Providence
Medicare Advantage Plans

2023 Enrollment Guide

Service Area Medical only - Reverence + Focus

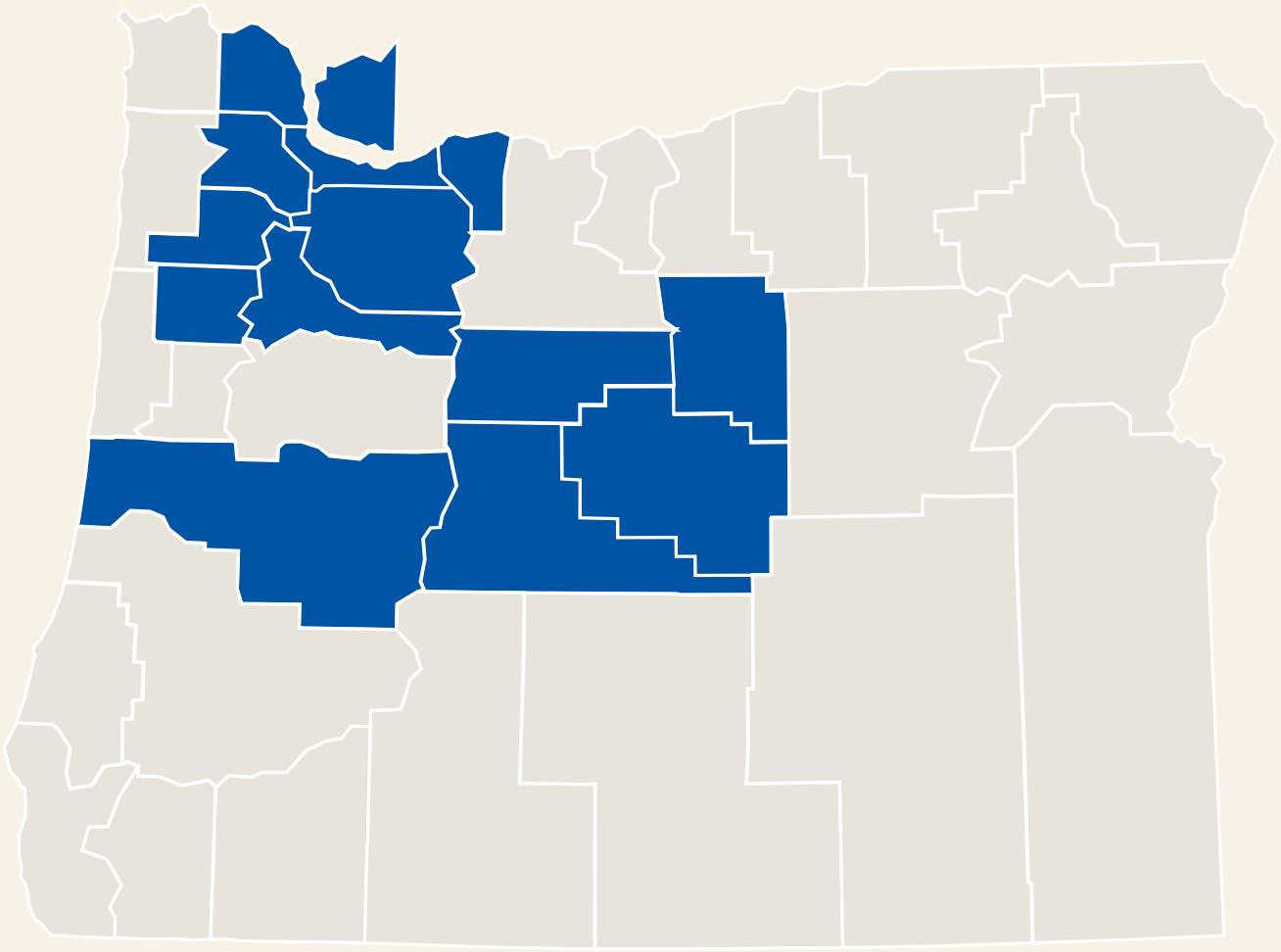
Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multomah, Polk, Washington, Wheeler, Yamhill counties in Oregon and Clark County in Washington

2023 Providence Medicare

Service Area Map

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

+ **Providence Medicare Focus Medical (HMO)**
+ **Providence Medicare Reverence Medical (HMO-POS)**



Visit **ProvidenceTrueHealth.com/plan** for more information and to find other plans available in your area.

