Providence
Medicare Advantage Plans

2026 Summary of Benefits

Providence Medicare Reverence (HMO-POS)

January 1, 2026 – December 31, 2026

This plan is available in **Clackamas, Hood River, Lane, Multnomah, Washington, and Yamhill counties in Oregon and Benton, Clark, Franklin, Snohomish, Spokane, and Walla Walla counties in Washington.**

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When You Join Providence

You are not just part of an insurance policy but part of a community of care, focused on your health and well-being. This Summary of Benefits is provided to help you make the right health care decisions. It is a short guide of what we would cover and what you would pay if you joined our Providence Medicare Reverence (HMO-POS). To be clear, this is not a complete breakdown of benefits, and will not list every service that we cover, nor every limitation or exclusion. Plans may offer supplemental benefits in addition to Part C 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 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.

Not only do our plan members get all of the benefits covered by Original Medicare, they also get some extra benefits outlined in this summary.

Who Can Join?

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes Clackamas, Hood River, Lane, Multnomah, Washington, and Yamhill counties in Oregon and Benton, Clark, Franklin, Snohomish, Spokane, and Walla Walla counties in Washington.

Get In Touch

Questions? We're here to help: From April 1st to September 30th, the hours are Monday through Friday from 8 a.m. to 8 p.m. From October 1st to March 31st, the hours are Sunday through Saturday (7 days a week) from 8 a.m. to 8 p.m.

- 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 /1-800-855-7100)
- You can also visit us online at **ProvidenceHealthAssurance.com**

Helpful Resources

- Visit **ProvidenceHealthAssurance.com/findaprovider** to see our plan's Provider Directory or to request a printed copy. You can also call us to have a printed copy mailed to you.
- 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 Reverence (HMO-POS)

Monthly Plan Premium	$25 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	Your yearly limit(s) for this plan:	
	In-network: $6,750	Out-of-network: No Maximum

Benefits		In-Network	Out-Of-Network
Inpatient Hospital Coverage[1]		$300 copayment each day for days 1-6 and $0 copayment each day for day 7 and beyond	50% of the total cost per admission
Outpatient Hospital Coverage[1]		$250 copayment for outpatient surgery at a hospital facility	50% of the total cost
Ambulatory Surgical Center (ASC) Services[1]		$250 copayment for outpatient surgery at an Ambulatory Surgical Center	50% of the total cost
Doctor Visits	Primary Care Provider Visit	$15 copayment	50% of the total cost
	Specialist Visit	$30 copayment	50% of the total cost
Preventive Care (e.g., annual check-ups, immunizations, flu shots)		You pay nothing	50% of the total cost
Emergency Care		$130 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived.	
Urgently Needed Services		$25 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.	

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. For 2026, referrals are not required for in-network specialists visits and Medicare-covered services.

[1] Services may require prior authorization. See the Evidence of Coverage for more information

Providence Medicare Reverence (HMO-POS)

Benefits		In-Network	Out-Of-Network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g., MRI, ultrasounds, CT scans) [1]	20% of the total cost up to $250 per day	50% of the total cost
	Therapeutic Radiology Services[1]	20% of the total cost	50% of the total cost
	Outpatient X-rays	$15 copayment per day	50% of the total cost
	Diagnostic Tests and Procedures[1]	20% of the total cost	50% of the total cost
	Lab Services[1]	$0 copayment	50% of the total cost
Hearing Services	Medicare-Covered	$30 copayment	50% of the total cost
	Routine Exam	$0 copayment	Not covered
	Hearing Aids	$499 copayment per Standard hearing aid, $699 copayment per Advanced hearing aid, or $999 copayment per Premium hearing aid	Not covered
Dental Services	Medicare-Covered[1]	$30 copayment	50% of the total cost
	Embedded Preventive	$0 copayment Includes exams, fluoride treatment, cleanings, X-rays; limits apply	20% of the total cost Includes exams, fluoride treatment, cleanings, X-rays; limits apply
	Optional	Covered for additional premium; see the last two pages of this summary	
Vision Services	Medicare-Covered Exams/Screening	$30 copayment per exam $0 copayment for glaucoma screening	50% of the total cost per exam 50% of the total cost for glaucoma screening
	Routine Exam	There is no coinsurance, or copayment for one routine vision exam (including refraction) per calendar year.	
	Medicare-Covered Eyewear	$0 copayment for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery	50% 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. See the Evidence of Coverage for more information.

