

2008



FamilyCare

Health Plans



Summary of Benefits

PremierCare Plus

Introduction to the Summary of Benefits for PremierCare Plus

January 1, 2008 – December 31, 2008

Contract # H3818 / Plan 002

Thank you for your interest in PremierCare Plus. Our plan is offered by FamilyCare Health Plans, Inc., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. This plan is designed for people who meet specific enrollment criteria. This includes anyone who receives medical assistance from the state and Medicare. All cost sharing in this summary of benefits is based on your level of Medicaid eligibility. Please call FamilyCare Health Plans 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 FamilyCare Health Plans, Inc. and ask for the "Evidence of Coverage" for PremierCare Plus.

YOU HAVE CHOICES IN YOUR HEALTH CARE

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. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call FamilyCare Health Plans, Inc. at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information.

TTY 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 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 AVAILABLE?

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

WHO IS ELIGIBLE TO JOIN PREMIERCARE PLUS?

You can join PremierCare Plus if you are entitled to Medicare Part A and enrolled in Medicare Part B, are eligible for Medicaid, and live in the service area.

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

CAN I CHOOSE MY DOCTORS?

PremierCare Plus 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 Directory for an up-to-date list or visit us at www.familycareinc.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. Neither FamilyCare Health Plans, Inc. nor the Original Medicare Plan will pay for these services.

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

PremierCare Plus does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

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

PremierCare Plus 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 current Pharmacy Network List or visit us at www.familycareinc.org. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

PremierCare Plus 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 view our complete formulary on our Web site at www.familycareinc.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 PRESCRIPTION DRUG PLAN COSTS?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join PremierCare Plus, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-Medicare (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

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, 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.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may 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 FamilyCare Health Plans, Inc. for more details about this program.

Please call FamilyCare Health Plans, Inc. for more information about this plan.

Visit us at www.familycareinc.org or, call us:

Customer Service Hours: Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. - 8:00 p.m.
Pacific Standard Time

We have extended hours for Open Enrollment:
(November 15 – March 30), 7 days a week.

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

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

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

Prospective members should call (866)-225-2273 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.

SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
1 - Premium and Other Important Information	<p>You pay the Medicare Part B premium of \$96.40 each month.</p> <p>You pay \$135.00 for the yearly Medicare Part B deductible.</p>	<p>All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.</p>
2 - Doctor and Hospital Choice <i>(For more information, see Emergency - #15 and Urgently Needed Care - #16)</i>	<p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>You must go to network doctors, specialists, and hospitals.</p> <p>You need a referral to go to network hospitals and certain doctors, including specialists for certain services.</p> <p>Unless otherwise noted, out-of-network services are not covered.</p>
INPATIENT CARE		
3 - Inpatient Hospital Care <i>(Includes Substance Abuse and Rehabilitation Services)</i>	<p>You pay for each benefit period:</p> <ul style="list-style-type: none"> ▪ Day(s) 1-60: an initial deductible of \$1024 ▪ Days 61-90: \$256 each day ▪ Days 91-150: \$512 per lifetime reserve day (4) <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.(3)</p> <p>Lifetime reserve days can only be used once.</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>You pay for each benefit period:</p> <ul style="list-style-type: none"> ▪ Day(s) 1-60: an initial deductible of \$0 (1) ▪ Days 61-90: \$128 each day (1) <p>Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:</p> <ul style="list-style-type: none"> ▪ Lifetime Reserve Days 1-60: \$250 copay per day (4) <p>You pay one initial deductible of \$520 for services received at a network hospital.</p> <p>You are covered for 90-days each benefit period.</p> <p>Except in an emergency, your provider must tell FamilyCare Health Plans, Inc. you are going to be admitted to the hospital.</p>
4 - Inpatient Mental Health Care	<p>You pay the same deductible and copayments as inpatient hospital care (above) except Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p>	<p>You pay the same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care")</p> <p>You pay one initial deductible of \$520 or services received at a network hospital.</p> <p>Medicare beneficiaries may only receive 190 days in a</p>

(1) Each year, you pay a total of one \$135 deductible for Medicare Part B expenses.

