

Enrollment Kit 2012



PremierCare

Value Rx : Choice Rx : Choice

This is an advertisement

FamilyCare

HEALTH PLANS



SUMMARY OF BENEFITS

January 1, 2012–December 31, 2012



PremierCare Value Rx
PremierCare Choice Rx
PremierCare Choice

H3818, Plans 014, 003 and 004

H3818_KIT_00010 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 | familycarehealthplans.org



Section I: Introduction to the Summary of Benefits Report
for PremierCare Value Rx (HMO), PremierCare Choice Rx (HMO) and PremierCare Choice (HMO)
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 Value Rx (HMO), Choice Rx (HMO) and Choice (HMO).

Our plans are offered by FAMILYCARE HEALTH PLANS, INC., a Medicare Advantage Health Maintenance Organization (HMO). This *Summary of Benefits* tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call FamilyCare Health Plans and ask for the "Evidence of Coverage" for the plan you are interested in.

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 Value Rx (HMO), Choice Rx (HMO) or Choice (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program. You may join or leave a plan only at certain times. Please call FamilyCare at the telephone 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 Value Rx (HMO), Choice Rx (HMO), Choice (HMO) 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 ARE PREMIERCARE VALUE RX (HMO), CHOICE RX (HMO) AND CHOICE (HMO) AVAILABLE?

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

There is more than one plan listed in this *Summary of Benefits*. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

WHO IS ELIGIBLE TO JOIN PREMIERCARE VALUE RX (HMO), CHOICE RX (HMO) OR CHOICE (HMO)?

You can join PremierCare Value Rx (HMO), Choice Rx (HMO) or Choice (HMO) 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 are generally not eligible to enroll in PremierCare Value Rx (HMO), Choice Rx (HMO) or Choice (HMO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

PremierCare Value Rx (HMO), Choice Rx (HMO) and Choice (HMO) have 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 services 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 Value Rx (HMO) and Choice Rx (HMO) have 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 Value Rx (HMO) and Choice Rx (HMO) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs. PremierCare Choice (HMO) does cover Medicare Part B prescription drugs, but does not cover Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

PremierCare Value Rx (HMO) and Choice Rx (HMO) use 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 website at familycarehealthplans.org.

If you are currently taking a drug that is not on our formulary or is 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 Value Rx (HMO), Choice Rx (HMO) or Choice (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. Please refer to the *Evidence of Coverage* (EOC) for the QIO contact information.

As a member of PremierCare Value Rx (HMO), Choice Rx (HMO) or Choice (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. 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 FamilyCare Health Plans 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 FamilyCare Health Plans 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 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 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 Value Rx (HMO), Choice Rx (HMO) or Choice (HMO).

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 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 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 1-866-225-2273 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 Value Rx, PremierCare Choice Rx & PremierCare Choice

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|---|--|---|--|
| #1 Premium and other important information | <p>In 2011, the monthly Part B premium was \$96.40 and may change for 2012 and the annual Part B deductible amount was \$162 and may change for 2012. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> | <p>General</p> <p>\$125 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network</p> <p>\$3,400 out-of-pocket limit for Medicare-covered services.</p> | <p>General</p> <p>\$74 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network</p> <p>\$3,400 out-of-pocket limit for Medicare-covered services.</p> | <p>General</p> <p>\$49 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>In-Network</p> <p>\$3,400 out-of-pocket limit for Medicare-covered services.</p> |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|--|---|---|---|---|
| #2 Doctor and hospital choice (For more information, see Emergency care #15 and Urgently needed care #16.) | You may go to any doctor, specialist or hospital that accepts Medicare. | In-Network You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits) | In-Network You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits) | In-Network You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits). |
| INPATIENT CARE | | | | |
| #3 Inpatient hospital care (Includes substance abuse and rehabilitation services) | In 2011, the amounts for each benefit period were: Days 1-60: \$1,132 deductible Days 61-90: \$283 per day Days 91-150: \$566 per lifetime reserve day. 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. | In-Network No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1-6: \$160 co-pay per day Days 7-90: \$0 co-pay per day \$0 co-pay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. | In-Network No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1-6: \$295 co-pay per day Days 7-90: \$0 co-pay per day \$0 co-pay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. | In-Network No limit to the number of days covered by the plan each hospital stay. For Medicare-covered hospital stays: Days 1-6: \$295 co-pay per day Days 7-90: \$0 co-pay per day \$0 co-pay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|--|--|--|--|
| #4 Inpatient mental health care | <p>In 2011, the amounts for each benefit period were:</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 limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</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> <p>For Medicare-covered hospital stays:</p> <p>Days 1–6: \$160 co-pay per day</p> <p>Days 7–90: \$0 co-pay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</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> <p>For Medicare-covered hospital stays:</p> <p>Days 1–6: \$295 co-pay per day</p> <p>Days 7–90: \$0 co-pay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</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> <p>For Medicare-covered hospital stays:</p> <p>Days 1–6: \$295 co-pay per day</p> <p>Days 7–90: \$0 co-pay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |
| #5 Skilled nursing facility (SNF) (In a Medicare-certified skilled nursing facility) | <p>In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1–20: \$0 per day</p> <p>Days 21–100: \$141.50 per day</p> <p>These amounts may change for 2012.</p> <p>100 days 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. You must</p> | <p>General</p> <p>Authorization rules may apply</p> <p>In-Network</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>\$0 co-pay for SNF services.</p> | <p>General</p> <p>Authorization rules may apply</p> <p>In-Network</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1–20: \$0 co-pay per day</p> <p>Days 21–100: \$25 co-pay per day</p> | <p>General</p> <p>Authorization rules may apply</p> <p>In-Network</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>For SNF stays:</p> <p>Days 1–20: \$0 co-pay per day</p> <p>Days 21–100: \$25 co-pay per day</p> |

