

Enrollment Kit 2012



Plus

This is an advertisement

FamilyCare

HEALTH PLANS



SUMMARY OF BENEFITS

January 1, 2012–December 31, 2012



PremierCare Plus

H3818, Plan 002

H3818_KIT_00012 CMS Approved 09/19/2011

FamilyCare Health Plans, Inc. | 825 NE Multnomah, Suite 300 | Portland, OR 97232
1-866-225-CARE (2273) toll-free | 503-345-5701 local | www.familycarehealthplans.org

PremierCare Plus has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until December 31, 2013. NCQA's approval is based on a review of the PremierCare Plus Model of Care and is an indicator of compliance with CMS requirements. NCQA's approval is not an endorsement by CMS and/or NCQA of PremierCare Plus or the quality of service provided by PremierCare Plus. PremierCare Plus will still need to be approved each year by CMS in order to operate. If you have questions regarding our approval by the NCQA, please contact us at 1-866-798-CARE (2273). (TTY users should call 1 800 735 2900.) Hours are 8 am-8 pm, Monday-Friday



Section I: Introduction to the Summary of Benefits Report for PremierCare Plus (HMO SNP)

January 1, 2012–December 31, 2012

Portland Metro (Clackamas, Multnomah and Washington counties)
and Clatsop, Morrow and Umatilla Counties, Oregon

Thank you for your interest in PremierCare Plus (HMO SNP).

Our plan is offered by FAMILYCARE HEALTH PLANS, INC., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP). This plan is designed for people who meet specific enrollment criteria.

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

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

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

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

YOU HAVE CHOICES IN YOUR HEALTHCARE

As a Medicare beneficiary, you can choose

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

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

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

HOW CAN I COMPARE MY OPTIONS?

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

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

WHERE IS PREMIERCARE PLUS (HMO SNP) AVAILABLE?

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

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

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

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

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

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

CAN I CHOOSE MY DOCTORS?

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

You can ask for a current provider directory. For an updated list, visit us at www.familycarehealthplans.org. Our customer service number is listed at the end of this introduction.

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

If you choose to go to a doctor outside of our network, you must pay for these ser-

vices yourself except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services

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

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

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

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

WHAT IS A PRESCRIPTION DRUG FORMULARY?

PremierCare Plus (HMO SNP) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our 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 MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

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

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see www.medicare.gov "Programs for People with Limited Income and Resources" in the publication *Medicare & You*.
- The Social Security Administration at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your state Medicaid office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in its entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan.

Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it

must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

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

As a member of PremierCare Plus (HMO SNP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-

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

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

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

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

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

- Some antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

- Osteoporosis drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Eprex®): 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 administered through DME.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Health and Drug Plans," then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan.

Our customer service number is listed below.

Please call FamilyCare Health Plans, Inc. for more information about PremierCare Plus (HMO SNP).

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

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,
8 am–8 pm Pacific

Current members should call toll-free 1-866-798-CARE (2273) for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-735-2900)

Prospective members should call toll-free 1-866-225-CARE (2273) for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-735-2900)

Current members should call locally 503-345-5702 for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-735-2900)

Prospective members should call locally 503-345-5701 for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-735-2900)

Current members should call toll-free 1-866-798-CARE (2273) for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-735-2900)

Prospective members should call toll-free 1-866-225-CARE (2273) for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-735-2900)

Current members should call locally 503-345-5702 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-735-2900)

Prospective members should call locally 503-345-5701 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-735-2900)

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.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call Customer Service at the phone number listed above.

Este documento puede estar disponible en otro idioma que no sea inglés. Para más información, comuníquese con el Servicio de Atención al Cliente al número que aparece arriba.

Tài liệu này có thể có ở dạng ngôn ngữ khác ngoài tiếng Anh. Để biết thêm thông tin, xin vui lòng gọi tới số điện thoại Dịch vụ Khách hàng có trong danh mục điện thoại nêu trên.

Этот документ может быть доступен на других языках, помимо английского. Для получения дополнительной информации, позвоните в службу поддержки по телефону, числящемуся выше.

Section II: Summary of Benefits Table for PremierCare Plus

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#1 Premium and other important information	<p>The Medicare cost-sharing amount may vary based on your level of Medicaid eligibility.</p> <p>In 2011, the monthly Part B premium was \$0 or \$96.40 and may change for 2012 and the annual Part B deductible amount was \$0 or \$162 and may change for 2012.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>*Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for original Medicare services.</p> <p>** Please consult with your plan about cost sharing when receiving services from out-of-network providers.</p> <p>\$36.50 monthly plan premium in addition to your monthly Medicare Part B premium.*</p> <p>In-Network</p> <p>In 2011 the annual Part B deductible amount was \$0 or \$162 and may change for 2012.</p> <p>\$3,400 out-of-pocket limit for Medicare-covered services*</p>
#2 Doctor and hospital choice (For more information, see Emergency Care #15 and Urgently needed care #16.)	<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		
#3 Inpatient hospital care (Includes substance abuse and rehabilitation services)	<p>In 2011, the amounts for each benefit period were:</p> <p>\$0 or</p> <p>Days 1-60: \$1,132 deductible*</p> <p>Days 61-90: \$283 per day*</p> <p>Days 91-150: \$566 per lifetime reserve day.</p> <hr/> <p style="text-align: right;">Continues</p>	<p>In-Network</p> <p>Plan covers 90 days each benefit period.</p> <p>In 2011, the amounts for each benefit period were \$0 or:</p> <p>Days 1-60: \$1,132 deductible*</p> <p>Days 61-90: \$283 per day*</p> <p>Days 91-150: \$566 per lifetime reserve day*</p> <hr/> <p style="text-align: right;">Continues</p>

