2017 Providence Medicare Advantage Plan Information

Thank you for your interest in applying for the Providence Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Providence within 7 days of the application receipt.

Enrollment Packet – click links below to view the information

Star Rating
Download Application: Choice, Choice + Rx, Extra, Extra + Rx / Prime / Compass & Latitude
Summary of Benefits: Choice & Choice + Rx / Extra & Extra + Rx / Prime / Compass & Latitude
Provider Directory
Formulary
Multi-language Support

Initial Enrollment Period (IEP)

If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.

Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15th and December 7th. ***If they are signed prior to October 15th they will be returned to you with a new application.*** If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.

Special Enrollment Period (SEP)

There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Fax: 1.541.284.2994 or 888.632.5470
Secure File Upload: Click here
Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: http://www.orhi.us

Y0062_MULTIPLAN_CDA INSURANCE Oregon Accepted effective 7/31/2016

PROVIDENCE
Medicare Advantage Plans
A division of Providence Health Assurance

Providence Medicare Advantage Plans is an HMO, HMO-POS, and HMO SNP plan with a Medicare and Oregon Health Plan contract. Enrollment in Providence Medicare Advantage Plans depends on contract renewal.

Section I

Introduction to the Summary of Benefits for
Providence Medicare Choice (HMO-POS) and Providence Medicare Choice + RX (HMO-POS)
January 1, 2017 – December 31, 2017
These plans are available in Clackamas, Columbia, Lane, Marion, Multnomah, Polk, Washington and Yamhill counties in Oregon; Clark County in Washington

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This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please refer to the "Evidence of Coverage."

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Providence Medicare Choice (HMO-POS**) and **Providence Medicare Choice + RX (HMO-POS)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Providence Medicare Choice (HMO-POS) and Providence Medicare Choice + RX (HMO-POS)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Providence Medicare Choice (HMO-POS)** and **Providence Medicare Choice + RX (HMO-POS)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you may pay an extra premium for these benefits)

For additional information, call us at 1-800-603-2340. TTY users call 711.

Section I – Introduction to Summary of Benefits

Things to Know About Providence Medicare Choice (HMO-POS) and Providence Medicare Choice + RX (HMO-POS)

Hours of Operation

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

Providence Medicare Choice (HMO-POS) and Providence Medicare Choice + RX (HMO-POS) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-603-2340. TTY users call 711.
- If you are not a member of this plan, call toll-free 1-800-457-6064. TTY users call 711.
- Our website: www.ProvidenceHealthAssurance.com

Who can join?

To join **Providence Medicare Choice (HMO-POS) or Providence Medicare Choice + RX (HMO-POS),** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Oregon: Clackamas, Columbia, Lane, Marion, Multnomah, Polk, Washington, Yamhill, and Clark County in Washington.

Providence Medicare Choice + RX (HMO-POS) covers both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Which doctors, hospitals, and pharmacies can I use?

Providence Medicare Choice (HMO-POS) and **Providence Medicare Choice + RX (HMO-POS)** have a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's Provider and Pharmacy Directory at our website (www.ProvidenceHealthAssurance.com/providerdirectory)
Or, call us and we will send you a copy of the Provider and Pharmacy Directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

- **Our plan members get *all* of the benefits covered by Original Medicare.**
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.ProvidenceHealthAssurance.com
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?
Our plan groups each medication into one of five “tiers”. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Providence Health Assurance for details.

