



2022 Enrollment Guide

Service Area 4

Crook, Deschutes, Hood River, Jefferson and Wheeler counties



Enrolling in Medicare

What to

Expect





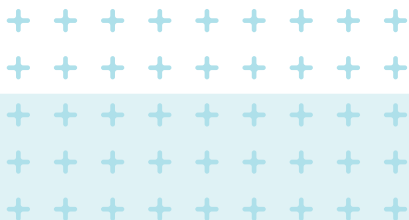
The Providence Way

For more than 160 years, Providence has helped to set the health and well-being standard for the region. As our organization has grown, our efforts have aligned under a single mission: to bring True Health to each and every member of the community.

True Health is a commitment to caring for the whole self: mind, body, and spirit. The concept is rooted in the idea that the healthier each of us are, the healthier we all are. We don't deliver True Health to members as a single tool or finished product, because it's more than that. It's an idea, a set of goals that evolve as we learn — a legacy we build together.

We all deserve True Health.

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Medicare 101

Getting Started





Enrolling in Medicare can be complex,
but we're here to keep it from getting confusing.

This guide will explain what your options are and help
you take the next step with confidence.



Before you can enroll in a Medicare Advantage plan,
you'll need to be fully enrolled in Original Medicare.





Original Medicare

Original Medicare is basic health coverage managed by the federal government and is a combination of two programs: Part A and Part B.

Part A **Hospital Insurance**

- + Inpatient hospital services
- + Skilled nursing facility care
- + Hospice care
- + Home healthcare

Part A usually comes at no cost if you or your spouse paid Medicare taxes for at least 10 years.

Part B **Medical Insurance**

- + Outpatient services
- + Doctor visits
- + Outpatient lab tests and x-rays

Part B is paid for based on income and is usually deducted from your Social Security or Railroad Pension.



What's Not Covered?

Original Medicare covers a lot, but not everything. About 20% of typical out-of-pocket medical costs are left up to you as the individual to cover.

Original Medicare *doesn't cover services like:*

- + Most prescription drugs
- + Dental
- + Vision
- + Hearing aids
- + Alternative Care

With Providence Medicare Advantage Plans, you will get the additional coverage you need along with financial peace of mind.



To speak with an expert, call **1-833-949-0263 (TTY: 711)** or explore and enroll online at **MyTruePlans.com**





Extending Coverage. Controlling Costs.

Additional Medicare Coverage

Many Original Medicare members choose additional Medicare coverage or a Medicare Supplement plan to help them with the costs and services they need.





Additional coverage comes in three forms:

- + **Medicare Advantage** (Part C)
- + **Prescription Drug Coverage** (Part D)
- + **Medicare Supplement** (Medigap)

If you feel that you would benefit from additional Medicare coverage, rest assured that Providence can help you find a plan to meet your needs — whatever they may be.

To speak with an expert, call **1-833-949-0263 (TTY: 711)**
or explore and enroll online at **MyTruePlans.com**





Part C

Medicare Advantage

Providence Medicare Advantage Plans include Parts A, B, and many include Part D, while offering extra benefits and services not covered by Original Medicare, such as:

- + Eyeglasses
- + Hearing coverage
- + Wellness programs

While Original Medicare has no out-of-pocket maximum, Providence Medicare Advantage Plans do, giving you more financial freedom and dependability.

Because it is additional coverage, if you enroll in a Part C plan, you'll also continue to pay your Part B premium.



To speak with an expert, call **1-833-949-0263 (TTY: 711)**
or explore and enroll online at **MyTruePlans.com**


Part D

Prescription Drug Coverage

Original Medicare doesn't cover prescriptions, so private insurers offer prescription drug coverage plans to help with the out-of-pocket costs of:

- + Brand-name drugs
- + Generic drugs

If you don't enroll in Part D coverage when you enroll in Original Medicare, you end up paying a late enrollment penalty. Luckily, most Providence Medicare Advantage Plans include Part D coverage, and there are many standalone Part D plans offered on the market. So you have options.



Medigap

Medicare Supplement Plans*

Medicare Supplement plans are designed to help with the out-of-pocket costs associated with Original Medicare.

Medicare Supplement lets you pay a set cost per month, rather than paying for services as you go. With this coverage, you can visit any Medicare-accepting provider or specialist nationwide and without referral.

*Medicare Supplement does not cover prescription drugs, so you will need to pair it with a Medicare Part D plan. Additionally, Medicare Supplement cannot be combined with a Medicare Advantage plan (Part C).

Original Medicare

Who's Eligible?



To be eligible for Medicare Parts A and B, you must be a U.S. citizen or a permanent legal resident for at least five years and be age 65 or older.



If you're under age 65, you're eligible if you:

- + Are permanently disabled and have received disability benefits for at least 24 months
- + Have end-stage renal disease (ESRD)
- + Have Lou Gehrig's disease (ALS)



Enrolling in Medicare at age 65

If you are collecting Social Security or a Railroad Retirement Pension, you will be automatically enrolled into Medicare Parts A and B.



If you are not collecting Social Security or a Railroad Retirement Pension, you will need to apply for Medicare Parts A and B.

- + Apply on the Social Security website: ssa.gov/benefits/medicare
- + Visit your local Social Security office
- + Call Social Security at **1-800-772-1213** or the Railroad Retirement Board (if you worked there) at **1-877-772-5772**

One plan. Many advantages.

Providence Medicare Advantage Plans

In addition to having a variety of plan options to meet your healthcare needs and match your lifestyle, our plans come with a host of cost-saving health and fitness perks to give you more, save you money, and help you on your journey to True Health.