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#3 Inpatient hospital care (Continued)	<p>Continued</p> <hr/> <p>These amounts may change for 2012. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>Continued</p> <hr/> <p>These amounts may change for 2012. You will not be charged additional cost sharing for professional services. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
#4 Inpatient mental health care	<p>In 2011, the amounts for each benefit period were \$0 or:</p> <p>Days 1-60: \$1,132 deductible*</p> <p>Days 61-90: \$283 per day*</p> <p>Days 91-150: \$566 per lifetime reserve day*</p> <p>These amounts may change for 2012</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime only</p> <hr/>	<p>In 2011, the amounts for each benefit period were \$0 or:</p> <p>Days 1-60: \$1,132 deductible*</p> <p>Days 61-90: \$283 per day*</p> <p>Days 91-150: \$566 per lifetime reserve day*</p> <p>These amounts may change in 2012.</p> <p>In-Network</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <hr/>

Continues

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Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#4 Inpatient mental health care (Continued)	Continued if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	Continued Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
#5 Skilled nursing facility (SNF)	In 2011, the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1-20: \$0 per day* Days 21-100: \$0 or \$141.50 per day* These amounts may change for 2012. 100 days each benefit period A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	General Authorization rules may apply In-Network No limit to the number of days covered by the plan each hospital stay. No prior hospital stay is required. In 2011, the amounts for each benefit period were \$0 or: Days 1-20: \$0 per day* Days 21-100: \$141.50 per day* These amounts may change for 2012. You will not be charged additional cost sharing for professional services.

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#6 Home health care (Includes medically necessary intermittent skilled nursing care, home health aide services, rehabilitation services, etc.)	\$0 co-pay	General Authorization rules may apply In-Network \$0 co-pay for each Medicare-covered home health visits*
#7 Hospice	You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.
OUTPATIENT CARE		
#8 Doctor office visits	0% or 20% co-insurance	General Authorization rules may apply In-Network \$0 co-pay for each primary care doctor visit for Medicare-covered benefits.* \$0 co-pay for each specialist visit for Medicare-covered benefits.*

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#9 Chiropractic services	Supplemental routine care not covered 0% or 20% co-insurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers	General Authorization rules may apply In-Network 0–20% of cost for each Medicare-covered visit* Medicare-covered chiropractic visits are for manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
#10 Podiatry services	Supplemental routine care not covered 0% or 20% co-insurance for medically necessary foot care, including care for medical conditions affecting the lower limbs	General Authorization rules may apply In-Network 0–20% of cost for each Medicare-covered visit** Medicare-covered podiatry benefits are for medically-necessary foot care.
#11 Outpatient mental health care	0% or 40% co-insurance for most outpatient mental health services 0% or 40% co-insurance of the Medicare-approved amount for each service you get from a qualified professional as part of a partial hospitalization program. “Partial hospitalization program” is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.	General Authorization rules may apply In-Network \$0 co-pay for Medicare-covered visits* 0% or 20% of the cost for Medicare-covered partial hospitalization program services*

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#12 Outpatient substance abuse care	0% or 20% co-insurance	General Authorization rules may apply In-Network 0% or 20% of the cost for Medicare-covered individual therapy visits* 0% or 20% of the cost for Medicare-covered group visits*
#13 Outpatient services/surgery	0% or 20% co-insurance for the doctor's services Specified co-payment for outpatient hospital facility services Co-pay cannot exceed the Part A inpatient hospital deductible. 0% or 20% co-insurance for ambulatory surgical center facility services	General Authorization rules may apply In-Network 0% or 20% of the cost for each Medicare-covered ambulatory surgical center visit* 0% or 20% of the cost for each Medicare-covered outpatient hospital facility visit*
#14 Ambulance services (Medically necessary ambulance services)	0% or 20% co-insurance	In-Network 0% or 20% of the cost for Medicare-covered ambulance benefits.* If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.
#15 Emergency care (You may go to any emergency room if you reasonably believe you need emergency care.)	0% or 20% co-insurance for the doctor's services Specified co-payment for outpatient hospital facility emergency services. Emergency services co-pay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room	General \$0 or \$50 co-pay for Medicare-covered emergency room visits Not covered outside the US except under limited circumstances. Contact the plan for more details.

Continues

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#15 Emergency care (Continued)	<p><u>Continued</u></p> <p>co-pay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit.</p> <p>Not covered outside the US except under limited circumstances.</p>	
#16 Urgently needed care (This is NOT emergency care, and in most cases is out-of-the-service area.)	<p>0% or 20% co-insurance</p> <p>NOT covered outside the US except under limited circumstances.</p>	<p>General</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 hours for the same condition, you pay \$0 for the urgently needed care visit.</p>
#17 Outpatient rehabilitation services (Occupational therapy, physical therapy, speech and language therapy)	<p>0% or 20% co-insurance</p>	<p>General</p> <p>Authorization rules may apply</p> <p>In-Network</p> <p>0–20% of cost for Medicare-covered occupational therapy visits*</p> <p>\$0 co-pay for Medicare-covered physical and/or speech and language therapy visits*</p>
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
#18 Durable medical equipment (includes wheelchairs, oxygen, etc.)	<p>0% or 20% co-insurance</p>	<p>General</p> <p>Authorization rules may apply</p> <p>In-Network</p> <p>0% or 20% of the cost for Medicare-covered items*</p>

