



2010

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Questions? Please call us at 866-798-CARE (2273)
TTY: 800-735-2900

Also, please visit us at www.FamilyCareHealthPlans.org

Summary of Benefits PREMIERCARE Plus

Introduction to the Summary of Benefits Report for PremierCare Plus (HMO) January 1, 2010 - December 31, 2010

Contract # H3818 / Plan 002

Thank you for your interest in PremierCare Plus. Our plan is offered by FamilyCare Health Plans a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. 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 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 and ask for the "Evidence of Coverage."

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.

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 at the number listed at the end of this introduction or call 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, OR. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN PREMIERCARE PLUS?

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

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 PROVIDER?

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 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 Provider outside of our network, you must pay for these services yourself. Neither PremierCare Plus 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 pharmacy directory 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 see our complete formulary on our Web site at www.familycarehealthplans.org.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 PremierCare Plus 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 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 alpha 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.

PLEASE CALL FAMILYCARE HEALTH PLANS FOR MORE INFORMATION ABOUT PREMIERCARE PLUS.

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

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

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

Prospective members should call toll-free (866)-225-2273 for questions related to the Medicare (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.

Prospective members should call toll-free (866)-225-2273 for questions related to the Medicare Part D Prescription Drug program.

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.

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BENEFIT CATEGORY	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 2009 the monthly Part B Premium was \$0 or \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$0 or \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>\$0 monthly plan premium in addition to your monthly Medicare Part B premium.*</p> <p>All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.</p> <p>In-Network</p> <p>In 2009 the yearly Part B deductible amount was \$0 or \$135 and will change for 2010.</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>In 2009 the amounts for each benefit period were \$0 or:</p> <ul style="list-style-type: none"> • Days 1 - 60: \$1068 deductible* • Days 61 - 90: \$267 per day* • Days 91 - 150: \$534 per lifetime reserve day* <p>These amounts will change for 2010.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</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</p>	<p>In-Network</p> <p>In 2009 the amounts for each benefit period, \$0 or: Days 1-60: \$1068 deductible* Days 61-90: \$267 per day* Days 91-150: \$534 per lifetime reserve day*</p> <p>*These amounts will change for 2010.</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Plan covers 90 days each benefit period.</p> <p>Except in an emergency, your provider must tell the plan that</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
3 - Inpatient Hospital Care (continued)	benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	you are going to be admitted to the hospital.
4 - Inpatient Mental Health Care	<p>Same deductible and copay 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>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care").</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</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</p> <p>(in a Medicare-certified skilled nursing facility)</p>	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <ul style="list-style-type: none"> • Days 1 - 20: \$0 per day* • Days 21 - 100: \$0 or \$133.50 per day* <p>These amounts will change for 2010.</p> <p>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. There is no limit to the number of benefit periods you can have.</p>	<p>Authorization rules may apply.</p> <p>In-Network</p> <p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <ul style="list-style-type: none"> • Days 1 - 20: \$0 per day* • Days 21 - 100: \$133.50 per day* <p>These amounts will change for 2010.</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>No limit on days covered each benefit period.</p> <p>No prior hospital stay is required.</p>
<p>6 - Home Health Care</p> <p>(Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	\$0 copay.	<p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered home health visits.*</p>
7 - Hospice	<p>You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	You must get care from a Medicare-certified hospice.

