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Enrollment Kit PREMIERCARE Plus



Questions? Please call us at 866-798-CARE (2273) TTY: 800-735-2900
Also, please visit us at www.FamilyCareHealthPlans.org



Thank you for your interest in PremierCare Medicare Advantage plans (HMO), offered by FamilyCare Health Plans, Inc. Choosing the right Medicare Plan is important! We hope to help you make a good plan selection that will fit your lifestyle and bring you all the advantages a great health plan has to offer.

FamilyCare Health Plans can save you money each month, and increase your benefits and services.

Here at FamilyCare Health Plans, your individual health needs are important to us. We are a local, Portland-based company and work hard to keep you healthy.

As a member of your community, we have been proudly serving Oregonians for over 25 years with quality health care, bringing you the peace of mind you deserve when choosing a health plan.

Enclosed you will find information about our unique Medicare health plan options for 2011. When you choose one of our Medicare plans, your calls will be answered by our Medicare experts and our local team will help you get the care you need. As a plan member, you'll have access to a 24-hour Nurse Advice Line and access to our pharmacy support staff 24 hours a day, 7 days a week.

You'll find that our combination of local care coordination, the extra services and benefits included in all of our plans, and our low monthly premiums will help you access the quality health care that you deserve.

Medicare can be confusing. We're here to help you understand your Medicare benefits and to explain how our unique plan options can help you get the most from your Medicare benefits. If you have any questions, we are here for you Monday through Friday, 8 am to 8 pm. Call us toll free at 1-866-225-CARE (2273). TTY users please call 1-800-735-2900. Or you can complete the enclosed enrollment application and return it to us in the postage paid, self-addressed envelope.

You may get more information about Medicare Advantage plans, including general information regarding Part D benefits, by calling Medicare at 1-800-MEDICARE (1-800-633-4227) or online at <http://www.medicare.gov>.

Thank you again for considering PremierCare Medicare Advantage plans, offered by FamilyCare Health Plans. Your Health is Our Mission!

Sincerely,

FamilyCare Health Plans

H3818_MA_PCP_DM052v5 CMS Approved 10/01/2010

Introduction to the Summary of Benefits Report

For PREMIERCARE PLUS (HMO SNP)

January 1, 2011 - December 31, 2011

PORTLAND METRO, CLATSOP, MORROW and UMATILLA COUNTIES

Contract # H3818 / Plan 002

Thank you for your interest in PremierCare Plus (HMO SNP). Our plan is offered by FamilyCare Health Plans, Inc., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP). This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Please call PremierCare Plus (HMO SNP) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call PremierCare Plus (HMO SNP) and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTHCARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like PremierCare Plus (HMO SNP). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call PremierCare Plus (HMO SNP) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare PremierCare Plus (HMO SNP) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can

see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS PREMIERCARE PLUS (HMO SNP) AVAILABLE?

The service area for this plan includes: Clackamas, Clatsop, Morrow, Multnomah, Umatilla and Washington Counties, OR. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN PREMIERCARE PLUS (HMO SNP)?

You can join PremierCare Plus (HMO SNP) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area.

However, individuals with End Stage Renal Disease generally are not eligible to enroll in PremierCare Plus (HMO SNP) unless they are members of our organization and have been since their dialysis began.

You must also receive assistance from the state to join this plan.

Please call plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

PremierCare Plus (HMO SNP) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current Provider/Pharmacy Directory or, for an up-to-date list, visit us at www.familycarehealthplans.org.

Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example,

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emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

PremierCare Plus (HMO SNP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a Provider/Pharmacy Directory or visit us at <http://www.familycarehealthplans.org>. Our customer service number is listed at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

PremierCare Plus (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

PremierCare Plus (HMO SNP) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our website at www.familycarehealthplans.org.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

*1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication *Medicare & You*.

*The Social Security Administration at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY/TDD users should call 1-800-325-0778; or Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of PremierCare Plus (HMO SNP), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of PremierCare Plus (HMO SNP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug

that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact PremierCare Plus (HMO SNP) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact PremierCare Plus (HMO SNP) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia clotting factors: Self-administered clotting factors if you have hemophilia.