Medicare Star Ratings

Every year, Medicare evaluates plans based on a 5-star rating system. These star ratings, given by the Centers for Medicare and Medicaid Services (CMS), help you evaluate how well our plan is doing, so you can compare it to the ratings of other plans on the market.

We always aim as high as possible, consistently reaching 4.5 – 5 out of 5 stars.

See this year's star rating for Providence Medicare Advantage Plans in the folder at the back of this enrollment kit.





Embedded Dental

Preventive dental coverage is included on all plans at no additional cost.



Alternative Care

Get coverage for acupuncture, naturopathy, and chiropractic treatments on some plans.



Medical Alert System

Sign up for 24/7 access to emergency help at the press of a button, including professional intervention and personal response at no cost.



\$0 Rx Copays

Some plans offer \$0 copays on Tier 1 generic drugs as well as reduced costs for 90-day supplies at preferred and mail-order pharmacies.



Vision Coverage

On any plan, you'll get allowances for routine eye exams and for vision hardware like eyeglasses and contact lenses.



Behavioral Health

We are here, whether you need services in a primary care clinic, a psychiatry clinic, an outpatient, or inpatient setting.



Fitness Membership

A no-cost Standard Fitness Network membership through Silver&Fit™ lets you work out in the gym. You can also work out at home using a Home Fitness Kit.



Hearing Coverage

Manage your hearing with one \$0 routine exam per year and up to two hearing aids per year (no coverage on Dual Plus).



Care Options

At no cost, you get same-day visits at ExpressCare Clinics, online visits using ExpressCare Virtual, and 24/7 access to a registered nurse through ProvRN.



Frequently Asked Questions



Are my medications covered?

Lists of covered prescriptions can be found in prescription drug formularies, which live online at: [ProvidenceHealthAssurance.com/formulary](https://www.providencehealthassurance.com/formulary).

If you would like a printed copy of the formulary, you can request that one be mailed to you by visiting the link above or calling the number below.

Formularies are available for Part D prescription drug plans only.



Where do I find a provider?

Find a provider or pharmacy by using our online search tool at:

[ProvidenceHealthAssurance.com/findaprovider](https://www.providencehealthassurance.com/findaprovider).

If you'd like a printed copy of the provider and/or pharmacy directory, you can request that it be mailed to you by calling the number below or visiting the link above.



Who can I call for help?

We are always here to help. Call us at **1-833-949-0263 (TTY: 711)**

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




Providence Medicare Advantage Plans

How to Enroll

Here are several ways to enroll in Providence Medicare Advantage Plans — choose whichever one is most convenient for you. We can't wait to welcome you into the Providence community.

- + Enroll online with our secure enrollment form at:
ProvidenceHealthAssurance.com/enroll.
- + Enroll by phone by contacting the Providence Medicare Advantage Plans Sales Team at **1-833-949-0263 (TTY: 711)**. Service is available 8 a.m. to 8 p.m. (Pacific Time), seven days a week (Oct. 1 – Dec. 7) and Monday – Friday (Dec. 8 – Sept. 30).
- + Enroll one-on-one by scheduling a meeting with a local agent.
- + Enroll via mail or fax by completing an enrollment form and sending to:
Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548
Fax: 503-574-8653



After enrolling, you will receive a notice in the mail acknowledging receipt of your enrollment request.

- + Medicare's annual enrollment period is October 15 – December 7.
- + Individuals must have both Part A and Part B to enroll.

What to Expect

After Enrollment



ID card and welcome guide

Your member ID card and welcome guide will arrive 7-10 business days after your enrollment is confirmed. The welcome guide gives you valuable information about how to use your plan, how and where to get care, benefit features, and other member resources.



Confirmation and Rx subsidy

After completing and submitting your enrollment form, you will receive a Confirmation of Enrollment letter that includes an effective date of coverage. Members on a plan with prescription drug coverage who qualify for extra help will receive a letter that informs them of their adjusted premium and details their prescription drug cost-sharing benefit.



Within your first 90 days

Within 90 days of enrollment, your Care Management team will send you a Health Risk Assessment by mail. This will help us to better understand your healthcare goals and provide seamless access to quality care.

If you would like to connect with us sooner, need assistance with navigating your healthcare, or would like to talk with an RN directly, please call

503-574-7247 (TTY: 711), 8 a.m. to 5 p.m. (Pacific Time), Monday – Friday.



After we confirm your enrollment with Medicare, you may cancel any Medigap or supplemental coverage that you have.

If you were on a Medicare Advantage plan or Medicare Cost plan when you enrolled:

- + Your enrollment in that plan will automatically be cancelled.
- + You do not have to notify the insurance carrier that you want to cancel. Medicare will take care of that when they transfer you to Providence Medicare Advantage Plans.

If you are a first-time member of a Medicare health plan, Medicare Advantage or Medicare Cost plan:

- + You may have a trial period during which you have certain rights to leave Providence Medicare Advantage Plans and purchase a Medigap policy.

Once enrolled in our plan:

- + You are generally limited to making changes between October 15 – December 7.
- + In special circumstances, Medicare may give you an opportunity to switch to another plan.



Please contact **1-800-MEDICARE (1-800-633-4227)** or visit **www.Medicare.gov** for further information about Medicare benefits and services. TTY users can call **1-877-486-2048** 24 hours a day, seven days a week (Pacific Time).





Notes

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 Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-603-2340 (TTY: 711).

Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-603-2340 (TTY: 711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-603-2340 (TTY: 711).