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#19 Prosthetic devices (Includes braces, artificial limbs, eyes, etc.)	0% or 20% co-insurance	General Authorization rules may apply In-Network 0% or 20% of the cost for Medicare-covered items
#20 Diabetes programs and supplies	0% or 20% co-insurance for Diabetes self-management training 0% or 20% co-insurance for Diabetes supplies 0% or 20% co-insurance for diabetic therapeutic shoes or inserts	In-Network \$0 co-pay for Diabetes self-management training* 0% or 20% of the cost for Diabetes monitoring supplies* 0% or 20% of the cost for therapeutic shoes or inserts*
#21 Diagnostic tests, x-rays, lab services, and radiology services	0% or 20% co-insurance for diagnostic tests and x-rays \$0 co-pay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	General Authorization rules may apply In-Network 0% or 20% of the cost for Medicare-covered lab services* 0% or 20% of the cost for Medicare-covered diagnostic procedures and tests* 0% or 20% of the cost for Medicare-covered x-rays* 0% or 20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays)* 0% or 20% of the cost for Medicare-covered therapeutic radiology services*

Continues

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#21 Diagnostic tests, x-rays, lab services, and radiology services (Continued)	<p>Continued</p> <hr/> 0% or 20% co-insurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.	
#22 Cardiac and pulmonary rehabilitation services	0% or 20% co-insurance for cardiac rehabilitation services 0% or 20% co-insurance for pulmonary rehabilitation services 0% or 20% co-insurance for intensive cardiac rehabilitation services This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	General Authorization rules may apply In-Network 0% or 20% of the cost for Medicare-covered cardiac rehabilitation services* 0% or 20% of the cost for Medicare-covered intensive cardiac rehabilitation services* 0% or 20% of the cost for Medicare-covered pulmonary rehabilitation services*
PREVENTIVE SERVICES		
#23 Preventive services and wellness/education programs	No co-insurance, co-payment or deductible for the following: <ul style="list-style-type: none"> - Abdominal aortic aneurysm screening - Bone mass measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. - Cardiovascular screening <hr/> Continues	General \$0 co-pay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> - Abdominal aortic aneurysm screening - Bone mass measurement - Cardiovascular screening - Cervical and vaginal cancer screening (Pap test and pelvic exam) - Colorectal cancer screening - Diabetes screening - Influenza vaccine - Hepatitis B vaccine - HIV screening <hr/> Continues

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#23 Preventive services and wellness/ education programs (Continued)	<p><u>Continued</u></p> <ul style="list-style-type: none"> – Cervical and vaginal cancer screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. – Colorectal cancer screening – Diabetes screening – Influenza vaccine – Hepatitis B vaccine for people with Medicare who are at risk – HIV Screening. \$0 co-pay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy – Breast cancer screening (mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. 	<p><u>Continued</u></p> <ul style="list-style-type: none"> – Breast cancer screening (mammogram) – Medical nutrition therapy services – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal vaccine – Prostate cancer screening (Prostate specific antigen (PSA) test only) – Smoking cessation (Counseling to stop smoking) – Welcome to Medicare Physical Exam (Initial Preventive Physical Exam). <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p> <p>In-Network</p> <p>The plan covers the following education/ wellness programs:</p> <ul style="list-style-type: none"> – Written health education materials, including newsletters – Nursing Hotline
	<u>Continues</u>	

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
<p>#23 Preventive services and wellness/ education programs (Continued)</p>	<p>Continued</p> <hr/> <p>Medicare covers one baseline mammogram for women between ages 35–39.</p> <ul style="list-style-type: none"> – Medical Nutrition therapy services. 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 and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease – Personalized Prevention Plan Services (Annual Wellness Visits) – Pneumococcal vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. – Prostate cancer screening–Prostate specific antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. – Smoking cessation (counseling to stop smoking). Covered <hr/> <p style="text-align: right;">Continues</p>	

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#23 Preventive services and wellness/ education programs (Continued)	<p>Continued</p> <hr/> <p>if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>– Welcome to Medicare physical exam (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows: During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare physical exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months.</p>	
#24 Kidney disease and conditions	<p>0% or 20% co-insurance for renal dialysis</p> <p>0% or 20% co-insurance for kidney disease education services</p>	<p>General</p> <p>Authorization rules may apply</p> <p>In-Network</p> <p>0% or 20% of the cost for renal dialysis*</p> <p>\$0 co-pay for kidney disease education services*</p>

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#25 Outpatient prescription drugs	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B General</p> <p>\$0 annual 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 General</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, or – Have access to Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your-prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance, when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan and Medicare.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from PremierCare Plus (HMO SNP) for certain drugs.</p>

