



2024 Benefit Highlights

Providence Medicare Timber + Rx (HMO)

Providence Medicare Bridge + Rx (HMO-POS)

Providence Medicare Choice + Rx (HMO-POS)

Providence Medicare Extra + Rx (HMO)

Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion,
Polk, Wheeler counties in Oregon and Clark County in Washington

Providence Medicare Advantage Plans – Part C



	Providence Medicare Timber + 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	\$5,500	\$4,700	\$10,000 combined
Benefits	You pay	You pay	
Doctor office visit (PCP)	\$0	\$0	\$25
Specialist visit	\$40	\$30	\$50
Preventive care	\$0	\$0	30%
Inpatient hospital	Days 1-4: \$450 per day Day 5 and beyond: \$0 per day	Days 1-6: \$325 per day Day 7 and beyond: \$0 per day	30%
Skilled nursing facility	Days 1-20: \$0 Days 21-100: \$184 per day	Days 1-20: \$0 Days 21-100: \$160 per day	30%
Outpatient surgery	\$250 Ambulatory \$450 Hospital	\$250 Ambulatory \$375 Hospital	30%
Diabetic supplies	\$0 – 20%	\$0 – 20%	30%
Lab	\$0	\$0	30%
X-ray	\$15	\$10	30%
Diagnostic radiology	20% up to \$250	20% up to \$250	30%
Outpatient diagnostic tests & procedures	20%	20%	30%
Chiropractic	18 visits: \$20	18 visits: \$20	No coverage
Acupuncture	18 visits: \$20	18 visits: \$20	
Naturopathy	6 visits: \$20	6 visits: \$20	
Therapy: PT, OT, ST	\$40	\$30	30%
Durable medical equipment	20%	20%	30%
Home health	\$0	\$0	30%
Telehealth**	\$0 PCP \$40 Specialist	\$0 PCP \$30 Specialist	\$25 PCP \$50 Specialist
	Worldwide coverage	Worldwide coverage	
Urgent care	\$25	\$30	
Emergency room*	\$90	\$90	
Ambulance (ground or air)	\$250 one way	\$250 one way	

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

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

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

Providence Medicare Advantage Plans – Part C



	Providence Medicare Choice + Rx (HMO-POS)		Providence Medicare Extra + Rx (HMO)
Monthly premium with prescription drug coverage	\$71		\$155
	In-network	Out-of-network	In-network
Medical deductible	\$0	\$0	\$0
Out-of-pocket maximum	\$4,500	\$10,000 combined	\$3,400
Benefits	You pay		You pay
Doctor office visit (PCP)	\$15	\$25	\$0
Specialist visit	\$30	\$50	\$20
Preventive care	\$0	20%	\$0
Inpatient hospital	Days 1-6: \$300 per day Day 7 and beyond: \$0 per day	20%	Days 1-5: \$250 per day Day 6 and beyond: \$0 per day
Skilled nursing facility	Days 1-20: \$0 Days 21-100: \$160 per day	20%	Days 1-20: \$0 Days 21-100: \$150 per day
Outpatient surgery	\$250 Ambulatory \$250 Hospital	20% 20%	\$100 Ambulatory \$150 Hospital
Diabetic supplies	\$0 – 20%	20%	\$0 – 20%
Lab	\$0	20%	\$0
X-ray	\$15	20%	\$0
Diagnostic radiology	20% up to \$250	20%	15% up to \$250
Outpatient diagnostic tests & procedures	20%	20%	20%
Chiropractic Acupuncture Naturopathy	No coverage	No coverage	No coverage
Therapy: PT, OT, ST	\$30	20%	\$20
Durable medical equipment	20%	20%	20%
Home health	\$0	20%	\$0
Telehealth**	\$15 PCP \$30 Specialist	\$25 PCP \$50 Specialist	\$0 PCP \$20 Specialist
	Worldwide coverage		Worldwide coverage
Urgent care	\$25		\$25
Emergency room*	\$90		\$70
Ambulance (ground or air)	\$250 one way		\$250 one way

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Pharmacy coverage – Part D

	Providence Medicare Timber + Rx (HMO)		Providence Medicare Bridge + Rx (HMO-POS)		Providence Medicare Choice + Rx (HMO-POS)		Providence Medicare Extra + Rx (HMO)	
Annual deductible	\$0		\$0		\$0		\$0	
	30-day	100-day	30-day	100-day	30-day	100-day	30-day	100-day
Preferred generic	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Generic	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10
Preferred brand	\$37	\$111 \$74 for mail order	\$37	\$111 \$74 for mail order	\$37	\$88.80 \$74 for mail order	\$37	\$74
Non-preferred drugs	\$100	\$300	\$100	\$300	\$100	\$240	\$90	\$180
Specialty drugs	33%	Not available	33%	Not available	33%	Not available	33%	Not available

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.