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2022

Medicare Advantage Plan Comparison

Providence Medicare Compass + Rx (HMO-POS)

Providence Medicare Latitude + Rx (HMO-POS)

Service Area 4

Crook, Deschutes, Hood River, Jefferson
and Wheeler counties

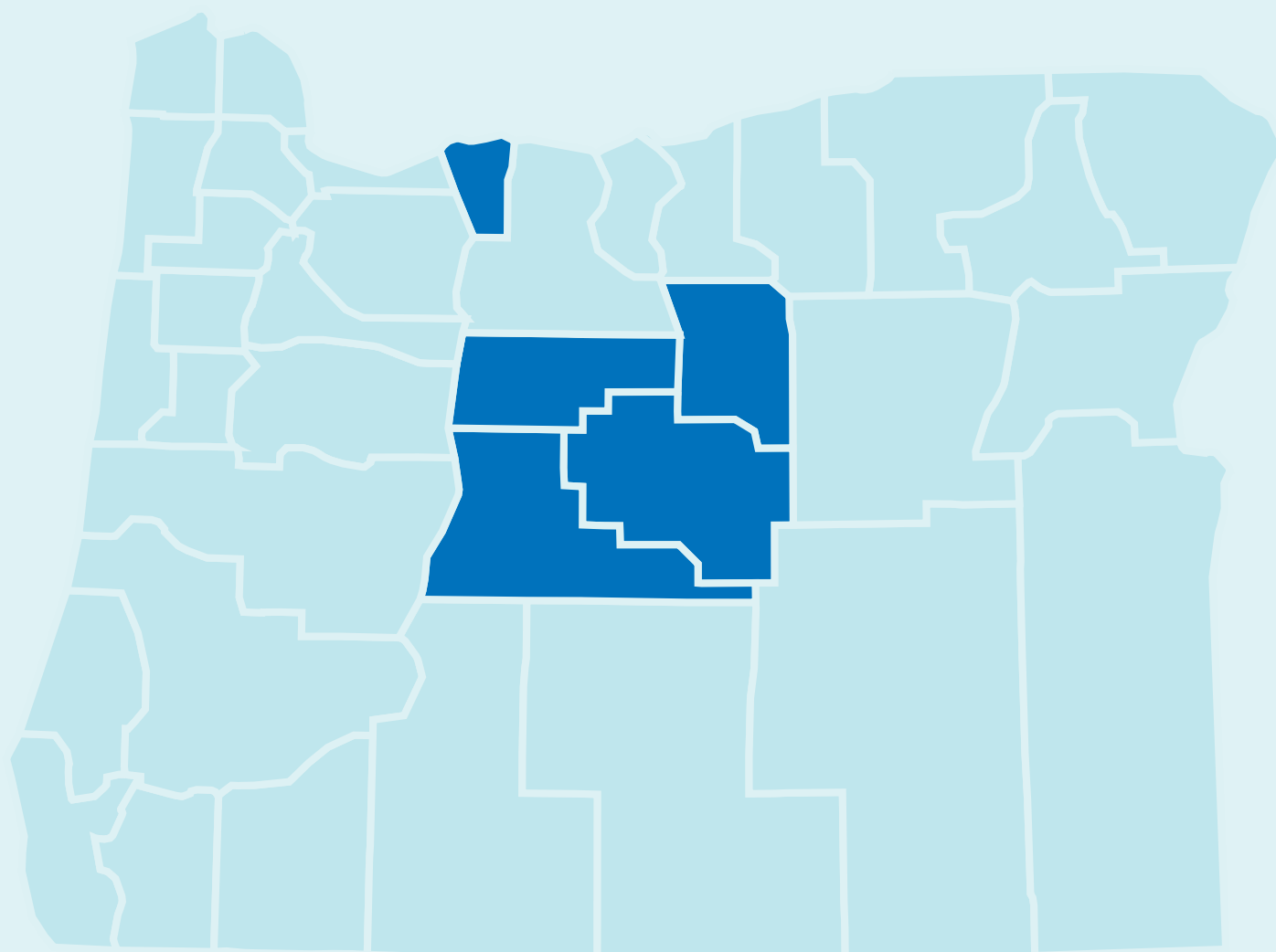


2022 Providence Medicare Service Area Map

Crook, Deschutes, Hood River, Jefferson and
Wheeler counties

+ Providence Medicare Compass + Rx (HMO-POS)

+ Providence Medicare Latitude + Rx (HMO-POS)



Visit [ProvidenceHealthAssurance.com](https://www.ProvidenceHealthAssurance.com) for more information.

+ + +
+ + +
One plan. Many advantages.

Providence Medicare Advantage Plans

Providence Medicare Advantage Plans come with a host of cost-saving health and wellness perks to give you more, save you money, and help you on your journey to True Health.



Fitness Membership

A no-cost Standard Fitness Network membership through Silver&Fit™ lets you work out in the gym. You can also work out at home using a Home Fitness Kit.



Dental Coverage

Now with preventive dental benefits included and additional optional benefits as needed to supplement your coverage.



\$0 Rx Deductible

Some plans offer \$0 deductible as well as reduced costs for 90-day supplies at preferred and mail-order pharmacies.



Insulin Benefit

Most plans now offer predictable and affordable access to insulin. You will pay no more than a \$35 copay on Select Insulin.



OTC Allowance

Most plans now offer a quarterly over-the-counter allowance to purchase health and wellness items.



Vision Coverage

On any plan, you'll get allowances for routine eye exams and for vision hardware like eyeglasses and contact lenses.

Have questions? We are always here to help.