Continues

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#25 Outpatient prescription drugs (Continued)		<p data-bbox="883 239 1003 273">Continued</p> <hr/> <p data-bbox="883 285 1455 663">You must go to certain pharmacies for a very limited number of drugs due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.Medicare.gov.</p> <p data-bbox="883 676 1451 827">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 data-bbox="883 840 1451 1024">If you request a formulary exception for a drug and PremierCare Plus approves the exception, you will pay the generic cost share for generic drugs and the brand cost share for brand drugs.</p> <p data-bbox="883 1037 1032 1071">In-Network</p> <p data-bbox="883 1083 1312 1117">You pay \$0 annual deductible.</p> <p data-bbox="883 1129 1107 1163">Initial Coverage</p> <p data-bbox="883 1176 1445 1247">Depending on your income and institutional status, you pay the following:</p> <p data-bbox="883 1260 1377 1331">For generic drugs (including brand drugs treated as a generic), either:</p> <ul data-bbox="883 1344 1169 1470" style="list-style-type: none"> <li data-bbox="883 1344 1130 1377">– A \$0 co-pay; or <li data-bbox="883 1390 1169 1423">– A \$1.10 co-pay; or <li data-bbox="883 1436 1123 1470">– A \$2.60 co-pay <p data-bbox="883 1482 1253 1516">For all other drugs, either:</p> <ul data-bbox="883 1528 1169 1654" style="list-style-type: none"> <li data-bbox="883 1528 1130 1562">– A \$0 co-pay; or <li data-bbox="883 1575 1169 1608">– A \$3.30 co-pay; or <li data-bbox="883 1621 1123 1654">– A \$6.50 co-pay <p data-bbox="883 1667 1120 1701">Retail pharmacy</p> <p data-bbox="883 1713 1429 1747">You can get drugs the following ways:</p> <ul data-bbox="883 1759 1331 1839" style="list-style-type: none"> <li data-bbox="883 1759 1312 1793">– One-month (30-day) supply <li data-bbox="883 1806 1331 1839">– Three-month (90-day) supply <hr/> <p data-bbox="1347 1856 1471 1890" style="text-align: right;">Continues</p>

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
<p>#25 Outpatient prescription drugs (Continued)</p>		<p>Continued</p> <hr/> <p>Long Term Care Pharmacy You can get drugs the following way: One-month (31-day) supply Mail Order You can get drugs the following ways: – One-month (30-day) supply – Three-month (90-day) supply Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay a \$0 co-pay. Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan’s service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy’s full charge for the drug and submit documentation to receive reimbursement from PremierCare Plus (HMO SNP). You can get drugs the following way: – 10-day supply Out-of-Network Initial Coverage Depending on your income and institutional status, you will be reimbursed by PremierCare Plus (HMO SNP) up to the plan’s cost of the drug minus the following: For generic drugs purchased out-of-network (including brand drugs treated as generic), either: – A \$0 co-pay; or – A \$1.10 co-pay; or – A \$2.60 co-pay</p> <hr/> <p style="text-align: right;">Continues</p>

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
#25 Outpatient prescription drugs (Continued)		<p>Continued</p> <hr/> <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> - A \$0 co-pay; or - A \$3.30 co-pay; or - A \$6.50 co-pay. <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed in full for drugs purchased out-of-network.</p>
#26 Dental services	Preventive dental services (such as cleaning) not covered.	<p>In-Network</p> <p>\$0 co-pay for Medicare-covered dental benefits*</p> <p>In general, preventive dental benefits (such as cleaning) not covered</p>
#27 Hearing services	<p>Supplemental routine hearing exams and hearing aids not covered</p> <p>0% or 20% co-insurance for diagnostic hearing exams</p>	<p>In-Network</p> <p>In general, supplemental routine hearing exams and hearing aids not covered</p> <ul style="list-style-type: none"> - 0% of the cost for Medicare-covered diagnostic hearing exams*
#28 Vision services	<p>0% or 20% co-insurance for diagnosis and treatment of diseases and conditions of the eye</p> <p>Supplemental 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>\$0 co-pay for</p> <ul style="list-style-type: none"> - One pair of eyeglasses or contact lenses after cataract surgery* - Up to 1 pair of glasses every year - Up to 1 pair of contacts every year - \$0 co-pay for exams to diagnose and treat diseases and conditions of the eye - \$0 co-pay for up to 1 supplemental routine eye exam every year <p>\$100 plan coverage limit for eyeglasses (lenses and frames) every year</p> <p>\$65 plan coverage limit for contact lenses every year</p>
Over-the-counter items	Not covered	<p>General</p> <p>The plan does not cover over-the-counter items.</p>

Benefit Category	Original Medicare	PremierCare Plus (HMO SNP)
Transportation (Routine)	Not covered	In-Network The plan does not cover supplemental routine transportation
Acupuncture	Not covered	In-Network The plan does not cover acupuncture

The FamilyCare Advantage

We understand that shopping for a Medicare Advantage plan is complicated. Our goal is to treat you with respect, answer your questions in plain language, and help you choose a health plan you will be happy with.

As a not-for-profit organization, our priority is making certain you get the care you want and the service you deserve. It's why we emphasize:

Easy access to your doctor

The most-direct route to better care is a straight line from you to your doctor. We are committed to helping you see your doctor promptly. In fact, we earned five out of five stars for "access to primary care" in 2010 Plan Ratings from the Centers for Medicare and Medicaid Services (CMS). (CMS Plan Ratings change each year.)

We believe in traditional one-on-one relationships between patients and doctors. Working together as a team, you and your doctor make better medical decisions. As a PremierCare Plus (HMO) member, your primary care choices include providers who practice family medicine, internal medicine or women's health (Ob/Gyn).

When you need specialty care, your primary care provider can help you find a specialist. And PremierCare members never need "pre-authorization" to see one of our network specialists.

You also have the freedom to choose where to go for emergency care.

Friendly, dependable customer service

Good service is the key to building lasting relationships with our members. When you call with a question about your plan,

you'll reach Customer Service representatives with training in Medicare, Medicare Advantage and the Oregon Health Plan. And because they work at our home office in Portland, they have direct access to information about your benefits so they can give you prompt answers.

No surprise bills

When you see a doctor in our network, you never have to worry about a surprise bill for covered medical services. What you pay is spelled out in your *Evidence of Coverage*.

Out-of-pocket protection

PremierCare Plus (HMO) protects your nest egg with annual out-of-pocket limits. Once your total co-pays and co-insurance reach \$3,400, PremierCare will pay 100% of your covered medical expenses for the rest of the year.