Continues

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|--|---|---|---|
| #5 Skilled nursing facility (Continued) | Continued pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. | | | |
| #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 \$20 co-pay for each Medicare-covered home health visit | General Authorization rules may apply In-Network \$20 co-pay for each Medicare-covered home health visit | General Authorization rules may apply In-Network \$20 co-pay for each Medicare-covered home health visit |
| #7 Hospice | You pay part of the cost for outpatient drugs and 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. | General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select 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 | 20% co-insurance | General Authorization rules may apply In-Network \$15 co-pay for each primary care doctor visit for Medicare-covered benefits \$30 co-pay for each in-area, network urgent care Medicare-covered visit \$30 co-pay for each specialist visit for Medicare-covered benefits | General Authorization rules may apply In-Network \$20 co-pay for each primary care doctor visit for Medicare-covered benefits \$35 co-pay for each in-area, network urgent care Medicare-covered visit \$35 co-pay for each specialist visit for Medicare-covered benefits | General Authorization rules may apply In-Network \$20 co-pay for each primary care doctor visit for Medicare-covered benefits \$35 co-pay for each in-area, network urgent care Medicare-covered visit \$35 co-pay for each specialist visit for Medicare-covered benefits |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|--------------------------------------|---|--|--|--|
| #9 Chiropractic services | Supplemental routine care not covered 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 provider | In-Network \$20 co-pay for each Medicare-covered visit. 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. | In-Network \$20 co-pay for each Medicare-covered visit. 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. | In-Network \$20 co-pay for each Medicare-covered visit. 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. |
| #10 Podiatry services | Supplemental routine care not covered 20% co-insurance for medically necessary foot care, including care for medical conditions affecting the lower limbs | General Authorization rules apply. In-Network \$30 co-pay for each Medicare-covered visit \$30 co-pay for each supplemental routine visit Medicare-covered podiatry benefits are for medically-necessary foot care. | General Authorization rules apply. In-Network \$35 co-pay for each Medicare-covered visit \$35 co-pay for each supplemental routine visit Medicare-covered podiatry benefits are for medically-necessary foot care. | General Authorization rules apply. In-Network \$35 co-pay for each Medicare-covered visit \$35 co-pay for each supplemental routine visit Medicare-covered podiatry benefits are for medically-necessary foot care. |
| #11 Outpatient mental health care | 40% co-insurance for most outpatient mental health services Specified co-payment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Co-pay cannot exceed the Part A inpatient hospital deductible. “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 \$30 co-pay for each Medicare-covered individual therapy visit \$30 co-pay for each Medicare-covered group therapy visit \$30 co-pay for each Medicare-covered individual therapy visit with a psychiatrist \$30 co-pay for each Medicare-covered group therapy visit with a psychiatrist \$0 co-pay for Medicare-covered partial hospitalization program services | General Authorization rules may apply In-Network \$35 co-pay for each Medicare-covered individual therapy visit \$35 co-pay for each Medicare-covered group therapy visit \$35 co-pay for each Medicare-covered individual therapy visit with a psychiatrist \$35 co-pay for each Medicare-covered group therapy visit with a psychiatrist \$0 co-pay for Medicare-covered partial hospitalization program services | General Authorization rules may apply In-Network \$35 co-pay for each Medicare-covered individual therapy visit \$35 co-pay for each Medicare-covered group therapy visit \$35 co-pay for each Medicare-covered individual therapy visit with a psychiatrist \$35 co-pay for each Medicare-covered group therapy visit with a psychiatrist \$0 co-pay for Medicare-covered partial hospitalization program services |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|---|--|--|--|
| #12 Outpatient substance abuse care | 20% co-insurance for the doctor's services | General Authorization rules may apply In-Network \$0 co-pay for Medicare-covered visits | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered individual visits 20% of the cost for Medicare-covered group visits | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered individual visits 20% of the cost for Medicare-covered group visits |
| #13 Outpatient services/surgery | 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. 20% co-insurance for ambulatory surgical center facility services | General Authorization rules may apply In-Network 10% of the cost for each Medicare-covered ambulatory surgical center visit 10% of the cost for each Medicare-covered outpatient hospital facility visit | General Authorization rules may apply In-Network 20% of the cost for each Medicare-covered ambulatory surgical center visit 20% of the cost for each Medicare-covered outpatient hospital facility visit | General Authorization rules may apply In-Network 20% of the cost for each Medicare-covered ambulatory surgical center visit 20% of the cost for each Medicare-covered outpatient hospital facility visit |
| #14 Ambulance services (Medically necessary ambulance services) | 20% co-insurance | General Authorization rules may apply In-Network \$100 co-pay for Medicare-covered ambulance benefits If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits. | General Authorization rules may apply In-Network \$100 co-pay for Medicare-covered ambulance benefits If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits. | General Authorization rules may apply In-Network \$100 co-pay 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.) | 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 \$50 co-pay for Medicare-covered emergency room visits Worldwide coverage If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit. | General \$50 co-pay for Medicare-covered emergency room visits Worldwide coverage If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit. | General \$50 co-pay for Medicare-covered emergency room visits Worldwide coverage If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit. |

