Providence
Medicare Advantage Plans

Medicare Advantage Plan Comparison

Providence Medicare Prime + Rx (HMO)
Providence Medicare Bridge + Rx (HMO-POS)
Providence Medicare Choice + Rx (HMO-POS)
Providence Medicare Extra + Rx (HMO)

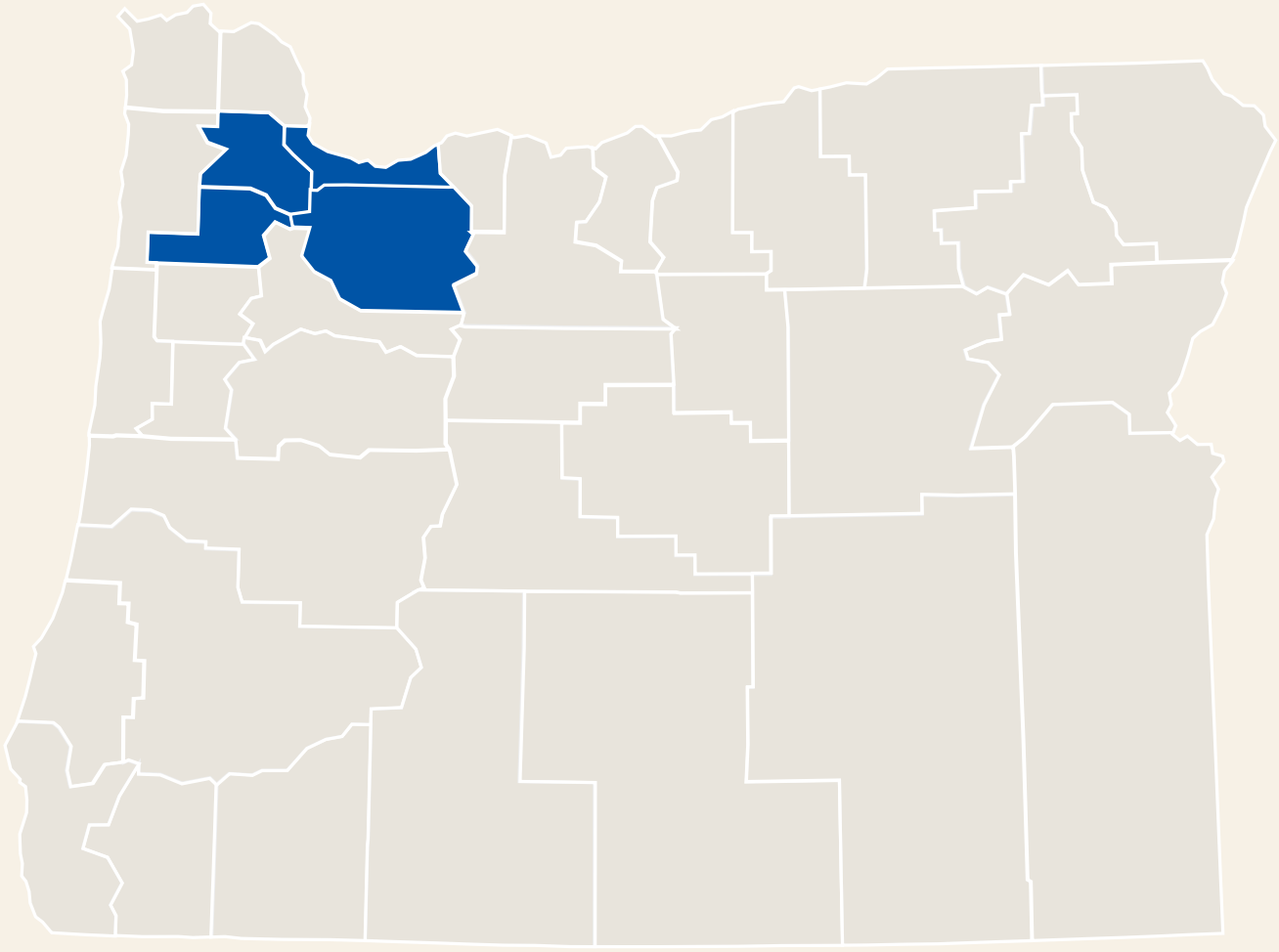
Service Area 1
Clackamas, Multnomah, Washington, Yamhill counties in Oregon

2023 Providence Medicare

Service Area Map

Clackamas, Multnomah, Washington and Yamhill counties

+ **Providence Medicare Prime + Rx (HMO)**
+ **Providence Medicare Bridge + Rx (HMO-POS)**
+ **Providence Medicare Choice + Rx (HMO-POS)**
+ **Providence Medicare Extra + Rx (HMO)**



Visit **ProvidenceTrueHealth.com/plan** for more information and to find other plans available in your area.