- Injectable drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some oral cancer drugs: If the same drug is available in injectable form.
- Oral anti-nausea drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs provided through DME.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select “Compare Medicare Prescription Drug Plans” or “Compare Health Plans and Medigap Policies in Your Area” to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below. Please call FamilyCare Health Plans, Inc. for more information about PremierCare Plus (HMO SNP). Visit us at familycarehealthplans.org or, call us: Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday and Friday, 8 am–8 pm Pacific

Current members should call toll-free 866-798-2273 for questions related to the Medicare Advantage Program. (TTY/TDD 800-735-2900)

Prospective members should call toll-free 866-225-2273 for questions related to the Medicare Advantage Program. (TTY/TDD 800-735-2900)

Current members should call locally 503-345-5702 for questions related to the Medicare Advantage Program. (TTY/TDD 800-735-2900)

Prospective members should call locally 503-345-5701 for questions related to the Medicare Advantage Program. (TTY/TDD 800-735-2900)

Current members should call toll-free 866-798-2273 for questions related to the Medicare Part D Prescription Drug program (TTY/TDD 800-735-2900)

Prospective members should call toll-free

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866-225-2273 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 800-735-2900)

Current members should call locally 503-345-5702 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 800-735-2900)

Prospective members should call locally 503-345-5701 for questions related to the Medicare

Part D Prescription Drug program. (TTY/TDD 800-735-2900)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats or languages.

Benefit	Original Medicare	PremierCare Plus
<p>1. Premium and Other Important Information</p>	<p>The Medicare cost-sharing amount may vary based on your level of Medicaid eligibility.</p> <p>In 2010, the monthly Part B premium was \$0 or \$96.40 and may change for 2011, and the yearly Part B deductible amount was \$0 or \$155 and may change for 2011.*</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General</p> <p>*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.</p> <p>**Please consult with your plan when receiving services from out-of-network providers.</p> <p>\$35.30 monthly plan premium in addition to your monthly Medicare Part B premium.*</p> <p>0% or 20% of the cost of Medicare-covered preventative services.</p> <p>In-Network</p> <p>In 2010, the yearly Part B deductible amount was \$0 or \$155 and may change for 2011.</p> <p>\$3,400 out-of-pocket limit.</p> <p>This limit includes only Medicare-covered services.</p>
<p>2. Doctor and Hospital Choice</p> <p>(For more information, see emergency #15 and Urgently Needed Care #16)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network</p> <p>You must go to network doctors, specialists and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p>
INPATIENT CARE		
<p>3. Inpatient Hospital Care</p> <p>(Includes substance abuse & rehabilitation services)</p>	<p>In 2010, the amounts for each benefit period were:</p> <p>\$0 or:</p> <p>Days 1-60: \$1,100 deductible</p> <p>Days 61-90: \$275 per day</p> <p>Days 91-150: \$550 per lifetime reserve day</p> <p>These amounts will change for 2011.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.</p> <p style="text-align: right;"><i>Continued on Page 6</i></p>	<p>In-Network</p> <p>Plan covers 90 days each benefit period.</p> <p>In 2010, the amounts for each benefit period were:</p> <p>\$0 or</p> <p>Days 1-60: \$1,100 deductible*</p> <p>Days 61-90: \$275 per day*</p> <p>Days 91-150: \$550 per lifetime reserve day</p> <p>These amounts may change for 2011.</p> <p>You will not be charged additional cost sharing for professional services.</p> <p style="text-align: right;"><i>Continued on Page 6</i></p>

Benefit	Original Medicare	PremierCare Plus
<p>Inpatient Hospital Care (Continued from Page 5)</p>	<p><i>Continued from page 5</i></p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><i>Continued from page 5</i></p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>4. Inpatient Mental Health Care</p>	<p>Same deductible and co-pay as inpatient hospital care. (See “Inpatient Hospital Care” above.)</p> <p>190-day lifetime limit in a psychiatric hospital.</p>	<p>In-Network</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Same deductible and co-pay as inpatient hospital care (See “Inpatient Hospital Care”)</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>5. Skilled Nursing Facility (SNF) (In a Medicare-certified nursing facility)</p>	<p>In 2010, the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1–20: \$0 per day</p> <p>Days 21–100: \$137.50 per day</p> <p>These amounts will change for 2011. 100 days for each benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>General</p> <p>Authorization rules may apply</p> <p>In-Network</p> <p>No limit on days covered each benefit period.</p> <p>No prior hospital stay is required.</p> <p>In 2010, the amounts for each benefit period were:</p> <p>\$0 or:</p> <p>Days 1–20: \$0 per day*</p> <p>Days 21–100: \$137.50 per day.</p> <p>These amounts may change for 2011.</p> <p>You will not be charged additional cost sharing for professional services.</p>

Benefit	Original Medicare	PremierCare Plus
6. Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 co-pay	General Authorization rules may apply. In-Network \$0 co-pay for Medicare-covered home health visits.*
7. Hospice	You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.
OUTPATIENT CARE		
8. Doctor Office Visits	0% or 20% co-insurance	General Authorization rules may apply. In-Network 0% or 20% of the cost for each specialist visit for Medicare-covered benefits.* 0% or 20% of the cost for each specialist visit for Medicare-covered benefits*
9. Chiropractic Services	Routine care not covered 0% or 20% co-insurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	General Authorization rules may apply. In-Network 0% or 20% of the cost for each Medicare-covered visit.* Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
10. Podiatry Services	Routine care not covered. 0% or 20% co-insurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	General Authorization rules may apply. In-Network 0% or 20% of the cost for each Medicare-covered visit.* Medicare-covered podiatry benefits are for medically-necessary foot care.