Prescription for convenience

Pick up and refill prescriptions where it's convenient for you. PremierCare network pharmacies include:

- Locally owned neighborhood drug-stores in every part of our service area.
- Rite Aid and Walgreen pharmacies.
- Albertson's, Fred Meyer and Safeway prescription counters.
- Bi-Mart, Costco, Target and Wal-Mart.

For ultimate convenience, you can use our mail-delivery pharmacy service to have

prescription refills sent directly to your home. (Some drugs can't be mailed because of handling restrictions.) For some long-term prescriptions, you can receive a three-month supply for two month's co-pay.

One-on-one care coordination

If you have a condition that involves multiple medical specialties, we'll work one-on-one with you to make sure you get the care you need. Our care coordinators are registered nurses, licensed pharmacists and other medical professionals with clinical experience.

Proactive health

Staying healthy is the best medicine. PremierCare Plus (HMO) covers annual physicals, flu and pneumonia vaccinations, breast, cervical and prostate cancer screening, and smoking cessation—all with no co-pay.

Travel with confidence

Travel without worry knowing that PremierCare Plus (HMO) covers emergency and urgent care anywhere in the US.

Vision coverage included

Beginning in 2012, PremierCare Plus (HMO) covers routine vision care and annual eye exams, plus a \$100 prescription eyewear credit every year.

Around the clock medical advice

Sometimes, you have a healthcare question that just can't wait. Members can contact our 24-hour hotline to speak with an experienced professional nurse.

Standing up for your rights

As a non-profit, we believe Medicare is a right you have earned.

Getting the most from your plan

Your PremierCare member ID card

Within 10 days after your application has been approved, you will receive a PremierCare Plus (HMO) member ID card. Use this card whenever you see a doctor or (if your plan covers Part D benefits) fill a prescription.

Use this card in place of your Medicare card. You should keep your Medicare card in a safe place.

You and your primary care provider (PCP)

As a PremierCare Plus (HMO) member,

you will be "paneled" with a primary care provider (PCP) who will work one-on-one with you to provide most of your care. If you are a new PremierCare Plus (HMO) member and have a PCP who is already in our network, you can continue to see that provider. Just give us a call and let us know who you want to be paneled with.

Having a PCP helps make healthcare more personal. The longer you work together, the better your PCP will come to know you and your personal medical needs. If you need specialty care, your PCP will help you select a specialist and coordinate care.

A PCP can be a doctor of medicine or doctor of osteopathy certified in family medicine,

internal medicine, or – for women – obstetrics and gynecology (Ob/Gyn). (Children under 18 who are eligible for Medicare Advantage may have a PCP who is a pediatrician.)

A PCP may also be a licensed nurse practitioner (LNP) or a physician assistant (PA). LNPs and PAs complete rigorous medical training and are licensed to provide most basic healthcare services.

You can change your PCP for any reason at any time. Simply call Customer Service and we will help you select a new PCP.

24-hour nurse hotline

Sometimes you have a healthcare question that just can't wait. Call our 24-hour/7 days a week hotline to speak with an experienced licensed nurse.

\$0 co-pay benefits

Many benefits to help you stay healthy have a \$0 co-pay.

- Vaccinations – Pneumonia, Hepatitis B and annual flu shots
- Annual physical

- Breast exams and Pap tests
- Prostate exams
- Colorectal cancer screening
- Bone Mass Measurement
- Smoking Cessation
- HIV testing

Lower prescription drug costs

Using generic drugs can stretch your healthcare dollar. Generics are drugs that have the same therapeutic effect as higher cost brand-name drugs. If the actual cost of a generic is lower than your co-pay, you will pay the smaller generic amount.

Prescription coordination

If you have multiple medical conditions, you may be invited to join a medication therapy management (MTM) program. The MTM program, which is available to you at no added cost, will look all of your prescriptions and how they work together. It can recommend specific drugs or drug combinations that will treat your conditions more effectively.

Frequently asked questions

How do I make an appointment?

Call your providers office and let them know that you are a PremierCare Plus (HMO) member.

Can I choose my own PCP?

If you are new to our plan and already have

a PCP, you can look in our *Provider/Pharmacy Directory* to see if he or she is a member of our network. You will receive a provider directory when you are enrolled in PremierCare Plus (HMO), or you can browse our provider directory online at www.familycarehealthplans.org on the internet

If your PCP is in our network, call Customer Service and let us know that you want to continue seeing that provider.

If your PCP is not in our network, Customer Service will help you select a PCP on the

basis of specialty, languages spoken, and location.

Can I change my PCP?

Yes. Call Customer Service and we will help you find a different provider who is accepting new patients. You can choose a provider on the basis of specialty, languages spoken, and address.

Do I need an authorization to see a specialist?

No. You should work with your PCP to decide what kind of care you need, but you do not need an “advanced authorization” to see an in-network specialist.

Can I see a doctor who is not in the FamilyCare network?

PremierCare Plus is a health maintenance organization (HMO), a type of health plan that manages healthcare quality and costs through contracts with healthcare providers. By joining our plan, you agree to get care from providers in our network except in certain situations.

If you need emergency or urgent care, you may see any provider. You may also be authorized to see an out-of-network provider if:

- A network provider is not available to see you.
- You need a specialist and there is no network specialist available in your area. (You will need an authorization before we will cover service from an out-of-network provider. Your PCP can contact us and request an authorization for you.)

Your PCP can help you get the care you need. You may also contact Customer Ser-

vice for help finding a provider.

What do I do in an emergency?

PremierCare Plus (HMO) covers urgent and emergency care anywhere in the US.