Call us at **1-833-949-0263 (TTY: 711)** 8 a.m. to 8 p.m. (Pacific Time), seven days a week (Oct. 1 – Dec. 7) and Monday – Friday (Dec. 8 – Sept. 30)

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 Advantage Plans – Part C

	Providence Medicare Compass + Rx (HMO-POS)		Providence Medicare Latitude + Rx (HMO-POS)	
Monthly premium with prescription drug coverage	\$55		\$195	
	In-network	Out-of-network	In-network	Out-of-network
Medical deductible	\$0	\$0	\$0	\$0
Out-of-pocket maximum	\$5,900	\$10,000 combined	\$5,500	\$5,500 combined
Benefits	You pay		You pay	
Doctor office visit (PCP)	\$10	\$25	\$10	\$25
Specialist visit	\$40 \$50 no referral	\$50	\$40 \$50 no referral	\$50
Preventive care	\$0	30%	\$0	30%
Inpatient hospital	Days 1-5: \$360/day Day 6 and beyond: \$0/day Days 1-20: \$0	30%	Days 1-5: \$275/day Day 6 and beyond: \$0/day Days 1-20: \$0	30%
Skilled nursing facility	Days 21-100: \$160/day	30%	Days 21-100: \$150/day	30%
Outpatient surgery	\$350 Ambulatory \$350 Hospital	30%	\$450 Ambulatory \$450 Hospital	30%
Diabetic supplies	\$0 – 20%	30%	\$0 – 20%	30%
Lab	\$0	30%	\$0	30%
X-ray	\$0	30%	\$0	30%
Outpatient diagnostic tests & procedures	20%	30%	20%	30%
Therapy: PT, OT, ST	\$40	30%	\$40	30%
Durable medical equipment	20%	30%	20%	30%
Home health	\$0	30%	\$0	30%
Telehealth	\$0 – \$40	\$0 – \$50	\$0 – \$40	\$0 – \$50
	Worldwide coverage		Worldwide coverage	
Urgent care	\$50		\$50	
Emergency room*	\$90		\$90	
Ambulance (ground)	\$250 one way		\$250 one way	

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

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 Providence Medicare Advantage Plans 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 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.

Pharmacy coverage – Part D

	Providence Medicare Compass + Rx (HMO-POS)		Providence Medicare Latitude + Rx (HMO-POS)	
Annual deductible ^{††}	\$0		\$120	
	30-day	90-day	30-day	90-day
Preferred generic	\$3	\$3	\$0	\$0
Generic	\$12	\$12	\$10	\$10
Preferred brand	\$47	\$94	\$45	\$90
Non-preferred drugs	\$100	\$200	\$90	\$180
Specialty drugs	33%	Not available	30%	Not available
Vaccines	\$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

^{††}Deductible is waived on all generic tiers (Tier 1 and Tier 2) as well as Tier 6 vaccines.

Copays listed are for Preferred Network pharmacies only; other pharmacy copays may cost more.

Initial coverage	Coverage gap	Catastrophic coverage
Phase 1	Phase 2	Phase 3
When the total paid by you and the plan reaches \$4,430, 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 \$7,050. After that, Phase 3 begins.	You pay whichever of these is larger: either 5% coinsurance for the costs of the drug or \$3.95 copay for generic drugs; \$9.85 copay for brand-name or specialty drugs.

Dental, hearing, vision and more

	Providence Medicare Compass + Rx (HMO-POS)	Providence Medicare Latitude + Rx (HMO-POS)
Preventive dental	\$15	\$15
Routine eye exams	Up to \$75 allowance per year	Up to \$75 allowance per year
Prescription eyeglasses or contact lenses*	\$210 allowance per year	\$250 allowance per year
Routine hearing exam (one per year)**	\$0	\$0
Hearing aids (two per year)	\$699 or \$999 per hearing aid	\$699 or \$999 per hearing aid
Over-the-counter allowance	\$50 per quarter	\$175 per quarter
Post discharge meals	\$0 – two meals per day for 14 days	\$0 – two meals per day for 14 days
Medical alert system	\$0	\$0
Fitness center membership***	\$0	\$0

*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.

2022 Optional Supplemental Dental Benefits

Plans that include Basic or Enhanced option:

Providence Medicare Compass + Rx (HMO-POS), Latitude + Rx (HMO-POS)

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 ⁶	50%	60%	50%	60%
Crowns and bridges ⁷	50%	60%	50%	60%
Oral surgery	Not covered		50%	60%
Endodontics (root canals)	Not covered		50%	60%
Periodontics (deep cleaning)	Not covered		50%	60%

***Important notes:** Members must use a Medicare contracted provider. Out-of-network 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 can have two basic cleanings, or one cleaning and one problem-focused visit per calendar year)

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

⁵ Panoramic X-ray – limited to once every 60 months

⁶ \$250 lifetime denture benefit

⁷ Crown/bridge max. (Basic) – \$100 per tooth per year; crown/bridge max. (Enhanced) – \$500 per year

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.

Out-of-network/non-contracted providers are under no obligation to treat Providence Medicare Advantage Plans 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.

Medicare can be complex.

We're here to keep it from getting confusing.

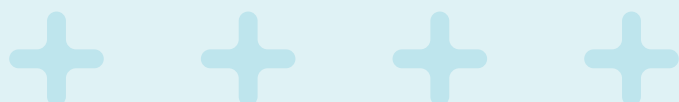
Whatever your healthcare needs are, Providence offers a Medicare Advantage plan that has you covered. Explore the plan options in your area, and don't hesitate to call us if you have questions. **Medicare experts are ready and waiting to help you.**

Have questions?

We are always here to help.

Call us at **1-833-949-0263 (TTY: 711)**

8 a.m. to 8 p.m. (Pacific Time), 7 days a week.