SECTION II

Benefit	Original Medicare	PremierCare Plus
11. Outpatient Mental Health Care	0% or 45% co-insurance for most outpatient mental health services.	<p>General Authorization rules may apply.</p> <p>In-Network 0% or 20% of the cost for each Medicare-covered individual or group therapy visit.*</p>
12. Outpatient Substance Abuse Care	0% or 20% co-insurance	<p>General Authorization rules may apply.</p> <p>In-Network 0% or 20% of the cost for Medicare-covered individual or group visits.*</p>
13. Outpatient Services and Surgery	<p>0% or 20% co-insurance for the doctor</p> <p>Specified co-payment for outpatient hospital facility charges Co-pay cannot exceed the Part A inpatient hospital deductible.</p> <p>20% co-payment for ambulatory surgical center facility charges</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% or 20% of the cost for each Medicare-covered ambulatory surgical center visit.*</p> <p>0% or 20% of the cost for each Medicare-covered outpatient hospital facility visit.*</p>
14. Ambulance Services (Medically necessary ambulance services)	0% or 20% co-insurance	<p>In-Network 0% or 20% of the cost for Medicare-covered ambulance benefits.*</p> <p>If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.</p>
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	<p>0% or 20% co-insurance for the doctor</p> <p>Specified co-payment for outpatient hospital emergency room (ER) facility charge.</p> <p>ER co-pay cannot exceed Part A inpatient hospital deductible.</p> <p>You don't have to pay the emergency room co-pay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>Not covered outside the U.S. except under limited circumstances</p>	<p>General \$0 or \$50 co-pay for Medicare-covered emergency room visits.</p> <p>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</p>

Benefit	Original Medicare	PremierCare Plus
16. Urgently Needed Care (This is NOT emergency care and, in most cases, is out-of-the-service area.)	0% or 20% co-insurance or a set co-pay Not covered outside the U.S. except under limited circumstances	General 0% or 20% of the cost for Medicare-covered urgently needed care visits.* If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the urgently-needed care visit.
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/ Psychological Services, and more)	0% or 20% co-insurance	General Authorization rules may apply. In-Network \$0 or \$10 co-pay for Medicare-covered occupational therapy visits.* \$0 or \$10 co-pay for Medicare-covered physical and/or speech and language therapy visits.* 0% or 20% of the cost for Medicare-covered cardiac rehab services.*
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18. Durable Medical Equipment (Includes wheel-chairs, oxygen, etc.)	0% or 20% co-insurance	General Authorization rules may apply. In-Network 0% or 20% of the cost for Medicare-covered items*
19. Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	0% or 20% co-insurance	General Authorization rules may apply. In-Network 0% or 20% of the cost for Medicare-covered items.
20. Diabetes Self-Monitoring Training, Nutrition Therapy and Supplies (Includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/ glaucoma test, and foot exam/ therapeutic soft shoes)	0% or 20% co-insurance Nutrition therapy is for people who have diabetes or kidney disease (<i>but aren't on dialysis or haven't had a kidney transplant</i>) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	In-Network 0% or 20% of the cost for Diabetes self-monitoring training.* 0% or 20% of the cost for nutrition therapy for Diabetes.* 0% or 20% of the cost for Diabetes supplies.

SECTION II

Benefit	Original Medicare	PremierCare Plus
<p>21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>0% or 20% co-insurance for diagnostic tests and x-rays \$0 co-pay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply. In-Network 0% or 20% of the cost for Medicare-covered lab services.* 0% or 20% of the cost for Medicare-covered diagnostic procedures and tests.* 0% or 20% of the cost for Medicare-covered x-rays. 0% or 20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays).* 0% or 20% of the cost for Medicare-covered therapeutic radiology services.*</p>
PREVENTIVE SERVICES		
<p>22. Bone Mass Measurement</p>	<p>No co-insurance, co-payment or deductible. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>In-Network 0% or 20% of cost for Medicare-covered bone mass measurement.*</p>
<p>23. Colorectal Screening Exams (For people with Medicare age 50 and older)</p>	<p>No co-insurance, co-payment or deductible for screening colonoscopy or screening flexible sigmoidoscopy Covered when you are high risk or when you are age 50 and older.</p>	<p>In-Network 0% or 20% of cost for Medicare-covered bone mass measurement.*</p>
<p>24. Immunizations (Flu vaccine, Hepatitis B vaccine—<i>for people with Medicare who are at risk</i>, Pneumonia vaccine)</p>	<p>\$0 co-pay for Flu and Pneumonia and Hepatitis B vaccines You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>In-Network \$0 co-pay for flu and pneumonia vaccines. No referral needed for flu and Pneumonia vaccines. 0% or 20% of the cost for Hepatitis B vaccine.*</p>
<p>25. Mammograms (Annual Screening) (For women with Medicare age 40 and older)</p>	<p>No co-insurance, co-payment or deductible. No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between ages 35 and 39.</p>	<p>In-Network 0% or 20% of the cost for Medicare-covered screening mammograms.*</p>