For emergency care, go to the nearest hospital emergency department. **You do NOT need authorization for emergency care.**

For urgent care, you can contact your PCP and ask for an urgent appointment. If your PCP is unavailable, you can see another doctor or go to a minor emergency center **without requesting prior authorization.**

How do I know if I need urgent care or emergency care?

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

“Urgently needed care” is a non-emergency situation when you need medical care right away because of an illness, injury or condition that you did not expect or anticipate, but your health is not in serious danger.

What happens if I’m traveling and need care or prescriptions?

In addition to covering emergency and urgent care anywhere in the world, PremierCare covers dialysis while you travel. You may have to pay any charges when you receive care and then submit a claim to cover the cost of care. Call Customer Service or consult your *Evidence of Coverage* for more information.

If you are traveling outside of our service area and need a prescription, you may be able to fill your prescription at a national pharmacy (such as Walgreen’s or Safeway)

that is part of our network. Contact Customer Service using the numbers on the cover of this booklet for help in locating an in-network pharmacy.

If you cannot reach Customer Service, or if there is no in-network pharmacy available, PremierCare Plus (HMO) will cover up to a 10-day supply from an out-of-network pharmacy. See your *Evidence of Coverage* for more information.

If you're planning a long trip, you may be able to get an extended supply of your prescription in advance. See your *Evidence of Coverage* for more information.

How do I fill a prescription?

You can fill your prescriptions at any phar-

macy in our network. Present your PremierCare Plus (HMO) member ID to the pharmacist.

You may also order refills from our mail-delivery prescription drug service.

See your *Evidence of Coverage* for details.

Does PremierCare cover chiropractic or alternative care?

PremierCare Plus (HMO) coverage for chiropractic care and massage is limited to Medicare-approved treatment. See your *Evidence of Coverage* for details.

PremierCare Plus (HMO) does not cover naturopathy, homeopathy, acupuncture or other forms of alternative care.

YOUR VSP VISION BENEFITS

Benefit	Frequency	Co-pay	Your coverage from a VSP Doctor
Routine exam	Every 12 months	\$0	Covered in full when you use a VSP provider
Prescription eyewear—Your choice of glasses <i>OR</i> contact lenses			
Frames & lenses	Every 12 months	\$0	Single vision, lined bifocal and lined trifocal lenses are covered up to \$100.
Contacts	Every 12 months	\$0	One pair of lenses covered up to \$65 in lieu of eyeglasses lenses & frames*
Your VSP Vision Benefits are available from VSP providers listed in the <i>Provider/Pharmacy Directory</i> you receive when you enroll in a PremierCare Medicare Advantage Plan. For more information, icall VSP Member Services toll-free at 1-800-877-7195 5 am to 7 pm, Monday through Friday, or visit www.vsp.com .			

*When you choose contact lenses instead of eyeglasses, your \$65 allowance applies towards the cost of your contacts and the contact lens exam. This exam is in addition to your routine exam and assures that your contacts fit properly.

Current soft contact wearers may qualify for VSP's Lense Care Program, which includes a contact lens exam and initial supply of replacement lenses.

Section IV: Medicaid-covered services

In this section, you can see a summary of the Medicaid benefits you may receive through the Oregon Health Plan.

As long as you are eligible for the Oregon Health Plan and Medicare Parts A and B, the Medicaid Benefits Packages you can have through the Oregon Health Plan are:

- The QMB + OHP Limited Drug Benefit Package or
- The OHP with Limited Drug Benefit Package.

Please contact your state Medicaid caseworker if you do not know which benefit package you have through the Oregon Health Plan.

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

Oregon Health Plan (OHP) Medicaid Benefit Packages:

QMB+OHP with Limited Drug Benefit Package

This benefit package is for people who qualify to have their Medicare Parts A and B cost sharing paid for by Medicaid. If you receive the QMB + OHP with Limited Drug Benefit Package, you get the benefits listed in the chart beginning on page 30.

The cost-sharing amounts listed in Sec-

tion 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 B prescription drug cost sharing.

OHP with Limited Drug Benefit Package

This benefit package is for people who only qualify to have their Medicare Parts A and B cost sharing paid for by Medicaid for services normally covered by the Oregon Health Plan. If you receive the OHP with Limited Drug Benefit Package, you get the benefits listed in the chart that begins on page 30.

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

If you receive a Medicare-covered service that is not normally covered by the Oregon Health Plan, you will have to pay the Medicare Parts A- and B-cost sharing yourself. See page 38 for more information on services not covered by the Oregon Health Plan.

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

Oregon Health Plan (Medicaid) benefits table

Benefit category	Medicaid (Member pays)	PremierCare Plus (Member pays)
#1 Premium & other important information	This is a brief summary. Please refer to the Oregon Health Plan member handbook for a detailed description of Medicaid benefits available to eligible Oregonians.	All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.
#2 Doctor & hospital choice (For more information, see Emergency care #15 and Urgently needed care #16.)	Allows patient to go to any provider that accepts Medicaid	You must go to network doctors, specialists and hospitals. Referral required for network hospitals and specialist (for certain benefits)
INPATIENT CARE		
#3 Inpatient hospital care	\$0 co-payment for Medicaid-covered services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#4 Inpatient mental health care	\$0 co-payment for Medicaid covered services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#5 Skilled nursing facility (In a Medicare-certified skilled nursing facility.)	\$0 co-payment for Medicaid-covered services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services

