2018 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 Summary of Benefits: Choice & Extra / Enrich / Prime / Compass & Latitude Pharmacy & Provider Search Formulary

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: https://medicare-oregon.com/

Y0062_MULTIPLAN_CDA INSURANCE Oregon Accepted 2017

PROVIDENCE
Medicare Advantage Plans

A division of Providence Health Assurance

Summary of Benefits

January 1, 2018 – December 31, 2018

Providence Medicare Choice (HMO-POS)
Providence Medicare Choice + RX (HMO-POS)
Providence Medicare Extra (HMO)
Providence Medicare Extra + RX (HMO)

These Plans are available in Clackamas, Columbia, Lane, Marion, Multnomah, Polk, Washington and Yamhill counties in Oregon; Clark County in Washington.

2018

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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 SUMMARY OF BENEFITS

This booklet gives you a summary of what we cover and what you pay. It does not 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." To obtain a copy of the EOC please contact customer service at 1-800-603-2340 or visit us online to request one at **www.ProvidenceHealthAssurance.com**.

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), Providence Medicare Choice + RX (HMO-POS), Providence Medicare Extra (HMO) or Providence Medicare Extra + RX (HMO)**

TIPS FOR COMPARING YOUR MEDICARE CHOICES

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

- If you want to compare our plans 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://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), Providence Medicare Choice + RX (HMO-POS), Providence Medicare Extra (HMO) and Providence Medicare Extra + RX (HMO)**

- 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)

THINGS TO KNOW ABOUT PROVIDENCE MEDICARE CHOICE (HMO-POS), PROVIDENCE MEDICARE CHOICE + RX (HMO-POS), PROVIDENCE MEDICARE EXTRA (HMO) AND PROVIDENCE MEDICARE EXTRA + RX (HMO)

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

PROVIDENCE MEDICARE CHOICE (HMO-POS), PROVIDENCE MEDICARE CHOICE + RX (HMO-POS), PROVIDENCE MEDICARE EXTRA (HMO), AND PROVIDENCE MEDICARE EXTRA + RX (HMO) 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), Providence Medicare Choice + RX (HMO-POS), Providence Medicare Extra (HMO) and Providence Medicare Extra + RX (HMO)** 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 and Yamhill counties; Clark County in Washington

Providence Medicare Choice + RX (HMO-POS) and Providence Medicare Extra + RX (HMO) cover 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), Providence Medicare Choice + RX (HMO-POS), Providence Medicare Extra (HMO) and Providence Medicare Extra + RX (HMO) 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.

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 on our RX plans. 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 each 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 benefits stages that occur after you meet your deductible as applicable: 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.

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.

SECTION II- SUMMARY OF BENEFITS				
	Providence Medicare Choice (HMO-POS)	**Providence Medicare Choice + Rx (HMO-POS)**	**Providence Medicare Extra (HMO)**	**Providence Medicare Extra + RX (HMO)**
MONTHLY PREMIUM, DEDUCTIBLE, AND MAXIMUM OUT-OF-POCKET RESPONSIBILITY				
Monthly premium	$45.00 In addition, you must continue to pay your Medicare Part B premium.	$88.00 In addition, you must continue to pay your Medicare Part B premium.	$109.00 In addition, you must continue to pay your Medicare Part B premium.	$165.00 In addition, you must continue to pay your Medicare Part B premium
Deductible	There is no medical deductible for in or out-of-network services.	There is no medical deductible for in or out-of-network services.	There is no medical deductible for this plan.	There is no medical deductible for this plan.
Out-of-pocket maximum	Your yearly limit(s) in this plan • In-network: $3,400 • Out-of-network: $6,700	Your yearly limit(s) in this plan • In-network: $3,400 • Out-of-network: $6,700	Your yearly limit(s) in this plan • In-network: $3,400	Your yearly limit(s) in this plan • In-network: $3,400

