

# 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 15<sup>th</sup> to December 7<sup>th</sup>. This will give you a January 1<sup>st</sup> effective date for your new plan.

## Annual Enrollment Period (AEP)

Applications must be signed and dated on, or between October 15<sup>th</sup> and December 7<sup>th</sup>. ***If they are signed prior to October 15<sup>th</sup> they will be returned to you with a new application.*** If they are received after December 7<sup>th</sup>, 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](mailto: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

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.

# 2021 Summary of Benefits

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## **Providence Medicare Prime + Rx (HMO)**

**January 1, 2021 – December 31, 2021**

This plan is available in Clackamas, Multnomah, Washington and Yamhill 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 Prime + Rx (HMO) 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](https://www.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 Clackamas, Multnomah, Washington and Yamhill 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](https://www.providencehealthassurance.com)

## Helpful resources

- + Visit [ProvidenceHealthAssurance.com/findaprovider](https://www.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](https://www.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](https://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 Prime + Rx (HMO)

|  |   |
|--|---|
| Monthly Plan Premium   | \$0<br>You must continue to pay your Medicare Part B premium.             |
| Deductible   | \$0<br>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: \$5,900   |

| Benefits                                  |                               | In-network   |
|---|-------------------------------|--|
| Inpatient Hospital Coverage <sup>1</sup>  |                               | \$450 copayment each day for days 1-4 and \$0 copayment each day for day 5 and beyond  |
| Outpatient Hospital Coverage <sup>1</sup> |                               | \$450 copayment for outpatient surgery at a hospital facility  |
| Ambulatory Surgery Center <sup>1</sup>    |                               | \$400 copayment for outpatient surgery at an Ambulatory Surgery Center   |
| Doctor Visits                             | Primary Care Provider Visit   | \$0 copayment  |
|   | Specialist Visit <sup>2</sup> | \$40 copayment   |
| Preventive Care                           |                               | You pay nothing  |
| Emergency Care                            |                               | \$90 copayment<br>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<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care.    |

<sup>1</sup> Services may require prior authorization.

<sup>2</sup> Services may require a referral from your doctor.

# Providence Medicare Prime + Rx (HMO)

| Benefits   |   | In-network  |
|--|---|---|
| <b>Diagnostic Services/<br/>Labs/Imaging<sup>1</sup></b> | Diagnostic Radiology Services (e.g. MRI, ultrasounds, CT scans) | 20% of the total cost   |
|  | Therapeutic Radiology Services                                  | 20% of the total cost   |
|  | Outpatient X-rays   | \$15 copayment per day  |
|  | Diagnostic Tests and Procedures                                 | 20% of the total cost   |
|  | Lab Services  | \$0 copayment   |
| <b>Hearing Services</b>                                  | Medicare-Covered <sup>2</sup>                                   | \$40 copayment  |
|  | Routine Exam  | \$0 copayment   |
|  | Hearing Aids  | \$499 copayment per Advanced hearing aid or a \$799 copayment per Premium hearing aid                           |
| <b>Dental Services</b>                                   | Medicare-Covered <sup>2</sup>                                   | \$40 copayment  |
|  | Embedded Preventive   | \$15 copayment<br>Includes exams, cleanings, X-rays; limits apply   |
|  | Optional  | Covered for additional premium; see last page of this summary   |
| <b>Vision Services</b>                                   | Medicare-Covered Exams <sup>2</sup> /Screening                  | \$40 copayment per exam<br>\$0 copayment for glaucoma screening   |
|  | Routine Exam  | Allowance of up to \$75 per calendar year for a routine vision exam (including refraction)                      |
|  | Medicare-Covered Eyewear  | 20% 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 \$100 per calendar year for any combination of routine prescription eyewear                  |
| <b>Mental Health Services<sup>1</sup></b>                | Inpatient Visit   | \$320 copayment each day for days 1-5 and \$0 copayment each day for days 6-90                                  |
|  | Outpatient Individual and Group Therapy Visit                   | \$40 copayment  |

<sup>1</sup> Services may require prior authorization.

<sup>2</sup> Services may require a referral from your doctor.

## Providence Medicare Prime + Rx (HMO)

| Benefits  | In-network  |
|---|---|
| Skilled Nursing Facility (SNF) <sup>1</sup>   | \$0 copayment each day for days 1-20 and \$184 copayment each day for days 21-100                           |
| Physical Therapy <sup>1</sup>   | \$40 copayment  |
| Ambulance <sup>1</sup>  | \$250 copayment   |
| Transportation  | Not covered   |
| Medicare Part B Drugs <sup>1</sup>  | 20% of the total cost   |
| Alternative Care (combined benefit limit for chiropractic, acupuncture & naturopath services) | Chiropractic: \$20 copayment<br>Naturopath and Acupuncture Specialist: \$40 copayment<br>\$500 plan maximum |

<sup>1</sup> Services may require prior authorization.

<sup>2</sup> Services may require a referral from your doctor.

# Prescription Drug Benefits

## Providence Medicare Prime + Rx (HMO)

| Prescription Drug Deductible |                   |
|------------------------------|-------------------|
| Tier 1 (Preferred Generic)   | Deductible waived |
| Tier 2 (Generic)             |                   |
| Tier 3 (Preferred Brand)     | \$150             |
| Tier 4 (Non-Preferred Drug)  |                   |
| Tier 5 (Specialty)           |                   |

|                  |  |
|------------------|--|
| 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)                     | \$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     |

| Standard Retail Cost Sharing |                       |                 |                 |
|------------------------------|-----------------------|-----------------|-----------------|
| Tier 1 (Preferred Generic)   | \$16 copayment        | \$32 copayment  | \$48 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 Prime + Rx (HMO)

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.

|   |  |
|---|--|
| <p>Coverage Gap<br/>(Applies to all tiers)</p>          | <p>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.</p> <p>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.</p> |
| <p>Catastrophic Coverage<br/>(Applies to all tiers)</p> | <p>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.</p>   |

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 Prime + Rx (HMO)

## 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.

| <b>Option 1: Basic Wrap Dental</b>                                 |   |   |
|--|---|---|
| Benefits include: Preventive (See Page 4) and Comprehensive Dental |   |   |
| Monthly Premium  | Additional \$29.40 per month.<br>You must keep paying your Medicare Part B premium. |   |
| <b>Benefits</b>  | <b>In-network</b>   | <b>Out-of-network</b>                       |
| 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%<br>Fillings (silver, composite) |
| Major Restorative Care*  | You pay 50%   | You pay 60%                                 |

| <b>Option 2: Enhanced Wrap Dental</b>                        |   |   |
|--|---|---|
| Benefits include: Preventive Dental and Comprehensive Dental |   |   |
| Monthly Premium  | Additional \$42.20 per month.<br>You must keep paying your Medicare Part B premium. |   |
| <b>Benefits</b>  | <b>In-network</b>   | <b>Out-of-network</b>                       |
| 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%<br>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.