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Providence Medicare Advantage Plans – Part C

	Providence Medicare Prime + Rx (HMO)	Providence Medicare Bridge + Rx (HMO-POS)	
Monthly premium with prescription drug coverage	$0	$35	
	In-network	**In-network**	**Out-of-network**
Medical deductible	$0	$0	$0
Out-of-pocket maximum	$4,500	$4,900	$10,000 combined
Benefits	**You pay**	**You pay**	
Doctor office visit (PCP)	$0	$0	$25
Specialist visit	$40	$35 $50 no referral	$50
Preventive care	$0	$0	30%
Inpatient hospital	Days 1-4: $450/day Day 5 and beyond: $0/day	Days 1-6: $325/day Day 7 and beyond: $0/day	30%
Skilled nursing facility	Days 1-20: $0 Days 21-100: $184/day	Days 1-20: $0 Days 21-100: $160/day	30%
Outpatient surgery	$400 Ambulatory $450 Hospital	$250 Ambulatory $375 Hospital	30%
Diabetic supplies	$0 – 20%	$0 – 20%	30%
Lab	$0	$0	30%
X-ray	$15	$10	30%
Outpatient diagnostic tests & procedures	20%	20%	30%
Alternative care Chiropractic Acupuncture Naturopathy	($500 maximum) $20 $40 $40	($500 maximum) $20 $35 $35	No coverage
Therapy: PT, OT, ST	$40	$35	30%
Durable medical equipment	20%	20%	30%
Home health	$0	$0	30%
Telehealth**	$0 PCP $40 Specialist	$0 PCP $35 Specialist	$25 PCP $50 Specialist
	Worldwide coverage	**Worldwide coverage**	
Urgent care	$50	$50	
Emergency room*	$90	$90	
Ambulance (ground or air)	$250 one way	$250 one way	

*Copay waived if you are admitted to the hospital within 24 hours for the same condition.

**You will pay the cost sharing that applies to the services.

Other charges and limits may apply. Please refer to Evidence of Coverage for more information. Out-of-network/non-contracted providers are under no obligation to treat Plan 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.

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

Providence Medicare Advantage Plans – Part C

	Providence Medicare Choice + Rx (HMO-POS)		Providence Medicare Extra + Rx (HMO)
Monthly premium with prescription drug coverage	$89		$173
	In-network	**Out-of-network**	**In-network**
Medical deductible	$0	$0	$0
Out-of-pocket maximum	$4,500	$10,000 combined	$3,400
Benefits	**You pay**		**You pay**
Doctor office visit (PCP)	$15	$25	$0
Specialist visit	$30 $50 no referral	$50	$20
Preventive care	$0	30%	$0
Inpatient hospital	Days 1-6: $300/day Day 7 and beyond: $0/day	30%	Days 1-5: $250/day Day 6 and beyond: $0/day
Skilled nursing facility	Days 1-20: $0 Days 21-100: $160/day	30%	Days 1-20: $0 Days 21-100: $150/day
Outpatient surgery	$250 Ambulatory $250 Hospital	30% 30%	$100 Ambulatory $150 Hospital
Diabetic supplies	$0 – 20%	30%	$0 – 20%
Lab	$0	30%	$0
X-ray	$15	30%	$0
Outpatient diagnostic tests & procedures	20%	30%	20%
Alternative care Chiropractic Acupuncture Naturopathy	No coverage	No coverage	No coverage
Therapy: PT, OT, ST	$30	30%	$20
Durable medical equipment	20%	30%	20%
Home health	$0	30%	$0
Telehealth**	$15 PCP $30 Specialist	$25 PCP $50 Specialist	$0 PCP $20 Specialist
	Worldwide coverage		**Worldwide coverage**
Urgent care	$50		$50
Emergency room*	$90		$70
Ambulance (ground or air)	$250 one way		$250 one way

*Copay waived if you are admitted to the hospital within 24 hours for the same condition.

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Pharmacy coverage – Part D

	Providence Medicare Prime + Rx (HMO)		Providence Medicare Bridge + Rx (HMO-POS)		Providence Medicare Choice + Rx (HMO-POS)		Providence Medicare Extra + Rx (HMO)	
Annual deductible††	$150		$0		$240		$0	
	30-day	**90-day**	**30-day**	**90-day**	**30-day**	**90-day**	**30-day**	**90-day**
Preferred generic	$0	$0	$0	$0	$4	$8	$0	$0
Generic	$10	$10	$10	$10	$13	$31.20	$10	$10
Preferred brand	$47	$141	$47	$141	$47	$112.80	$45	$90
Non-preferred drugs	$100	$300	$100	$300	$100	$240	$90	$180
Specialty drugs	30%	Not available	33%	Not available	29%	Not available	33%	Not available
Vaccines	$0	Not available	$0	Not available	$0	Not available	$0	Not available
Select Insulin	$35 max. on Select Insulin	$35 max. on Select Insulin	$35 max. on Select Insulin	$35 max. on Select Insulin	$35 max. on Select Insulin	$35 max. on Select Insulin	$35 max. on Select Insulin	$35 max. on Select Insulin

††Deductible is waived on all generic tiers (Tier 1 and Tier 2) as well as Tier 6 vaccines.
For Choice + Rx (HMO-POS) and Extra + Rx (HMO), you continue to pay your Tier 1 cost-shares in Phase 2 Coverage Gap. For all plans, you continue to pay your Tier 6 $0 cost-share in Phase 2 Coverage Gap. All other cost-shares will be 25%.
Copays listed are for Preferred Network pharmacies only; other pharmacy copays may cost more.
The Formulary and pharmacy network may change at any time. You will receive notice when necessary.