Section II – Summary of Benefits

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
How much is the monthly premium?	$45.00 per month. In addition, you must keep paying your Medicare Part B premium.	$88.00 per month. In addition you must keep paying your Medicare Part B premium.
How much is the deductible?	There is no medical deductible for in and out of network services.	There is no medical deductible for in and out of network services. There is a separate $100.00 deductible for Part D coverage (Pharmacy benefits).
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $3,400 for services you receive from in-network providers. $6,700 for services you receive from out-of-network providers. $6,700 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $3,400 for services you receive from in-network providers. $6,700 for services you receive from out-of-network providers. $6,700 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in and out-of-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in and out-of-network benefits. Contact us for the services that apply.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Inpatient Hospital Coverage[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: $300 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond Out-of-network: 20% of the cost Benefit periods begin the day you go into a hospital or skilled nursing facility and end when you haven't received any inpatient hospital care or skilled nursing facility care for 60 days in a row.	Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: $300 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for days 91 and beyond Out-of-network: 20% of the cost Benefit periods begin the day you go into a hospital or skilled nursing facility and end when you haven't received any inpatient hospital care or skilled nursing facility care for 60 days in a row.
Doctor's Visits *(Primary and Specialist)*[2]	Primary care physician visit: In-network: $15 copay Out-of-network: $30 copay Specialist visit: In-network: $30 copay Out-of-network: $40 copay If your doctor provides additional services, a separate cost-sharing amount may apply.	Primary care physician visit: In-network: $15 copay Out-of-network: $30 copay Specialist visit: In-network: $30 copay Out-of-network: $40 copay If your doctor provides additional services, a separate cost-sharing amount may apply.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Preventive Care	In-network: You pay nothing Out-of-network: 20% of the cost Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual routine physical exam • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Health and wellness education programs* • HIV screening • Immunizations • Medical nutrition therapy • Obesity screening and counseling to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	In-network: You pay nothing Out-of-network: 20% of the cost Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Annual routine physical exam • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Health and wellness education programs* • HIV screening • Immunizations • Medical nutrition therapy • Obesity screening and counseling to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Preventive Care - Continued	• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care* • "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered. If your doctor provides additional services, a separate cost-sharing amount may apply. *Please refer to the benefit sections below for further description of benefits.	• Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care* • "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered. If your doctor provides additional services, a separate cost-sharing amount may apply. *Please refer to the benefit sections below for further description of benefits.
Emergency Care	$75 copay Worldwide Coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.	$75 copay Worldwide Coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.
Urgent Care	$40 copay Worldwide Coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.	$40 copay Worldwide Coverage If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Coverage" section of this booklet for other costs.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Diagnostic Services/Labs/ Imaging[1]	Diagnostic radiology services (such as MRIs, ultrasounds, CT scans): In-network: 20% of the cost Out-of-network: 20% of the cost Diagnostic tests and procedures: In-network: You pay nothing Out-of-network: 20% of the cost Lab services: In-network: You pay nothing Out-of-network: 20% of the cost Outpatient x-rays: In-network: 20% of the cost Out-of-network: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): In-network: 20% of the cost Out-of-network: 20% of the cost If your doctor provides additional services, a separate cost-sharing amount may apply.	Diagnostic radiology services (such as MRIs, ultrasounds, CT scans): In-network: 20% of the cost Out-of-network: 20% of the cost Diagnostic tests and procedures: In-network: You pay nothing Out-of-network: 20% of the cost Lab services: In-network: You pay nothing Out-of-network: 20% of the cost Outpatient x-rays: In-network: 20% of the cost Out-of-network: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): In-network: 20% of the cost Out-of-network: 20% of the cost If your doctor provides additional services, a separate cost-sharing amount may apply.
Hearing Services[2]	Exam to diagnose and treat hearing and balance issues: In-network: $30 copay Out-of-network: 20% of the cost Hearing aids are not covered.	Exam to diagnose and treat hearing and balance issues: In-network: $30 copay Out-of-network: 20% of the cost Hearing aids are not covered.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Dental Services[2]	Limited dental services (this does not include services in connection with routine care, treatment, filling, removal, or replacement of teeth): In-network: $30 copay Out-of-network: 20% of the cost Medicare-covered dental includes surgery of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease, or services that would be covered if provided by a medical provider. Only Medicare-covered dental services are covered under this plan.	Limited dental services (this does not include services in connection with routine care, treatment, filling, removal, or replacement of teeth): In-network: $30 copay Out-of-network: 20% of the cost Medicare-covered dental includes surgery of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease, or services that would be covered if provided by a medical provider. Only Medicare-covered dental services are covered under this plan.
Vision Services[2]	Exam to diagnose and treat diseases and conditions of the eye: In-network: $30 copay Out-of-network: $40 copay Medicare-covered preventive Glaucoma Screening: In-network: You pay nothing Out-of-network: 20% of the cost Medicare-covered Eyeglasses or contact lenses after cataract surgery: In-network: You pay nothing Out-of-network: 20% of the cost	Exam to diagnose and treat diseases and conditions of the eye: In-network: $30 copay Out-of-network: $40 copay Medicare-covered preventive Glaucoma Screening: In-network: You pay nothing Out-of-network: 20% of the cost Medicare-covered Eyeglasses or contact lenses after cataract surgery: In-network: You pay nothing Out-of-network: 20% of the cost

