they transfer you to Providence Medicare Advantage Plans.

If you are new to Medicare and you enroll for a Medicare Advantage or Medicare Cost plan:

- You may have a chance to leave the plan and buy a Medigap policy. This is called a trial period.

Once you enroll for our plan:

- You can usually only make changes between October 15 and December 7.
- In some special cases, Medicare might let you switch to a different plan.

> Please contact **1-800-MEDICARE (1-800-633-4227)** or visit **Medicare.gov** for further information about Medicare benefits and services. TTY users can call **1-877-486-2048** 24 hours a day, seven days a week (Pacific Time).

Notes

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.

The Formulary may change at any time. You will receive notice when necessary.

Every year, Medicare evaluates plans based on a 5-star rating system.

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Providence
Medicare Advantage Plans

Providence
Medicare Advantage Plans

2024 Benefit Highlights

Providence Medicare Prime + Rx (HMO)
Providence Medicare Bridge + Rx (HMO-POS)
Providence Medicare Choice + Rx (HMO-POS)
Providence Medicare Extra + Rx (HMO)

Clackamas, Multnomah, Washington, Yamhill counties in Oregon

Providence Medicare Advantage Plans – Part C

Providence Medicare Advantage Plans

	Providence Medicare Prime + Rx (HMO)	Providence Medicare Bridge + Rx (HMO-POS)	
Monthly premium with prescription drug coverage	$0	$29	
	In-network	**In-network**	**Out-of-network**
Medical deductible	$0	$0	$0
Out-of-pocket maximum	$4,500	$4,700	$10,000 combined
Benefits	**You pay**	**You pay**	
Doctor office visit (PCP)	$0	$0	$25
Specialist visit	$35	$30	$50
Preventive care	$0	$0	30%
Inpatient hospital	Days 1-4: $450 per day Day 5 and beyond: $0 per day	Days 1-6: $325 per day Day 7 and beyond: $0 per day	30%
Skilled nursing facility	Days 1-20: $0 Days 21-100: $184 per day	Days 1-20: $0 Days 21-100: $160 per day	30%
Outpatient surgery	$250 Ambulatory $450 Hospital	$250 Ambulatory $375 Hospital	30%
Diabetic supplies	$0 – 20%	$0 – 20%	30%
Lab	$0	$0	30%
X-ray	$15	$10	30%
Diagnostic radiology	20% up to $250	20% up to $250	30%
Outpatient diagnostic tests & procedures	20%	20%	30%
Chiropractic Acupuncture Naturopathy	18 visits: $20 18 visits: $20 6 visits: $20	18 visits: $20 18 visits: $20 6 visits: $20	No coverage
Therapy: PT, OT, ST	$35	$30	30%
Durable medical equipment	20%	20%	30%
Home health	$0	$0	30%
Telehealth**	$0 PCP $35 Specialist	$0 PCP $30 Specialist	$25 PCP $50 Specialist
	Worldwide coverage	**Worldwide coverage**	
Urgent care	$25	$30	
Emergency room*	$90	$90	
Ambulance (ground or air)	$250 one way	$250 one way	

*Copay waived if you are admitted to the hospital within 24 hours for the same condition.

**You will pay the cost sharing that applies to the services.

Other charges and limits may apply. Please refer to Evidence of Coverage for more information. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

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Providence Medicare Advantage Plans – Part C

Providence Medicare Advantage Plans

	Providence Medicare Choice + Rx (HMO-POS)		Providence Medicare Extra + Rx (HMO)
Monthly premium with prescription drug coverage	$71		$155
	In-network	**Out-of-network**	**In-network**
Medical deductible	$0	$0	$0
Out-of-pocket maximum	$4,500	$10,000 combined	$3,400
Benefits	**You pay**		**You pay**
Doctor office visit (PCP)	$15	$25	$0
Specialist visit	$30	$50	$20
Preventive care	$0	20%	$0
Inpatient hospital	Days 1-6: $300 per day Day 7 and beyond: $0 per day	20%	Days 1-5: $250 per day Day 6 and beyond: $0 per day
Skilled nursing facility	Days 1-20: $0 Days 21-100: $160 per day	20%	Days 1-20: $0 Days 21-100: $150 per day
Outpatient surgery	$250 Ambulatory $250 Hospital	20% 20%	$100 Ambulatory $150 Hospital
Diabetic supplies	$0 – 20%	20%	$0 – 20%
Lab	$0	20%	$0
X-ray	$15	20%	$0
Diagnostic radiology	20% up to $250	20%	15% up to $250
Outpatient diagnostic tests and procedures	20%	20%	20%
Chiropractic Acupuncture Naturopathy	No coverage	No coverage	No coverage
Therapy: PT, OT, ST	$30	20%	$20
Durable medical equipment	20%	20%	20%
Home health	$0	20%	$0
Telehealth**	$15 PCP $30 Specialist	$25 PCP $50 Specialist	$0 PCP $20 Specialist
	Worldwide coverage		**Worldwide coverage**
Urgent care	$25		$25
Emergency room*	$90		$70
Ambulance (ground or air)	$250 one way		$250 one way

*Copay waived if you are admitted to the hospital within 24 hours for the same condition.

