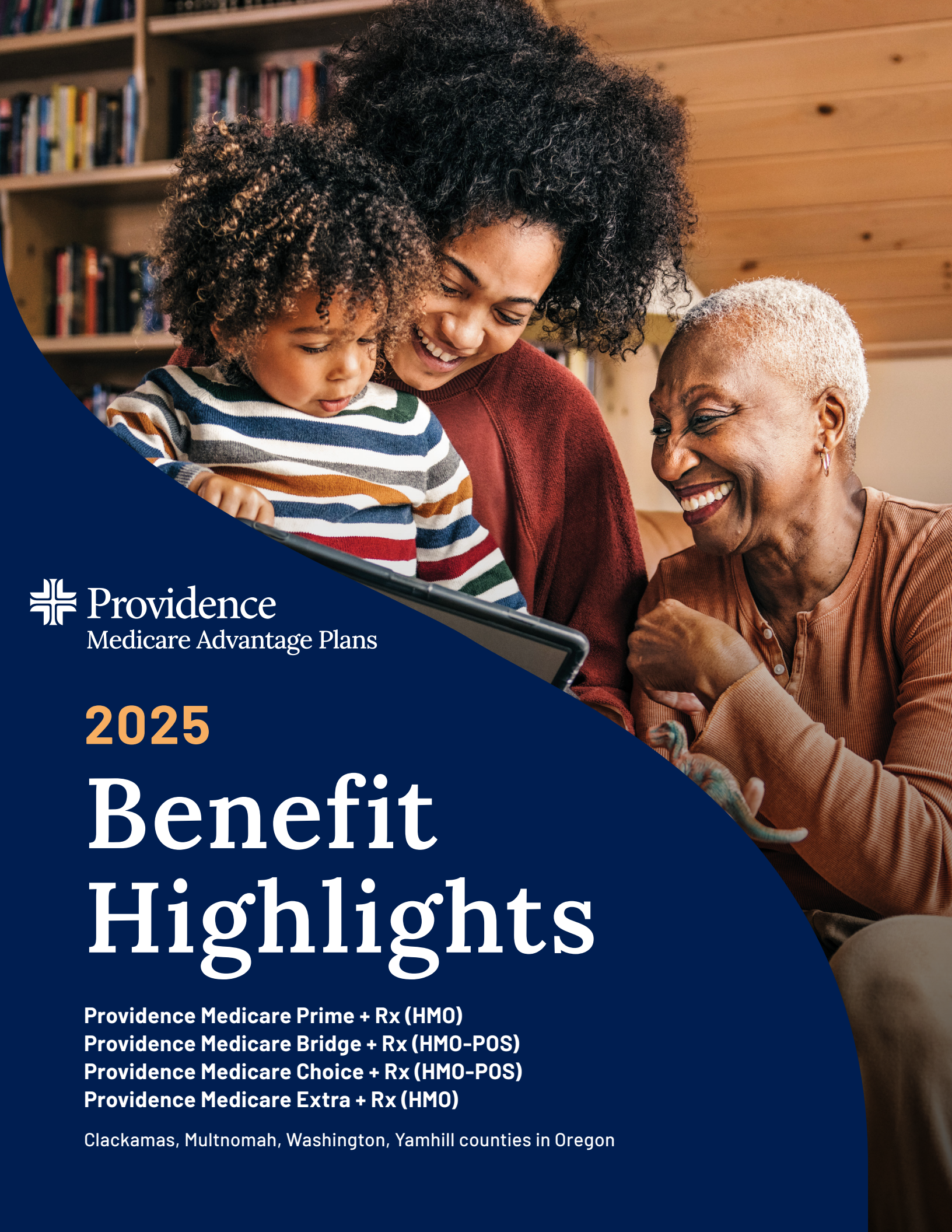

Providence
Medicare Advantage Plans

2025

Benefit Highlights

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

Clackamas, Multnomah, Washington, Yamhill counties in Oregon

Providence Medicare Advantage Plans

– Part C

	Providence Medicare Prime + Rx (HMO)	Providence Medicare Bridge + Rx (HMO-POS)	
Monthly premium with prescription drug coverage	$0	$29	
	In-network	**In-network**	**Out-of-network**
Medical deductible	$0	$0	$0
Out-of-pocket Maximum	$5,000	$6,500	No maximum
Benefits	**You pay**	**You pay**	
Doctor office visit (PCP)	$0	$0	$25
Specialist visit	$35	$30	$50
Preventive care	$0	$0	30%
Inpatient hospital	1-4 days: $450 5-90 days: $0	1-6 days: $325 7-90 days: $0	30%
Skilled nursing facility	1-20 days: $0 21-100 days: $214	1-20 days: $0 21-100 days: $214	30%
Outpatient surgery - Ambulatory	$250	$250	30%
Outpatient surgery - Hospital	$450	$375	30%
Diabetic supplies	$0	$0	30%
Lab	$0	$0	30%
X-ray	$15	$10	30%
Diagnostic radiology	20%	20%	30%
Outpatient diagnostic tests & procedures	20%	20%	30%
Chiropractic	$20/18 visits	$20/18 visits	Not Covered
Acupuncture	$20/18 visits	$20/18 visits	Not Covered
Naturopathy	$20/6 visits	$20/6 visits	Not Covered
Therapy: PT, OT, ST	$35	$30	30%
Durable medical equipment	20%	20%	30%
Home health	$0	$0	30%
Telehealth - Primary**	$0	$0	N/A
Telehealth - Specialist**	$35	$30	N/A
Worldwide Coverage	**In-network**	**In-network**	**Out-of-network**
Urgent care	$25	$30	N/A
Emergency room*	$125	$125	N/A
Ambulance - Ground no transport	$50	$50	$50
Ambulance - Ground emergency transport	$275	$275	$275
Ambulance - Air	$275	$275	$275

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

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

Other charges and limits may apply. Please refer to Evidence of Coverage for more information. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Providence Medicare Advantage Plans

– Part C

	Providence Medicare Choice + Rx (HMO-POS)		Providence Medicare Extra + Rx (HMO)
Monthly premium with prescription drug coverage	$82		$161
	In-network	**Out-of-network**	**In-network**
Medical deductible	$0	$0	$0
Out-of-pocket Maximum	$5,000	No maximum	$4,000
Benefits	**You pay**		**You pay**
Doctor office visit (PCP)	$15	$25	$0
Specialist visit	$30	$50	$20
Preventive care	$0	20%	$0