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Providence Medicare Advantage Plans – Part C

	Providence Medicare Reverence (HMO-POS)		Providence Medicare Focus Medical (HMO)
Monthly premium	$51		$128
	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 no referral	$50	$20
Preventive care	$0	30%	$0
Inpatient hospital	Days 1-6: $300/day Day 7 and beyond: $0/day	30%	Days 1-5: $250/day Day 6 and beyond: $0/day
Skilled nursing facility	Days 1-20: $0 Days 21-100: $160/day	30%	Days 1-20: $0 Days 21-100: $150/day
Outpatient surgery	$250 Ambulatory $250 Hospital	30%	$200 Ambulatory $250 Hospital
Diabetic supplies	$0 – 20%	30%	$0 – 20%
Lab	$0	30%	$0
X-ray	$15	30%	$0
Outpatient diagnostic tests & procedures	20%	30%	20%
Alternative care Chiropractic Acupuncture Naturopathy	($500 maximum) $20 $30 $30	No coverage	($500 maximum) $20 $20 $20
Therapy: PT, OT, ST	$30	30%	$20
Durable medical equipment	20%	30%	20%
Home health	$0	30%	$0
Telehealth**	$15 PCP $30 Specialist	$25 PCP $50 Specialist	$0 PCP $20 Specialist
	Worldwide coverage		**Worldwide coverage**
Urgent care	$50		$50
Emergency room*	$90		$70
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 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 Reverence (HMO-POS)	Providence Medicare Focus Medical (HMO)
Preventive dental	$0	$0
Routine eye exams	Up to $75 allowance per year	Up to $75 allowance per year
Prescription eyeglasses or contact lenses*	$250 allowance per year	$250 allowance per year
Routine hearing exam (one per year)**	$0 copay	$0 copay
Hearing aids (two per year)	$399 or $699 per hearing aid	$399 or $699 per hearing aid
Over-the-counter allowance	$75 allowance per quarter	$75 allowance 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
Wigs for hair loss related to chemotherapy	20% for synthetic 1 wig per year	20% for synthetic 1 wig per year

*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.

2023 Optional Supplemental Dental Benefits

Plans that include Basic or Enhanced option:
Providence Medicare Reverence (HMO-POS), Providence Medicare Focus Medical (HMO)

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	50% $250 Lifetime Denture Benefit	60%	50% $250 Lifetime Denture Benefit	60%
Crowns and bridges	50% $100 limit per tooth per year	60%	50% $500 limit per year	60%
Oral surgery	Not covered		50%	60%
Endodontics (root canals)	Not covered		50%	60%
Periodontics (deep cleaning)	Not covered		50%	60%

***Important notes:** Members may use any licensed dentist. Non-Medicare 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 may receive two periodic oral evaluations or one periodic oral evaluation and one problem-focused oral evaluation per calendar year)

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

[5] Full mouth and Panoramic X-ray – limited to once every 60 months

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.

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.

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Pre-Enrollment

Checklist

Providence Medicare Advantage Plans

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

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **ProvidenceHealthAssurance.com/EOC** 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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

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/co-insurance may change every year.
- 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, the provider must agree to treat you. Except in an emergency or urgent situation, 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.
- Effect on current coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

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Expires: 07/31/2024

Providence
Medicare Advantage Plans

2023 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.

Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

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

Select the plan you want to join:

☐ Providence Medicare Focus Medical (HMO) - $128 per month

☐ Providence Medicare Reverence (HMO-POS) - $51 per month

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

☐ **Basic:** $32.50 per month.

☐ **Enhanced:** $45.10 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) _____

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 _____

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) Effective Date (Optional) __ __/__ __/__ __ __ __

Medical (Part B) 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.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- 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 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.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer.**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

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 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.**

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 1-844-791-1468, 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 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.

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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.