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(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

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SECTION TWO		
BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
4 - Inpatient Mental Health Care (cont)		Psychiatric Hospital in a lifetime. Except in an emergency, your provider must tell FamilyCare Health Plans, Inc. you are going to be admitted to the hospital.
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	You pay for each benefit period, after at least a 3-day covered hospital stay: <ul style="list-style-type: none"> ▪ Day(s) 1-20: \$0 for each day ▪ Days 21-100: \$128 for each day <p>There is a limit of 100 days for each benefit period.(3)</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>	You pay: <ul style="list-style-type: none"> ▪ Day(s) 1-20: \$0 for each day (3) ▪ Days 21-100: \$128 for each day (3) <p>You are covered for 100 days each benefit period.(3)</p> <p>No prior hospital stay is required.</p> <p>Prior Authorization is required. Contact plan for details.</p>
6 - Home Health Care <i>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i>	There is no co-payment for all covered home health visits.	There is no copayment for Medicare-covered home health visits. Authorization rules may apply for services. Contact plan for details.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.
OUTPATIENT CARE		
8 - Doctor Office Visits	You pay 20% of Medicare approved amounts. (1)(2)	You pay 20% of the cost for each primary care doctor office visit for Medicare-covered services.(1)(2) You pay 20% of the cost for each specialist visit for Medicare-covered services. (1)(2) Authorization rules may apply for services. Contact plan for details.

(1) Each year, you pay a total of one \$135 deductible for Medicare Part B expenses.

(2) If a doctor or supplier chooses not to accept assignment to provide Medicare services, their costs are often higher, which means you may pay more.

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

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SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
9 - Chiropractic Services	<p>You pay 20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a Chiropractor or other qualified provider.</p> <p>You pay 100% for routine care</p> <p>You pay 20% of the Medicare-approved amounts (1)(2)</p>	<p>You pay 20% of the cost for each Medicare-covered visit (1)(2)</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
10 - Podiatry Services	<p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 20% of the Medicare-approved amounts (1)(2)</p> <p>You pay 100% for routine care.</p>	<p>You pay 20% of the cost for each Medicare-covered visit (1)(2)</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
11 - Outpatient Mental Health Care	<p>You pay 50% coinsurance for most outpatient mental health services (1)(2)</p>	<p>You pay 0% to 20% of the cost for each Medicare-covered individual or group therapy visit. (1)(2)</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
12 - Outpatient Substance Abuse Care	<p>You pay 20% of Medicare-approved amounts (1)(2)</p>	<p>You pay 0% to 20% of the cost for Medicare-covered individual or group visits.(1)(2)</p> <p>Except in emergency, your provider must obtain authorization from FamilyCare Health Plans, Inc.</p>
13 - Outpatient Services/Surgery	<p>You pay 20% of Medicare-approved amounts for the doctor (1)(2)</p> <p>You pay 20% of outpatient facility charges (1)(2)</p>	<p>You pay 20% of the cost for each Medicare-covered visit to an ambulatory surgical center.(1)(2)</p> <p>You pay 20% of the cost for each Medicare-covered visit to an outpatient hospital facility.(1)(2)</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
14 - Ambulance Services (<i>Medically necessary ambulance services</i>)	<p>You pay 20% of Medicare-approved amounts or applicable fee schedule charge. (1)(2)</p>	<p>You pay 20% of the cost for Medicare-covered ambulance services. (1)(2)</p>

(1) Each year, you pay a total of one \$135 deductible for Medicare Part B expenses.

