2019 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: Prime & Choice / Focus, Select & Extra / Timber, Choice, Compass, Latitude & Enrich
Summary of Benefits: Choice / Enrich / Extra / Focus / Prime / Select / Timber / 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 2019

PROVIDENCE
Medicare Advantage Plans

A division of Providence Health Assurance

Summary of Benefits

January 1, 2019 – December 31, 2019

Providence Medicare Compass + RX (HMO-POS)

Providence Medicare Latitude + RX (HMO-POS)

These Plans are available in Crook, Deschutes, Hood River, Jefferson and Wheeler Counties.

2019

H9047_2019AMSB08_M_ACCEPTED

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

This booklet gives you a summary of what **Providence Medicare Compass + RX (HMO-POS) AND Providence Medicare Latitude + RX (HMO-POS)** covers 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/EOC**.

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

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.

THINGS TO KNOW ABOUT PROVIDENCE MEDICARE COMPASS + RX (HMO-POS) OR PROVIDENCE MEDICARE LATITUDE + RX (HMO-POS)

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

PROVIDENCE MEDICARE COMPASS + RX (HMO-POS) and PROVIDENCE MEDICARE LATITUDE + 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**
- Our plan members get all of the benefits covered by Original Medicare.
- Some of the extra benefits are outlined in this booklet.

WHO CAN JOIN

To join **Providence Medicare Compass + RX (HMO-POS) or Providence Medicare Latitude + 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: Crook, Deschutes, Hood River, Jefferson and Wheeler.

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. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **www.providencehealthassurance.com/formulary**

	Providence Medicare Compass + RX (HMO-POS)		Providence Medicare Latitude + RX (HMO-POS)	
Monthly Plan Premium	$99 In addition, you must continue to pay your Medicare Part B premium.		$195 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.			
Maximum Out-of-pocket Responsibility	Your yearly limit(s) in this plan			
	In-network: $6,700	Out-of-network: $10,000	In-network: $5,500	Out-of-network: $5,500

SERVICES WITH A[1] MAY REQUIRE PRIOR AUTHORIZATION
SERVICES WITH A[2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR

Benefits		In-network	Out-of-network	In-network	Out-of-network
Inpatient Hospital Coverage[1]		$360 copay per day for days 1-5 You pay $0 per day days 6 & beyond	50% of the cost	$275 copay per day for days 1- 5 You pay $0 per day days 6 & beyond	30% of the cost
Outpatient Hospital Coverage[1]		$475 copay outpatient surgery	50% of the cost	$250 copay outpatient surgery	30% of the cost
Doctor Visits[2]	Primary	$20 copay	50% of the cost	$15 copay	30% of the cost
	Specialist	$45 copay	50% of the cost	$40 copay	30% of the cost
Preventive Care		You pay nothing	50% of the cost	You pay nothing	30% of the cost
Emergency Care		$90 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.*		$90 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.*	
Urgently Needed Services		$65 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.*	

		Providence Medicare Compass + RX (HMO-POS)		Providence Medicare Latitude + RX (HMO-POS)	
Benefits		**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Diagnostic Services/Lab/ Imaging[1]	Diagnostic radiology services	20% of the cost	50% of the cost	20% of the cost	30% of the cost
	Diagnostic test and procedures	20% of the cost	50% of the cost	20% of the cost	30% of the cost
	Lab Services	$15 copay per day	50% of the cost	$10 copay per day	30% of the cost
	Outpatient x-rays	$15 copay per day	50% of the cost	$15 copay per day	30% of the cost
	Therapeutic radiology services	20% of the cost	50% of the cost	20% of the cost	30% of the cost
Hearing Services[2]	Medicare-covered	$45 copay	50% of the cost	$40 copay	30% of the cost
	Routine exam	$45 copay	Not covered	$45 copay	Not covered
Dental Services[2]	Medicare-covered	$45 copay	50% of the cost	$40 copay	30% of the cost
	Optional	Covered for additional premium, see below		Covered for additional premium, see below	
Vision Services	Medicare-covered	$45 copay	50% of the cost	$40 copay	30% of the cost
	Routine exam	Allowance of up to $60 per calendar year for a routine vision exam (including refraction)		Allowance of up to $60 per calendar year for a routine vision exam (including refraction)	
	Routine eyeglasses or contact lenses	Allowance of up to $250 per calendar year for any combination of routine prescription eyewear.		Allowance of up to $250 per calendar year for any combination of routine prescription eyewear	
Mental Health Services[1]	Inpatient visit	$280 copay per day for days 1-5. You pay nothing for days 6-190	50% of the cost	$220 copay per day for days 1-6. You pay nothing for days 7-190.	30% of the cost
	Outpatient individual and group therapy visit	$40 copay	50% of the cost	$40 copay	30% of the cost
Skilled Nursing Facility[1]		You pay nothing for days 1-20 $160 copay per day for days 21-100	50% of the cost	You pay nothing for days 1-20 $150 copay per day for days 21-100	30% of the cost
Physical therapy		$40 copay	50% of the cost	$40 copay	30% of the cost
Ambulance[1]		$250 copay		$200 copay	
Transportation		Not covered		Not covered	
Medicare Part B Drugs[1]		20% of the cost	50% of the cost	20% of the cost	30% of the cost