Inpatient hospital	1-6 days: $300 7-90 days: $0	20%	1-5 days: $250 6-90 days: $0
Skilled nursing facility	1-20 days: $0 21-100 days: $214	20%	1-20 days: $0 21-100 days: $214
Outpatient surgery - Ambulatory	$250	20%	$100
Outpatient surgery - Hospital	$350	20%	$150
Diabetic supplies	$0	20%	$0
Lab	$0	20%	$0
X-ray	$15	20%	$0
Diagnostic radiology	20%	20%	15%
Outpatient diagnostic tests & procedures	20%	20%	20%
Chiropractic	Not Covered	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered	Not Covered
Naturopathy	Not Covered	Not Covered	Not Covered
Therapy: PT, OT, ST	$30	20%	$20
Durable medical equipment	20%	20%	20%
Home health	$0	20%	$0
Telehealth - Primary**	$0	N/A	$0
Telehealth - Specialist**	$30	N/A	$20
Worldwide Coverage	**In-network**	**Out-of-network**	**In-network**
Urgent care	$25	N/A	$25
Emergency room*	$125	N/A	$125
Ambulance - Ground no transport	$50	$50	$50
Ambulance - Ground emergency transport	$275	$275	$275
Ambulance - Air	$275	$275	$275

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

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

Other charges and limits may apply. Please refer to Evidence of Coverage for more information. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost sharing that applies to out-of-network services.

Pharmacy coverage – Part D

	Providence Medicare Prime + Rx (HMO)		Providence Medicare Bridge + Rx (HMO-POS)		Providence Medicare Choice + Rx (HMO-POS)		Providence Medicare Extra + Rx (HMO)	
Annual deductible	$250 (waived on tier 1 & 2)		$0		$0		$0	
Part D Insulin	$35		$35		$35		$35	
	30-day	**100-day**	**30-day**	**100-day**	**30-day**	**100-day**	**30-day**	**100-day**
Preferred generic	$0 $0 Mail order	$0 $0 Mail order	$0 $0 Mail order	$0 $0 Mail order	$0 $0 Mail order	$0 $0 Mail order	$0 $0 Mail order	$0 $0 Mail order
Generic	$10 $0 Mail order	$30 $0 Mail order	$10 $0 Mail order	$30 $0 Mail order	$10 $0 Mail order	$30 $0 Mail order	$10 $0 Mail order	$30 $0 Mail order
Preferred brand	$40	$120	$40	$120	$40	$120	$40	$120
Non-preferred drugs	$100	$300	$100	$300	$100	$240	$90	$180
Specialty drugs	30%	N/A	33%	N/A	33%	N/A	33%	N/A

Mail order for maintenance medications, get up to a 100-day supply shipped right to you from our in-network mail order pharmacies. Copays listed are for Preferred Network pharmacies only; other pharmacy copays may cost more.