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(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

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SECTION TWO		
BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
14 - Ambulance Services (cont)		If you are admitted to the hospital, you pay \$0 for Medicare covered ambulance benefits.
15 - Emergency Care <i>(You may go to any emergency room if you reasonably believe you need emergency care.)</i>	<p>You pay 20% of the facility charge or a set copay per emergency room.(1)(2)</p> <p>You pay 20% of doctor charges. (1)(2)</p> <p>You don't have to pay the emergency room copay 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>You pay \$ 0 for each Medicare-covered emergency room visit. If you are admitted to the hospital within 24 hour(s) for the same condition, see benefit description for Inpatient Hospital Care. (3)</p> <p>NOT covered outside the U.S. except under limited circumstances. Contact plan for more details.</p>
16 - Urgently Needed Care <i>(This is NOT emergency care, and in most cases, is out of the service area.)</i>	<p>You pay 20% of Medicare-approved amounts or applicable co-payment (1)(2)</p> <p>NOT covered outside the U.S. except under limited circumstances</p>	<p>You pay 20% of the cost for each Medicare-covered urgently needed care visit. You do not pay this amount if you are admitted to the hospital within 24 hour(s) for the same condition.(1) See benefit description for Inpatient Hospital Care</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>
17 - Outpatient Rehabilitation Services <i>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</i>	You pay 20% of Medicare-approved amounts. (1)(2)	<p>You pay 20% of the cost for each Medicare-covered Occupational Therapy visit. (1)</p> <p>You pay 20% of the cost for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.</p> <p>Authorization rules may apply for services. Contact plan for details.</p>
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment <i>(includes wheelchairs, oxygen, etc.)</i>	You pay 20% of Medicare-approved amounts. (1) (2)	You pay 20% of the cost for each Medicare-covered item. (1) Authorization rules may apply for services. Contact plan for details.

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SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
19 - Prosthetic Devices <i>(includes braces, artificial limbs and eyes, etc.)</i>	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for each Medicare-covered item. Authorization rules may apply for services. Contact plan for details.
20 - Diabetes Self-Monitoring Training and Supplies <i>(includes coverage for glucose monitors, test strips, lancets, and self-management training)</i>	You pay 20% of Medicare-approved amounts. (1)(2)	You pay 20% of the cost for Medicare-covered Diabetes self-monitoring training. (1) You pay 20% of the cost for Nutrition Therapy for Diabetes. (1) You pay 20% of the cost for each Medicare-covered Diabetes Supply item. (1)
21 - Diagnostic Tests, X-Rays, and Lab Services	You Pay 20% of Medicare-approved amounts, except for approved lab service. (1)(2) There is no co-payment for Medicare-approved 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.	You pay: <ul style="list-style-type: none"> ▪ 20% of the cost for Medicare-covered lab services. (1) ▪ 20% of the cost for Medicare-covered diagnostic procedures and tests. (1) ▪ 20% of the cost for Medicare-covered X-rays. (1) ▪ 20% of the cost for Medicare-covered diagnostic radiology services. (1) ▪ 20% of the cost for Medicare-covered therapeutic radiology services. (1)
PREVENTIVE SERVICES		
22 - Bone Mass Measurements <i>(for people with Medicare who are at risk)</i>	You pay 20% of Medicare-approved amounts. (1)(2) Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	You pay 20% of the cost for each Medicare-covered Bone Mass Measurement. (1)
23 - Colorectal Screening Exams <i>(for people with Medicare age 50 and older)</i>	You pay 20% of Medicare-approved amounts. (1)(2) Covered when you are high risk or when you are age 50 and older.	You pay 20% of the cost for each Medicare-covered Colorectal Screening exam. (1)

(1) Each year, you pay a total of one \$135 deductible for Medicare Part B expenses.

(2) If a doctor or supplier chooses not to accept assignment to provide Medicare services, their costs are often higher, which means you may pay more.

