

The coverage and benefits you deserve are just 3 simple steps away

1. Call a local FamilyCare expert.
2. Compare the coverage and benefits you already have or need.
3. Choose the PremierCare Medicare Advantage plan that gives you the benefits and affordability you want.

## PremierCare Medicare Advantage Plans

|  | Your Current Plan | PremierCare Advantage Rx  | PremierCare Value Rx | PremierCare Choice Rx | PremierCare Choice | PremierCare Select Rx  | PremierCare Plus*  |
|--|-------------------|---|----------------------|-----------------------|--------------------|--|--|
| <b>Monthly Premium</b>                               |                   | \$140   | \$95                 | \$44                  | \$21               | \$144  | \$0*   |
|  |                   | <b>You Pay</b>  | <b>You Pay</b>       | <b>You Pay</b>        | <b>You Pay</b>     | <b>You Pay</b>   | <b>You Pay</b>   |
| <b>Out-of-Pocket Maximum</b>                         |                   | \$2,500   | \$2,500              | \$3,400               | \$3,400            | \$2,500  | \$0  |
| <b>Inpatient Hospital Care</b>                       |                   |   |                      |                       |                    |  | *PremierCare Plus is available to people who qualify for both Medicare and Oregon Health Plan/Medicaid.<br><br><a href="#">Click here to learn more about benefits and cost-sharing for this plan.</a> |
| Days 1–5   |                   | \$160   | \$160                | \$300                 | \$300              | \$100  |  |
| Days 6–90  |                   | \$0   | \$0                  | \$0                   | \$0                | \$0  |  |
| Additional days                                      |                   | \$0   | \$0                  | \$0                   | \$0                | \$0  |  |
| Days covered per hospitalization†                    |                   | No limit  | No Limit             | No limit              | No limit           | No limit   |  |
| <b>Office Visit</b>                                  |                   |   |                      |                       |                    |  |  |
| Yearly Physical                                      |                   | \$0   | \$0                  | \$0                   | \$0                | \$0  |  |
| Primary Care   |                   | \$15  | \$15                 | \$20                  | \$20               | \$15   |  |
| Specialist   |                   | \$30  | \$30                 | \$35                  | \$35               | \$30   |  |
| <b>Outpatient Surgery</b>                            |                   | 10% of cost   | 10% of cost          | 20% of cost           | 20% of cost        | 10% of cost  |  |
| <b>Ambulance</b>                                     |                   | \$50  | \$50                 | \$50                  | \$50               | \$50   |  |
| <b>Emergency Visit</b>                               |                   | \$50  | \$50                 | \$50                  | \$50               | \$50   |  |
| <b>Urgent Care Visit</b>                             |                   | \$30  | \$30                 | \$35                  | \$35               | \$30   |  |
| <b>X-rays</b>  |                   | 10% of costs  | 10% of costs         | 20% of costs          | 20% of costs       | 10% of costs   |  |
| <b>Lab Tests</b>                                     |                   | \$0   | %0                   | 20% of costs          | 20% of costs       | \$0  |  |
| <b>Prescription Drugs</b>                            |                   |   |                      |                       |                    |  |  |
| Yearly Deductible                                    |                   | \$100   | \$100                | \$175                 | Not covered        | \$0  |  |
| Diabetic Drug Tier                                   |                   | —   | —                    | —                     | —                  | \$0  |  |
| Generic Tier   |                   | \$7   | \$7                  | \$7                   | Not covered        | \$7  |  |
| Preferred Tier                                       |                   | \$30  | \$30                 | \$30                  | Not covered        | \$30   |  |
| Non-preferred Tier                                   |                   | \$70  | \$70                 | \$65                  | Not covered        | \$60   |  |
| Specialty Tier                                       |                   | 30% of costs  | 30% of costs         | 28% of costs          | Not covered        | 33% of costs   |  |
| <b>Dental</b><br>(Offered through Willamette Dental) |                   |   |                      |                       |                    |  |  |
| Routine Exam & Fluoride Treatment                    |                   | \$12  | Not covered          | Not covered           | Not covered        | \$12   |  |
| Routine Cleaning                                     |                   | \$35  |                      |                       |                    | \$35   |  |
| X-ray  |                   | \$8–\$40  | Not covered          | Not covered           | Not covered        | \$8–\$40   |  |
| <b>Vision</b>  |                   |   |                      |                       |                    |  |  |
| Routine yearly exam                                  |                   | \$0   | Not Covered          | Not Covered           | Not Covered        | \$0  |  |
| Prescription glasses or contacts                     |                   | Covers one pair every two years (\$100 limit on glasses & \$65 on contacts) | Not Covered          | Not Covered           | Not Covered        | Covers one pair every year (\$100 limit on glasses & \$65 on contacts) |  |

†No limit to the number of days per benefit period. A benefit period begins on the day you go into a hospital or skilled nursing facility. A new benefit period begins when you have gone for 60 days without hospital or skilled nursing care.