**You will pay the cost sharing that applies to the services.

Other charges and limits may apply. Please refer to Evidence of Coverage for more information. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

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Pharmacy coverage – Part D

	Providence Medicare Prime + Rx (HMO)		Providence Medicare Bridge + Rx (HMO-POS)		Providence Medicare Choice + Rx (HMO-POS)		Providence Medicare Extra + Rx (HMO)	
Annual deductible	$0		$0		$0		$0	
	30-day	**100-day**	**30-day**	**100-day**	**30-day**	**100-day**	**30-day**	**100-day**
Preferred generic	$0	$0	$0	$0	$0	$0	$0	$0
Generic	$10	$10	$10	$10	$10	$10	$10	$10
Preferred brand	$37	$111 $74 for mail order	$37	$111 $74 for mail order	$37	$88.80 $74 for mail order	$37	$74
Non-preferred drugs	$100	$300	$100	$300	$100	$240	$90	$180
Specialty drugs	33%	Not available	33%	Not available	33%	Not available	33%	Not available

Mail order for maintenance medications, get up to a 100-day supply shipped right to you from our in-network mail order pharmacies. Copays listed are for Preferred Network pharmacies only; other pharmacy copays may cost more.

For all Part D insulin products, you will pay no more than $35 per month.
For all ACIP-recommended Part D Vaccines, you will have no cost-share. The Formulary and pharmacy network may change at any time. You will receive notice when necessary.

Initial coverage	Coverage gap
Phase 1	Phase 2
When the total paid by you and the plan reaches $5,030, Phase 2 begins.	You continue to pay your Tier 1 and Tier 2 cost-shares in Phase 2 Coverage Gap. All other cost-shares will be 25%. You stay in this stage until your out-of-pocket costs reach $8,000. After that, you pay nothing.

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.

Providence
Medicare Advantage Plans

Dental, hearing, vision, and more

	Providence Medicare Prime + Rx (HMO)	Providence Medicare Bridge + Rx (HMO-POS)	Providence Medicare Choice + Rx (HMO-POS)	Providence Medicare Extra + Rx (HMO)
Flexible Benefit Card Over-the-counter items Incentive rewards for completing healthy activities	 No coverage Up to $50 per year	 $70 to spend per quarter Up to $50 per year	 No coverage Up to $50 per year	 $195 to spend per quarter Up to $50 per year
Preventive dental	$0	$0 in-network, 20% out-of-network	$0 in-network, 20% out-of-network	$0
Routine eye exam (one per year)	$0	$0	$0	$0
Prescription eyeglasses or contact lenses*	$250 to spend per year	$250 to spend per year	$250 to spend per year	$250 to spend per year
Routine hearing exam (one per year)**	$0 copay	$0 copay	$0 copay	$0 copay
Hearing aids (two per year)**	$699 or $999 per hearing aid	$699 or $999 per hearing aid	$699 or $999 per hearing aid	$699 or $999 per hearing aid
Meal delivery after inpatient hospital stay	$0 – two meals per day for 14 days	$0 – two meals per day for 14 days	$0 – two meals per day for 14 days	$0 – two meals per day for 14 days
Personal Emergency Response System	$0	$0	$0	$0
Fitness center membership	$0	$0	$0	$0
Wigs for hair loss related to chemotherapy	$0 for synthetic 1 wig per year	$0 for synthetic 1 wig per year	$0 for synthetic 1 wig per year	$0 for synthetic 1 wig per year
Non-emergent medical transportation benefit	No coverage	No coverage	No coverage	$0 for 24 one-way trips per year

*You are responsible for any cost above the allowance for prescription eyeglasses or contact lenses.

**You must see a TruHearing provider. Other charges and limits may apply.

Providence
Medicare Advantage Plans

2024 Optional Supplemental Dental Benefits

Plans that include Basic or Enhanced option:

Providence Medicare Bridge + Rx (HMO-POS), Choice + Rx (HMO-POS), Extra + Rx (HMO), Prime + Rx (HMO).