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SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
24 - Immunizations <i>(Flu vaccine, Hepatitis B vaccine-for people with Medicare who are at risk, Pneumonia vaccine)</i>	There is no co-payment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. (1)(2) You may only need the pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no copayment for the Pneumonia and Flu vaccines. No referral necessary for Medicare-covered influenza and pneumonia vaccines. You pay 20% of the cost for the Hepatitis B vaccine. (1)
25 - Mammograms (Annual Screening) <i>(for women with Medicare age 40 and older)</i>	You pay 20% of Medicare-approved amounts. (2) Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	You pay 20% of the cost for each Medicare-covered Screening Mammogram.(1) No referral necessary for Medicare-covered screenings.
26 - Pap Smears/Pelvic Exams <i>(for women with Medicare)</i>	There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk. (2) You pay 20% of Medicare-approved amounts for Pelvic Exams. (2)	You pay 0% to 20% of the cost for Medicare-covered pap smears and pelvic exams. (1)
27 - Prostate Cancer Screening Exams <i>(for men with Medicare age 50 and older)</i>	You pay 20% coinsurance for the digital rectal exam. There is no copay for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	You pay 0% to 20% of the cost for Medicare-covered prostate cancer screening. (1)
28- ESRD (End Stage Renal Disease)	You pay 20% coinsurance for dialysis	You pay 0% to 20% of the cost for in and out-of-area dialysis. (1) You pay 20% of the cost for Nutrition Therapy for Renal Disease. (1) Authorization rules may apply. Out-of-area Renal Dialysis services do not require authorization.

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(2) If a doctor or supplier chooses not to accept assignment to provide Medicare services, their costs are often higher, which means you may pay more.

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

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SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
<p>29 - Prescription Drugs</p> <p>Drugs covered under Medicare Part B (Original Medicare)</p> <p>Drugs covered under Medicare Part D (Prescription Drug Benefit)</p> <p>General Information</p>	<p>You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.</p>	<p>You pay 20 % of the cost for Part B-covered drugs. (1)</p> <p>You pay 20% of the cost for Part B-covered chemotherapy drugs. (1)</p> <p>You pay \$0 to \$56 yearly deductible (amount depends on your income).</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.familycareinc.org on the web.</p> <p>The plan offers national in-network prescription coverage. This means that you will pay the same 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 both you and the plan.</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 FamilyCare Health Plans, Inc. for certain drugs.</p> <p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to the special handling requirements of these drugs. 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>

(1) Each year, you pay a total of one \$135 deductible for Medicare Part B expenses.

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(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

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SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
29 - Prescription Drugs (cont)		
Initial Coverage		Depending upon your income level, you pay \$ 0 to \$ 2.25 copay, or 15% coinsurance for generic drugs (including brand drugs treated as generic). You pay either \$ 0 to \$ 5.60 copay or 15% coinsurance for all other drugs.
In-Network Retail Pharmacy		You may receive drugs for the following: <ul style="list-style-type: none"> ▪ one month (31 day) supply ▪ three month (90 day) supply
Long Term Care Pharmacy		You may receive drugs for the following: <ul style="list-style-type: none"> ▪ one month (31 day) supply ▪ three month (90 day) supply
Mail Order		You may receive drugs for the following: <ul style="list-style-type: none"> ▪ one month (31 day) supply ▪ three month (90 day) supply
Catastrophic Coverage		After your yearly out-of-pocket drug costs reach \$4050, you pay \$0 for your drugs or \$2.25 copay for generic drugs (including brand drugs treated as generic) and \$5.60 copay for all other drugs.
Out-of-Network		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 pay more than the copay if you get your drugs at an out-of-network pharmacy.
Out-of-Network Initial Coverage		Depending on your income, you pay either \$0 to \$2.25 copay, or 15% coinsurance for generic drugs (including brand drugs treated as generic). You pay either \$0 to \$5.60 copay, or 15% coinsurance for all other drugs.
Out-of-Network Catastrophic Coverage		After your yearly out-of-pocket drug costs reach \$4050, you pay \$0 for your drugs or \$2.25 copay for generic drugs (including brand drugs treated as generic) and \$5.60 copay for all other drugs.