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Vision Services[2] Continued	Routine eye exam (for up to 1 every calendar year): In-network: $20 copay Out-of-network: $20 copay. The maximum reimbursement is $45. Routine eyeglasses or contact lenses: In-network: Routine basic lenses, including glass or plastic, single vision, lined bifocal, lined trifocal, or lenticular prescription lens are covered in full. There is a $100 benefit limit for routine eyeglass frames or contacts every two calendar years. Out-of-network: Routine vision hardware reimbursement is as follows for a total benefit of up to $100 every two calendar years: Single Vision lenses: $30 Bifocal or Progressive lenses: $50 Trifocal lenses: $65 Frame: $70 Elective Contact Lenses (in lieu of glasses): $85 Routine Vision Services are administered by VSP at 1-800-877-7195.	Routine eye exam (for up to 1 every calendar year): In-network: $20 copay Out-of-network: $20 copay. The maximum reimbursement is $45. Routine eyeglasses or contact lenses: In-network: Routine basic lenses, including glass or plastic, single vision, lined bifocal, lined trifocal, or lenticular prescription lens are covered in full. There is a $100 benefit limit for routine eyeglass frames or contacts every two calendar years. Out-of-network: Routine vision hardware reimbursement is as follows for a total benefit of up to $100 every two calendar years: Single Vision lenses: $30 Bifocal or Progressive lenses: $50 Trifocal lenses: $65 Frame: $70 Elective Contact Lenses (in lieu of glasses): $85 Routine Vision Services are administered by VSP at 1-800-877-7195.
Mental Health Services[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Mental Health Services[1] – continued	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-network: $225 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 Out-of-network: 20% of the cost Outpatient individual and group therapy visit: In-network: $30 copay Out-of-network: 20% of the cost Mental Health Services are administered by Optum at 1-800-711-4577	Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-network: $225 copay per day for days 1 through 7 You pay nothing per day for days 8 through 90 Out-of-network: 20% of the cost Outpatient individual and group therapy visit: In-network: $30 copay Out-of-network: 20% of the cost Mental Health Services are administered by Optum at 1-800-711-4577
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. In-network: You pay nothing for days 1 through 20 $150 copay per day for days 21 through 100 Out-of-network: 20% of the cost	Our plan covers up to 100 days in a SNF. In-network: You pay nothing for days 1 through 20 $150 copay per day for days 21 through 100 Out-of-network: 20% of the cost