Benefit	Original Medicare	PremierCare Plus
<p>26. Pap Smears and Pelvic Exams (For women with Medicare)</p>	<p>No co-insurance, co-payment or deductible for Pap smears No co-insurance, co-payment or deductible for pelvic and clinical breast exams Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p>	<p>In-Network 0% or 20% of the cost for Medicare-covered Pap smears and pelvic exams.*</p>
<p>27. Prostate Cancer Screening Exams (For men with Medicare age 50 and older)</p>	<p>0% or 20% co-insurance for the digital rectal exam \$0 for the PSA test; 0% or 20% co-insurance for other related services Covered once a year for all men with Medicare over age 50</p>	<p>In-Network 0% or 20% of the cost for Medicare-covered prostate cancer screening.*</p>
<p>28. End-Stage Renal Disease</p>	<p>0% or 20% co-insurance for renal dialysis 0% or 20% co-insurance for nutrition therapy for end-stage renal disease. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General Authorization rules may apply. In-Network 0% or 20% of the cost for renal dialysis* 0% or 20% of the cost for nutrition therapy for end-stage renal disease.*</p>

Table continues on page 12

Benefit	Original Medicare	PremierCare Plus
29. Prescription Drugs	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General</p> <p>\$0 yearly deductible for Part B-covered drugs.*</p> <p>0% or 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.*</p> <p>Drugs covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.familycarehealthplans.org on the web.</p> <p>Different out-of-pocket costs may apply for people who:</p> <ul style="list-style-type: none"> Have limited incomes, Live in long term care facilities, or Have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from PremierCare Plus (HMO SNP) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to</p> <p style="text-align: right;"><i>Continued on Page 13</i></p>

Benefit	Original Medicare	PremierCare Plus
<p>Prescription Drugs <i>Continued from Page 12</i></p>		<p><i>Continued from Page 12</i></p> <p>special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>In-Network You pay a \$0 yearly deductible.</p> <p>Initial Coverage Depending on your income and institutional status, you pay the following: For generic drugs (including brand drugs treated as generic), either: A \$0 co-pay; or A \$1.10 co-pay; or A \$2.50 co-pay For all other drugs, either: A \$0 co-pay; or A \$3.30 co-pay; or \$6.30 co-pay.</p> <p style="text-align: center;">Retail Pharmacy</p> <p>You can get drugs the following ways: One-month (30-day) supply Three-month (90-day) supply</p> <p style="text-align: center;">Long-Term Care Pharmacy</p> <p>You can get drugs the following ways: One-month (31-day) supply</p> <p style="text-align: center;">Mail Order</p> <p>You can get drugs the following ways: One-month (30-day) supply Three-month (90-day) supply</p> <p style="text-align: right;"><i>Continued on Page 14</i></p>

Benefit	Original Medicare	PremierCare Plus
<p data-bbox="142 226 316 296">Prescription Drugs</p> <p data-bbox="107 306 310 375"><i>Continued from Page 13</i></p>		<p data-bbox="951 226 1268 260"><i>Continued from Page 13</i></p> <p data-bbox="951 275 1268 308">Catastrophic Coverage</p> <p data-bbox="951 321 1471 390">After your yearly out-of-pocket drug costs reach \$4,550, you pay a \$0 co-pay.</p> <p data-bbox="951 405 1179 438">Out-of-Network</p> <p data-bbox="951 451 1476 856">Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from PremierCare Plus (HMO SNP).</p> <p data-bbox="951 871 1433 905">You can get drugs the following way:</p> <p data-bbox="951 917 1133 951">10-day supply</p> <p data-bbox="951 963 1401 997">Out-of-Network Initial Coverage</p> <p data-bbox="951 1010 1476 1140">Depending on your income and institutional status, you will be reimbursed by PremierCare Plus (HMO SNP) up to the full cost of the drug minus the following:</p> <p data-bbox="951 1152 1451 1251">For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <ul data-bbox="951 1264 1195 1381" style="list-style-type: none"> <li data-bbox="951 1264 1154 1297">A \$0 co-pay; or <li data-bbox="951 1310 1195 1344">A \$1.10 co-pay; or <li data-bbox="951 1356 1149 1390">A \$2.50 co-pay <p data-bbox="951 1402 1422 1457">For all other drugs purchased out-of-network, either:</p> <ul data-bbox="951 1470 1195 1587" style="list-style-type: none"> <li data-bbox="951 1470 1154 1503">A \$0 co-pay; or <li data-bbox="951 1516 1195 1549">A \$3.30 co-pay; or <li data-bbox="951 1562 1154 1596">A \$6.30 co-pay. <p data-bbox="951 1608 1268 1663">Out-of-Network Catastrophic Coverage</p> <p data-bbox="951 1675 1443 1814">After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed in full for drugs purchased out-of-network.</p>