Benefits include: Preventative (See EOS Chapter 4) and Comprehensive Dental	Basic		Enhanced	
Monthly premium	$33		$45	
Plan benefits	**In-network member responsibility**	**Out-of-network member responsibility***	**In-network member responsibility**	**Out-of-network member responsibility***
Office visit copay	No copay		No copay	
Annual deductible[1]	$50	$150	$50	$150
Annual maximum	$1,000		$1,500	
Waiting periods	None		None	
Provider network	Delta Dental Medicare Advantage		Delta Dental Medicare Advantage	
Out-of-network reimbursement	Maximum allowable charge		Maximum allowable charge	
Diagnostic and Preventative Services				
Oral examinations[2]	$0	20%	$0	20%
Bitewing X-rays[3]	$0	20%	$0	20%
Panoramic & other diagnostic X-rays[4]	$0	20%	$0	20%
Comprehensive Dental Services				
Simple extractions	50%	60%	50%	60%
Basic fillings	30%	60%	30%	60%
Dentures	50% $1,000 Lifetime Denture Benefit	60%	50% $1,500 Lifetime Denture Benefit	60%
Crowns and bridges	50%	60%	50%	60%
Oral surgery	Not covered		50%	60%
Endodontics (root canals)	Not covered		50%	60%
Periodontics (deep cleaning)	Not covered		50%	60%

***Important notes:** Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members are encouraged to use an in-network Dental provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

[1] Deductibles are waived for diagnostic and preventive services
[2] Oral Examination – limited to two per calendar year
[3] Bitewing or Periapical X-rays – one bitewing series or one bitewing series plus periapical as needed (up to 10) per calendar year
[4] Full mouth and Panoramic X-ray – limited to once every 5 years

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.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Providence
Medicare Advantage Plans

Medicare can be complex.

We're here to keep it from getting confusing.

Whatever your healthcare needs are, Providence offers a Medicare Advantage plan that has you covered. Explore the plan options in your area, and don't hesitate to call us if you have questions. Providence Medicare Advantage experts are ready and waiting to help you.

Have questions?

We are always here to help.

Call us at **1-833-949-0263 (TTY: 711)** 8 a.m. to 8 p.m. (Pacific Time), seven days a week (Oct. 1 – Dec. 7) and Monday – Friday (Dec. 8 – Sept. 30).

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Providence
Medicare Advantage Plans

Want to learn more?

Here is how to connect with us.

Call us for information, to enroll, or to make a personal appointment at

1-833-949-0263 (TTY: 711)

8 a.m. to 8 p.m. (Pacific Time), seven days a week (Oct. 1 – Dec. 7)
Monday – Friday (Dec. 8 – Sept. 30)

Check us out online for more information or to enroll at

ProvidenceTrueHealth.com/Guides

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Pre-Enrollment

Checklist

Providence Medicare Advantage Plans

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)**, 8 a.m. to 8 p.m. (Pacific Time), seven days a week.

Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **ProvidenceHealthAssurance.com/EOC** 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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

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 D-SNP).
- Benefits, premiums, and/or copayments/co-insurance may change every year.
- 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, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- Providence Medicare Dual Plus (HMO D-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.
- Effect on current coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

OMB No. 0938-1378
Expires: 07/31/2024

Providence
Medicare Advantage Plans

2024 Medicare Advantage Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

What happens next?

Submit your completed and signed form using one of the three options below. Once they process your request to join, they'll contact you.

01 By mail:
Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

02 Scan and fax pages to:
503-574-8653

03 Scan and email pages to:
provMedicare@providence.org

How do I get help with this form?

- Call Providence Medicare Advantage Plans at **503-574-6508** or **1-855-234-2495 (TTY: 711)**.
- Or, call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY: **1-877-486-2048**.
- **En español:** Llame a Providence Medicare Advantage Plans al **503-574-6508** or **1-855-234-2495/TTY: 711** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

OMB No. 0938-1378
Expires: 07/31/2024

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

- ☐ Providence Medicare Bridge + Rx (HMO-POS) - $29 per month
- ☐ Providence Medicare Choice + Rx (HMO-POS) - $71 per month
- ☐ Providence Medicare Extra + Rx (HMO) - $155 per month
- ☐ Providence Medicare Prime + Rx (HMO) - $0 per month

To enroll in an Optional Supplemental Dental Plan*, please select the plan you want to join:

- ☐ **Basic:** $33 per month
- ☐ **Enhanced:** $45 per month
- ☐ Do not want Optional Supplemental Dental Plan

*I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional supplemental dental plan selected. Additionally, I understand that I must pay the optional supplemental dental plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan.