Benefit category	Medicaid (Member pays)	PremierCare Plus (Member pays)
#6 Home health care (Includes medically necessary intermittent skilled nursing care, home health aid services, rehabilitation services, etc.)	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#7 Hospice	\$0 co-payment for Medicaid-covered services	You must get care from a Medicare-certified hospice.
OUTPATIENT CARE		
#8 Doctor office visits	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	In-Network \$0 co-payment for Medicaid-covered services
#9 Chiropractic services	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#10 Podiatry services	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#11 Outpatient mental health care	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#12 Outpatient substance abuse care	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services

Benefit category	Medicaid (Member pays)	PremierCare Plus (Member pays)
#13 Outpatient services/surgery	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#14 Ambulance services (Medically necessary ambulance services)	\$0 co-payment for Medicaid-covered services	In-Network \$0 co-payment for Medicaid-covered services
#15 Emergency care (You may go to any emergency room if you reasonably believe you need emergency care)	\$0 co-payment for Medicaid-covered services	In-Network \$0 co-payment for Medicaid-covered services
#16 Urgently needed care (This is NOT emergency care and, in most cases, is out of the service area)	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	In-Network \$0 co-payment for Medicaid-covered services
#17 Outpatient rehabilitation services (Occupational therapy, physical therapy, & speech & language therapy)	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services

Benefit category	Medicaid (Member pays)	PremierCare Plus (Member pays)
OUTPATIENT MEDICAL SERVICES & SUPPLIES		
#18 Durable medical equipment	\$0 co-payment for Medicaid-covered services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#19 Prosthetic devices	\$0 co-payment for Medicaid-covered services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#20 Diabetes self-monitoring training, nutrition therapy, & supplies	\$0 co-payment for Medicaid-covered services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
#21 Diagnostic tests, x-rays & lab services	\$0 co-payment for Medicaid-covered services	Prior authorization rules may apply In-Network \$0 co-payment for Medicaid-covered services
PREVENTIVE SERVICES		
#22 Bone mass measurement	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services*	In-Network \$0 co-payment for Medicaid-covered services
#23 Colorectal screening exams	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services*	In-Network \$0 co-payment for Medicaid-covered services
#24 Routine Immunizations	\$0 co-payment for Medicaid-covered services except immunizations given for travel or other reasons	In-Network \$0 co-payment for Medicaid-covered services
#25 Mammograms (Annual screening) Covered annually under Medicaid	\$0 co-payment for Medicaid-covered services	In-Network \$0 co-payment for Medicaid-covered services

*Some services may not include a co-payment if accessed in settings such as outpatient diagnostic settings at a hospital.

Benefit category	Medicaid (Member pays)	PremierCare Plus (Member pays)
#26 Pap tests & pelvic exams (Covered annually under Medicaid)	\$0 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	In-Network \$0 co-payment for Medicaid-covered services
#27 Prostate cancer screening exams	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	In-Network \$0 co-payment for Medicaid-covered services
#28 End-Stage Renal Disease	\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services	In-Network \$0 co-payment for Medicaid-covered services
#29 Prescription drugs	\$1 co-payment for preferred generic and preferred brand-name drugs \$3 co-payment for non-preferred generic drugs and non-preferred brand-name drugs Mental health drugs are covered by the state and not your Medicaid managed care health plan	Part D medications Covered by your Medicare health plan (See Section II for details) Part B Medications You pay \$0 yearly deductible for Part B-covered drugs. In-Network \$0 co-payment for Medicaid-covered service (not including Part B-covered chemotherapy drugs). Prior authorization rules may apply \$0 co-payment for Medicaid-covered services for Part B-covered chemotherapy drugs. Prior authorization rules may apply Medicaid-covered medications – Over-the-counter drugs when accompanied by a prescription – Benzodiazepine & barbituate drugs when accompanied by a prescription

Continues

Benefit category	Medicaid (Member pays)	PremierCare Plus (Member pays)
#29 Prescription drugs (Continued)		<p>Continued</p> <hr/> <ul style="list-style-type: none"> – Drugs when used for the symptomatic relief of cough or colds when accompanied by a prescription – Vitamins and minerals when accompanied by a prescription <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary online at www.familycarehealthplans.org.</p>
#30 Dental services	<p>\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services</p> <p>\$0 co-payment for Medicaid-covered dental diagnostic and preventive routine checkup services</p>	<p>Dental coverage is covered by dental care organization</p>
#31 Hearing services	<p>\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services</p>	<p>Prior authorization rules may apply</p> <p>In-Network</p> <p>\$0 co-payment for Medicaid-covered services</p>
#32 Vision services	<p>\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services</p>	<p>Prior authorization rules may apply</p> <p>In-Network</p> <p>\$0 co-payment for Medicaid-covered services</p> <p>(See Section II, #28 Vision Services)</p>
#33 Physical exams	<p>\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services</p>	<p>Prior authorization rules may apply</p> <p>In-Network</p> <p>\$0 co-payment for Medicaid-covered services</p>

Benefit category	Medicaid (Member pays)	PremierCare Plus (Member pays)
#34 Health/wellness education	Not covered	<p>This plan covers the following health/wellness education benefits</p> <ul style="list-style-type: none"> – Written health education materials, including newsletters – Nutrition training – Nursing hotline <p>\$0 co-pay for Medicare-covered smoking cessation counseling session.*</p>
#35 Other non-covered Medicare services that will be covered by the Oregon Health Plan (Medicaid) Preventive 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-Provera – Sterilizations 	<p>\$3 co-payment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services</p> <p>\$0 co-payment for Medicaid-covered x-ray, lab, routine immunization and family planning services</p>	<p>Prior authorization rules may apply</p> <p>In-Network</p> <p>\$0 co-payment for Medicaid-covered services</p>
Continues		

Benefit category	Medicaid (Member pays)	PremierCare Plus (Member pays)
<p>#35 Other non-covered Medicare services that will be covered by the Oregon Health Plan (Medicaid) (Continued) Other Oregon Health Plan services</p> <ul style="list-style-type: none"> – Death with dignity services[§] – Abortions[§] – Mental health drugs <p>§Please note: These services are covered by the state and not by your Medicaid managed care health plan.</p>		

Services that are not covered by the Oregon Health Plan (Exclusions)

Not all medical treatments are covered. When you need medical treatment, contact your primary care provider (PCP). These are some of the exclusions. (This list does not include **every** exclusion.)