Benefit	Original Medicare	PremierCare Plus
30. Dental Services	Preventive dental services (such as cleaning) not covered.	In-Network \$0 co-pay for Medicare-covered dental benefits.* In general, preventive dental benefits (such as cleaning) not covered.
31. Hearing Services	Routine hearing exams and hearing aids not covered. 0% or 20% co-insurance for diagnostic hearing exams.	In-Network In general, routine hearing exams and hearing aids not covered. 0% or 20% of the cost for Medicare-covered diagnostic hearing exams.*
32. Vision Services	0% or 20% co-insurance for diagnosis and treatment of diseases and conditions of the eye Routine eye exams and glasses not covered Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	In-Network Non-Medicare-covered eye exams and glasses not covered. 0% or 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.* 0% or 20% of the cost for exams to diagnose and treat diseases and conditions of the eye.*
33. Physical Exams “Welcome to Medicare” and Annual Wellness Visit	When you get Medicare Part B, then you are eligible as follows: During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit. After your first 12 months, you can get one annual Wellness visit every 12 months. There is no co-insurance, co-payment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit. The Welcome to Medicare exam does not include lab tests.	In-Network When you get Medicare Part B, you can get a one-time physical within the first 12 months of your new Part B coverage. The coverage does not include lab tests. Routine exams not covered. 0% to 20% of the cost for Medicare-covered benefits*
34. Health and Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each <i>Continued on Page 16</i>	General Authorization rules may apply. In-Network The plan covers the following health/wellness education benefits: <i>Continued on Page 16</i>

SECTION II

Benefit	Original Medicare	PremierCare Plus
<p>35. Health and Wellness Education <i>Continued from Page 15</i></p>	<p><i>Continued from Page 15</i> counseling attempt includes up to four face-to-face visits. You pay co-insurance, and Part B deductible applies. \$0 co-pay for the HIV screening, but you generally pay 0% or 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p>	<p><i>Continued from Page 15</i> Written health education materials, including Newsletters Nursing Hotline \$0 co-pay for each Medicare-covered smoking cessation counseling session. \$0 co-pay of the cost for each Medicare-covered HIV screening. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p>
<p>Transportation (Routine)</p>	<p>Not covered</p>	<p>In-Network This plan does not cover routine transportation.</p>
<p>Acupuncture</p>	<p>Not covered</p>	<p>In-Network This plan does not cover acupuncture.</p>

ADDITIONAL INFORMATION THAT WILL BE HELPFUL IN UNDERSTANDING YOUR BENEFITS

FamilyCare understands it can be hard to transition to a new health plan. We will work hard to help you understand what will be happening as you move on to our plan. Below is some information that will help you understand how our plan works. Please contact us if you have additional questions or need clarification on anything you have received from us. We look forward to working with you.

YOUR ANNUAL PHYSICAL EXAM

FamilyCare encourages you to partner with your primary care physician so that he or she can effectively evaluate your healthcare needs. Unlike Medicare's one-time initial physical exam, FamilyCare is providing you with an annual physical exam benefit with a \$0 co-pay.

This comprehensive annual physical exam includes x-ray services, preventive medicine evaluation, age and gender appropriate health history assessment, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures. With this unique benefit, your doctor can help you stay healthy, and it costs you nothing out of pocket. Please contact your provider to set up an appointment.

URGENT AND EMERGENCY CARE COVERAGE AVAILABLE WORLDWIDE

Your coverage includes a worldwide benefit for urgent or emergency care. To use this benefit, you will need to notify the provider of your coverage with FamilyCare and in most cases, pay for the services and be reimbursed by the plan. For FamilyCare to process any claim, we need to have the following information:

1. Name of provider
2. Address of provider
3. Tax Identification number of the provider
4. National provider identification number
5. Medicare provider identification number
6. Date of service
7. Type of service provided
8. Medical condition being treated
9. Itemized charges for the services provided

If you have any questions about what to pay a provider or where to send a paper claim you may call Customer Service.