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
OUTPATIENT CARE		
8 - Doctor Office Visits	0% or 20% coinsurance.	<p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% or 20% of the cost for each primary care doctor visit for Medicare-covered benefits.</p> <p>0% or 20% of the cost for each specialist visit for Medicare-covered benefits.</p>
9 - Chiropractic Services	<p>Routine care not covered.</p> <p>0% or 20% coinsurance 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.</p>	<p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% or 20% of the cost for Medicare-covered visits. *</p> <p>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.</p>
10 - Podiatry Services	<p>Routine care not covered.</p> <p>0% or 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% or 20% of the cost for each Medicare-covered visit.*</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
11 - Outpatient Mental Health Care	0% or 45% coinsurance for most outpatient mental health services.	<p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% or 20% of the cost for each Medicare-covered individual or group therapy visit.*</p>
12 - Outpatient Substance Abuse Care	0% or 20% coinsurance.	<p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% or 20% of the cost for Medicare-covered individual or group visits.*</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
13 - Outpatient Services/Surgery	<p>0% or 20% coinsurance for the doctor.</p> <p>0% or 20% of outpatient facility charges.</p>	<p>Authorization rules may apply.</p> <p>In-Network</p> <p>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>
<p>14 - Ambulance Services</p> <p>(medically necessary ambulance services)</p>	<p>0% or 20% coinsurance.</p>	<p>In-Network</p> <p>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>
<p>15 - Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>0% or 20% coinsurance for the doctor.</p> <p>0% or 20% of facility charge.</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>\$0 or \$50 copay 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> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency visit.</p>
<p>16 - Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>0% or 20% coinsurance.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>0% or 20% of the cost for Medicare-covered urgently needed care visits.*</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.</p>
<p>17 - Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>0% or 20% coinsurance.</p>	<p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% of the cost for Medicare-covered Occupational Therapy visits.*</p> <p>0% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.*</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
<p>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</p>		
<p>18 - Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)</p>	<p>0% or 20% coinsurance.</p>	<p>Authorization rules may apply. In-Network 0% or 20% of the cost for Medicare-covered items.*</p>
<p>19 - Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)</p>	<p>0% or 20% coinsurance.</p>	<p>Authorization rules may apply. In-Network 0% or 20% of the cost for Medicare-covered items.*</p>
<p>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>0% or 20% coinsurance. 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>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% of the cost for Diabetes supplies.*</p>
<p>21 - Diagnostic Tests, X-Rays, and Lab Services</p>	<p>0% or 20% coinsurance for diagnostic tests and x-rays \$0 copay 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>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.* 0% or 20% of the cost for Medicare-covered therapeutic radiology services.*</p>
<p>PREVENTIVE SERVICES</p>		
<p>22 - Bone Mass Measurement (for people with Medicare who are at risk)</p>	<p>0% or 20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>In-Network 0% or 20% of the cost for Medicare-covered bone mass measurement. *</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
<p>23 - Colorectal Screening Exams</p> <p>(for people with Medicare age 50 and older)</p>	<p>0% or 20% coinsurance.</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p>In-Network</p> <p>0% or 20% of the cost for Medicare-covered colorectal screenings. *</p>
<p>24 – Immunizations</p> <p>(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu and Pneumonia Vaccines.</p> <p>0% or 20% coinsurance for Hepatitis B Vaccine.</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>In-Network</p> <p>\$0 copay for Flu and Pneumonia vaccines.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>0% or 20% of the cost for Hepatitis B vaccine.*</p>
<p>25 - Mammograms (Annual Screening)</p> <p>(for women with Medicare age 40 and older)</p>	<p>0% or 20% coinsurance</p> <p>No referral needed.</p> <p>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.</p>	<p>In-Network</p> <p>0% or 20% of the cost for Medicare-covered screening mammograms.*</p>
<p>26 - Pap Smears and Pelvic Exams</p> <p>(for women with Medicare)</p>	<p>\$0 copay for Pap smears</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>0% or 20% coinsurance for Pelvic Exams.</p>	<p>In-Network</p> <p>0% or 20% of the cost for Medicare-covered pap smears and pelvic exams.*</p>
<p>27 - Prostate Cancer Screening Exams</p> <p>(for men with Medicare age 50 and older)</p>	<p>0% or 20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 0% or 20% coinsurance for other related services</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>In-Network</p> <p>0% or 20% of the cost for Medicare-covered prostate cancer screening.*</p>
<p>28 - End-Stage Renal Disease</p>	<p>0% or 20% coinsurance for renal dialysis</p> <p>0% or 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>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>Authorization rules may apply.</p> <p>In-Network</p> <p>0% or 20% of the cost for renal dialysis*</p> <p>0% or 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.*</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
<p>29 - Prescription Drugs</p>	<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>\$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>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.</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, <p>or</p> <ul style="list-style-type: none"> • 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 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</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
29 - Prescription Drugs (continued)		<p>of drugs, due to special handling, provider coordination, or patient education requirements for these drugs 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 or 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</p> <p>\$0 yearly deductible.</p> <p>Initial Coverage</p> <p>Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> • A \$0 copay; or • A \$1.10 copay; or • A \$2.50 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> • A \$0 copay; or • A \$3.30 copay; or • A \$6.30 copay. <p>Retail Pharmacy</p> <p>You can get drugs the following way(s):</p> <ul style="list-style-type: none"> • one-month (31-day) supply • three-month (90-day) supply <p>Long Term Care Pharmacy</p> <p>You can get drugs the following way(s):</p> <ul style="list-style-type: none"> • one-month (31-day) supply