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Skilled Nursing Facility (SNF)[1] - continued	Benefit periods begin the day you go into a hospital or skilled nursing facility and end when you haven't received any inpatient hospital care or skilled nursing facility care for 60 days in a row.	Benefit periods begin the day you go into a hospital or skilled nursing facility and end when you haven't received any inpatient hospital care or skilled nursing facility care for 60 days in a row.
Rehabilitation Services[1]	Occupational therapy visit: In-network: $30 copay Out-of-network: 20% of the cost Physical therapy and Speech and Language therapy visit: In-network: $30 copay Out-of-network: 20% of the cost	Occupational therapy visit: In-network: $30 copay Out-of-network: 20% of the cost Physical therapy and Speech and Language therapy visit: In-network: $30 copay Out-of-network: 20% of the cost
Ambulance[1]	$250 copay You pay a $40 copay for each authorized one-way transport from an out-of-network facility to an in-network facility. This copay applies to each way of a Medicare covered or medically approved ambulance transport.	$250 copay You pay a $40 copay for each authorized one-way transport from an out-of-network facility to an in-network facility. This copay applies to each way of a Medicare covered or medically approved ambulance transport.
Transportation	Not covered	Not covered
Foot Care *(podiatry services)*[2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: In-network: $30 copay Out-of-network: 20% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: In-network: $30 copay Out-of-network: 20% of the cost

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Medical Equipment/Supplies[1]	Durable Medical Equipment and supplies: In-network: 20% of the cost Out-of-network: 20% of the cost Prosthetic devices and related supplies: In-network: 20% of the cost Out-of-network: 20% of the cost Diabetic supplies such as monitoring supplies and therapeutic shoes or inserts: In-network: You pay nothing Out-of-network: 20% of the cost All in-network durable medical equipment (DME) such as therapeutic shoes or inserts, must be provided by Providence Home Services or other network providers.	Durable Medical Equipment and supplies: In-network: 20% of the cost Out-of-network: 20% of the cost Prosthetic devices and related supplies: In-network: 20% of the cost Out-of-network: 20% of the cost Diabetic supplies such as monitoring supplies and therapeutic shoes or inserts: In-network: You pay nothing Out-of-network: 20% of the cost All in-network durable medical equipment (DME) such as therapeutic shoes or inserts, must be provided by Providence Home Services or other network providers.
Wellness Programs *(e.g., fitness)*	$500 annual benefit for health and wellness classes offered at participating Providence facilities. In-network: You pay nothing. Out-of-network: Not available. The fitness/gym benefit includes free monthly membership at contracted gyms, orientation to the facility, and classes. Additionally, you can receive an at home fitness kit from our contracted vendors. In-network: You pay nothing Out-of-network: Not available.	$500 annual benefit for health and wellness classes offered at participating Providence facilities. In-network: You pay nothing. Out-of-network: Not available. The fitness/gym benefit includes free monthly membership at contracted gyms, orientation to the facility, and classes. Additionally, you can receive an at home fitness kit from our contracted vendors. In-network: You pay nothing Out-of-network: Not available.

Section II – Summary of Benefits

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Medicare Part B Drugs[1]	For Part B drugs such as chemotherapy drugs: In-network: 20% of the cost Out-of-network: 20% of the cost Other Part B drugs: In-network: 20% of the cost Out-of-network: 20% of the cost A separate cost-sharing may apply for the cost of administration.	For Part B drugs such as chemotherapy drugs: In-network: 20% of the cost Out-of-network: 20% of the cost Other Part B drugs: In-network: 20% of the cost Out-of-network: 20% of the cost A separate cost-sharing may apply for the cost of administration.
Chiropractic Care[2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) In-network: $20 copay Out-of-network: 20% of the cost Benefit is limited to Medicare-covered chiropractic services.	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position) In-network: $20 copay Out-of-network: 20% of the cost Benefit is limited to Medicare-covered chiropractic services.
Home Health Care[1]	In-network: 15% of the cost Out-of-network: 20% of the cost All in-network home health care and services must be provided and arranged through Providence Home Services or other network provider.	In-network: 15% of the cost Out-of-network: 20% of the cost All in-network home health care and services must be provided and arranged through Providence Home Services or other network provider.

COVERED MEDICAL AND HOSPITAL BENEFITS		
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Hospice	You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. Original Medicare pays for your care once hospice begins. We may coordinate benefits with Original Medicare for any non-hospice related care provided plan rules are followed.	You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. Original Medicare pays for your care once hospice begins. We may coordinate benefits with Original Medicare for any non-hospice related care provided plan rules are followed.
Outpatient Substance Abuse[1]	Individual and Group therapy visit: In-network: $30 copay Out-of-network: 20% of the cost Outpatient Substance Abuse Care is administered by Optum at 1-800-711-4577	Individual and Group therapy visit: In-network: $30 copay Out-of-network: 20% of the cost Outpatient Substance Abuse Care is administered by Optum at 1-800-711-4577
Outpatient Surgery[1]	Ambulatory surgical center: In-network: $250 copay Out-of-network: 20% of the cost Outpatient hospital: In-network: $250 copay Out-of-network: 20% of the cost	Ambulatory surgical center: In-network: $250 copay Out-of-network: 20% of the cost Outpatient hospital: In-network: $250 copay Out-of-network: 20% of the cost
Renal Dialysis[1]	Medicare-covered renal dialysis treatment: In-network: 20% of the cost Out-of-network: 20% of the cost Medicare-covered kidney disease education: In-network: You pay nothing Out-of-network: 20% of the cost	Medicare-covered renal dialysis treatment: In-network: 20% of the cost Out-of-network: 20% of the cost Medicare-covered kidney disease education: In-network: You pay nothing Out-of-network: 20% of the cost

Section II – Summary of Benefits

<table>
<tr><th colspan="6">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><th></th><th>Providence Medicare Choice (HMO-POS)</th><th colspan="4">Providence Medicare Choice + RX (HMO-POS)</th></tr>
<tr><td>Initial Coverage</td><td>Pharmacy coverage is not an option on this plan.</td><td colspan="4">After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,700. 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.</td></tr>
<tr><td></td><td></td><td colspan="4">Preferred Retail Cost-Sharing</td></tr>
<tr><td rowspan="6"></td><td rowspan="6"></td><td>Tier</td><td>One-month supply</td><td>Two-month supply</td><td>Three-month supply</td></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$6 copay</td><td>$12 copay</td><td>$14.40 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$15 copay</td><td>$30 copay</td><td>$36 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td><td>$94 copay</td><td>$112.80 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>25% of the cost</td><td>25% of the total cost for a 31-60 day supply</td><td>25% of the total cost for a 61-90 day supply</td></tr>
<tr><td>Tier 5 (Specialty)</td><td>30% of the cost</td><td>Not Offered</td><td>Not Offered</td></tr>
</table>

PRESCRIPTION DRUG BENEFITS					
	Providence Medicare Choice (HMO-POS)	Providence Medicare Choice + RX (HMO-POS)			
		Standard Retail Cost-Sharing			
		Tier	One-month supply	Two-month supply	Three-month supply
		Tier 1 (Preferred Generic)	$12 copay	$24 copay	$36 copay *Plus any difference in the cost if you were to have used a preferred pharmacy for any fills 84 days or greater.
		Tier 2 (Generic)	$20 copay	$40 copay	$60 copay *Plus any difference in the cost if you were to have used a preferred pharmacy for any fills 84 days or greater.
		Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay *Plus any difference in the cost if you were to have used a preferred pharmacy for any fills 84 days or greater."
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost	25% of the cost *Plus any difference in the cost if you were to have used a preferred pharmacy for any fills 84 days or greater.
		Tier 5 (Specialty)	30% of the cost	Not Offered	Not Offered

PRESCRIPTION DRUG BENEFITS					
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**			
		Preferred Mail Order Cost Sharing			
		Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
		Tier 1 (Preferred Generic)	$6 copay	$12 copay	$14.40 copay
		Tier 2 (Generic)	$15 copay	$30 copay	$36 copay
		Tier 3 (Preferred Brand)	$47 copay	$94 copay	$112.80 copay
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost	25% of the cost
		Tier 5 (Specialty)	30% of the cost	Not Offered	Not Offered
		Standard Mail Order Cost-Sharing			
		Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
		Tier 1 (Preferred Generic)	$12 copay	$24 copay	$36 copay *Plus any difference in the cost if you were to have used a preferred pharmacy for any fills 84 days or greater.

PRESCRIPTION DRUG BENEFITS					
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**			
		Tier 2 (Generic)	$20 copay	$40 copay	$60 copay *Plus any difference in the cost if you were to have used a preferred pharmacy for any fills 84 days or greater.
		Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay *Plus any difference in the cost if you were to have used a preferred pharmacy for any fills 84 days or greater.
		Tier 4 (Non-Preferred Drug)	25% of the cost	25% of the cost	25% of the cost *Plus any difference in the cost if you were to have used a preferred pharmacy for any fills 84 days or greater.
		Tier 5 (Specialty)	30% of the cost	Not Offered	Not Offered
		If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy. You may get drugs from a standard in-network pharmacy, but may pay more than you pay at a preferred in-network pharmacy. Your yearly deductible for Part D (pharmacy) coverage is $100. You must pay this amount before the cost shares above apply.			

Section II – Summary of Benefits

PRESCRIPTION DRUG BENEFITS		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Coverage Gap		Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700.
Coverage Gap - continued		After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: 5% of the cost, or $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.

Section II – Summary of Benefits

OPTIONAL SUPPLEMENTAL DENTAL		
Please Note: **Optional Benefits:** ***(You must pay an extra premium each month for these benefits)***[1] **Cost-Sharing:** ***(While you can see any dentist, our In-Network providers have agreed to accept a contracted rate for the services they provide. This means cost-sharing will be lower if you see an In-Network provider.)***[2]		
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + RX (HMO-POS)**
Option 1: **Basic Dental**	Benefits Include: Preventive Dental Comprehensive Dental	Benefits Include: Preventive Dental Comprehensive Dental
How much is my monthly premium?[1]	Additional $33.70 per month. You must keep paying your Medicare Part B and monthly plan premiums.	Additional $33.70 per month. You must keep paying your Medicare Part B premium and monthly plan premiums.
How much is The deductible?[1]	In-Network: $50.00 Out-of-Network: $150.00	In-Network: $50.00 Out-of-Network: $150.00
Is there any limit on how much I will pay for my covered services?[1,2]	Our plan pays up to $1,000 every year.	Our plan pays up to $1,000 every year.
Diagnostic and Preventive Care (Deductible waived – Class 1)[1,2]	In-Network: You pay 0% Out-of-Network: You pay 20% Services include: • Oral Exams - limited to two per calendar year including a maximum of one comprehensive evaluation per 36 months • One emergency or problem focused exam per calendar year. • Bitewing X-rays - limited to two per calendar year • Periapical X-ray	In-Network: You pay 0% Out-of-Network: You pay 20% Services include: • Oral Exams - limited to two per calendar year including a maximum of one comprehensive evaluation per 36 months • One emergency or problem focused exam per calendar year. • Bitewing X-rays - limited to two per calendar year • Periapical X-ray

