2021 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 001, Extra 001 / Focus & Select / Timber, Bridge 2, Choice 002, Extra 002 / 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 2021

Pre-Enrollment Checklist

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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), 8 a.m. to 8 p.m. (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/coinsurance may change on January 1, 2021.
- ☐ 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 non-contracted 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 copay 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.

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2021 Summary of Benefits

Providence Medicare Latitude + Rx (HMO-POS)

January 1, 2021 – December 31, 2021

This plan is available in **Crook, Deschutes, Hood River, Jefferson and Wheeler counties in Oregon.**

When you join Providence

You're part of something bigger than an insurance policy. You're part of a community of care, focused on your health and well-being. To help you make the right health care decisions, we're providing this summary of benefits, a succinct guide that breaks down what we would cover and what you would pay if you joined our Providence Medicare Latitude + Rx (HMO-POS) plan. To be clear, this summary of benefits is just that, a summary. It doesn't list every service that we cover nor every limitation or exclusion.

For a complete list of services that we cover, please refer to the Evidence of Coverage (EOC). You can request a printed copy by visiting **ProvidenceHealthAssurance.com/EOC** or by calling our Customer Service department at one of the numbers listed in the "Get in touch" section below.

Plan overview

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.

Our plan members get all of the benefits covered by Original Medicare as well as some extra benefits outlined in this summary.

Who can join?

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes Crook, Deschutes, Hood River, Jefferson and Wheeler counties in Oregon.

Get in touch

Questions? We're here to help seven days a week from 8 a.m. to 8 p.m. (Pacific Time).

+ If you're a member of this plan, call us toll-free at 1-800-603-2340 (TTY: 711)
+ If you're not a member of this plan, call us toll-free at 1-800-457-6064 (TTY: 711)
+ You can also visit us online at **ProvidenceHealthAssurance.com**

Helpful resources

+ Visit **ProvidenceHealthAssurance.com/findaprovider** to see our plan's Provider and Pharmacy Directory or to request a printed copy. You can also call us to have a printed copy mailed to you.
+ Want to see our plan's formulary (list of Part D prescription drugs), including any restrictions? Visit **ProvidenceHealthAssurance.com/Formulary**, or give us a call for a printed copy.
+ To learn more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook, view it online at **www.Medicare.gov** or request a printed copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Providence Medicare Latitude + Rx (HMO-POS)

Monthly Plan Premium	$195 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 (does not include prescription drugs)	Your yearly limit(s) for this plan:	
	In-network: $5,500	Out-of-network: $5,500 combined

Benefits		In-network	Out-of-network
Inpatient Hospital Coverage[1]		$275 copayment each day for days 1-5 and $0 copayment each day for day 6 and beyond	30% of the total cost per admission
Outpatient Hospital Coverage[1]		$450 copayment for outpatient surgery at a hospital facility	30% of the total cost
Ambulatory Surgery Center[1]		$450 copayment for outpatient surgery at an Ambulatory Surgery Center	30% of the total cost
Doctor Visits	Primary Care Provider Visit	$10 copayment	$25 copayment
	Specialist Visit[2]	$40 copayment $50 copayment no referral	$50 copayment
Preventive Care		You pay nothing	30% of the total cost
Emergency Care		$90 copayment 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		$50 copayment If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care.	

Out-of-network/non-contracted providers are under no obligation to treat Providence Medicare Latitude + Rx (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 Latitude + Rx (HMO-POS)

