

A photograph of a middle-aged couple smiling and laughing together in a vineyard. The woman is in the foreground, wearing a light blue denim jacket with embroidery and a necklace with a butterfly pendant. The man is behind her, wearing a blue and white plaid shirt over a white t-shirt. They are both looking towards the right. The background shows green grapevines and a bright, sunny sky.

 **Providence**  
Medicare Advantage Plans

**2026**

# Benefit Highlights

**Providence Medicare Timber + Rx (HMO)**

**Providence Medicare Extra + Rx (HMO)**

**Providence Medicare Focus Medical (HMO)**

**Providence Medicare Reverence (HMO-POS)**

Lane and Hood River counties in Oregon, and Clark County in Washington

# Providence Medicare Advantage Plans

## – Part C

	Providence Medicare Timber + Rx (HMO)	Providence Medicare Extra + Rx (HMO)
Monthly premium with prescription drug coverage	\$0	\$161
	<b>In-network</b>	<b>In-network</b>
Medical deductible	\$0	\$0
Out-of-pocket Maximum	\$6,750	\$4,200
<b>Benefits</b>	<b>You pay</b>	<b>You pay</b>
Doctor office visit (PCP)	\$0	\$0
Specialist visit	\$40	\$20
Preventive care	\$0	\$0
Inpatient hospital	1-4 days: \$450 5-90 days: \$0	1-5 days: \$250 6-90 days: \$0
Skilled nursing facility	1-20 days: \$0 21-100 days: \$218	1-20 days: \$0 21-100 days: \$218
Outpatient surgery - Ambulatory	\$250	\$100
Outpatient surgery - Hospital	\$450	\$150
Diabetic supplies	\$0	\$0
Lab	\$0	\$0
X-ray	\$15	\$0
Diagnostic radiology	20% up to \$250	15% up to \$250
Outpatient diagnostic tests & procedures	20%	20%
Therapy: PT, OT, ST	\$40	\$20
Durable medical equipment	20%	20%
Home health	\$0	\$0
Telehealth - Primary**	\$0	\$0
Telehealth - Specialist**	\$40	\$20
<b>Worldwide Coverage</b>	<b>In-network</b>	<b>In-network</b>
Urgent care	\$25	\$25
Emergency room*	\$130	\$130
Ambulance - Ground no transport	\$50	\$50
Ambulance - Ground emergency transport	\$275	\$275
Ambulance - Air	\$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 Revere (HMO-POS)		Providence Medicare Focus Medical (HMO)
Monthly premium	\$25		\$120
	In-network	Out-of-network	In-network
Medical deductible	\$0	\$0	\$0
Out-of-pocket Maximum	\$6,750	No maximum	\$4,200
Benefits	You pay		You pay
Doctor office visit (PCP)	\$15	50%	\$0
Specialist visit	\$30	50%	\$20
Preventive care	\$0	50%	\$0
Inpatient hospital	1-6 days: \$300 7-90 days: \$0	50%	1-5 days: \$250 6-90 days: \$0
Skilled nursing facility	1-20 days: \$0 21-100 days: \$218	50%	1-20 days: \$0 21-100 days: \$218
Outpatient surgery - Ambulatory	\$250	50%	\$200
Outpatient surgery - Hospital	\$250	50%	\$250
Diabetic supplies	\$0	50%	\$0
Lab	\$0	50%	\$0
X-ray	\$15	50%	\$0
Diagnostic radiology	20% up to \$250	50%	15% up to \$250
Outpatient diagnostic tests & procedures	20%	50%	20%
Therapy: PT, OT, ST	\$30	50%	\$20
Durable medical equipment	20%	50%	20%
Home health	\$0	50%	\$0
Telehealth - Primary**	\$15	50%	\$0
Telehealth - Specialist**	\$30	50%	\$20
Worldwide Coverage	In-network	Out-of-network	In-network
Urgent care	\$25		\$25
Emergency room*	\$130		\$130
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 Timber + Rx (HMO)		Providence Medicare Extra + Rx (HMO)		Providence Medicare Reverence (HMO-POS)		Providence Medicare Focus Medical (HMO)	
Annual deductible	\$250 (waived on tier 1 & 2)		\$0		N/A		N/A	
Part D Insulin	\$35		\$35		N/A		N/A	
	30-day	100-day	30-day	100-day	30-day	100-day	30-day	100-day
Preferred generic	\$0	\$0	\$0	\$0	N/A	N/A	N/A	N/A
Generic	\$10 \$0 Mail order	\$30 \$0 Mail order	\$10 \$0 Mail order	\$30 \$0 Mail order	N/A	N/A	N/A	N/A
Preferred brand	\$47 \$40 Mail order	\$141 \$120 Mail order	\$40	\$120	N/A	N/A	N/A	N/A
Non-preferred drugs	\$100	\$300	\$90	\$270	N/A	N/A	N/A	N/A
Specialty drugs	30%	N/A	33%	N/A	N/A	N/A	N/A	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 adult Vaccines, you will have no cost-share. The Formulary and pharmacy network may change at any time. You will receive notice when necessary.