What is a medical emergency?

A "medical emergency" is when you believe your health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness or a medical condition that is quickly getting much worse.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it wasn't a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger, as explained in "What is a medical emergency" above. If you get any extra care after the doctor says it wasn't a medical emergency, the Plan will pay its portion of the covered additional care only if you get it from a network provider. We will pay our portion of the covered additional care from an out-of-network provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" given below.

What is the difference between a medical emergency and urgently needed care?

The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A "medical emergency" occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. "Urgently needed care" is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger, and you are generally outside of the service area.

How to get urgently needed care

If, while temporarily outside the Plan's service area, you require urgently needed care, then you may get this care from any provider.

If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the Plan according to its procedures and requirements as outlined earlier in this section.

Continued from Page 17

How to submit a paper claim for emergency or urgently needed care

When you receive emergency or urgently needed healthcare services from a provider who is not part of our network, you are responsible for paying your plan cost sharing amount and you should tell the provider to bill our Plan for the balance of the payment they are due. However, if you have received a bill from the provider, please send that claim to FamilyCare Health Plans so we can pay the provider the amount they are owed.

CHOOSING A PRIMARY CARE PHYSICIAN (PCP)

If you are choosing a provider you have not seen in the past

It is important that you establish a good relationship with your PCP. We encourage you to contact your provider and set an initial appointment as soon as possible after your effective date on the plan. This will help eliminate any issues that could prevent you from getting needed services at a later date.

If you choose a provider that you are already established with

You need to let the provider know that you have changed plans and now have insurance coverage through FamilyCare Health Plans. This will allow them to confirm coverage and bill the correct plan. At the time of your appointment, it is important that you confirm that the provider is contracted with FamilyCare Health Plans.

USING GENERIC MEDICATIONS

As the cost of medical care increases, one way to help control some of your costs is to consider using generic medications whenever possible. Generic medications meet the same standards of safety and effectiveness as brand name medications at a fraction of the cost. Please contact your provider to discuss your medications and the options you have available to you under our plan.

IMMUNIZATIONS

Flu and Pneumonia immunizations can be administered by either a pharmacy or your provider for \$0 co-payment. Other immunizations such as Hepatitis B may be available for those at risk for 0% or 20% co-insurance.

VACCINATIONS

Zostavax vaccination can be administered at the pharmacy for your normal co-insurance or co-payment. If you choose to have this administered at your provider's office, the entire cost is paid up front (vaccine and administration) and reimbursed this amount less your normal co-insurance or co-payment. If you choose to obtain the vaccination at the pharmacy and have your provider administer the vaccination, you will pay the normal co-insurance or co-payment and then the full administration cost charged by your provider. You are reimbursed the administration charge less any in-network charge.

MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, are taking many prescription drugs, and have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help our members utilize their medications appropriately. For example, these programs help us make sure our members are using appropriate drugs to treat their medical conditions and help us identify possible medication interactions.

We may contact members who qualify for these programs. If we contact you, we hope you will join so we can help you manage your medications. Remember, you don't need to pay anything extra to participate. If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

SUMMARY OF BENEFITS

Medicaid-covered Services

In this section you can see a summary of the Medicaid benefits you may receive through the Oregon Health Plan (OHP). As long as you are eligible for the Oregon Health Plan and Medicare Parts A and B, the Medicaid Benefits Packages you can have through the Oregon Health Plan are the QMB + OHP Limited Drug Benefit Package or the OHP with Limited Drug Benefit Package. Please contact your State Medicaid case worker if you do not know which benefit package you have through the Oregon Health Plan.

This section does not list every Medicaid service covered or list every limitation or exclusion. To get a complete list of Medicaid benefits, please contact your Medicaid health plan Customer Services. **You must be eligible for Oregon Health Plan/Medicaid in order to receive the benefits listed in this section.**

OREGON HEALTH PLAN (OHP) MEDICAID BENEFIT PACKAGES:

QMB + OHP with Limited Drug Benefit Package

This benefit package is for people who qualify to have their Medicare Parts A and B cost sharing paid for by Medicaid. If you receive the QMB + OHP with Limited Drug Benefit Package, you get the benefits listed in the chart beginning on page 20.

The cost sharing amounts listed in Section II for the Medicare Parts A and B covered services are paid for

you by your Medicaid health plan. Your provider cannot bill you for any amounts beyond what your Medicare and Medicaid plans pay.