- ☐ I am new to Medicare.
- ☐ I am leaving employer or union coverage on (insert date):___ ___ /___ ___/___ ___
- ☐ 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): ___ ___ /___ ___/___ ___
- ☐ I am enrolling during the Annual Enrollment Period (October 15-December 7)
- ☐ I am enrolling during a Special Enrollment Period (insert special enrollment being used) _____
- ☐ 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).
- ☐ 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):___ ___ /___ ___/___ ___
- ☐ I recently was released from incarceration. I was released on (insert date):___ ___ /___ ___/___ ___
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date):___ ___ /___ ___/___ ___
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date):___ ___ /___ ___/___ ___
- ☐ 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): ___ ___ /___ ___/___ ___
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ I recently left a PACE program on (insert date):___ ___ /___ ___/___ ___
- ☐ 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.
- ☐ 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):___ ___ /___ ___/___ ___
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date):___ ___ /___ ___/___ ___
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan (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): ___ ___ /___ ___ /___ ___
- ☐ I recently received notice of a Medicare entitlement determination for a retroactive effective date. (Please attach a copy of your entitlement notice.) I 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

Providence Medicare Advantage Plans

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

If you did not find a selection that best describes your racial or ethnic identity in Section 2, please make a selection from the following list. Which of the following describes your racial or ethnic identity? Please check all that apply.

Native Hawaiian or Pacific Islander

- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Tongan

White

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

Other

- ☐ Other
- ☐ I don't know.
- ☐ I 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

Black or African American

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

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Asian

- ☐ Cambodian
- ☐ Communities of Myanmar
- ☐ Hmong
- ☐ Laotian
- ☐ South 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

What is your preferred written language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Simplified Chinese
- ☐ Russian
- ☐ Other
- ☐ Decline/Unknown

If you did not find a selection that best describes your gender identity in Section 1, please make a selection from the following list. How do you identify?

- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Non-binary
- ☐ Other
- ☐ Don't know
- ☐ Decline to Answer

Providence
Medicare Advantage Plans

2023 Summary of Benefits

Providence Medicare Focus Medical (HMO)

January 1, 2023 – December 31, 2023

This plan is available in Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Clark County in Washington.

H9047_2023AMSB33_M MDC-901B

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 Focus Medical (HMO) 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 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.

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

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 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 Focus Medical (HMO)

Monthly Plan Premium	$128 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: $3,400

Benefits		In-network
Inpatient Hospital Coverage[1]		$250 copayment each day for days 1-5 and $0 copayment each day for day 6 and beyond
Outpatient Hospital Coverage[1]		$250 copayment for outpatient surgery at a hospital facility
Ambulatory Surgical Center (ASC) Services[1]		$200 copayment for outpatient surgery at an Ambulatory Surgical Center
Doctor Visits	Primary Care Provider Visit	$0 copayment
	Specialist Visit[2]	$20 copayment
Preventive Care		You pay nothing
Emergency Care		$70 copayment If you are admitted to the hospital within 24 hours, the emergency care copayment will be waived.
Urgently Needed Services		$50 copayment If you are admitted to the hospital within 24 hours, the urgent care copayment will be waived.

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

Providence Medicare Focus Medical (HMO)

Benefits		In-network
Diagnostic Services/ Labs/Imaging	Diagnostic Radiology Services (e.g. MRI, ultrasounds, CT scans)[1]	15% of the total cost
	Therapeutic Radiology Services	15% of the total cost
	Outpatient X-rays	$0 copayment
	Diagnostic Tests and Procedures[1]	20% of the total cost
	Lab Services	$0 copayment
Hearing Services	Medicare-Covered[2]	$20 copayment
	Routine Exam	$0 copayment
	Hearing Aids	$399 copayment per Advanced hearing aid or $699 copayment per Premium hearing aid
Dental Services	Medicare-Covered[2]	$20 copayment
	Embedded Preventive	$0 copayment Includes exams, cleanings, X-rays; limits apply
	Optional	Covered for additional premium; see last page of this summary
Vision Services	Medicare-Covered Exams[2]/Screening	$20 copayment per exam $0 copayment 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
	Routine Eyeglasses or Contact Lenses	Allowance of up to $250 per calendar year for any combination of routine prescription eyewear
Mental Health Services	Inpatient Visit[1]	$200 copayment each day for days 1-7 and $0 copayment each day for days 8-90
	Outpatient Individual and Group Therapy Visit[1]	$20 copayment