COVERED MEDICAL AND HOSPITAL BENEFITS				
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)**	**Providence Medicare Extra (HMO)**	**Providence Medicare Extra + RX (HMO)**
Inpatient Hospital Coverage[1]	In-network: $375 copay per day for days 1 through 6 You pay $0 per day days 7 & beyond Out-of-network: 30% of the cost	In-network: $375 copay per day for days 1 through 6 You pay $0 per day days 7 & beyond Out-of-network: 30% of the cost	In-network: $250 copay per day for days 1 through 5 You pay $0 per day for days 6 & beyond	In-network: $250 copay per day for days 1 through 5 You pay $0 per day for days 6 & beyond
Outpatient Hospital Coverage[1]	In-network: $250 copay outpatient surgery Out-of-network: 30% of the cost outpatient surgery	In-network: $250 copay outpatient surgery Out-of-network: 30% of the cost outpatient surgery	In-network: $150 copay outpatient surgery	In-network: $150 copay outpatient surgery
Doctor's Visits (Primary and Specialist)[2]	Primary Care Provider: In-network: $15 copay Out-of-network: 30% of the cost Specialist visit: In-network: $30 copay Out-of-network: 30% of the cost	Primary Care Provider: In-network: $15 copay Out-of-network: 30% of the cost Specialist visit: In-network: $30 copay Out-of-network: 30% of the cost	Primary Care Visit: In-network: $10 copay Specialist: In-network: $20 copay	Primary Care Visit: In-network: $10 copay Specialist: In-network: $20 copay
Preventive Care	In-network: You pay nothing Out-of-network: 30% of the cost	In-network: You pay nothing Out-of-network: 30% of the cost	In-network: You pay nothing	In-network: You pay nothing
Emergency Care	$80 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.	$80 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.	$80 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.	$80 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Urgent Care	$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost of urgent care.	$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost of urgent care.	$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost of urgent care.	$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost of urgent care.

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)**	**Providence Medicare Extra (HMO)**	**Providence Medicare Extra + RX (HMO)**
Diagnostic Services/Labs/ Imaging[1]	Diagnostic radiology services (such as MRIs, ultrasounds, CT Scans): In-network: 20% of the cost Out-of-network: 30% of the cost Therapeutic radiology services): In-network: 20% of the cost Out-of-network: 30% of the cost Outpatient x-rays: In-network: $15 copay per day Out-of-network: 30% of the cost Diagnostic test and procedures: In-network: 10% of the cost Out-of-network: 30% of the cost Lab Services: In-network: $10 copay per day Out-of-network: 30% of the cost	Diagnostic radiology services (such as MRIs, ultrasounds, CT Scans): In-network: 20% of the cost Out-of-network: 30% of the cost Therapeutic radiology services): In-network: 20% of the cost Out-of-network: 30% of the cost Outpatient x-rays: In-network: $15 copay per day Out-of-network: 30% of the cost Diagnostic test and procedures: In-network: 10% of the cost Out-of-network: 30% of the cost Lab Services: In-network: $10 copay per day Out-of-network: 30% of the cost	Diagnostic radiology services (such as MRIs, ultrasounds, CT Scans): In-network: 15% of the cost Therapeutic radiology services: In-network: 15% of the cost Outpatient x-rays: In-network: 0% of the cost Diagnostic test and procedures: In-network: $0 copay Lab services: In-network: $0 copay	Diagnostic radiology services (such as MRIs, ultrasounds, CT Scans): In-network: 15% of the cost Therapeutic radiology services: In-network: 15% of the cost Outpatient x-rays: In-network: 0% of the cost Diagnostic test and procedures: In-network: $0 copay Lab services: In-network: $0 copay
Hearing Services[2]	In-network: $30 copay Out-of-network: 30% of the cost Medicare-covered	In-network: $30 copay Out-of-network: 30% of the cost Medicare-covered	In-network: $20 copay Medicare-covered	In-network: $20 copay Medicare-covered

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)**	**Providence Medicare Extra (HMO)**	**Providence Medicare Extra + RX (HMO)**
Dental Services[2]	In-network: $30 copay Out-of-network: 30% of the cost Medicare-covered	In-network: $30 copay Out-of-network: 30% of the cost Medicare-covered	In-network: $20 copay Medicare-covered	In-network: $20 copay Medicare-covered
Vision Services	Routine eye exam: In & out of network: $0 copay up to $45 allowance per calendar year with a qualified licensed provider Routine eyeglasses or contact lenses: In & out of network: $200 benefit per calendar year with a qualified licensed provider	Routine eye exam: In & out of network: $0 copay up to $60 allowance per calendar year with a qualified licensed provider Routine eyeglasses or contact lenses: In & out of network: $300 benefit per calendar year with a qualified licensed provider	Routine eye exam: In & out of network: $0 copay up to $45 allowance per calendar year with a qualified licensed provider Routine eyeglasses or contact lenses: In & out of network: $200 benefit per calendar year with a qualified licensed provider	Routine eye exam: In & out of network: $0 copay up to $60 allowance per calendar year with a qualified licensed provider Routine eyeglasses or contact lenses: In & out of network: $300 benefit per calendar year with a qualified licensed provider
Mental Health Services[1]	Inpatient visit: In-network: $280 copay per day for days 1-7. You pay nothing for days 8-190 Out-of-network: 30% of the cost Outpatient individual and group therapy visit: In-network: $30 copay Out-of-network: 30% of the cost	Inpatient visit: In-network: $280 copay per day for days 1-7. You pay nothing for days 8-190 Out-of-network: 30% of the cost Outpatient individual and group therapy visit: In-network: $30 copay Out-of-network: 30% of the cost	Inpatient visit: In-network: $200 copay per day for days 1-7. You pay nothing for days 8-190 Outpatient individual and group therapy visit: In-network: $20 copay	Inpatient visit: In-network: $200 copay per day for days 1-7. You pay nothing for days 8-190 Outpatient individual and group therapy visit: In-network: $20 copay
Skilled Nursing Facility[1]	In-network: You pay nothing for days 1-20 $160 copay per day for days 21-100 Out-of-network: 30% of the cost	In-network: You pay nothing for days 1-20 $160 copay per day for days 21-100 Out-of-network: 30% of the cost	In-network: You pay nothing for days 1-20 $150 copay per day for days 21-100	In-network: You pay nothing for days 1-20 $150 copay per day for days 21-100