The Reverence and Focus plans do not include Part D prescription drug coverage. If you don't have creditable prescription drug coverage, such as VA coverage and you delay enrolling in Part D, you may incur a late enrollment penalty when you eventually do enroll.

## Stage 1: Rx Deductible

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 brand, non-preferred, and specialty Tiers 3, 4, and 5.

## Stage 2: Initial Coverage

You stay in this stage until your out-of-pocket costs reach \$2,100, then you move to Stage 3.

## Stage 3: Catastrophic Coverage

In this stage, you pay nothing for your covered Part D drugs.

# Dental, hearing, vision, and more

	<b>Providence Medicare Timber + Rx (HMO)</b>	<b>Providence Medicare Extra + Rx (HMO)</b>	<b>Providence Medicare Reverence (HMO-POS)</b>	<b>Providence Medicare Focus Medical (HMO)</b>
	<b>You pay</b>	<b>You pay</b>	<b>You pay</b>	<b>You pay</b>
Preventive dental	\$0	\$0	\$0 In-network, 20% Out-of-network	\$0
Routine eye exam (one per year)	\$0	\$0	\$0	\$0
Routine hearing exam (one per year)**	\$0	\$0	\$0	\$0
Hearing aids (two per year)**	\$499/\$699/\$999	\$499/\$699/\$999	\$499/\$699/\$999	\$499/\$699/\$999
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
	<b>You get</b>	<b>You get</b>	<b>You get</b>	<b>You get</b>
Flexible Benefit Card Over-the-counter items	N/A	\$240/Every six months	\$100/Every six months	\$100/Every six months
Prescription eyeglasses or contact lenses*	\$100/Every year	\$150/Every year	\$250/Every year	\$250/Every year
Meal delivery after inpatient hospital stay	N/A	14 days/28 meals	14 days/28 meals	14 days/28 meals

\*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. Up to two hearing aids per year (one per ear) with copayments of \$499 per aid for Standard, \$699 per aid for Advanced, or \$999 per aid for Premium.

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.

# 2026 Optional Supplemental Dental Benefits

	In-network	Out-of-network*	In-network	Out-of-network*
<b>Benefits include: Preventive (See EOC Chapter 4) and Comprehensive Dental</b>	<b>Basic</b>		<b>Enhanced</b>	
Monthly premium	\$39		\$56	
Annual deductible <sup>1</sup>	\$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 <sup>2</sup>	\$0	20%	\$0	20%
Panoramic & other diagnostic X-rays <sup>3</sup>	\$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.

<sup>1</sup> Deductibles are waived for diagnostic and preventive services.

<sup>2</sup> Bitewing or Periapical X-rays – one bitewing series or one bitewing series plus periapical as needed (up to 10) per calendar year.

<sup>3</sup> 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.





## 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/EnrollGuide26](https://TheProvidenceAdvantage.com/EnrollGuide26)**