First Name _____ Last Name _____ Middle Initial (Optional) _____

__ __/__ __/__ __ __ __
Birth Date (MM/DD/YYYY)

SEX: ☐ Male ☐ Female

( ) -
Phone Number

Permanent Residence Street Address (Don't enter a PO Box)

City _____ County (Optional) _____ State _____ ZIP Code _____

Email Address

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

Street Address

City _____ State _____ ZIP Code _____

Your Medicare information:

__ __ __ __-__ __ __-__ __ __ __
Medicare Number

__ __/__ __/__ __ __ __
Hospital (Part A) Effective Date (Optional)

__ __/__ __/__ __ __ __
Medical (Part B) Effective Date (Optional)

Answer these important questions:

Will you have other coverage in addition to Providence Medicare Advantage Plans? ☐ Yes ☐ No

Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

If "yes," please list your other coverage and your identification (ID) number for this coverage.

_____

Name of other coverage

_____ _____

ID number for this coverage Group number for this coverage

Check all that apply: ☐ Medical ☐ Vision ☐ Dental ☐ Prescription

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Providence Medicare Advantage Plans.
- By joining this Medicare Advantage Plan I acknowledge that Providence Medicare Advantage Plans will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that when my Providence Medicare Advantage Plans coverage begins, I must get all of my medical and prescription drug benefits from Providence Medicare Advantage Plans. Benefits and services provided by Providence Medicare Advantage Plans and contained in my Providence Medicare Advantage Plans "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Providence Medicare Advantage Plans will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1. This person is authorized under State law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare.

_____ ___ ___/___ ___/___ ___

Signature **Today's Date**

If you are the authorized representative, sign above and fill out these fields:

_____ _____

Name Address

( ) -

_____ _____

Phone Number Relationship to enrollee

AGENT USE ONLY

_____ ___ ___/___ ___/___ ___

Agent Name Date

_____ ___ ___/___ ___/___ ___

NPN # Requested date of coverage

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

List your Primary Care Provider (PCP), clinic, or health center:

_____

If you do not provide a PCP, one will be assigned.

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** or **503-574-8000** if you need information in an accessible format other than what's listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time). TTY users can call 711.

Do you work?

☐ Yes ☐ No

Does your spouse work?

☐ Yes ☐ No

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Providence Medicare Advantage Plans the Part D-IRMAA.

Please select a premium payment option:

☐ Get 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: 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.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

OMB No. 0938-1378
Expires: 07/31/2024

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 new to Medicare.
- ☐ 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 was released from incarceration. I was released on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently obtained lawful presence status in the United States. I got this status 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 recently left a PACE program on (insert date): ___ ___ /___ ___/___ ___
- ☐ 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): ___ ___ /___ ___/___ ___

- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan (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 enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date): ___ ___ /___ ___/___ ___
- ☐ I was impacted by a significant network change with my current plan and was notified on (insert date): ___ ___ /___ ___/___ ___
- ☐ I recently received notice of a Medicare entitlement determination for a retroactive effective date. (Please attach a copy of your entitlement notice.) I was notified 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).

  _____

> 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).

Providence
Medicare Advantage Plans

Providence
Medicare Advantage Plans

2024 Summary of Benefits

Providence Medicare Bridge + Rx (HMO-POS)

January 1, 2024 – December 31, 2024

This plan is available in **Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark County in Washington.**

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 Bridge + Rx (HMO-POS). 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** 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 Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark county in Washington.

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**

Helpful Resources

- Visit **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**, 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 Bridge + Rx (HMO-POS)

Monthly Plan Premium	$29 In addition, you must continue to pay your Medicare Part B premium.	
Annual Medical Deductible	$0 There is no medical deductible for in- or out-of-network services.	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) for this plan:	
	In-network: $4,700	Out-of-network: $10,000 combined

Benefits		In-Network	Out-Of-Network
Inpatient Hospital Coverage[1]		$325 copayment each day for days 1-6 and $0 copayment each day for day 7 and beyond	30% of the total cost per admission
Outpatient Hospital Coverage[1]		$375 copayment for outpatient surgery at a hospital facility	30% of the total cost
Ambulatory Surgical Center (ASC) Services[1]		$250 copayment for outpatient surgery at an Ambulatory Surgical Center	30% of the total cost
Doctor Visits	Primary Care Provider Visit	$0 copayment	$25 copayment
	Specialist Visit	$30 copayment	$50 copayment
Preventive Care (e.g., annual checkups, immunizations, flu shots)		You pay nothing	30% of the total cost
Emergency Care		$90 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived.	
Urgently Needed Services		$30 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.	

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services. For 2024, referrals are no longer required for in-network specialists visits and Medicare-covered services.