Initial coverage	Coverage gap
Phase 1	Phase 2

When the total paid by you and the plan reaches \$5,030, Phase 2 begins.

You continue to pay your Tier 1 and Tier 2 cost-shares in Phase 2 Coverage Gap. All other cost-shares will be 25%. You stay in this stage until your out-of-pocket costs reach \$8,000. After that, you pay nothing.

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.



Dental, hearing, vision, and more

	Providence Medicare Timber + Rx (HMO)	Providence Medicare Bridge + Rx (HMO-POS)	Providence Medicare Choice + Rx (HMO-POS)	Providence Medicare Extra + Rx (HMO)
Flexible Benefit Card				
Dental flex	\$350 to spend per year	No coverage	No coverage	No coverage
Over-the-counter items	\$40 to spend per quarter	\$70 to spend per quarter	No coverage	\$195 to spend per quarter
Incentive rewards for completing healthy activities	Up to \$50 per year	Up to \$50 per year	Up to \$50 per year	Up to \$50 per year
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 to spend per year	\$250 to spend per year	\$250 to spend per year	\$250 to spend per year
Routine hearing exam (one per year)**	\$0 copay	\$0 copay	\$0 copay	\$0 copay
Hearing aids (two per year)**	\$699 or \$999 per hearing aid	\$699 or \$999 per hearing aid	\$699 or \$999 per hearing aid	\$699 or \$999 per hearing aid
Meal delivery after inpatient hospital stay	\$0 – two meals per day for 14 days	\$0 – two meals per day for 14 days	\$0 – two meals per day for 14 days	\$0 – two meals per day for 14 days
Personal Emergency Response System	\$0	\$0	\$0	\$0
Fitness center membership	\$0	\$0	\$0	\$0
Wigs for hair loss related to chemotherapy	\$0 for synthetic 1 wig per year	\$0 for synthetic 1 wig per year	\$0 for synthetic 1 wig per year	\$0 for synthetic 1 wig per 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.

2024 Optional Supplemental Dental Benefits

Plans that include Basic or Enhanced option:

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

Benefits include: Preventative (See EOS Chapter 4) and Comprehensive Dental	Basic		Enhanced	
	In-network member responsibility	Out-of-network member responsibility*	In-network member responsibility	Out-of-network member responsibility*
Monthly premium	\$33		\$45	
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	Delta Dental Medicare Advantage		Delta Dental Medicare Advantage	
Out-of-network reimbursement	Maximum allowable charge		Maximum allowable charge	
Diagnostic and Preventative Services				
Oral examinations ²	\$0	20%	\$0	20%
Bitewing X-rays ³	\$0	20%	\$0	20%
Panoramic & other diagnostic X-rays ⁴	\$0	20%	\$0	20%
Comprehensive Dental Services				
Simple extractions	50%	60%	50%	60%
Basic fillings	30%	60%	30%	60%
Dentures	\$1,000 Lifetime Denture Benefit		\$1,500 Lifetime Denture Benefit	
Crowns and bridges	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:** 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 Oral Examination – limited to two per calendar year

³ Bitewing or Periapical X-rays – one bitewing series or one bitewing series plus periapical as needed (up to 10) per calendar year

⁴ Full mouth and Panoramic X-ray – limited to once every 5 years

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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. Providence Medicare Advantage 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), seven days a week (Oct. 1 – Dec. 7) and Monday – Friday (Dec. 8 – Sept. 30).



Want to learn more?

Here is how to connect with us.



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

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

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Check us out online for more information or to enroll at

[ProvidenceTrueHealth.com/Guides](https://www.providencetruehealth.com/guides)