Providence Medicare Compass + RX (HMO-POS) Prescription Drug Benefits			
Initial Coverage	After you pay your yearly deductible you pay the following until your total yearly drug costs reach $3,820. 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)	$5 copay	$10 copay	$12 copay
Tier 2 (Generic)	$12 copay	$24 copay	$28.80 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)	27% of the cost	Not offered	Not offered
	Standard Retail Cost-Sharing		
Tier 1 (Preferred Generic)	$12 copay	$24 copay	$36 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)	27% 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 $270. 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 $3,820. After you enter the coverage gap, you pay 25% of the plan's cost for the covered brand name drugs and 37% of the plan's cost for covered generic drugs until your costs total $5,100, 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 $5,100, you pay the greater of: 5% of the cost or $3.40 copay for generic (including brand drugs treated as generic) and an $8.50 copay for all other drugs.		

Providence Medicare Latitude + RX (HMO-POS) Prescription Drug Benefits			
Initial Coverage	After you pay your yearly deductible you pay the following until your total yearly drug costs reach $3,820. 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)	$4 copay	$8 copay	$9.60 copay
Tier 2 (Generic)	$10 copay	$20 copay	$24 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$112.80 copay
Tier 4 (Non-preferred Drug)	$90 copay	$180 copay	$216 copay
Tier 5 (Specialty)	33% of the cost	Not offered	Not offered
	Standard Retail Cost-Sharing		
Tier 1 (Preferred Generic)	$10 copay	$20 copay	$30 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)	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. Your yearly deductible for Part D (pharmacy) coverage is $270. You must pay this amount before the cost shares above apply.			
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 $3,820. After you enter the coverage gap, you pay 25% of the plan’s cost for the covered brand name drugs and 37% of the plan’s cost for covered generic drugs until your costs total $5,100, 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 $5,100, you pay the greater of: 5% of the cost or $3.40 copay for generic (including brand drugs treated as generic) and an $8.50 copay for all other drugs.		

This information is not a complete description of benefits. Call 1-*800-603-2340, TTY users call 711 for more information.*

OPTIONAL SUPPLEMENTAL DENTAL: Optional Benefit ***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 1: Basic 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.*	
Benefits	In-network	Out-of-network
Deductible[1]	$50	$150
Annual Benefit Maximum[1,2]	$1,000 per year	
Diagnostic and Preventive Care[1,2]	You pay 0%	You pay 20%
Basic Care[1,2]	You pay 50%	You pay 60% • Fillings (Silver) • Fillings (Composite)
Major Restorative Care[1,2]	You pay 50%	You pay 60%
Option 2: Enhanced 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.*	
Benefits	In-network	Out-of-network
Deductible[1]	$50	$150
Annual Benefit Maximum[1,2]	$1,500 per year	
Diagnostic and Preventive Care[1,2]	You pay 0%	You pay 20%
Basic Care[1,2]	You pay 50%	You pay 60% • Fillings (Silver) • Fillings (Composite)
Major Restorative Care[1]	You pay 50%	You pay 60%