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

- Cancer sores
- Diaper rash
- Corns/salluses
- Sunburn
- Food poisoning
- Sprains

Personal comfort or convenience items (Radios, telephones, hot tubs, 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 a member of your household

Any service 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 programs
- Infertility services

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



Grievance, Coverage Determinations, Exceptions and Appeal Procedures

What is a Grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with PremierCare or one of our network providers that does not relate to a decision about payment or benefits. For example, you would file a grievance if you have a problem with a long waiting time at a provider office or difficulty scheduling an appointment.

If our customer service agent is unable to achieve a resolution, we have a formal procedure to have your complaint reviewed. Grievances may be filed either orally or in writing, and must be filed no later than 60 days after the event or incident. PremierCare will assist you with completing the process of filing a grievance. Please call our Customer Service number, 1-866-798-2273 or TTY/TDD 1-800-735-2900, if you wish to file a grievance. We are here for you Monday through Friday, 8 a.m. to 8 p.m. We do have extended hours during Open Enrollment—contact us for more details.

You can also mail a written grievance to:

FamilyCare Health Plans, Inc.
825 NE Multnomah, Suite 300
Portland, OR 97232

All grievances submitted in writing will be responded to in writing.

PremierCare will take prompt, appropriate action, including a full investigation of your grievance. PremierCare will inform you of its investigation results as quickly as your health status requires, but no later than 30 days after the grievance was filed.

If your grievance concerns the quality of care you received, you may choose to file a written complaint with the Oregon Quality Improvement Organization (QIO) instead of or in addition to filing a grievance with PremierCare:

Acumentra Health
2020 SW Fourth Avenue, Suite 520
Portland, OR 97201-4960
503-279-0100

What is a Coverage Determination?

A coverage determination is a decision made by PremierCare on whether or not to provide or pay for a treatment or service, or on what your share of the cost will be. Coverage determinations include exception requests for prescription drugs. You must contact us if you would like to request a coverage determination (including an exception). If your request for a treatment or service is denied, you will receive a written denial letter and information on how to file an appeal. Please call our Customer Service department at 1-866-798-2273 or TTY/TDD 1-800-235-7900 for assistance with any coverage determination request. We are here for you Monday through Friday, 8 a.m. to 8 p.m. We do have extended hours during Open Enrollment—contact us for more details.

What is an Exception?

You have the right to ask us for an “exception” if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. If you request a formulary exception, your doctor must provide a statement to support your request. If your request for an exception is approved, it will be granted for the remainder of the plan year (or longer in some cases). If your request for an exception is denied, you will receive a written denial letter and information on how to file an appeal. Please call our Customer Service number, 1-866-798-2273 or TTY/TDD 1-800-735-2900, for assistance with any exception request. We are here for you Monday through Friday, 8 a.m. to 8 p.m. We do have extended hours during Open Enrollment—contact us for more details.

What is an Appeal?

An appeal is any of the procedures for review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about a benefit, payment, or prescription drug. PremierCare members have 60 days from the date of an unfavorable coverage determination to file a written request for an appeal (unless a request for additional time is approved). Please call our Customer Service number, 1-866-798-2273 or TTY/TDD 1-800-735-2900, for assistance with any appeals request. We are here for you Monday through Friday, 8 a.m.–8 p.m. We do have extended hours during Open Enrollment—contact us for more details.

Your appeal request will be reviewed by a person with an appropriate clinical background who was not involved in the initial denial. PremierCare will make a decision on a prescription drug appeal within 7 days and on other types of service within 30 days. You have the right to request an “expedited” or “fast” appeal if you believe that processing your appeal in the standard time frame could jeopardize your life or health. You may also file a grievance if your request for a “fast appeal” is denied.

If your appeal is denied by PremierCare, you have the right to further levels of appeal. These include review by an Independent Review Entity, an Administrative Law Judge, the Medicare Appeals Council, and a Judicial Review hearing. Complete information on these levels of appeal is provided when a denial is issued.

There are also special appeal processes that relate to PremierCare’s decision to end coverage of a hospital or nursing home stay, or treatment by a comprehensive rehabilitation facility or home health agency. In these situations, you will be provided with advance notice that further treatment will not be covered and you will have the right to an immediate review of this decision through the Oregon Quality Improvement Organization/QIO:

Acumentra Health
2020 SW Fourth Avenue, Suite 520
Portland, OR 97201-4960
503-279-0100



FamilyCare Health Plans, Inc., is a Coordinated Care Plan with a Medicare Advantage contract and a contract with the Oregon Medicaid program.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information, contact the plan.

Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1, 2013.

H3818_KIT_00051 CMS Approved 08/28/2011

FamilyCare

HEALTH PLANS



FamilyCare Health Plans

825 NE Multnomah, Suite 300
Portland, OR 97232

Welcome to FamilyCare Health Plans

Please visit us at www.familycarehealthplans.org

Questions? Please call us Monday - Friday 8am to 8pm

CALL: 866-225-CARE (2273) **TTY:** 800-735-2900