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)**	**Providence Medicare Extra (HMO)**	**Providence Medicare Extra + RX (HMO)**
Rehabilitation Services	Occupational Therapy Visit: In-network: $30 copay Out-of-network: 30% of the cost Physical therapy and Speech and Language therapy visit In-network: $30 copay Out-of-network: 30% of the cost	Occupational Therapy Visit: In-network: $30 copay Out-of-network: 30% of the cost Physical therapy and Speech and Language therapy visit In-network: $30 copay Out-of-network: 30% of the cost	Occupational Therapy Visit: In-network: $20 copay Physical therapy and Speech and Language therapy visit In-network: $20 copay	Occupational Therapy Visit: In-network: $20 copay Physical therapy and Speech and Language therapy visit In-network: $20 copay
Ambulance[1]	$250 copay	$250 copay	$250 copay	$250 copay
Transportation	Not covered	Not covered	Not covered	Not covered
Medicare Part B Drugs[1]	In-network: 20% of the cost Out-of-network: 30% of cost	In-network: 20% of the cost Out-of-network: 30% of cost	In-network: 20% of the cost	In-network: 20% of the cost
Foot Care (podiatry services)[2]	In-network: $30 copay Out-of-network: 30% of the cost	In-network: $30 copay Out-of-network: 30% of the cost	In-network: $20 copay	In-network: $20 copay

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)**	**Providence Medicare Extra (HMO)**	**Providence Medicare Extra + RX (HMO)**
Medical Equipment and Supplies[1]	Durable medical equipment and supplies: In-network: 20% of the cost Out-of-network: 30% of the cost Prosthetic devices: In-network: 20% of the cost Out-of-network: 30% of the cost Diabetic supplies: In-network: $0 copay Out-of-network: 30% of the cost Diabetic therapeutic shoes or inserts: In-network: 10% of the cost Out-of-network: 30% of the cost	Durable medical equipment and supplies: In-network: 20% of the cost Out-of-network: 30% of the cost Prosthetic devices: In-network: 20% of the cost Out-of-network: 30% of the cost Diabetic supplies: In-network: $0 copay Out-of-network: 30% of the cost Diabetic therapeutic shoes or inserts: In-network: 10% of the cost Out-of-network: 30% of the cost	Durable medical equipment and supplies: In-network: 20% of the cost Prosthetic devices: In-network: 20% of the cost Diabetic supplies: In-network: $0 copay Diabetic therapeutic shoes or inserts: In-network: $0 copay	Durable medical equipment and supplies: In-network: 20% of the cost Prosthetic devices: In-network: 20% of the cost Diabetic supplies: In-network: $0 copay Diabetic therapeutic shoes or inserts: In-network: $0 copay
Wellness Program	$500 annual benefit for health and wellness classes offered at participating Providence facilities	$500 annual benefit for health and wellness classes offered at participating Providence facilities	$500 annual benefit for health and wellness classes offered at participating Providence facilities	$500 annual benefit for health and wellness classes offered at participating Providence facilities

Prescription Drug Bene its ForProvidence Medicare Choice + RX (HMO-POS) Plan ONLY			
Initial Coverage	After you pay your yearly deductible you pay the following until your total yearly drug costs reach $3,750. 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		
	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic)	$7 copay	$14 copay	$16.80 copay
Tier 2 (Generic)	$18 copay	$36 copay	$43.20 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$112.80 copay
Tier 4 (Non-preferred Drug)	$100 copay	$200 copay	$240 copay
Tier 5 (Specialty)	28% of the cost	Not offered	Not offered
	Standard Retail Cost-Sharing		
	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic)	$14 copay	$28 copay	$42 copay
Tier 2 (Generic)	$20 copay	$40 copay	$60 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay
Tier 4 (Non-preferred Drug)	$100 copay	$200 copay	$300 copay
Tier 5 (Specialty)	28% 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 $240. You must pay this amount before the cost shares above apply. Note: The Deductible is waived for Generic Tiers (Tiers 1 & 2).			
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 the drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan’s cost for the covered brand name drugs and 44% of the plan’s cost for covered generic drugs until your costs total $5,000, 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 $5,000, you pay the greater of: 5% of the cost or $3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copay for all other drugs.		