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

Providence Medicare Bridge + Rx (HMO-POS)

Benefits		In-Network	Out-Of-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans) [1]	20% of the total cost up to $250 per day	30% of the total cost
	Therapeutic Radiology Services[1]	20% of the total cost	30% of the total cost
	Outpatient X-rays	$10 copayment per day	30% of the total cost
	Diagnostic Tests and Procedures[1]	20% of the total cost	30% of the total cost
	Lab Services[1]	$0 copayment	30% of the total cost
Hearing Services	Medicare-Covered	$35 copayment	30% of the total cost
	Routine Exam	$0 copayment	Not covered
	Hearing Aids	$699 copayment per Advanced hearing aid or $999 copayment per Premium hearing aid	Not covered
Dental Services	Medicare-Covered[1]	$35 copayment	30% of the total cost
	Embedded Preventive	$0 copayment Includes exams, fluoride treatment, cleanings, X-rays; limits apply	20% of the total cost Includes exams, fluoride treatment, cleanings, X-rays; limits apply
	Optional	Covered for additional premium; see last page of this summary	
Vision Services	Medicare-Covered Exams/Screening	$35 copayment per exam $0 copayment for glaucoma screening	30% of the total cost per exam 30% of the total cost for glaucoma screening
	Routine Exam	There is no coinsurance, or copayment one routine vision exam (including refraction) per calendar year.	
	Medicare-Covered Eyewear	20% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	30% of the total cost 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	

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

Providence Medicare Bridge + Rx (HMO-POS)

Benefits		In-Network	Out-Of-Network
Mental Health Services	Inpatient Visit[1]	$300 copayment each day for days 1-5 and $0 copayment each day for days 6-90	30% of the total cost per admission
	Outpatient Individual[1] and Group Therapy Visit[1]	$30 copayment	30% of the total cost
Skilled Nursing Facility (SNF)[1]		$0 copayment each day for days 1-20 and $160 copayment each day for days 21-100	30% of the total cost for each benefit period (days 1-100)
Physical Therapy[1]		$30 copayment	30% of the total cost
Ambulance[1]		$250 copayment	
Transportation		Not covered	
Medicare Part B Drugs[1]		0% - 20% of the total cost (Insulin cost share up to $35 per month)	30% of the total cost (Insulin cost share up to $35 per month)
Alternative Care (visit limits)		Chiropractic: $20 copayment; 18 visits every calendar year Acupuncture: $20 copayment; 18 visits every calendar year Naturopath: $20 copayment; 6 visits every calendar year	Not covered
Meal Delivery Program (post-discharge only)		$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization	Not covered
Over-the-Counter Items		$70 allowance every three months (retail card, catalog, online, mail, and telephonic ordering)	
Personal Emergency Response System (PERS)		$0 copayment	Not covered
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.

Prescription Drug Benefits

Providence Medicare Bridge + Rx (HMO-POS)

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 network 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)	$10 copayment	$10 copayment	$10 copayment
Tier 3 (Preferred Brand)	$37 copayment ($35 copayment for Insulin)	$74 copayment ($35 copayment for Insulin)	Preferred Retail: $111 copayment Mail Order: $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

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

Prescription Drug Benefits

Providence Medicare Bridge + Rx (HMO-POS)

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)	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. 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.

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)	$10 copayment	$10 copayment	$10 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
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

Prescription Drug Benefits

Providence Medicare Bridge + Rx (HMO-POS)

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.

Optional Supplemental Dental

Providence Medicare Bridge + Rx (HMO-POS)

Please Note:

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

Option 1: Providence Basic Dental Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $33.00 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,000 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

Optional Supplemental Dental

Providence Medicare Bridge + Rx (HMO-POS)

Option 2: Providence Enhanced Dental Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $45.00 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,500 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

*Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members must use a Medicare-contracted provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

Providence
Medicare Advantage Plans

Form Approved
OMB# 0938-1421

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.

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Providence
Medicare Advantage Plans

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 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.

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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 nan1-800-603-2340 (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ございます。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。

Providence
Medicare Advantage Plans

2024 Summary of Benefits

Providence Medicare Choice + Rx (HMO-POS)

January 1, 2024 – December 31, 2024

This plan is available in **Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark county in Washington.**

H9047_2024PD_PHA129_M MDC-912C

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 Choice + Rx (HMO-POS). 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** 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 Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark county in Washington.

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**

Helpful Resources

- Visit **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**, 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 Choice + Rx (HMO-POS)

Monthly Plan Premium	$71 In addition, you must continue to pay your Medicare Part B premium.	
Annual Medical Deductible	$0 There is no medical deductible for in- or out-of-network services.	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) for this plan:	
	In-network: $4,500	Out-of-network: $10,000 combined

Benefits		In-Network	Out-Of-Network
Inpatient Hospital Coverage[1]		$300 copayment each day for days 1-6 and $0 copayment each day for day 7 and beyond	20% of the total cost per admission
Outpatient Hospital Coverage[1]		$250 copayment for outpatient surgery at a hospital facility	20% of the total cost
Ambulatory Surgical Center (ASC) Services[1]		$250 copayment for outpatient surgery at an Ambulatory Surgical Center	20% of the total cost
Doctor Visits	Primary Care Provider Visit	$15 copayment	$25 copayment
	Specialist Visit	$30 copayment	$50 copayment
Preventive Care (e.g., annual check-ups, immunizations, flu shots)		You pay nothing	20% of the total cost
Emergency Care		$90 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived.	
Urgently Needed Services		$25 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.	