Section II – Summary of Benefits

OPTIONAL SUPPLEMENTAL DENTAL		
Please Note: **Optional Benefits:** ***(You must pay an extra premium each month for these benefits)***[1] **Cost-Sharing:** ***(While you can see any dentist, our In-Network providers have agreed to accept a contracted rate for the services they provide. This means cost-sharing will be lower if you see an In-Network provider.)***[2]		
Diagnostic And Preventive Care (Deductible waived –Class 1)[1,2] - continued	• Diagnostic X-ray, full mouth or panoramic- limited to once every 5 years • Teeth Cleaning (Prophylaxis – cleaning, scaling, and polishing teeth) - limited to two per calendar year • Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)	• Diagnostic X-ray, full mouth or panoramic- limited to once every 5 years • Teeth Cleaning (Prophylaxis – cleaning, scaling, and polishing teeth) - limited to two per calendar year • Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
Basic Care[1,2]	In-Network: You pay 50% Out-of-Network: You pay 60% • Fillings (Silver) • Fillings (Composite)	In-Network: You pay 50% Out-of-Network: You pay 60% • Fillings (Silver) • Fillings (Composite)
Major Restorative Care[1,2]	In-Network: You pay 50% Out-of-Network: You pay 60% Services Include: • Crowns & Bridges – Annual maximum of $100 per tooth. • Denture partials and completes - $250 per lifetime • Extractions, Erupted Tooth – **not covered** • Oral Surgery – Certain minor surgery – **not covered** • Endodontics (Root Canals) – **not covered** • Periodontics – **not covered**	In-Network: You pay 50% Out-of-Network: You pay 60% Services Include: • Crowns & Bridges – Annual maximum of $100 per tooth. • Denture partials and completes - $250 per lifetime • Extractions, Erupted Tooth – **not covered** • Oral Surgery – Certain minor surgery – **not covered** • Endodontics (Root Canals) – **not covered** • Periodontics – **not covered**

Section II – Summary of Benefits

OPTIONAL SUPPLEMENTAL DENTAL		
Please Note: **Optional Benefits:** ***(You must pay an extra premium each month for these benefits)***[1] **Cost-Sharing:** ***(While you can see any dentist, our In-Network providers have agreed to accept a contracted rate for the services they provide. This means cost-sharing will be lower if you see an In-Network provider.)***[2]		
Option 2: **Enhanced Dental**	Benefits Include: Preventive Dental Comprehensive Dental	Benefits Include: Preventive Dental Comprehensive Dental
How much is my monthly premium?[1]	Additional $48.20 per month. You must keep paying your Medicare Part B premium and monthly plan premiums.	Additional $48.20 per month. You must keep paying your Medicare Part B premium and monthly plan premiums.
How much is the deductible?[1]	In-Network: $50.00 Out-of-Network: $150.00	In-Network: $50.00 Out-of-Network: $150.00
Is there any limit on how much I will pay for my covered services?[1,2]	Our plan pays up to $1,500 every year.	Our plan pays up to $1,500 every year.
Diagnostic and Preventive Care (Deductible waived – Class 1)[1,2]	In-Network: You pay nothing Out-of-Network: You pay 20% Services include: • Oral Exams - limited to two per calendar year including a maximum of one comprehensive evaluation per 36 months • One emergency or problem focused exam per calendar year. • Bitewing X-rays - limited to two per calendar year • Periapical X-ray	In-Network: You pay nothing Out-of-Network: You pay 20% Services include: • Oral Exams - limited to two per calendar year including a maximum of one comprehensive evaluation per 36 months • One emergency or problem focused exam per calendar year. • Bitewing X-rays - limited to two per calendar year • Periapical X-ray

Section II – Summary of Benefits

OPTIONAL SUPPLEMENTAL DENTAL		
Please Note: **Optional Benefits:** ***(You must pay an extra premium each month for these benefits)***[1] **Cost-Sharing:** ***(While you can see any dentist, our In-Network providers have agreed to accept a contracted rate for the services they provide. This means cost-sharing will be lower if you see an In-Network provider.)***[2]		
Diagnostic And Preventive Care (Deductible waived –Class 1)[1,2] - continued	• Diagnostic X-ray, full mouth or panoramic- limited to once every 5 years • Teeth Cleaning (Prophylaxis – cleaning, scaling, and polishing teeth) - limited to two per calendar year • Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)	• Diagnostic X-ray, full mouth or panoramic- limited to once every 5 years • Teeth Cleaning (Prophylaxis – cleaning, scaling, and polishing teeth) - limited to two per calendar year • Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service)
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This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.