You will still have to pay your Medicare Part D prescription drug cost sharing.

OHP with Limited Drug Benefit Package

This benefit package is for people who only qualify to have their Medicare Parts A and B cost sharing paid for by Medicaid for services normally covered by the Oregon Health Plan. If you receive the OHP with Limited Drug Benefit Package you get the benefits listed in the chart below.

The cost sharing amounts listed in Section II for Medicare Parts A- and B-covered services will be covered only for services that the Oregon Health Plan would normally cover. Your provider cannot balance bill you for any amounts beyond what your Medicare and Medicaid plans pay for services normally covered by the Oregon Health Plan.

If you receive a Medicare covered service that is not normally covered by the Oregon Health Plan you will have to pay the Medicare Parts A and B cost sharing yourself. See page 30 for more information on services not covered by the Oregon Health Plan.

You will still have to pay your Medicare Part D prescription drug cost sharing.

SECTION IV

Below is a list of services that are covered by the Oregon Health Plan Medicaid and PremierCare Plus, our Medicaid-managed care plan. (Does not include every service available.)

BENEFIT CATEGORY	OREGON HEALTH PLAN MEDICAID (Member costs)	PREMIERCARE PLUS (Member costs)
1. Premium and Other Important Information	This is a brief summary. Please refer to Oregon Health Plan member handbook for a detailed description of Medicaid benefits available to eligible Oregonians.	All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.
2. Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	Allows patients to go to any provider that accepts Medicaid.	You must go to network doctors, specialists and hospitals. Referral required for network hospitals and specialists (for certain benefits).
INPATIENT CARE		
3. Inpatient Hospital Care	\$0 co-payment for Medicaid-covered services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
4. Inpatient Mental Health Care	\$0 co-payment for Medicaid-covered services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
5. Skilled Nursing Facility (In a Medicare-certified skilled nursing facility)	\$0 co-payment for Medicaid-covered services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
6. Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
7. Hospice	\$0 co-payment for Medicaid-covered services.	You must get care from a Medicare-certified hospice.
OUTPATIENT CARE		
8. Doctor Office Visits	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	In-Network \$0 co-payment for Medicaid-covered service.

BENEFIT CATEGORY	OREGON HEALTH PLAN MEDICAID (Member costs)	PREMIERCARE PLUS (Member costs)
9. Chiropractic Services	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	In-Network \$0 co-payment for Medicaid-covered service.
10. Podiatry Services	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	In-Network \$0 co-payment for Medicaid-covered service.
11. Outpatient Mental Health Care	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
12. Outpatient Substance Abuse Care	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
13. Outpatient Services/ Surgery	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
14. Ambulance Services (Medically necessary ambulance services)	\$0 co-payment for Medicaid-covered services.	In-Network \$0 co-payment for Medicaid-covered service.
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	\$0 co-payment for Medicaid-covered services.	In-Network \$0 co-payment for Medicaid-covered service.
16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	In-Network \$0 co-payment for Medicaid-covered service.

SECTION IV

BENEFIT CATEGORY	OREGON HEALTH PLAN MEDICAID (Member costs)	PREMIERCARE PLUS (Member costs)
17. Outpatient Re- habilitation Services (Occupational therapy, physical therapy and speech & language therapy)	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18. Durable Medical Equip- ment	\$0 co-payment for Medicaid-covered services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
19. Prosthetic Devices	\$0 co-payment for Medicaid-covered services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
20. Diabetes Self- Monitoring Training, Nutrition Therapy, and Supplies	\$0 co-payment for Medicaid-covered services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
21. Diagnostic Tests, X-Rays, and Lab Services	\$0 co-payment for Medicaid-covered services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
PREVENTIVE SERVICES		
22. Bone Mass Measurement	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	In-Network \$0 co-payment for Medicaid-covered service.
23. Colorectal Screening Exams	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	In-Network \$0 co-payment for Medicaid-covered service.
24. Immunizations	\$0 co-payment for Medicaid-covered services.	In-Network \$0 co-payment for Medicaid-covered service.
25. Mammograms (Annual Screen- ing) Covered annually under Medicaid	\$0 co-payment for Medicaid-covered services.	In-Network \$0 co-payment for Medicaid-covered service.