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services. For 2024, referrals are no longer required for in-network specialists visits and Medicare-covered services.

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

Providence Medicare Choice + Rx (HMO-POS)

Benefits		In-Network	Out-Of-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans) [1]	20% of the total cost up to $250 per day	20% of the total cost
	Therapeutic Radiology Services[1]	20% of the total cost	20% of the total cost
	Outpatient X-rays	$15 copayment per day	20% of the total cost
	Diagnostic Tests and Procedures[1]	20% of the total cost	20% of the total cost
	Lab Services[1]	$0 copayment	20% of the total cost
Hearing Services	Medicare-Covered	$30 copayment	20% of the total cost
	Routine Exam	$0 copayment	Not covered
	Hearing Aids	$699 copayment per Advanced hearing aid or $999 copayment per Premium hearing aid	Not covered
Dental Services	Medicare-Covered[1]	$30 copayment	20% of the total cost
	Embedded Preventive	$0 copayment Includes exams, fluoride treatment, cleanings, X-rays; limits apply	20% of the total cost Includes exams, fluoride treatment, cleanings, X-rays; limits apply
	Optional	Covered for additional premium; see last page of this summary	
Vision Services	Medicare-Covered Exams/Screening	$30 copayment per exam $0 copayment for glaucoma screening	20% of the total cost per exam 20% of the total cost 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	20% of the total cost 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	

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

Providence Medicare Choice + Rx (HMO-POS)

Benefits		In-Network	Out-Of-Network
Mental Health Services	Inpatient Visit[1]	$275 copayment each day for days 1-6 and $0 copayment each day for days 7-90	20% of the total cost per admission
	Outpatient Individual[1] and Group Therapy Visit[1]	$30 copayment	20% of the total cost
Skilled Nursing Facility (SNF)[1]		$0 copayment each day for days 1-20 and $160 copayment each day for days 21-100	20% of the total cost for each benefit period (days 1-100)
Physical Therapy[1]		$30 copayment	20% of the total cost
Ambulance[1]		$250 copayment	
Transportation		Not covered	
Medicare Part B Drugs[1]		0% - 20% of the total cost (Insulin cost share up to $35 per month)	20% of the total cost (Insulin cost share up to $35 per month)
Meal Delivery Program (post-discharge only)		$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization	Not covered
Personal Emergency Response System (PERS)		$0 copayment	Not covered
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 Evidence of Coverage for more information.

Prescription Drug Benefits

Providence Medicare Choice + Rx (HMO-POS)

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 network 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)	$10 copayment	$10 copayment	$10 copayment
Tier 3 (Preferred Brand)	$37 copayment ($35 copayment for Insulin)	$74 copayment ($35 copayment for Insulin)	Preferred Retail: $88.80 copayment Mail Order: $74 copayment ($35 copayment for Insulin)
Tier 4 (Non-Preferred Drug)	$100 copayment	$200 copayment	$240 copayment
Tier 5 (Specialty)	33% of the total cost	Not Covered	Not Covered

Standard Retail Cost Sharing			
	Up to 30 days	**Up to 60 days**	**Up to 100 days**
Tier 1 (Preferred Generic)	$14 copayment	$28 copayment	$42 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

Prescription Drug Benefits

Providence Medicare Choice + Rx (HMO-POS)

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)	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. 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.

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)	$10 copayment	$10 copayment	$10 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
Standard Retail Cost Sharing			
Tier 1 (Preferred Generic)	$14 copayment	$28 copayment	$42 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

Prescription Drug Benefits

Providence Medicare Choice + Rx (HMO-POS)

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.

Optional Supplemental Dental

Providence Medicare Choice + Rx (HMO-POS)

Please Note:

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

Option 1: Providence Dental Basic Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $33.00 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,000 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

Optional Supplemental Dental

Providence Medicare Choice + Rx (HMO-POS)

Option 2: Providence Dental Enhanced Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $45.00 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,500 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

*Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members must use a Medicare-contracted provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

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Multi-Language Insert

Multi-language Interpreter Services

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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。

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Providence
Medicare Advantage Plans

2024 Summary of Benefits

Providence Medicare Extra + Rx (HMO)

January 1, 2024 – December 31, 2024

This plan is available in Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Linn, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark County in Washington.