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




ProvidenceHealthAssurance.com

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.






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, 2022.
-  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.

2022 MEDICARE ADVANTAGE ENROLLMENT REQUEST FORM

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan

To join a plan, you must:

- + Be a United States citizen or be lawfully present in the U.S.
- + Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- + Medicare Part A (Hospital Insurance)
- + Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- + Between October 15–December 7 each year (for coverage starting January 1)
- + Within 3 months of first getting Medicare
- + In certain situations where you're allowed to join or switch plans

Visit **Medicare.gov** to learn more about when you can sign up for a plan.

What do I need to complete this form?

- + Your Medicare Number (the number on your red, white, and blue Medicare card)
- + Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- + If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- + Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

What happens next?

Submit your completed and signed form using one of the three options below:

Providence Medicare Advantage Plans
P.O. Box 5548
Portland, OR 97228-5548

Scan and fax pages to:
503-574-8653

Scan and email pages to:
provMedicare@providence.org

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Providence Medicare Advantage Plans at **503-574-6508** or **1-855-234-2495**. TTY users can call **711**.

Or, call Medicare at **1-800-MEDICARE** (**1-800-633-4227**). TTY users can call **1-877-486-2048**.

En español: Llame a Providence Medicare Advantage Plans al **503-574-6508** or **1-855-234-2495**/TTY: **711** o a Medicare gratis al **1-800-633-4227** y oprima el 2 para asistencia en español y un representante estará disponible para asistirle.

Section 1 – All fields on this page are required (unless marked optional)

Select the plan you want to join:

- ☐ Providence Medicare Compass + Rx (HMO-POS) - \$55 per month
 - ☐ Providence Medicare Latitude + Rx (HMO-POS) - \$195 per month

To enroll in an Optional Supplemental Dental Plan*, please select the plan you want to join:

- ☐ **Basic:** \$32.50 per month.

*I understand enrollment in the plan listed above is optional. I also understand that I must maintain my coverage in Providence Medicare Advantage Plans in order to be enrolled in the optional supplemental dental plan selected. Additionally, I understand that I must pay the optional supplemental dental plan premium in order to maintain my coverage. I will read the optional benefit plan information when I receive it and learn my responsibilities as a member and what services are covered by the plan.

FIRST name	LAST name	Middle Initial (Optional)
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Birth date (MM/DD/YYYY) SEX: ☐ Male ☐ Female Phone number

Permanent Residence street address (Don't enter a PO Box)

City	County (Optional)	State	ZIP code
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Mailing address, if different from your permanent address (PO Box allowed):

Street Address

City _____ State _____ ZIP code _____

Your Medicare information:

_____ - _____ - _____ _____ / _____ / _____ _____ / _____ / _____
 Medicare Number Hospital (Part A) Medical (Part B)
 Effective Date (Optional) Effective Date (Optional)

Answer these important questions:

Will you have other coverage in addition to Providence Medicare Advantage Plans? ☐ Yes ☐ No

Some individuals may have other coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

If “yes,” please list your other coverage and your identification (ID) number for this coverage.

Name of other coverage

ID number for this coverage

Group number for this coverage

Check all that apply: ☐ Medical ☐ Vision ☐ Dental ☐ Prescription

IMPORTANT: Read and sign below:

- + I must keep both Hospital (Part A) and Medical (Part B) to stay in Providence Medicare Advantage Plans.
- + By joining this Medicare Advantage Plan I acknowledge that Providence Medicare Advantage Plans will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- + Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- + The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- + I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- + I understand that when my Providence Medicare Advantage Plans coverage begins, I must get all of my medical and prescription drug benefits from Providence Medicare Advantage Plans. Benefits and services provided by Providence Medicare Advantage Plans and contained in my Providence Medicare Advantage Plans "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Providence Medicare Advantage Plans will pay for benefits or services that are not covered.
- + I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment, and
 - 2) Documentation of this authority is available upon request by Medicare.

Signature

____/____/____
Today's date

If you are the authorized representative, sign above and fill out these fields:

Name Address

Phone number Relationship to enrollee



AGENT USE ONLY

AGENT NAME

____/____/____
DATE

NPN #

____/____/____
REQUESTED DATE OF
COVERAGE

Section 2 – All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

List your Primary Care Provider (PCP), clinic, or health center:

If you do not provide a PCP, one will be assigned.

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Providence Medicare Advantage Plans at 1-800-603-2340 or 503-574-8000 if you need information in an accessible format other than what's listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. (Pacific Time). TTY users can call 711.

Do you work?

☐ Yes ☐ No

Does your spouse work?

☐ Yes ☐ No

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Providence Medicare Advantage Plans the Part D-IRMAA.

Please select a premium payment option:

- ☐ Get a monthly bill – Once you receive your first bill, you can choose a different payment option:
- + You can pay by credit/debit card or checking/savings account: One-time or recurring payments can be made via your myProvidence account at myProvidence.com or through the Providence website at providence.org/premiumpay.
 - + You can pay by phone: Self Service is available 24 hours a day, 7 days a week, at 1-888-821-2097, TTY: 711.
- ☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. You may receive an invoice for the first few months before the withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you.