Providence Medicare Reverence (HMO-POS)

Benefits		In-Network	Out-Of-Network
Mental Health Services	Inpatient Visit[1]	$275 copayment each day for days 1-6 and $0 copayment each day for days 7-90	50% of the total cost per admission
	Outpatient Individual[1] and Group Therapy Visit[1]	$30 copayment	50% of the total cost
Skilled Nursing Facility (SNF)[1]		$0 copayment each day for days 1-20 and $218 copayment each day for days 21-100	50% of the total cost for each benefit period (days 1-100)
Physical Therapy[1]		$30 copayment	50% of the total cost
Ambulance[1]		$275 copayment	
Transportation		Not covered	
Medicare Part B Drugs[1]		0% – 20% of the total cost (Insulin cost share up to $35 per month)	50% of the total cost (Insulin cost share up to $35 per month)
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		$100 allowance every six months (retail card, catalog, online, mail, and telephonic ordering)	
Personal Emergency Response System (PERS)		$0 copayment	Not covered
Wellness Program		$0 copayment for monthly gym membership with participating fitness clubs	
Wig		There is no coinsurance, or copayment for one synthetic wig due to hair loss from chemotherapy	

[1] Services may require prior authorization. See the Evidence of Coverage for more information.

Optional Supplemental Dental

Providence Medicare Reverence (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: Providence Dental Basic Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $39 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 calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	You pay 50%	You pay 60%

Optional Supplemental Dental

Providence Medicare Reverence (HMO-POS)

Option 2: Providence Dental Enhanced Benefits include: Preventive (See Page 4) and Comprehensive Dental		
Monthly Premium	Additional $56 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 calendar year	
Diagnostic and Preventive Care*	You pay 0%	You pay 20%
Basic Care*	You pay 30% for fillings You pay 50% for all other services	You pay 60%
Major Restorative Care* (e.g., crowns, bridges)	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.

Providence
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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-603-2340 (TTY: 711) or speak to your provider."

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-603-2340 (TTY: 711) o hable con su proveedor.

Việt (Vietnamese)
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-603-2340 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

中文 (Chinese-Simplified)
注意：如果您说 中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-603-2340（文本电话：711）或咨询您的服务提供商。"

中文 (Chinese- Traditional)
注意：如果您說 中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-603-2340（TTY：711）或與您的提供者討論。」

РУССКИЙ (Russian)
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-603-2340 (TTY: 711) или обратитесь к своему поставщику услуг.

한국어 (Korean)
주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-603-2340 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오."

українська мова (Ukrainian)
УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-603-2340 (TTY: 711) або зверніться до свого постачальника».

日本語 (Japanese)
注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-603-2340（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

العربية (Arabic)
تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1- 800-603-2340 (711) أو تحدث إلى مقدم الخدمة".

ភាសាខ្មែរ (Khmer)
សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយដ៏សមរម្យក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-603-2340 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។”

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-603-2340 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.“

فارسي (Farsi)
توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-800-603-2340 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Français (French)
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-603-2340 (TTY : 711) ou parlez à votre fournisseur. »

ไทย (Thai)
หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-603-2340 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ”

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-603-2340 (TTY: 711) o makipag-usap sa iyong provider.”

አማርኛ (Amharic)
ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-603-2340 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።”

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-800-603-2340 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।”

ລາວ (Laos)
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ
ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-603-2340 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.”

ՀԱՅԵՐԵՆ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվական աջակցության անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես տրամադրվում են անվճար: Զանգահարեք 1-800-603-2340 հեռախոսահամարով (TTY՝ 711) կամ խոսեք Ձեր մատակարարի հետ:

Lus Hmoob (Hmong)
LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-800-603-2340 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.”

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-603-2340 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।”