Benefits		In-network	Out-of-network
Diagnostic Services/ Labs/Imaging[1]	Diagnostic Radiology Services (e.g. MRI, ultrasounds, CT scans)	15% of the total cost	30% of the total cost
	Therapeutic Radiology Services	15% of the total cost	30% of the total cost
	Outpatient X-rays	$0 copayment	30% of the total cost
	Diagnostic Tests and Procedures	20% of the total cost	30% of the total cost
	Lab Services	$0 copayment	30% of the total cost
Hearing Services	Medicare-Covered[2]	$40 copayment	30% of the total cost
	Routine Exam	$0 copayment	Not covered
	Hearing Aids	$699 copayment per Advanced hearing aid or a $999 copayment per Premium hearing aid	Not covered
Dental Services	Medicare-Covered[2]	$40 copayment	30% of the total cost
	Optional	Covered for additional premium; see last page of this summary	
Vision Services	Medicare-Covered Exams/Screening[2]	$40 copayment per exam $0 copayment for glaucoma screening	30% of the total cost per exam 30% of the total cost for glaucoma screening
	Routine Exam	Allowance of up to $75 per calendar year for a routine vision exam (including refraction)	
	Medicare-Covered Eyewear	$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	30% of the total cost for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery
	Routine Eyeglasses or Contact Lenses	Allowance of up to $250 per calendar year for any combination of routine prescription eyewear	

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

Providence Medicare Latitude + Rx (HMO-POS)

Benefits		In-network	Out-of-network
Mental Health Services[1]	Inpatient Visit	$220 copayment each day for days 1-6 and $0 copayment each day for days 7-90	30% of the total cost per admission
	Outpatient Individual and Group Therapy Visit	$40 copayment	30% of the total cost
Skilled Nursing Facility (SNF)[1]		$0 copayment each day for days 1-20 and $150 copayment each day for days 21-100	30% of the total cost for each benefit period (days 1-100)
Physical Therapy[1]		$40 copayment	30% of the total cost
Ambulance[1]		$250 copayment	
Transportation		Not covered	
Medicare Part B Drugs[1]		20% of the total cost	30% of the total cost

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

Prescription Drug Benefits

Providence Medicare Latitude + Rx (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)	$120

Initial Coverage	After you pay your yearly deductible you pay the following until your total yearly drug costs reach $4,130. 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 copayment	$0 copayment	$0 copayment
Tier 2 (Generic)	$10 copayment	$10 copayment	$10 copayment
Tier 3 (Preferred Brand)	$45 copayment	$90 copayment	$90 copayment
Tier 4 (Non-Preferred Drug)	$90 copayment	$180 copayment	$180 copayment
Tier 5 (Specialty)	30% of the total cost	Not covered	Not covered
Standard Retail Cost Sharing			
Tier 1 (Preferred Generic)	$12 copayment	$24 copayment	$36 copayment
Tier 2 (Generic)	$20 copayment	$40 copayment	$60 copayment
Tier 3 (Preferred Brand)	$47 copayment	$94 copayment	$141 copayment
Tier 4 (Non-Preferred Drug)	$100 copayment	$200 copayment	$300 copayment
Tier 5 (Specialty)	30% of the total cost	Not covered	Not covered

Prescription Drug Benefits

Providence Medicare Latitude + Rx (HMO-POS)

If you reside in a long-term 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.

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 $4,130. 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 $6,550, 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 $6,550, you pay the greater of: 5% of the cost or $3.70 copayment for generic (including brand drugs treated as generic) and a $9.20 copayment for all other drugs.

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

The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Optional Supplemental Dental
Providence Medicare Latitude + Rx (HMO-POS)

Please Note:

Optional Benefits: You must pay an extra premium each month for these benefits.
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.

Option 1: Dental Basic Benefits include: Preventive Dental and Comprehensive Dental		
Monthly Premium	Additional $33.70 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-network**	**Out-of-network**
Deductible	$50	$150
Annual Benefit Maximum	$1,000 per year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 50%	You pay 60% Fillings (silver, composite)
Major Restorative Care*	You pay 50%	You pay 60%

Option 2: Dental Enhanced Benefits include: Preventive Dental and Comprehensive Dental		
Monthly Premium	Additional $46.50 per month. You must keep paying your Medicare Part B and monthly plan premium.	
Benefits	**In-network**	**Out-of-network**
Deductible	$50	$150
Annual Benefit Maximum	$1,500 per year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 50%	You pay 60% Fillings (silver, composite)
Major Restorative Care*	You pay 50%	You pay 60%

*Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services.