By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- | | |
|---|---|
| <input type="checkbox"/> I am new to Medicare. | <input type="checkbox"/> I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date): ____/____/____ |
| <input type="checkbox"/> I am leaving employer or union coverage on (insert date): ____/____/____ | <input type="checkbox"/> I belong to a pharmacy assistance program provided by my state. |
| <input type="checkbox"/> I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date): ____/____/____ | <input type="checkbox"/> I recently left a PACE program on (insert date): ____/____/____ |
| <input type="checkbox"/> I am enrolling during the Annual Enrollment Period (October 15-December 7) or Special Enrollment Period. | <input type="checkbox"/> I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change. |
| <input type="checkbox"/> I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP) (January 1-March 31). | <input type="checkbox"/> I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into the facility on (insert date): ____/____/____
I moved/will move out of the facility on (insert date): ____/____/____ |
| <input type="checkbox"/> I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date): ____/____/____ | <input type="checkbox"/> I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date): ____/____/____ |
| <input type="checkbox"/> I recently was released from incarceration. I was released on (insert date): ____/____/____ | <input type="checkbox"/> My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan (insert date): ____/____/____ |
| <input type="checkbox"/> I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date): ____/____/____ | |
| <input type="checkbox"/> I recently obtained lawful presence status in the United States. I got this status on (insert date): ____/____/____ | |

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date): ____/____/____

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date): ____/____/____

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, State or local government entity.)

One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

Name of disaster impacted by:

Eligibility Period that was missed due to the disaster: (for example, the initial enrollment period, annual enrollment period, open enrollment period, or a special enrollment period).

☐ I was impacted by a significant network change with my current plan and was notified on (insert date): ____/____/____

If none of these statements applies to you or you're not sure, please contact Providence Medicare Advantage Plans at 1-800-603-2340 or 503-574-8000 (TTY users should call 711) to see if you are eligible to enroll. We are open seven days a week, 8 a.m. to 8 p.m. (Pacific Time).

Race/Ethnicity Questionnaire

The following questions will help us to better serve all communities. These questions are optional.

Which of the following describes your racial or ethnic identity?

Please check all that apply.

Hispanic or Latino/a/x

- ☐ Hispanic or Latino/a/x Central American
- ☐ Hispanic or Latino/a/x Mexican
- ☐ Hispanic or Latino/a/x South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian or Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other

- ☐ Other
- ☐ Don't know
- ☐ Don't want to answer

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)
- ☐ Slavic

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ **Yes** (please specify): _____
- ☐ **No:** I do not have just one primary racial or ethnic identity.
- ☐ **No:** I identify as Biracial or Multiracial.
- ☐ **N/A:** I only checked one category above.
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

What is your preferred spoken language?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other

2022 Summary of Benefits

Providence Medicare Compass + Rx (HMO-POS)

January 1, 2022 – December 31, 2022

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

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 Compass + Rx (HMO-POS)

Monthly Plan Premium	\$55 In addition, you must continue to pay your Medicare Part B premium.	
Annual Medical 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: \$5,900	Out-of-network: \$10,000 combined

Benefits		In-network	Out-of-network
Inpatient Hospital Coverage ¹		\$360 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		\$350 copayment for outpatient surgery at a hospital facility	30% of the total cost
Ambulatory Surgery Center ¹		\$350 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 Advantage Plans 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 Compass + Rx (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 total cost	30% of the total cost
	Therapeutic Radiology Services	20% of the total cost	30% of the total cost
	Outpatient X-rays	\$0 copayment	30% of the total cost
	Diagnostic Tests and Procedures ¹	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
	Embedded Preventive	\$15 copayment Includes exams, cleanings, X-rays; limits apply	Not covered
	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 \$210 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 Compass + Rx (HMO-POS)

Benefits		In-network	Out-of-network
Mental Health Services¹	Inpatient Visit	\$280 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 \$160 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
Meal Delivery Program (post-discharge only)		\$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization	Not covered
Over-the-Counter Items		\$50 allowance per quarter (catalog, online, mail, and telephonic ordering)	Not covered
Personal Emergency Response System (PERS)		\$0 copayment	Not covered
Wellness Program		\$0 copayment for monthly gym membership with participating fitness clubs	Not covered

¹ Services may require prior authorization.

² Services may require a referral from your doctor.

Prescription Drug Benefits

Providence Medicare Compass + Rx (HMO-POS)

Prescription Drug Deductible			
Yearly 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 \$4,430. 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)	\$3 copayment	\$3 copayment	\$3 copayment
Tier 2 (Generic)	\$12 copayment (\$10 copayment for Select Insulins)	\$12 copayment (\$10 copayment for Select Insulins)	\$12 copayment (\$10 copayment for Select Insulins)
Tier 3 (Preferred Brand)	\$47 copayment (\$35 copayment for Select Insulins)	\$70.50 copayment (\$35 copayment for Select Insulins)	\$94 copayment (\$35 copayment for Select Insulins)
Tier 4 (Non-Preferred Drug)	\$100 copayment	\$200 copayment	\$200 copayment
Tier 5 (Specialty)	33% of the total cost	Not covered	Not covered
Tier 6 (\$0 Part D Vaccines)	\$0 copayment	Not covered	Not covered
The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then, the insulin must be covered under Part B and will not be eligible for the Part D copays.			

Prescription Drug Benefits

Providence Medicare Compass + Rx (HMO-POS)

Standard Retail Cost Sharing			
	Up to 30 days	Up to 60 days	Up to 90 days
Tier 1 (Preferred Generic)	\$14 copayment	\$28 copayment	\$42 copayment
Tier 2 (Generic)	\$20 copayment (\$20 copayment for Select Insulins)	\$40 copayment (\$40 copayment for Select Insulins)	\$60 copayment (\$60 copayment for Select Insulins)
Tier 3 (Preferred Brand)	\$47 copayment (\$35 copayment for Select Insulins)	\$94 copayment (\$70 copayment for Select Insulins)	\$141 copayment (\$105 copayment for Select Insulins)
Tier 4 (Non-Preferred Drug)	\$100 copayment	\$200 copayment	\$300 copayment
Tier 5 (Specialty)	33% of the total cost	Not covered	Not covered
Tier 6 (\$0 Part D Vaccines)	\$0 copayment	Not covered	Not covered
The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then, the insulin must be covered under Part B and will not be eligible for the Part D copays.			

