

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/>

Y0062_MULTIPLAN_CDA INSURANCE Oregon 2020

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](https://www.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.

2020 Summary of Benefits

Providence Medicare Extra + Rx 001 (HMO)

Providence Medicare Extra + Rx 002 (HMO)

January 1, 2020 – December 31, 2020

Providence Medicare Extra + Rx 001 (HMO)

This plan is available in **Clackamas, Multnomah, Washington and Yamhill counties in Oregon.**

Providence Medicare Extra + Rx 002 (HMO)

This plan is available in **Columbia, Lane, Marion, and Polk counties in Oregon and Clark County in Washington.**

This booklet gives you a summary of what Providence Medicare Extra + Rx 001 (HMO) and Providence Medicare Extra + Rx 002 (HMO) 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 Extra + Rx 001 (HMO) and Providence Medicare Extra + Rx 002 (HMO)

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

Providence Medicare Extra + Rx 001 (HMO) and Providence Medicare Extra + Rx 002 (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: **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 Extra + Rx 001 (HMO) and Providence Medicare Extra + Rx 002 (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:

Providence Medicare Extra + Rx 001 (HMO):

- + Clackamas
- + Multnomah
- + Washington
- + Yamhill

Providence Medicare Extra + Rx 002 (HMO):

- + 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 Extra + Rx 001 (HMO)

Providence Medicare Extra + Rx 002 (HMO)

Monthly Plan Premium	\$173 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: \$3,400

Benefits		In-network
Inpatient Hospital Coverage ¹		\$250 copay per day for days 1-5; Days 6 and beyond \$0
Outpatient Hospital Coverage ¹		\$150 copay for outpatient surgery at a hospital facility
Ambulatory Surgery Center		\$100 copay for outpatient surgery at an Ambulatory Surgical Center
Doctor Visits ²	Primary Care Provider visit	\$0 copay
	Specialist visit	\$20 copay
Preventive Care		You pay nothing
Emergency Care		\$70 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.

¹ Services may require prior authorization.

² Services may require a referral from your doctor.

Providence Medicare Extra + Rx 001 (HMO)

Providence Medicare Extra + Rx 002 (HMO)

Benefits		In-network
Diagnostic Services/ Labs/Imaging ¹	Diagnostic radiology services (e.g. MRI, ultrasounds, CT scans) ¹	15% of the cost
	Therapeutic radiology services ¹	15% of the cost
	Outpatient X-rays ¹	\$0 copay
	Diagnostic test and procedures ¹	\$0 copay
	Lab services ¹	\$0 copay
Hearing Services ²	Medicare-covered	\$20 copay
	Routine exam	\$0 copay
	Hearing Aids	\$499 copay per hearing aid - Advanced \$799 copay per hearing aid - Premium
Dental Services ²	Medicare-covered	\$20 copay
	Optional	Covered for additional premium, see last page of this summary
	Preventive Dental	\$15 copay includes exams, cleanings, X-rays. Limit two per year.
Vision Services	Medicare-covered	\$20 copay
	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 \$215 per calendar year for any combination of routine prescription eyewear
Mental Health Services ¹	Inpatient visit	\$200 copay per day for days 1-7 \$0 You pay nothing for days 8-190
	Outpatient individual and group therapy visit	\$20 copay
Skilled Nursing Facility ¹		\$0 You pay nothing for days 1-20 \$150 copay for days 21-100
Therapy: Physical, Occupational, Speech ¹		\$20 copay
Ambulance ¹		\$250 copay one way
Transportation		24 one-way trips (25-mile max. per leg)
Medicare Part B drugs ¹		20% of the cost
Over-the-Counter items		\$175 per qtr. (Catalog, online & telephonic ordering)

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

Prescription Drug Benefits

Providence Medicare Extra + Rx 001 (HMO)

Providence Medicare Extra + Rx 002 (HMO)

Prescription Drug Deductible (Applies to all tiers)	There is no prescription drug deductible for this plan.		
Initial Coverage	You pay the following until your total yearly drug costs reach \$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)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	\$10 copay	\$20 copay	\$10 copay
Tier 3 (Preferred Brand)	\$45 copay	\$90 copay	\$90 copay
Tier 4 (Non-preferred Drug)	\$90 copay	\$180 copay	\$180 copay
Tier 5 (Specialty)	33% 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)	33% 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 Extra + Rx 001 (HMO)

Providence Medicare Extra + Rx 002 (HMO)

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 your Tier 1 cost-share for Tier 1 (Preferred Generic) drugs and 25% of the plan’s cost for the covered brand name drugs and 25% of the plan’s cost for other covered generic drugs until your costs total \$6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.		
Preferred Retail and Mail-Order Cost Sharing			
	Up to 30 days	Up to 60 days	Up to 90 days
Tier 1 (Preferred Generic)	\$0 copay	\$0 copay	\$0 copay
Tier 2 (Generic)	25% of the cost	25% of the cost	25% of the cost
Tier 3 (Preferred Brand)	25% of the cost	25% of the cost	25% of the cost
Tier 4 (Non-preferred Drug)	25% of the cost	25% of the cost	25% of the cost
Tier 5 (Specialty)	25% of the cost	Not offered	Not offered
Standard Retail Cost Sharing			
Tier 1 (Preferred Generic)	\$12 copay	\$24 copay	\$36 copay
Tier 2 (Generic)	25% of the cost	25% of the cost	25% of the cost
Tier 3 (Preferred Brand)	25% of the cost	25% of the cost	25% of the cost
Tier 4 (Non-preferred Drug)	25% of the cost	25% of the cost	25% of the cost
Tier 5 (Specialty)	25% of the cost	Not offered	Not offered
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 Extra + Rx 001 (HMO)

Providence Medicare Extra + Rx 002 (HMO)

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 Wrap Dental		
Benefits include: Preventive Dental and Comprehensive Dental		
Monthly premium ¹	Additional \$29.40 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 Wrap Dental		
Benefits include: Preventive Dental and Comprehensive Dental		
Monthly premium ¹	Additional \$42.20 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.