Prescription Drug Bene its For Providence Medicare Extra + RX (HMO) Plan ONLY			
Initial Coverage	You pay the following until your total yearly drug costs reach $3,750. 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		
	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)	$45 copay	$90 copay	$108 copay
Tier 4 (Non-preferred Drug)	25% of the cost	25% of the cos	25% of the cos
Tier 5 (Specialty)	33% of the cost	Not offered	Not offered
	Standard Retail Cost-Sharing		
	One-Month Supply	Two-Month Supply	Three-Month Supply
Tier 1 (Preferred Generic)	$12 copay	$24 copay	$36 copay
Tier 2 (Generic)	$20 copay	$40 copay	$60 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$135 copay
Tier 4 (Non-preferred Drug)	25% of the cost	25% of the cost	25% of the cost
Tier 5 (Specialty)	33% 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.			
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 the drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,750. After you enter the coverage gap, you pay 35% of the plan’s cost for the covered brand name drugs and 44% of the plan’s cost for covered generic drugs until your costs total $5,000, 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 $5,000, you pay the greater of: 5% of the cost or $3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copay for all other drugs. .		

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)**	**Providence Medicare Extra (HMO)**	**Providence Medicare Extra + RX (HMO)**
Option 1: Basic Dental	Benefits include: Preventive Dental Comprehensive Dental	Benefits include: Preventive Dental Comprehensive Dental	Benefits include: Preventive Dental Comprehensive Dental	Benefits include: Preventive Dental Comprehensive Dental
Monthly premium[1]	Additional $33.70 per month. You must keep paying your Medicare Part B and monthly plan premium.	Additional $33.70 per month. You must keep paying your Medicare Part B and monthly plan premium.	Additional $33.70 per month. You must keep paying your Medicare Part B and monthly plan premium.	Additional $33.70 per month. You must keep paying your Medicare Part B and monthly plan premium.
Deductible[1]	In-network: $50 Out-of-network: $150	In-network: $50 Out-of-network: $150	In-network: $50 Out-of-network: $150	In-network: $50 Out-of-network: $150
Annual Benefit Maximum[1,2]	$1000 per year	$1000 per year	$1000 per year	$1000 per year
Diagnostic and Preventive Care[1,2]	In-network: you pay 0% Out-of-network: You pay 20%	In-network: you pay 0% Out-of-network: You pay 20%	In-network: you pay 0% Out-of-network: You pay 20%	In-network: you pay 0% Out-of-network: You pay 20%
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)	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%	In-network: You pay 50% Out-of-network: You pay 60%	In-network: You pay 50% Out-of-network: You pay 60%	In-network: You pay 50% Out-of-network: You pay 60%

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)**	**Providence Medicare Extra (HMO)**	**Providence Medicare Extra + RX (HMO)**
Option 2: Enhanced Dental	Benefits include: Preventive Dental Comprehensive Dental	Benefits include: Preventive Dental Comprehensive Dental	Benefits include: Preventive Dental Comprehensive Dental	Benefits include: Preventive Dental Comprehensive Dental
Monthly premium[1]	Additional $46.50 per month. You must keep paying your Medicare Part B and monthly plan premium.	Additional $46.50 per month. You must keep paying your Medicare Part B and monthly plan premium..	Additional $46.50 per month. You must keep paying your Medicare Part B and monthly plan premium.	Additional $46.50 per month. You must keep paying your Medicare Part B and monthly plan premium.
Deductible[1]	In-network: $50 Out-of-network: $150	In-network: $50 Out-of-network: $150	In-network: $50 Out-of-network: $150	In-network: $50 Out-of-network: $150
Annual Benefit Maximum[1,2]	$1,500 per year	$1,500 per year	$1,500 per year	$1,500 per year
Diagnostic and Preventive Care[1,2]	In-network: you pay 0% Out-of-network: You pay 20%	In-network: you pay 0% Out-of-network: You pay 20%	In-network: you pay 0% Out-of-network: You pay 20%	In-network: you pay 0% Out-of-network: You pay 20%
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)	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]	In-network: You pay 50% Out-of-network: You pay 60%	In-network: You pay 50% Out-of-network: You pay 60%	In-network: You pay 50% Out-of-network: You pay 60%	In-network: You pay 50% Out-of-network: You pay 60%

This is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1st of each year. You must continue to pay your Part B premium. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary