



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 Select Rx

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

Contract # H3818 / Plan 015

Thank you for your interest in PremierCare Select Rx (HMO). 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.

If you have been diagnosed with Diabetes mellitus you may be able to join this plan. Please call PremierCare Select Rx 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 Select Rx. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you have one or more of the listed diseases you may enroll in the plan at any time but you may only leave the plan at certain times.

Please call PremierCare Select Rx 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 Select Rx 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 SELECT RX 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 SELECT RX?

You can join PremierCare Select Rx 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

Select Rx unless they are members of our organization and have been since their dialysis began.

You must have been diagnosed by your doctor with Diabetes mellitus to join this plan.

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

CAN I CHOOSE MY PROVIDERS?

PremierCare Select Rx 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 Select Rx nor the Original Medicare Plan will pay for these services.

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

PremierCare Select Rx 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 Select Rx 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.familycarehealthplans.org. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

PremierCare Select Rx 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.

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?

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.

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 Select Rx (HMO), 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.

For Oregon, Please contact Acumentra Health at (503) 279-0100.

As a member of PremierCare Select Rx (HMO), 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 Select Rx 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 Select Rx 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.
- Inhalation and Infusion Drugs provided through DME.

PLEASE CALL FAMILYCARE HEALTH PLANS FOR MORE INFORMATION ABOUT PREMIERCARE SELECT RX.

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.**

SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
<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. 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>\$129.60 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>\$1,500 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>You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p>
<p>INPATIENT CARE</p>		
<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>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. There is no limit to the number of benefit periods you can have.</p>	<p>For Medicare-covered hospital stays:</p> <p>Days 1-5: \$100 copay per day Days 6-90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your provider must tell the plan that you are going to be admitted to the hospital.</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
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>For Medicare-covered hospital stays:</p> <p>Days 1-5: \$100 copay per day Days 6-90: \$0 copay per day</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: \$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>\$0 copay for SNF services</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>Authorization rules may apply.</p>
<p>6 - Home Health Care</p> <p>(Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay</p>	<p>\$20 copay for each Medicare-covered home health visit.</p> <p>Authorization rules may apply.</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>	<p>You must get care from a Medicare-certified hospice.</p>
OUTPATIENT CARE		
8 - Doctor Office Visits	<p>20% coinsurance</p>	<p>See "Physical Exams," for more information.</p> <p>Authorization rules may apply.</p> <p>\$15 copay for each primary care doctor visit for Medicare-covered benefits.</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
8 - Doctor Office Visits (continued)		<p>\$20 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p>
9 - Chiropractic Services	<p>Routine care not covered.</p> <p>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>\$25 copay for each Medicare-covered visit.</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>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>\$20 copay for each Medicare-covered visit.</p> <p>\$10 copay for up to 12 routine visit(s) every year</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Authorization rules may apply.</p>
11 - Outpatient Mental Health Care	<p>45% coinsurance for most outpatient mental health services.</p>	<p>\$25 copay for each Medicare-covered individual or group therapy visit.</p> <p>Authorization rules may apply.</p>
12 - Outpatient Substance Abuse Care	<p>20% of the cost for Medicare-covered visits.</p>	<p>\$0 copay for Medicare-covered visits.</p> <p>Authorization rules may apply.</p>
13 - Outpatient Services/Surgery	<p>20% coinsurance for the doctor.</p> <p>20% of outpatient facility charges.</p>	<p>\$0 copay of the cost for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay of the cost for each Medicare-covered outpatient hospital facility visit.</p> <p>Authorization rules may apply.</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
<p>14 - Ambulance Services</p> <p>(medically necessary ambulance services)</p>	<p>20% coinsurance.</p>	<p>\$50 copay 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>20% coinsurance for the doctor.</p> <p>20% of facility charge, or a set copay per emergency room visit.</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>\$50 copay for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 24 hour(s) for the same condition, you pay \$0 for the emergency room 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>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>\$20 copay 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>20% coinsurance.</p>	<p>\$25 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p>Authorization rules may apply.</p>
<p>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</p>		
<p>18 - Durable Medical Equipment</p> <p>(Includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance.</p>	<p>20% of the cost for Medicare-covered items.</p> <p>Authorization rules may apply.</p>
<p>19 - Prosthetic Devices</p> <p>(Includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance.</p>	<p>20% of the cost for Medicare-covered items.</p> <p>Authorization rules may apply.</p>
<p>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</p> <p>(includes coverage for glucose monitors,</p>	<p>20% coinsurance.</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</p>	<p>\$0 copay of the cost for Diabetes self-monitoring training.</p> <p>\$0 copay of the cost for Nutrition Therapy for Diabetes.</p> <p>You pay 0% of the cost for Diabetes supplies.</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
test strips, lancets, screening tests, and self-management training)	dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	
21 - Diagnostic Tests, X-Rays, and Lab Services	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab Services</p> <p>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>\$0 copay for Medicare-covered lab services.</p> <ul style="list-style-type: none"> - diagnostic procedures and tests -X-rays. -diagnostic radiology services (not including X-rays) -therapeutic radiology services.
PREVENTIVE SERVICES		
22 - Bone Mass Measurement (for people with Medicare who are at risk)	<p>20% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	\$0 copay for Medicare-covered bone mass measurement.
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	<p>20% coinsurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	\$0 Medicare-covered colorectal screenings.
24 – Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	<p>\$0 copay for Flu and Pneumonia Vaccines</p> <p>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>\$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p>
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	<p>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>	\$0 copay for Medicare-covered screening mammograms.

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
<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>20% coinsurance for Pelvic Exams.</p>	<p>\$0 copay 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>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>\$0 copay for Medicare-covered prostate cancer screening.</p>
<p>28 - End-Stage Renal Disease</p>	<p>20% coinsurance for renal dialysis</p> <p>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>\$0 copay for renal dialysis</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p>Authorization rules may apply.</p>
<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>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs</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>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>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
29 - Prescription Drugs (continued)		<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 Select Rx 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 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>You pay the following until total yearly drug costs reach \$2,830.</p> <p>Retail Pharmacy</p> <p>Diabetic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of drugs this tier

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
29 - Prescription Drugs (continued)		<ul style="list-style-type: none"> • \$0 copay for a three-month (90-day) supply of drugs in this tier. <p>Generic</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier. • \$15 copay for a three-month (90-day) supply of drugs in this tier. <p>Preferred Brand</p> <ul style="list-style-type: none"> • \$30 copay for a one-month (31-day) supply of drugs in this tier • \$90 copay for a one-month (90-day) supply of drugs in this tier <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$60 copay for a one-month (31-day) supply of drugs in this tier • \$180 copay for a one-month (90-day) supply of drugs in this tier <p>Specialty</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier <p>Not all drugs on this tier are available at this extended day supply. Please contact the PremierCare Select Rx for more information.</p> <p>Long Term Care Pharmacy</p> <p>Diabetic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of drugs

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
29 - Prescription Drugs (continued)		<p>this tier</p> <p>Generic</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier. <p>Preferred Brand</p> <ul style="list-style-type: none"> • \$30 copay for a one-month (31-day) supply of drugs in this tier <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$60 copay for a one-month (31-day) supply of drugs in this tier <p>Specialty</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order</p> <p>Diabetic</p> <ul style="list-style-type: none"> • \$0 copay for a one-month (31-day) supply of drugs this tier • \$0 copay for a three-month (90-day) supply of drugs in this tier. <p>Generic</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs in this tier. • \$10 copay for a three-month (90-day) supply of drugs in this tier.

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BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
29 - Prescription Drugs (continued)		<p>Preferred Brand</p> <ul style="list-style-type: none"> • \$30 copay for a one-month (31-day) supply of drugs in this tier • \$60 copay for a one-month (90-day) supply of drugs in this tier <p>Non-Preferred Brand</p> <ul style="list-style-type: none"> • \$60 copay for a one-month (31-day) supply of drugs in this tier • \$120 copay for a one-month (90-day) supply of drugs in this tier <p>Specialty</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs in this tier • 33% coinsurance for a three-month (90) day supply of drugs in this tier <p>Not all drugs in this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Coverage Gap</p> <p>After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> • A \$2.50 copay for generic (including brand name drugs treated as generic) and a \$6.30 copay for all other drugs, or 5% coinsurance.

SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
29 - Prescription Drugs (continued)		<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 Select Rx.</p> <p>Out-of-Network Initial Coverage</p> <p>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830:</p> <p>Diabetic</p> <ul style="list-style-type: none"> • \$0 copay for a (10-day) supply of drugs in this tier • \$5 copay for a (10-day) supply of drugs in this tier • \$30 copay for a (10-day) supply of drugs in this tier • \$60 copay for a (10-day) supply of drugs in this tier • 33% coinsurance for a (10-day) supply of drugs in this tier <p>Out-of-Network Coverage Gap</p> <p>After your total yearly drug costs reach \$2,830, you pay 100% of the Pharmacy's full charge for drug purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by PremierCare Select Rx for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to PremierCare Select Rx so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
29 - Prescription Drugs (continued)		<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 to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> • A \$2.50 copay for generic (including brand name drugs treated as generic) and a \$6.30 copay for all other drugs, or 5% coinsurance.
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p>\$0 copay for Medicare-covered dental benefits.</p> <ul style="list-style-type: none"> • Up to 1 oral exam(s) every six months • \$12 copay for an office visit that includes: <ul style="list-style-type: none"> -up to one fluoride treatment(s) every year -\$35 copay for up to 1 cleaning(s) every six months -\$8-\$40 copay for up to 1 dental x-ray visit(s) every year <p>Plan offers additional comprehensive dental benefits.</p>
31 - Hearing Services	Routine hearing exams and hearing aids not covered. You pay 20% coinsurance for diagnostic hearing exams.	<p>\$0 copay for up to 1 hearing aid(s) every three years</p> <p>\$20 copay for Medicare-covered diagnostic hearing test(s) every year</p> <p>\$0 copay for up to 1 hearing aid fitting evaluation(s) every year</p> <p>\$500 limit for routine hearing tests and hearing aids every three years.</p>
32 - Vision Services	<p>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>\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>\$0 copay for exams to diagnose and treat diseases and conditions of the eye</p> <p>\$0 copay for routine exams</p> <p>\$0 copay for up to 1 pair(s) of glasses every year</p>

SECTION TWO

BENEFIT CATEGORY	ORIGINAL MEDICARE	PREMIERCARE SELECT RX
32 - Vision Services (continued)		\$0 copay for up to one pair(s) of contacts every year \$65 limit for eye exams and eye wear every year.
33 - Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. When you get Medicare Part B, you can get a onetime physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	\$0 copay for routine exams. Limit to 1 exam(s) every year.
34 - Health/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 counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	This plan covers the following health/wellness education benefits: <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Nutritional Training • Additional Smoking Cessation • Nursing Hotline • Nutritional benefit • Other Wellness Benefits \$0 copay for each Medicare-covered smoking cessation counseling session.
35 – Transportation (Routine)	Not covered.	Not covered.

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.

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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.

YOUR DENTAL BENEFITS

The Willamette Dental Plan is a managed dental care plan with facilities in Oregon, Washington, Idaho and Nevada. With this plan, you access care through the plan's providers. You select a primary care dentist and all future regularly scheduled appointments should be made with that provider. For specialty services, you will be referred to a Willamette Dental specialist located in your region.

To choose a dentist or schedule an appointment, simply call their Appointment Center at one of the following numbers: **Oregon:** (800) 461-8994; **Washington:** (800) 359-6019; **Idaho:** (800) 603-1738; **Nevada:** (866) 397-5251. The Appointment Center hours are: Monday – Thursday 7 a.m. – 8 p.m.; Friday 7 a.m. – 6 p.m.; Saturday 7 a.m. – 4 p.m.

You'll have your first appointment within 30 days after your initial call. Appointments for cleanings and non-emergency operative procedures will be scheduled between 45 and 60 days after your call. On your first visit, you will receive a thorough examination that may include X-rays. Your dentist will then develop a Personal Dental Care Plan based on your overall dental health. This treatment plan will determine the sequence and number of procedures to be undertaken on future visits. Children will receive a cleaning at their first appointment and adults will receive their first cleaning after the initial appointment. Your dentist will determine your cleaning schedule based on your oral health.

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Willamette Dental's first priority with new patients is to diagnose and treat urgent conditions that pose an immediate threat to oral health or that put one or more teeth at risk. The next step is to control the disease process and to promote wellness and health maintenance. Willamette Dental provides emergency coverage 24 hours a day, 365 days a year. Patients will be seen within approximately 24 hours for emergencies (pain, bleeding or swelling). If you schedule an emergency appointment during regular clinic hours, you pay the usual office visit charge. After hours the visit charge is usually higher. If you have a dental emergency while out of the Willamette Dental service area, services will be reimbursed at the amount stated in the Summary of Co-payments. For an emergency, you can see any licensed dentist to obtain relief from pain, bleeding or swelling. Questions about your dental plan or service should be directed to the Willamette Dental Patient Relations Department at (800) 460-7644 or email: relations@willamettedental.com. Visit their website at: www.WillametteDental.com.

Preventive Dental Care

With the Willamette Dental Plan, you choose a Willamette Dental dentist that is convenient to you. Co-payments are paid to the office at the time of service. Specific co-payments include:

	DENTAL BENEFIT	CO-PAYMENT
	Annual Maximum	No annual maximum
	Deductible	No deductible
	Office Visit	\$12 per visit
DIAGNOSTIC AND PREVENTIVE SERVICES	Routine and Emergency Exams	Covered at 100%
	Single X-rays	\$8
	Intra-Oral Complete Series of Panoramic X-rays	\$40
	Teeth Cleaning	\$35
RESTORATIVE DENTISTRY AND PROSTHETICS	Surface Amalgam	\$45 - \$85
	Crown Porcelain/Precious Metal	\$635
	Complete Upper or Lower Denture	\$870
	Bridge – per tooth	\$635
	Stainless Steel Permanent Crown	\$100
ENDODONTICS AND PERIODONTICS	Root canal therapy	\$200 - \$275
	Osseous Surgery – per quadrant	\$830
	Root Planning – per quadrant	\$255
ORAL SURGERY	Routine Extraction – Single Tooth	\$50
	Surgical Extraction	\$160
	Surgical Complex Impacted Extraction	\$250
MISCELLANEOUS	Local Anesthesia (Novocain)	Covered at 100%
	Nitrous Oxide (per visit)	\$20
	After Hours Emergency Care	\$20
	Missed Appointment Fee	\$20
	Out of Area Emergency Care Reimbursement up to:	\$100

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Exclusions and Limitations

The following are general services not covered under the Willamette Dental Insurance, Inc. plan: services rendered prior to coverage effective date or after coverage ends; replacement of an existing denture, crown or bridge less than five years after the date of the most recent replacement; replacement of a lost or stolen denture, crown or bridge; services or supplies related to the diagnosis or treatment of the temporomandibular joint; splints, night guards and other appliances used to increase vertical dimension or restore bite; study models and dental implants; surgery for fractures, cysts, tumor or cosmetic reasons; IV sedation and/or general anesthesia; service that is unnecessary. This means for example, that an inlay or only is not necessary dental care if an amalgam filling would serve in a functionally equivalent manner. If an enrollee elects to have procedures performed that equate to a higher level of care than the least-costly alternative or recommendation, the enrollee will be responsible for the costs over and above that of any applicable service co-payment charge for the least-costly alternative. **This is your plan. Please contact Willamette Dental for a complete description.**

YOUR VISION BENEFITS

Benefit	Frequency	Copayment	Your coverage from a [VSP] Doctor
<i>Eye Care Wellness – Regular exams are essential for protecting your visual wellness.</i>			
Exam	Every 12 months	\$0.00	Covered in full.
<i>Prescription Eyewear – You may choose between glasses and contacts.</i>			
Lenses	Every 12 months	No Copay Applies	Single Vision, lined bifocal and lined trifocal lenses are covered in full.
Frame	Every 12 months	No Copay Applies	Covered up to \$45.00
Contact Lenses	Every 12 months	No Copay Applies	Covered up to \$65.00 (in lieu of lenses and frames)
When you choose contacts instead of glasses, your \$65.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.			
Current soft contact lens wearers may qualify for additional benefits. Learn more by calling Customer Services.			
<i>Extra Discounts and Savings</i>			
<i>Laser Vision Correction Discounts</i>			
<ul style="list-style-type: none"> • Laser vision correction services are provided at a reduced cost through [VSP] network doctors and contracted laser surgery centers. 			
<i>Contacts</i>			
<ul style="list-style-type: none"> • 15% off cost of contact lens exam (fitting and evaluation)* 			
* Available from the same [VSP] doctor who provided your eye exam within the last 12 months			

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