BENEFIT CATEGORY	OREGON HEALTH PLAN MEDICAID (Member costs)	PREMIERCARE PLUS (Member costs)
<p>26. Pap Smears and Pelvic Exams</p> <p>Covered Annually under Medicaid</p>	<p>\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p> <p>\$0 co-payment for Medicaid-covered services</p>	<p>In-Network</p> <p>\$0 co-payment for Medicaid-covered service.</p>
<p>27. Prostate Cancer Screening Exams</p>	<p>\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p>	<p>In-Network</p> <p>\$0 co-payment for Medicaid-covered service.</p>
<p>28. End-Stage Renal Disease</p>	<p>\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p>	<p>In-Network</p> <p>\$0 co-payment for Medicaid-covered service.</p>
<p>29. Prescription Drugs</p>	<p>\$0 co-payment for preferred generic and preferred brand-name drugs.</p> <p>\$3 co-payment for non-preferred generic drugs and non-preferred brand name drugs.</p> <p>Mental health drugs are covered by the State and not your Medicaid managed care health plan.</p>	<p>Part D medications</p> <p>Covered by your Medicare health plan (See Section II for details)</p> <p>Part B Medications -</p> <p>You pay \$0 yearly deductible for Part B-covered drugs.</p> <p>In-Network</p> <p>\$0 co payment for Medicaid-covered service (not including Part B- covered chemotherapy drugs). Prior Authorization rules may apply</p> <p>\$0 co payment for Medicaid-covered service for Part B-covered chemotherapy drugs. Prior Authorization rules may apply.</p> <p>Medicaid Covered Medications</p> <ul style="list-style-type: none"> • Over –the-counter drugs when accompanied by a prescription • Benzodiazepine and barbiturate drugs when accompanied by a prescription • Drugs when used for the symptomatic relief of cough or colds when accompanied by a prescription • Vitamins and minerals when accompanied by a prescription <p>Mental Health Drugs are not covered by PremierCare Plus.</p> <p style="text-align: right;"><i>Continued on page 24</i></p>

SECTION IV

BENEFIT CATEGORY	OREGON HEALTH PLAN MEDICAID (Member costs)	PREMIERCARE PLUS (Member costs)
Prescription Drugs <i>Continued from page 23</i>		<i>Continued from page 23</i> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.familycarehealthplans.org on the web.
30. Dental Services	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services. \$0 co-payment for Medicaid-covered dental diagnostic and preventative routine checkup services	Dental coverage is covered by Dental Care Organization.
31. Hearing Services	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
32. Vision Services	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
33. Physical Exams	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.
34. Health/Wellness Education	Not Covered	This plan covers the following health/wellness education benefits: <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Nutrition training • Nursing Hotline \$0 co-pay for each Medicare-covered smoking cessation counseling session.*
35. Other Non-Covered Medicare Services that will be covered by the Oregon Health Plan: <i>Continued on page 25</i>	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services. \$0 co-payment for Medicaid-covered x-ray, lab, routine immunization and family planning services	Prior authorization rule may apply. In-Network \$0 co-payment for Medicaid-covered service.

BENEFIT CATEGORY	OREGON HEALTH PLAN MEDICAID (Member costs)	PREMIERCARE PLUS (Member costs)
<p>Other Non-Covered Medicare Services that will be covered by the Oregon Health Plan:</p> <p><i>Continued from page 24</i></p> <p>Preventative Services</p> <ul style="list-style-type: none"> • Maternity Case Management, including nutritional counseling • Maternity and newborn care • Well-child exams and immunizations <p>Family Planning Services:</p> <ul style="list-style-type: none"> • Including birth control pills, condoms, contraceptive implants, and Depo-Provera • Sterilizations <p>Other Oregon Health Plan Services:</p> <ul style="list-style-type: none"> • Death with dignity services* • Abortions* • Mental health drugs <p>*Please note: These services are covered by the State and not by your Medicaid managed care health plan.</p>		

**SERVICES THAT ARE NOT COVERED BY
THE OREGON HEALTH PLAN MEDICAID (EXCLUSIONS):**

Not all medical treatments are covered. When you need medical treatment, contact your Primary Care Provider. These are some of the exclusions (does not include every exclusion):

Medicare Part D-covered prescription drugs

Conditions where a “home” treatment is effective, such as applying an ointment, resting a painful joint, drinking plenty of fluids, or a soft diet. Such conditions include:

- Canker sores
- Diaper rash
- Corns/calluses
- Sunburn
- Food poisoning
- Sprains

Personal comfort or convenience items (radios, telephones, hot tubs, treadmills, etc.)

Services that are primarily cosmetic, such as:

- Benign skin tumors
- Cosmetic surgery
- Removal of scars

Conditions where treatment is not normally effective, such as:

- Some back surgery
- TMJ surgery
- Some transplants

Services performed by an immediate relative or member of your household

Any services received outside the United States

Non-emergency care if you go to a provider who is not a PremierCare Plus provider.

Other non-covered services include, but are not limited to, the following:

- Circumcision (routine)
- Weight loss program
- Infertility services

If you have questions about covered or non-covered services, contact your Medicaid health plan Customer Services.