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
29 - Prescription Drugs (continued)		<p>Mail Order</p> <p>You can get drugs the following way(s):</p> <ul style="list-style-type: none"> • one-month (31-day) supply • three-month (90-day) supply <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you pay a \$0 copay.</p> <p>Out-of-Network</p> <p>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.</p> <p>You can get drugs the following way:</p> <ul style="list-style-type: none"> • 10-day supply <p>Out-of-Network Initial Coverage</p> <p>Depending on your income and institutional status, you will be reimbursed by PremierCare Plus up to the full cost of the drug minus the following:</p> <p>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> • A \$0 copay; or • A \$1.10 copay; or • A \$2.5 copay <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> • A \$0 copay; or • A \$3.30 copay; or

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
29 - Prescription Drugs (continued)		<ul style="list-style-type: none"> A \$6.30 copay. <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed in full for drugs purchased out-of-network.</p>
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p>In-Network</p> <p>\$0 copay for Medicare-covered dental benefits.*</p> <p>In general, preventive dental benefits (such as cleaning) not covered.</p>
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>0% or 20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network</p> <p>In general, routine hearing exams and hearing aids not covered.</p> <p>0% or 20% of the cost for Medicare-covered diagnostic hearing exams.*</p>
32 - Vision Services	<p>0% or 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network</p> <p>Non-Medicare-covered eye exams and glasses not covered.</p> <p>0% or 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.*</p> <p>0% or 20% of the cost for exams to diagnose and treat diseases and conditions of the eye.*</p>
33 - Physical Exams	<p>0% or 20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one-time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network</p> <p>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.</p> <p>Routine exams not covered.</p> <p>0% to 20% of the cost for Medicare-covered benefits.*</p>
34 - Health/Wellness Education	<p>Smoking Cessation:</p> <p>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</p>	<p>In-Network</p> <p>This plan covers the following health/wellness education benefits:</p>

SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE PLUS
	counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	<ul style="list-style-type: none"> • Written health education materials, including Newsletters • Nutritional Training • Nursing Hotline <p>\$0 copay for each Medicare-covered smoking cessation counseling session. *</p>
35 – Transportation (Routine)	Not covered.	<p>In-Network</p> <p>This plan does not cover routine transportation.</p>
36 – Acupuncture	Not covered.	<p>In-Network</p> <p>This plan does not cover Acupuncture.</p>

ADDITIONAL INFORMATION THAT WILL BE HELPFUL IN UNDERSTANDING YOUR BENEFITS

FamilyCare understands that 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 copay.

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 well, 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 | 4) National Provider Identification number | 7) Type of service provided |
| 2) Address of Provider | 5) Medicare Provider Identification number | 8) Medical condition being treated |
| 3) Tax Identification number of the Provider | 6) Date of Service | 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 that 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" that is given below.

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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.

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

When you receive emergency or urgently needed health care 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 have an established 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 prevent any issues that may 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 are 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 named 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 copayment. Other immunizations such as Hepatitis B may be available for those at risk for 20% copayment.

SECTION THREE

VACCINATIONS

Zostavax vaccination can be administered at the pharmacy for your normal coinsurance or copayment. 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 coinsurance or copayment. If you choose to obtain the vaccination at the pharmacy and have your provider administer the vaccination, you will pay the normal coinsurance or copayment and then the full administration cost charged by your provider. You are reimbursed the administration charge less any in-network charge.

DIABETIC SUPPLIES

Glucose monitors, test strips, lancets, etc. are covered through our Diabetic Mail Order provider for \$0 copayment. If you choose to obtain your diabetic supplies at a retail pharmacy, you will pay 20% of the cost of the diabetic supplies.

MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who 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 that 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 that 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.

SECTION IV - SUMMARY OF BENEFITS

Medicaid Covered Services

In this section you can see a summary of the Medicaid benefits you receive through the Oregon Health Plan. Since you are eligible for 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.

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 below.

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 copayments.

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.

