2020 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, Bridge 1, Choice 1, Extra / Focus & Select / Timber, Bridge 2, Choice 2, Extra 2 / Compass & Latitude / Enrich
Summary of Benefits: Bridge 1 / Bridge 2 / Choice / Compass / Enrich / Extra / Focus / Prime / Select / Timber / 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/

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Medicare Advantage Plans
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Pre-Enrollment Checklist

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), 8am to 8pm (Pacific time), seven days a week.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **ProvidenceHealthAssurance.com** 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

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 on January 1, 2020.
+ 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 provided by a noncontracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay 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.

PROVIDENCE
Medicare Advantage Plans

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2020 Summary of Benefits

Providence Medicare Choice + Rx 001 (HMO-POS)
Providence Medicare Choice + Rx 002 (HMO-POS)

January 1, 2020 – December 31, 2020

Providence Medicare Choice + Rx 001 (HMO-POS)
This plan is available in **Clackamas, Multnomah, Washington and Yamhill counties in Oregon.**

Providence Medicare Choice + Rx 002 (HMO-POS)
This plan is available in **Columbia, Lane, Marion, and Polk counties in Oregon and Clark County in Washington.**

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This booklet gives you a summary of what Providence Medicare Choice + Rx 001 (HMO-POS) and Providence Medicare Choice + Rx 002 (HMO-POS) 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 **ProvidenceHealthAssurance.com/EOC**.

If you have any questions about this plan's benefits or costs, please contact Providence Medicare Advantage Plans 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 **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 Choice + Rx 001 (HMO-POS) and Providence Medicare Choice + Rx 002 (HMO-POS)

You can call us seven days a week from 8 a.m. to 8 p.m. (Pacific Time).

Providence Medicare Choice + Rx 001 (HMO-POS) and Providence Medicare Choice + Rx 002 (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: **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 Choice + Rx 001 (HMO-POS) and Providence Medicare Choice + Rx 002 (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:

Providence Medicare Choice + Rx 001 (HMO-POS):

+ Clackamas
+ Multnomah
+ Washington
+ Yamhill

Providence Medicare Choice + Rx 002 (HMO-POS):

+ Columbia
+ Lane
+ Marion
+ Polk
+ Clark (Washington)

You can see our plan's Provider and Pharmacy Directory at our website: **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, **ProvidenceHealthAssurance.com/Formulary**.

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.

Providence Medicare Choice + Rx 001 (HMO-POS)
Providence Medicare Choice + Rx 002 (HMO-POS)

Monthly Plan Premium	**$88** In addition, you must continue to pay your Medicare Part B premium.	
Deductible	**$0** There is no medical deductible for in or out-of-network services.	
Maximum Out-of-Pocket Responsibility	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** copay per day for days 1-6 You pay **$0** per day for days 7 and beyond	**30%** of the cost
Outpatient Hospital Coverage[1]		**$250** copay for outpatient surgery at a hospital facility	**30%** of the cost
Ambulatory Surgery Center[1]		**$250** copay for outpatient surgery at an Ambulatory Surgery Center	**30%** of the cost
Doctor Visits[2]	Primary Care Provider visit	**$15** copay	**$25** copay
	Specialist visit	**$30** **$50 no referral**	**$50** copay
Preventive Care		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 copay for emergency care.	
Urgently Needed Services		**$50** copay If you are admitted to the hospital within 24 hours, you do not have to pay copay for urgent care.	

Out-of-network/noncontracted providers are under no obligation to treat Providence Medicare Choice + Rx 001 (HMO-POS) or Providence Medicare Choice + Rx 002 (HMO-POS) 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.

[1] Services may require prior authorization. [2] Services may require a referral from your doctor.

Providence Medicare Choice + Rx 001 (HMO-POS)
Providence Medicare Choice + Rx 002 (HMO-POS)

Benefits		In-network	Out-of-network
Diagnostic Services/ Labs/Imaging[1]	Diagnostic radiology services (e.g. MRI, ultrasounds, CT scans)[1]	**20%** of the cost	**30%** of the cost
	Therapeutic radiology services[1]	**20%** of the cost	**30%** of the cost
	Outpatient X-rays[1]	**$15** copay	**30%** of the cost
	Diagnostic test and procedures[1]	**$0** copay	**30%** of the cost
	Lab services[1]	**$0** copay	**30%** of the cost
Hearing Services[2]	Medicare-covered	**$30** copay	**30%** of the cost
	Routine exam	**$0** copay	Not covered
	Hearing Aids	**$699** copay per hearing aid - Advanced **$999** copay per hearing aid - Premium	Not covered
Dental Services[2]	Medicare-covered	**$30** copay	**30%** of the cost
	Optional	Covered for additional premium, see last page of this summary	
Vision Services	Medicare-covered	**$30** copay	**30%** of the cost
	Routine exam	Allowance of up to **$75** per calendar year for a routine vision exam (including refraction)	
	Routine eyeglasses or contact lenses	Allowance of up to **$220** per calendar year for any combination of routine prescription eyewear	
Mental Health Services[1]	Inpatient visit	**$275** copay per day for days 1-6 **$0** You pay nothing for days 7-190	**30%** of the cost
	Outpatient individual and group therapy visit	**$30** copay	**30%** of the cost
Skilled Nursing Facility[1]		**$0** You pay nothing for days 1-20 **$160** copay for days 21-100	**30%** of the cost
Physical Therapy[1]		**$35** copay	**30%** of the cost
Ambulance[1]		**$250** copay one way	
Transportation		Not covered	
Medicare Part B drugs[1]		**20%** of the cost	**30%** of the cost

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Prescription Drug Benefits

Providence Medicare Choice + Rx 001 (HMO-POS)
Providence Medicare Choice + Rx 002 (HMO-POS)

Prescription Drug Deductible	
Tier 1 (Preferred Generic) Tier 2 (Generic)	Deductible waived
Tier 3 (Preferred Brand) Tier 4 (Non-preferred Drug) Tier 5 (Specialty)	**$240**

Initial Coverage	After you pay your yearly deductible you pay the following until your total yearly drug costs reach $4,020. 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 90 days**
Tier 1 (Preferred Generic)	**$4** copay	**$8** copay	**$8** copay
Tier 2 (Generic)	**$13** copay	**$26** copay	**$31.20** 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			
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 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.

Prescription Drug Benefits

Providence Medicare Choice + Rx 001 (HMO-POS)
Providence Medicare Choice + Rx 002 (HMO-POS)

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 $4,020. After you enter the coverage gap, you pay 25% of the plan’s cost for the covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.
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 $6,350, you pay the greater of: 5% of the cost or $3.60 copay for generic (including brand drugs treated as generic) and an $8.95 copay for all other drugs.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Optional Supplemental Dental

Providence Medicare Choice + Rx 001 (HMO-POS)
Providence Medicare Choice + Rx 002 (HMO-POS)

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 and 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, Composite)
Major Restorative Care[1,2]	You pay **50%**	You pay **60%**

Option 2: Enhanced Dental Benefits include: Preventive Dental and 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, Composite)
Major Restorative Care[1,2]	You pay **50%**	You pay **60%**

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.