When You Join Providence

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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?

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Providence Medicare Extra + Rx (HMO)

Monthly Plan Premium	$155 In addition, 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: $3,400

Benefits		In-Network
Inpatient Hospital Coverage[1]		$250 copayment each day for days 1-5 and $0 copayment each day for day 6 and beyond
Outpatient Hospital Coverage[1]		$150 copayment for outpatient surgery at a hospital facility
Ambulatory Surgical Center (ASC) Services[1]		$100 copayment for outpatient surgery at an Ambulatory Surgical Center
Doctor Visits	Primary Care Provider Visit	$0 copayment
	Specialist Visit	$20 copayment
Preventive Care (e.g., annual check-ups, immunizations, flu shots)		You pay nothing
Emergency Care		$70 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived.
Urgently Needed Services		$25 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.

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

Providence Medicare Extra + Rx (HMO)

Benefits		In-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans)[1]	15% of the total cost up to $250 per day
	Therapeutic Radiology Services[1]	15% of the total cost
	Outpatient X-rays	$0 copayment
	Diagnostic Tests and Procedures[1]	20% of the total cost
	Lab Services[1]	$0 copayment
Hearing Services	Medicare-Covered	$20 copayment
	Routine Exam	$0 copayment
	Hearing Aids	$699 copayment per Advanced hearing aid or $999 copayment per Premium hearing aid
Dental Services	Medicare-Covered[1]	$20 copayment
	Embedded Preventive	$0 copayment Includes exams, fluoride treatment, cleanings, X-rays; limits apply
	Optional	Covered for additional premium; see last page of this summary
Vision Services	Medicare-Covered Exams/Screening	$20 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]	$200 copayment each day for days 1-7 and $0 copayment each day for days 8-90
	Outpatient Individual[1] and Group Therapy Visit[1]	$20 copayment

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

Providence Medicare Extra + Rx (HMO)

Benefits	In-Network
Skilled Nursing Facility (SNF) [1]	$0 copayment each day for days 1-20 and $150 copayment each day for days 21-100
Physical Therapy[1]	$20 copayment
Ambulance[1]	$250 copayment
Transportation	$0 copayment for 24 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)
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	$195 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 Evidence of Coverage for more information.

Prescription Drug Benefits

Providence Medicare Extra + 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 network 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)	$10 copayment	$10 copayment	$10 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)	$90 copayment	$180 copayment	$180 copayment
Tier 5 (Specialty)	33% of the total cost	Not Covered	Not Covered

Standard Retail Cost Sharing			
	Up to 30 days	**Up to 60 days**	**Up to 100 days**
Tier 1 (Preferred Generic)	$12 copayment	$24 copayment	$36 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

Prescription Drug Benefits

Providence Medicare Extra + Rx (HMO)

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)	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. 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.

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)	$10 copayment	$10 copayment	$10 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
Standard Retail Cost Sharing			
Tier 1 (Preferred Generic)	$12 copayment	$24 copayment	$36 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

Prescription Drug Benefits

Providence Medicare Extra + Rx (HMO)

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.

Optional Supplemental Dental
Providence Medicare Extra + Rx (HMO)

Please Note:

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

Option 1: Providence Dental Basic Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $33.00 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,000 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

Optional Supplemental Dental

Providence Medicare Extra + Rx (HMO)

Option 2: Providence Dental Enhanced Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $45.00 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,500 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

*Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members must use a Medicare-contracted provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

Providence
Medicare Advantage Plans

Form Approved
OMB# 0938-1421

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 quí vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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.

Providence
Medicare Advantage Plans

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 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.

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Providence
Medicare Advantage Plans

2024 Summary of Benefits

Providence Medicare Prime + Rx (HMO)

January 1, 2024 – December 31, 2024

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Providence Medicare Prime + Rx (HMO)

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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: $4,500

Benefits		In-Network
Inpatient Hospital Coverage[1]		$450 copayment each day for days 1-4 and $0 copayment each day for day 5 and beyond
Outpatient Hospital Coverage[1]		$450 copayment for outpatient surgery at a hospital facility
Ambulatory Surgical Center (ASC) Services[1]		$250 copayment for outpatient surgery at an Ambulatory Surgical Center
Doctor Visits	Primary Care Provider Visit	$0 copayment
	Specialist Visit	$35 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		$25 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.