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

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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 OHP 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. In 2009 the yearly Part B deductible amount was \$0 or \$135 and will change for 2010.
2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	Allow 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 (includes Substance Abuse and Rehabilitation Services)	(\$0 copayment for Medicaid covered services.)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service
4 - Inpatient Mental Health Care	(\$0 copayment for Medicaid covered services.)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	(\$0 copayment for Medicaid covered services.)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service
6 - Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.	Prior Authorization rule may apply In-Network \$0 copay for Medicare-covered home health visits.
7 - Hospice	(\$0 copayment for Medicaid covered services.)	You must get care from a Medicare-certified hospice.

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

SECTION FOUR

BENEFIT CATEGORY	OREGON HEALTH PLAN - MEDICAID (Member costs)	PREMIERCARE PLUS (Member costs)
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment	(\$0 copayment for Medicaid covered services.)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service
19 - Prosthetic Devices	(\$0 copayment for Medicaid covered services.)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service
20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies	(\$0 copayment for Medicaid covered services.)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service
21 - Diagnostic Tests, X-Rays, and Lab Services	(\$0 copayment for Medicaid covered services.)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service apply.
PREVENTIVE SERVICES		
22 - Bone Mass Measurement	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.)	In-Network \$0 copayment for Medicaid covered service
23 - Colorectal Screening Exams	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.)	In-Network \$0 copayment for Medicaid covered service
24 - Immunizations	(\$0 copayment for Medicaid covered services.)	In-Network \$0 copayment for Medicaid covered service
25 - Mammograms (Annual Screening) Covered annually under Medicaid	(\$0 copayment for Medicaid covered services.)	In-Network \$0 copayment for Medicaid covered service

SECTION FOUR

BENEFIT CATEGORY	OREGON HEALTH PLAN - MEDICAID (Member costs)	PREMIERCARE PLUS (Member costs)
26 - Pap Smears and Pelvic Exams Covered annually under Medicaid	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.) (\$0 copayment for Medicaid covered services.)	In-Network \$0 copayment for Medicaid covered service
27 - Prostate Cancer Screening Exams	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.)	In-Network \$0 copayment for Medicaid covered service
28 - End-Stage Renal Disease	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.)	In-Network \$0 copayment for Medicaid covered service
29 - Prescription Drugs	\$1 - \$3 copayment for certain generic drugs and non-preferred brand name drugs.	<p>Part D medications -</p> <p>Covered under the primary coverage based on LIS level (\$0 – \$6 copayment for initial coverage, \$0 copayment after total Out-of pocket costs reach \$4350) See section two for details.</p> <p>Part B Medications -</p> <p>You pay \$0 yearly deductible for Part B-covered drugs.</p> <p>You pay 0% or 20% of the cost for Part B-covered drugs (not including</p> <p>Part B-covered chemotherapy drugs).</p> <p>You pay 0% or 20% of the cost for Part B-covered chemotherapy drugs.</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>
30 - Dental Services	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.) (\$0 copayment for Medicaid covered Dental diagnostic and preventative routine checkup services.)	Dental coverage is covered by Dental Care Organization
31 - Hearing Services	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.)	<p>Prior Authorization rule may apply</p> <p>In-Network \$0 copayment for Medicaid covered service</p>

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BENEFIT CATEGORY	OREGON HEALTH PLAN - MEDICAID (Member costs)	PREMIERCARE PLUS (Member costs)
32 - Vision Services	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service
33 - Physical Exams	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.)	Prior Authorization rule may apply In-Network \$0 copayment 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 • Nutritional Training • Nursing Hotline \$0 copay for each Medicare-covered smoking cessation counseling session.*
35 – Transportation	Not Covered.	This plan does not cover routine transportation.
36 – Acupuncture	Not Covered.	This plan does not cover Acupuncture.
37 – Other Non-Covered Medicare Services that will be covered by the Oregon Health Plan, Medicaid: Preventative Services <ul style="list-style-type: none"> • Maternity Case Management, including nutritional counseling. • Maternity and Newborn care • Well-child exams and immunizations Family Planning Services: <ul style="list-style-type: none"> • Including birth control pills, condoms, contraceptive implants, and Depo-Prevar • Sterilizations Other Medicaid Services: <ul style="list-style-type: none"> • Death with dignity services • Abortions • Mental health drugs 	(\$3 copayment for Visits to a doctor or other healthcare provider for Medicaid covered outpatient services.) (\$0 copayment for Medicaid covered x-ray, lab, routine immunization and family planning services)	Prior Authorization rule may apply In-Network \$0 copayment for Medicaid covered service

SECTION FOUR

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 Physician. 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.

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