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SECTION TWO		
BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
ADDITIONAL BENEFITS		
30 - Dental Services	In general, you pay 100% for preventive dental services.	In general, preventive dental benefits (such as cleaning) not covered. You pay 20% of the cost for Medicare-covered dental benefits. (1)
31 - Hearing Services	You pay 100% for routine hearing exams and hearing aids You pay 20% of Medicare-approved amounts for diagnostic hearing exams. (1)(2)	In general, you pay 100% for routine hearing exams and hearing aids. (1) You pay 20% of the cost for each Medicare-covered hearing exam (diagnostic hearing exams). (1)
32 - Vision Services	You pay 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses are not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	You pay 20% of the cost for exams to diagnose and treat diseases and conditions of the eye. (1) Non-Medicare-covered routine eye exams and glasses are not covered. You pay 0% to 20% of the cost for one pair of eyeglasses or contact lenses after each cataract surgery. (1)
33 - Physical Exams	You pay 20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage. When you get Medicare Part B, you can get a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.	When you get Medicare Part B, you can get a one-time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests. Routine exams not covered. You pay 0% to 20% of the cost for Medicare-covered benefits.(1)
34 - Health/Wellness Education	You pay 100%	You are covered for the following: <ul style="list-style-type: none"> ▪ Written health education materials, including Newsletter ▪ Smoking Cessation (classes & aids) ▪ Nursing Hotline

(1) Each year, you pay a total of one \$135 deductible for Medicare Part B expenses.

(2) If a doctor or supplier chooses not to accept assignment to provide Medicare services, their costs are often higher, which means you may pay more.

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. 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.

(4) Lifetime reserve days can only be used once.

Your Extra Benefits & Services

You receive all of the following extra benefits when you choose our PremierCare Plus plan:

Non-Emergency Transportation Coverage

You will also receive coverage for transportation expenses for up to 15 round trip non-emergency medical appointments (up to \$1000 maximum total cost).

Medical Supplies Allowance

Keeping you safe in your home is important to us! All PremierCare Plus members receive up to \$1000 in Safety Items for your home. These items could include wheelchair ramps, non-skid mats for your bathroom, handrails for halls and stairways, stability bars, and much more! Reducing the number of accidents in the home is one way we help keep our members healthy.

Dentures

Our plan will pay a maximum of \$2000 for dentures for our members. Please contact us for additional denture benefit details.

Your Value Added Services

Emergency Disaster Preparedness Kit

All PremierCare Plus members receive a free American Red Cross 72-hour Emergency Disaster Preparedness Kit. This kit contains food, water, and supplies to help you in an emergency.

24-Hour Nurse Advice Line

24 hours a day, 365 days per year, our registered nurses are just a phone call away. We're here to make sure you have the health care information you need, whenever you need it!

Our Medicare Prescription Drug Benefit is only available to members of PremierCare Choice Rx, PremierCare Advantage Rx, and PremierCare Plus.

You are eligible to enroll if you are entitled to Medicare benefits under Part A and are enrolled in Part B and reside in our service area.

You may enroll in a plan only during specific times of the year. Please contact our Customer Service Department to obtain more information.

You must receive all routine care from plan providers. If you obtain routine care from out-of-plan providers neither Medicare nor FamilyCare Health Plans will be responsible for costs.

You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third-party.

For full information on FamilyCare Health Plans Medicare benefits, call our Customer Service Department at 866-798-CARE or TTY 800-735-2900. We are here for you Monday - Friday, 8:00 a.m. to 8:00 p.m. We have extended hours during Open Enrollment - contact us for details.

FamilyCare Health Plans is a Medicare Advantage Organization with a Medicare Contract. Our contract with CMS is renewed annually and the availability of coverage beyond the end of the current contract year is not guaranteed.

You may be able to get extra help to pay for your prescription drug premiums and 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;

The Social Security Administration at
1-800-772-1213 between 7 a.m. and 7 p.m.,
Monday through Friday.

TTY/TDD users should call
1-800-325-0778; or Your State
Medicaid Office

*This document is available in
alternative formats.*

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FamilyCare

Health Plans