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

Providence Medicare Focus Medical (HMO)

Benefits	In-network
Skilled Nursing Facility (SNF)[1]	$0 copayment each day for days 1-20 and $150 copayment each day for days 21-100
Physical Therapy[1]	$20 copayment
Ambulance[1]	$250 copayment
Transportation	Not covered
Medicare Part B Drugs[1]	20% of the total cost
Alternative Care (combined benefit limit for chiropractic, acupuncture & naturopath services)	Chiropractic: $20 copayment Naturopath and Acupuncture Specialist: $20 copayment $500 plan maximum
Meal Delivery Program (post-discharge only)	$0 copayment for 2 meals per day for 14 days, following a qualifying inpatient hospitalization
Over-the-Counter Items	$75 allowance every three months (retail card, catalog, online, mail, and telephonic ordering)
Personal Emergency Response System (PERS)	$0 copayment
Wellness Program	$0 copayment for monthly gym membership with participating fitness clubs
Wig	20% of the total cost for one synthetic wig due to hair loss from chemotherapy

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

Optional Supplemental Dental
Providence Medicare Focus Medical (HMO)

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 $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: Providence Dental Enhanced 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.

Providence
Medicare Advantage Plans

2023 Summary of Benefits

Providence Medicare Reverence (HMO-POS)

January 1, 2023 – December 31, 2023

This plan is available in Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, and Yamhill counties in Oregon and Benton, Clark, Franklin, Snohomish, Spokane, and Walla Walla counties in Washington.

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 Reverence (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 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.

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 Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Marion, Multnomah, Polk, Washington, Wheeler, 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 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 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	$51 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: $4,500	Out-of-network: $10,000 combined

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	30% of the total cost per admission
Outpatient Hospital Coverage[1]		$250 copayment for outpatient surgery at a hospital facility	30% of the total cost
Ambulatory Surgical Center (ASC) Services[1]		$250 copayment for outpatient surgery at an Ambulatory Surgical Center	30% of the total cost
Doctor Visits	Primary Care Provider Visit	$15 copayment	$25 copayment
	Specialist Visit[2]	$30 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, the emergency care copayment will be waived.	
Urgently Needed Services		$50 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.

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

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	30% of the total cost
	Therapeutic Radiology Services	20% of the total cost	30% of the total cost
	Outpatient X-rays	$15 copayment per day	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]	$30 copayment	30% of the total cost
	Routine Exam	$0 copayment	Not covered
	Hearing Aids	$399 copayment per Advanced hearing aid or $699 copayment per Premium hearing aid	Not covered
Dental Services	Medicare-Covered[2]	$30 copayment	30% of the total cost
	Embedded Preventive	$0 copayment Includes exams, cleanings, X-rays; limits apply	
	Optional	Covered for additional premium; see last page of this summary	
Vision Services	Medicare-Covered Exams/Screening[2]	$30 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 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	30% of the total cost per admission
	Outpatient Individual and Group Therapy Visit[1]	$30 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]		$30 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
Alternative Care (combined benefit limit for chiropractic, acupuncture & naturopath services)		Chiropractic: $20 copayment Naturopath and Acupuncture Specialist: $30 copayment $500 plan maximum	Not covered
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		$75 allowance every three 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		20% of the total cost for one synthetic wig due to hair loss from chemotherapy	

[1] Services may require prior authorization.
[2] Services may require a referral from your doctor.

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 $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: Providence Dental Enhanced 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 their 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 cover- age 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.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2023 Medicare Star Ratings

Providence Medicare Advantage Plans - H9047

For 2023, Providence Medicare Advantage Plans - H9047 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★☆
Drug Services Rating:	★★★½☆

Providence Medicare Advantage Plans

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.

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.

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 (TTY). Current members please call 800-603-2340 (toll-free) or 711 (TTY).

Providence
Medicare Advantage Plans

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-603-2340 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-603-2340 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-603-2340 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-603-2340 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-603-2340 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-603-2340 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-603-2340 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Providence
Medicare Advantage Plans

Form Approved
OMB# 0938-1421

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-603-2340 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-603-2340 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على1-800-603-2340 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-603-2340 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-603-2340 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-603-2340 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan1-800-603-2340 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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