Initial coverage	Coverage gap	Catastrophic coverage
Phase 1	**Phase 2**	**Phase 3**
When the total paid by you and the plan reaches $4,660, Phase 2 begins.	You pay only 25% of the costs of brand-name drugs and 25% of the costs of generic drugs. You stay in this stage until your out-of-pocket costs reach $7,400. After that, Phase 3 begins.	You pay whichever of these is larger: either 5% coinsurance for the costs of the drug or $4.15 copay for generic drugs; $10.35 copay for brand-name or specialty drugs.

Dental, hearing, vision and more

	Providence Medicare Prime + Rx (HMO)	Providence Medicare Bridge + Rx (HMO-POS)	Providence Medicare Choice + Rx (HMO-POS)	Providence Medicare Extra + Rx (HMO)
Preventive dental	$0	$0	$0	$0
Routine eye exams	Up to $75 allowance per year	Up to $75 allowance per year	Up to $75 allowance per year	Up to $75 allowance per year
Prescription eyeglasses or contact lenses*	$100 allowance per year	$150 allowance per year	$220 allowance per year	$215 allowance per year
Routine hearing exam (one per year)**	$0 copay	$0 copay	$0 copay	$0 copay
Hearing aids (two per year)	$699 or $999 per hearing aid	$699 or $999 per hearing aid	$699 or $999 per hearing aid	$699 or $999 per hearing aid
Over-the-counter allowance	No coverage	$70 allowance per quarter	No coverage	$195 allowance per quarter
Post discharge meals	$0 – two meals per day for 14 days	$0 – two meals per day for 14 days	$0 – two meals per day for 14 days	$0 – two meals per day for 14 days
Medical alert system	$0	$0	$0	$0
Fitness center membership***	$0	$0	$0	$0
Wigs for hair loss related to chemotherapy	20% for synthetic 1 wig per year	20% for synthetic 1 wig per year	20% for synthetic 1 wig per year	20% for synthetic 1 wig per year

*You are responsible for any cost above the allowance for routine eye exams, prescription eyeglasses or contact lenses.

**You must see a TruHearing provider. Other charges and limits may apply.

***Premium fitness network is available for an additional cost per month.

2023 Optional Supplemental Dental Benefits

Plans that include Basic or Enhanced option:

Providence Medicare Prime + Rx (HMO) , Providence Medicare Bridge + Rx (HMO-POS), Providence Medicare Choice + Rx (HMO-POS), Providence Medicare Extra + Rx (HMO)

Benefits include: Preventive (See EOC Chapter 4) and Comprehensive Dental	Basic		Enhanced	
Monthly premium	$32.50		$45.10	
Plan benefits	**In-network member responsibility**	**Out-of-network member responsibility***	**In-network member responsibility**	**Out-of-network member responsibility***
Office visit copay	No copay		No copay	
Annual deductible[1]	$50	$150	$50	$150
Annual maximum	$1,000		$1,500	
Waiting periods	None		None	
Provider network	Any licensed dentist[2]		Any licensed dentist[2]	
Out-of-network reimbursement	Maximum allowable charge		Maximum allowable charge	
Diagnostic and Preventive Services				
Oral examinations[3]	$0	20%	$0	20%
Bitewing X-rays[4]	$0	20%	$0	20%
Panoramic and other diagnostic X-rays[5]	$0	20%	$0	20%
Comprehensive Dental Services				
Basic fillings and simple extractions	50%	60%	50%	60%
Dentures	50% $250 Lifetime Denture Benefit	60%	50% $250 Lifetime Denture Benefit	60%
Crowns and bridges	50% $100 limit per tooth per year	60%	50% $500 limit per year	60%
Oral surgery	Not covered		50%	60%
Endodontics (root canals)	Not covered		50%	60%
Periodontics (deep cleaning)	Not covered		50%	60%

***Important notes:** Members may use any licensed dentist. Non-Medicare dentists may charge more than the amount allowed by Providence Medicare Advantage Plans. If this happens, they may send members a "balance bill" for the difference between their charged amount and the amount paid by the plan.

[1] Deductibles are waived for diagnostic and preventive services

[2] Seeking care from a participating in-network dentist will reduce out-of-pocket costs and prevent a balance bill

[3] Oral Examination – limited to two per calendar year (you may receive two periodic oral evaluations or one periodic oral evaluation and one problem-focused oral evaluation per calendar year)

[4] Bitewing or Periapical X-rays – limited to two per calendar year

[5] Full mouth and Panoramic X-ray – limited to once every 60 months

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We all deserve True Health

Call us for information, to enroll, or to make a personal appointment at

1-833-949-0263 (TTY: 711)

8 a.m. to 8 p.m. (Pacific Time), seven days a week (Oct. 1 – Dec. 7)
Monday – Friday (Dec. 8 – Sept. 30)

Enroll online at

ProvidenceTrueHealth.com/guides

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