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)	<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 \$4,430.</p> <p>After you enter the coverage gap, you pay \$10-\$35 per month for Select Insulins, 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 \$7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>
The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then, the insulin must be covered under Part B and will not be eligible for the Part D copays.	

Prescription Drug Benefits

Providence Medicare Compass + Rx (HMO-POS)

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 \$7,050, you pay the greater of: 5% of the cost or \$3.95 copayment for generic (including brand drugs treated as generic) and a \$9.85 copayment for all other drugs.
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The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Optional Supplemental Dental

Providence Medicare Compass + 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: Basic Dental

Benefits include: Preventive (See Page 4) and Comprehensive Dental

Monthly Premium	Additional \$32.50 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	\$1,000 every year	
Diagnostic and Preventive Care*	\$0 copayment	You pay 20%
Basic Care*	You pay 50%	You pay 60%
Major Restorative Care*	You pay 50%	You pay 60%

Option 2: Enhanced Dental

Benefits include: Preventive (See Page 4) and Comprehensive Dental

Monthly Premium	Additional \$45.10 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 every year	
Diagnostic and Preventive Care*	\$0 copayment	You pay 20%
Basic Care*	You pay 50%	You pay 60%
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. Members must use a Medicare contracted provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

2022 Summary of Benefits

Providence Medicare Latitude + Rx (HMO-POS)

January 1, 2022 – December 31, 2022

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

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.	
Annual Medical 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 Advantage Plans 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) ¹	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 ¹	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
	Embedded Preventive	\$15 copayment Includes exams, cleanings, X-rays; limits apply	Not covered
	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 Services¹	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
Meal Delivery Program (post-discharge only)		\$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization	Not covered
Over-the-Counter Items		\$175 allowance per quarter (catalog, online, mail, and telephonic ordering)	Not covered
Personal Emergency Response System (PERS)		\$0 copayment	Not covered
Wellness Program		\$0 copayment for monthly gym membership with participating fitness clubs	Not covered

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)	Deductible waived
Tier 2 (Generic)	
Tier 3 (Preferred Brand)	\$120*
Tier 4 (Non-Preferred Drug)	
Tier 5 (Specialty)	
Tier 6 (\$0 Part D Vaccines)	Deductible waived
* There is no deductible for Select Insulins. During the Deductible Stage, your out-of-pocket costs for Select Insulins will be \$10-\$35 per month.	

Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$4,430. 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.
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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 for Select Insulins)	\$10 copayment (\$10 copayment for Select Insulins)	\$10 copayment (\$10 copayment for Select Insulins)
Tier 3 (Preferred Brand)	\$45 copayment (\$35 copayment for Select Insulins)	\$90 copayment (\$35 copayment for Select Insulins)	\$90 copayment (\$35 copayment for Select Insulins)
Tier 4 (Non-Preferred Drug)	\$90 copayment	\$180 copayment	\$180 copayment
Tier 5 (Specialty)	30% of the total cost	Not covered	Not covered
Tier 6 (\$0 Part D Vaccines)	\$0 copayment	Not covered	Not covered
The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then, the insulin must be covered under Part B and will not be eligible for the Part D copays.			

Prescription Drug Benefits

Providence Medicare Latitude + Rx (HMO-POS)

Standard Retail Cost Sharing			
	Up to 30 days	Up to 60 days	Up to 90 days
Tier 1 (Preferred Generic)	\$12 copayment	\$24 copayment	\$36 copayment
Tier 2 (Generic)	\$20 copayment (\$20 copayment for Select Insulins)	\$40 copayment (\$40 copayment for Select Insulins)	\$60 copayment (\$60 copayment for Select Insulins)
Tier 3 (Preferred Brand)	\$47 copayment (\$35 copayment for Select Insulins)	\$94 copayment (\$70 copayment for Select Insulins)	\$141 copayment (\$105 copayment for Select Insulins)
Tier 4 (Non-Preferred Drug)	\$100 copayment	\$200 copayment	\$300 copayment
Tier 5 (Specialty)	30% of the total cost	Not covered	Not covered
Tier 6 (\$0 Part D Vaccines)	\$0 copayment	Not covered	Not covered
The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then, the insulin must be covered under Part B and will not be eligible for the Part D copays.			

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)	<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 \$4,430.</p> <p>After you enter the coverage gap, you pay for Tier 1 (Preferred Generic) drugs, \$10-\$35 per month for Select Insulins, 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 \$7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p>
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Prescription Drug Benefits

Providence Medicare Latitude + Rx (HMO-POS)