For all Part D insulin products, you will pay no more than $35 per month. For all ACIP-recommended Part D Vaccines, you will have no cost-share. The Formulary and pharmacy network may change at any time. You will receive notice when necessary.

Stage 1: Rx Deductible	Stage 2: Initial Coverage	Stage 3: Catastrophic Coverage
This stage only applies to plans with a Part D deductible. You stay in this stage until you have met your Part D deductible for your Tier 3, 4, and 5 drugs.	You stay in this stage until your out-of-pocket costs reach $2,000, then you move to Stage 3.	In this stage, you pay nothing for your covered Part D drugs.

Dental, hearing, vision, and more

	Providence Medicare Prime + Rx (HMO)	Providence Medicare Bridge + Rx (HMO-POS)	Providence Medicare Choice + Rx (HMO-POS)	Providence Medicare Extra + Rx (HMO)
Flexible Benefit Card				
Over-the-counter items	$110/Every three months	$65/Every three months	$30/Every three months	$160/Every three months
Preventive dental	$0	$0 In-network, 20% Out-of-network	$0 In-network, 20% Out-of-network	$0
Routine eye exam (one per year)	$0	$0	$0	$0
Prescription eyeglasses or contact lenses*	$250/Every year	$250/Every year	$250/Every year	$250/Every year
Routine hearing exam (one per year)**	$0	$0	$0	$0
Hearing aids (two per year)**	$699-$999	$699-$999	$699-$999	$699-$999
Meal delivery after inpatient hospital stay	14 days/28 meals	14 days/28 meals	14 days/28 meals	14 days/28 meals
Personal Emergency Response System	$0	$0	$0	$0
Fitness center membership	$0	$0	$0	$0
Wigs for hair loss related to chemotherapy	$0	$0	$0	$0
Non-emergent medical transportation (one way)	N/A	N/A	N/A	24/Every year

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

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

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.

2025 Optional Supplemental Dental Benefits

	In-network	Out-of-network*	In-network	Out-of-network*
Benefits include: Preventive (See EOC Chapter 4) and Comprehensive Dental	**Basic**		**Enhanced**	
Monthly premium	$37.50		$53.50	
Annual deductible[1]	$50	$150	$50	$150
Annual maximum	$1,000/Every year		$1,500/Every year	
Waiting periods	None		None	
Provider network	Delta Dental Medicare Advantage		Delta Dental Medicare Advantage	
Out-of-network reimbursement	None		None	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Bitewing X-rays[2]	$0	20%	$0	20%
Panoramic & other diagnostic X-rays[3]	$0	20%	$0	20%
Simple extractions	50%	60%	50%	60%
Basic fillings	30%	60%	30%	60%
Dentures	50%	60%	50%	60%
Crowns and bridges	50%	60%	50%	60%
Oral surgery	Not Covered	Not Covered	50%	60%
Endodontics (root canals)	Not Covered	Not Covered	50%	60%
Periodontics (deep cleaning)	Not Covered	Not Covered	50%	60%

***Important notes:** Limitations and exclusions apply. Please refer to your Evidence of Coverage for a complete list of covered dental services. Members are encouraged to use an in-network Dental provider. Out-of-network dentists may charge more than the amount allowed by Providence Medicare Advantage Plans.

[1] Deductibles are waived for diagnostic and preventive services
[2] Bitewing or Periapical X-rays – one bitewing series or one bitewing series plus periapical as needed (up to 10) per calendar year
[3] Full mouth and Panoramic X-ray – limited to once every 5 years

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Providence
Medicare Advantage Plans

Want to learn more?

Here's how to connect with us.

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

1-833-874-0782 (TTY: 711)

8 a.m. to 5 p.m. (Pacific Time) Monday – Friday

Check us out online for more information or to enroll at

TheProvidenceAdvantage.com/SA1EnrollGuide

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