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

Providence Medicare Prime + Rx (HMO)

Benefits		In-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans)[1]	20% of the total cost up to $250 per day
	Therapeutic Radiology Services[1]	20% of the total cost
	Outpatient X-rays	$15 copayment per day
	Diagnostic Tests and Procedures[1]	20% of the total cost
	Lab Services[1]	$0 copayment
Hearing Services	Medicare-Covered	$40 copayment
	Routine Exam	$0 copayment
	Hearing Aids	$699 copayment per Advanced hearing aid or $999 copayment per Premium hearing aid
Dental Services	Medicare-Covered[1]	$40 copayment
	Embedded Preventive	$0 copayment Includes exams, fluoride treatment, cleanings, X-rays; limits apply
	Optional	Covered for additional premium; see last page of this summary
Vision Services	Medicare-Covered Exams/Screening	$40 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	20% of the total cost 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]	$320 copayment each day for days 1-5 and $0 copayment each day for days 6-90
	Outpatient Individual[1] and Group Therapy Visit[1]	$35 copayment

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

Providence Medicare Prime + Rx (HMO)

Benefits	In-Network
Skilled Nursing Facility (SNF) [1]	$0 copayment each day for days 1-20 and $184 copayment each day for days 21-100
Physical Therapy[1]	$35 copayment
Ambulance[1]	$250 copayment
Transportation	Not covered
Medicare Part B Drugs[1]	0% - 20% of the total cost (Insulin cost share up to $35 per month)
Alternative Care (visit limits)	Chiropractic: $20 copayment; 18 visits every calendar year Acupuncture: $20 copayment; 18 visits every calendar year Naturopath: $20 copayment: 6 visits every calendar year
Meal Delivery Program (post-discharge only)	$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization
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.

Prescription Drug Benefits

Providence Medicare Prime + 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 network 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)	$10 copayment	$10 copayment	$10 copayment
Tier 3 (Preferred Brand)	$37 copayment ($35 copayment for Insulin)	$74 copayment ($35 copayment for Insulin)	Preferred Retail: $111 copayment Mail Order: $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

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

Prescription Drug Benefits

Providence Medicare Prime + Rx (HMO)

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)	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. 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.

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)	$10 copayment	$10 copayment	$10 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
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

Prescription Drug Benefits

Providence Medicare Prime + Rx (HMO)

Catastrophic Coverage (Applies to all tiers)	After your yearly out-of-pocket 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.

Optional Supplemental Dental
Providence Medicare Prime + Rx (HMO)

Please Note:

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

Option 1: Providence Dental Basic Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $33.00 per month. You must keep paying your Medicare Part B premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,000 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

Optional Supplemental Dental

Providence Medicare Prime + Rx (HMO)

Option 2: Providence Dental Enhanced Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $45.00 per month. You must keep paying your Medicare Part B premium.	
Benefits	**In-Network**	**Out-Of-Network**
Deductible	$50	$150
Annual Benefit Maximum	$1,500 every calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

*Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members must use a Medicare-contracted provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

Providence
Medicare Advantage Plans

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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 quí vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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.

Providence
Medicare Advantage Plans

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 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 على1-800-603-2340 (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 nan1-800-603-2340 (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ございます。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。

IMPORTANT INFORMATION:

2024 Medicare Star Ratings

Official U.S. Government Medicare Information

Providence Medicare Advantage Plans - H9047

For 2024, Providence Medicare Advantage Plans - H9047 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	★★★½☆
Drug Services Rating:	★★★½☆

Providence Medicare Advantage Plans

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★	EXCELLENT
★★★★☆	ABOVE AVERAGE
★★★☆☆	AVERAGE
★★☆☆☆	BELOW AVERAGE
★☆☆☆☆	POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?

Contact Providence Medicare Advantage Plans 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time at 800-457-6064 (toll-free) or 711 (TTY). Current members please call 800-603-2340 (toll-free) or 711 (TTY).

Scope of Appointment

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment* prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.
(Refer to page 2 for product type descriptions)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment, or automatically enroll you in the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:

To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

*Scope of Appointment documentation is subject to CMS record retention requirements.

Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP): A stand-alone drug plan that adds prescription drug cover- age to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
Medicare Advantage Plans (Part C) and Cost Plans
Medicare Health Maintenance Organization (HMO): A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare Preferred Provider Organization (PPO) Plan: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Private Fee-For-Service (PFFS) Plan: A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare Point of Service (POS) Plan: A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.
Medicare Special Needs Plan (SNP): A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Medicare Medical Savings Account (MSA) Plan: MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
Medicare Cost Plan: In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.
Medicare Medicaid Plan (MMP): An MMP is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries.
Dental/Vision/Hearing Products
Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.
Hospital Indemnity Products
Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.
Medicare Supplement (Medigap) Products
Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

Providence
Medicare Advantage Plans

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

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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.

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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.

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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 quí vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 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.

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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 على1-800-603-2340 (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.

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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.

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