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)	25% of the total cost (\$10 copayment for Select Insulins)	25% of the total cost (\$10 copayment for Select Insulins)	25% of the total cost (\$10 copayment for Select Insulins)
Tier 3 (Preferred Brand)	25% of the total cost (\$35 copayment for Select Insulins)	25% of the total cost (\$35 copayment for Select Insulins)	25% of the total cost (\$35 copayment for Select Insulins)
Tier 4 (Non-Preferred Drug)	25% of the total cost	25% of the total cost	25% of the total cost
Tier 5 (Specialty)	25% of the total cost	Not covered	Not covered
Tier 6 (\$0 Part D Vaccines)	25% 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)	25% of the total cost (\$20 copayment for Select Insulins)	25% of the total cost (\$40 copayment for Select Insulins)	25% of the total cost (\$60 copayment for Select Insulins)
Tier 3 (Preferred Brand)	25% of the total cost (\$35 copayment for Select Insulins)	25% of the total cost (\$70 copayment for Select Insulins)	25% of the total cost (\$105 copayment for Select Insulins)
Tier 4 (Non-Preferred Drug)	25% of the total cost	25% of the total cost	25% of the total cost
Tier 5 (Specialty)	25% of the total cost	Not covered	Not covered
Tier 6 (\$0 Part D Vaccines)	25% of the total cost	Not covered	Not covered
<p>The Select Insulins are formulary insulins that are covered in Tiers 2 and 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then, the insulin must be covered under Part B and will not be eligible for the Part D copays.</p>			

Prescription Drug Benefits

Providence Medicare Latitude + Rx (HMO-POS)

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 \$7,050, you pay the greater of: 5% of the cost or \$3.95 copayment for generic (including brand drugs treated as generic) and a \$9.85 copayment for all other drugs.

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: Basic Dental		
Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional \$32.50 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	\$1,000 every year	
Diagnostic and Preventive Care*	\$0 copayment	You pay 20%
Basic Care*	You pay 50%	You pay 60%
Major Restorative Care*	You pay 50%	You pay 60%

Option 2: Enhanced Dental		
Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional \$45.10 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 every year	
Diagnostic and Preventive Care*	\$0 copayment	You pay 20%
Basic Care*	You pay 50%	You pay 60%
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. Members must use a Medicare contracted provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

Scope of Appointment

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment* prior to any individual sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

(Refer to page 2 for product type descriptions)

- ☐ **Stand-alone Medicare Prescription Drug Plans (Part D)**
- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Dental/Vision/Hearing Products**
- ☐ **Hospital Indemnity Products**
- ☐ **Medicare Supplement (Medigap) Products**

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment, or automatically enroll you in the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date:	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below:	
Representative's Name:	Your Relationship to the Beneficiary:
To be completed by Agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	
Initial Method of Contact: (Indicate here if beneficiary was a walk-in.)	
Agent's Signature:	
Plan(s) the agent represented during this meeting:	Date Appointment Completed:
Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:	

*Scope of Appointment documentation is subject to CMS record retention requirements.

Stand-alone Medicare Prescription Drug Plans (Part D)
Medicare Prescription Drug Plan (PDP): A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.
Medicare Advantage Plans (Part C) and Cost Plans
Medicare Health Maintenance Organization (HMO): A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare Preferred Provider Organization (PPO) Plan: A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Private Fee-For-Service (PFFS) Plan: A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you – not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare Point of Service (POS) Plan: A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.
Medicare Special Needs Plan (SNP): A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Medicare Medical Savings Account (MSA) Plan: MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
Medicare Cost Plan: In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.
Medicare Medicaid Plan (MMP): An MMP is a private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dual eligible Medicare beneficiaries.
Dental/Vision/Hearing Products
Plans offering additional benefits for consumers who are looking to cover needs for dental, vision or hearing. These plans are not affiliated or connected to Medicare.
Hospital Indemnity Products
Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.
Medicare Supplement (Medigap) Products
Plans offering a supplemental policy to fill "gaps" in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services, and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

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.

IMPORTANT INFORMATION:

2022 Medicare Star Ratings



Providence Medicare Advantage Plans - H9047

For 2022, Providence Medicare Advantage Plans - H9047 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★

Health Services Rating: ★★★★★

Drug Services Rating: ★★★★★

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.



This plan got
**MEDICARE'S
HIGHEST
RATING (5 stars)**

The number of stars show how well a plan performs.

★★★★★ EXCELLENT

★★★★☆ ABOVE AVERAGE

★★★☆☆ AVERAGE

★★☆☆☆ BELOW AVERAGE

★☆☆☆☆ POOR

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact Providence Medicare Advantage Plans 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time at 800-457-6064 (toll-free) or 711. Current members please call 800-603-2340 (toll-free) or 711.



A division of Providence Health Assurance

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445 (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-603-2340 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-603-2340 (TTY: 711).

Chinese: 注意：如果您使用繁體中文, 您可以免費獲得語言援助服務. 請致電 1-800-603- 2340 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-603-2340 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-603-2340 (TTY: 711) 번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-603-2340 (телетайп: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-603-2340 (TTY: 711).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-603-2340 (телетайп: 711).

Mon-Khmer, Cambodian: ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-603-2340 (TTY: 711)។

Japanese: 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-603-2340 (TTY:711) まで、お電話にてご連絡ください。

Amharic: ማሳሰቢያ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-603-2340 (መስማት ለተሳናቸው: 711)፡፡

Cushite (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-603-2340 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-603-2340 (رقم هاتف الصم والبكم: (TTY: 711).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-603-2340 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-603-2340 (TTY: 711).

Laotian: ໂປດຊາບ: ຖ້າ າວ່ າ ທ່ ານເວົ້ າພາສາ ລາວ, ການບໍລິການຊ່ ວຍເຫຼື ອດ້ ານພາສາ, ໂດຍບໍ່ເສັ ງຄ່ າ, ແມ່ ນມພັ ອມໃຫ້ ທ່ ານ. ໂທຮ 1-800-603-2340 (TTY: 711).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-603-2340 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-603-2340 (ATS: 711).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-603-2340 (TTY: 711)

Persian:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
تماس بگیرید.
فراهم می باشد. با 1-800-603-2340 (TTY: 711)

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

ProvidenceHealthAssurance.com

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.

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