Continues

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|--|--|---|---|---|
| #15 Emergency care (Continued) | Continued co-pay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the US except under limited circumstances | | | |
| #16 Urgently needed care (This is NOT emergency care and, in most cases, is out of the service area.) | 20% co-insurance, or a set co-pay NOT covered outside the US except under limited circumstances | General \$30 co-pay for Medicare-covered urgently needed care visits If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the urgently needed care visit. | General \$35 co-pay for Medicare-covered urgently needed care visits If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the urgently needed care visit. | General \$35 co-pay for Medicare-covered urgently needed care visits If you are admitted to the hospital within 24 hours for the same condition, you pay \$0 for the urgently needed care visit. |
| #17 Outpatient rehabilitation services (Occupational therapy, physical therapy, speech and language therapy) | 20% co-insurance | General Authorization rules may apply In-Network \$30 co-pay for Medicare-covered occupational therapy visits \$30 co-pay for Medicare-covered physical and/or speech and language therapy visits | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered occupational therapy visits 20% of the cost for Medicare-covered physical and/or speech and language therapy visits | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered occupational therapy visits 20% of the cost for Medicare-covered physical and/or speech and language therapy visits |
| OUTPATIENT MEDICAL SERVICES AND SUPPLIES | | | | |
| #18 Durable medical equipment (Includes wheel-chairs, oxygen, etc.) | 20% co-insurance | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered items | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered items | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered items |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|--|---|---|--|--|
| #19 Prosthetic devices (Includes braces, artificial limbs, eyes, etc.) | 20% co-insurance | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered items | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered items | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered items |
| #20 Diabetes programs and supplies | 20% co-insurance for diabetes self-management training 20% co-insurance for diabetes supplies 20% co-insurance for diabetic therapeutic shoes or inserts | General Authorization rules may apply In-Network 20% of the cost for Diabetes self-management training 20% of the cost for Diabetes monitoring supplies 20% of the cost for therapeutic shoes or inserts | General Authorization rules may apply In-Network 20% of the cost for Diabetes self-management training 20% of the cost for Diabetes monitoring supplies 20% of the cost for therapeutic shoes or inserts | General Authorization rules may apply In-Network 20% of the cost for Diabetes self-management training 20% of the cost for Diabetes monitoring supplies 20% of the cost for therapeutic shoes or inserts |
| #21 Diagnostic tests, x-rays, lab services, and radiology services | 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 co-pay for Medicare-covered items – Lab services – Diagnostic procedures and tests 10% of the cost for Medicare-covered x-rays 10% of the cost for Medicare-covered diagnostic radiology services (not including x-rays) 10% of the cost for Medicare-covered therapeutic radiology services | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered lab services 20% of the cost for Medicare-covered diagnostic procedures and tests 20% of the cost for Medicare-covered x-rays 20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays) 20% of the cost for Medicare-covered therapeutic radiology services | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered lab services 20% of the cost for Medicare-covered diagnostic procedures and tests 20% of the cost for Medicare-covered x-rays 20% of the cost for Medicare-covered diagnostic radiology services (not including x-rays) 20% of the cost for Medicare-covered therapeutic radiology services |

Continues

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|--|--|--|--|--|
| #21 Diagnostic tests, x-rays, lab services, and radiology services (Continued) | Continued <hr/> 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 | 20% co-insurance for cardiac rehabilitation services 20% co-insurance for pulmonary rehabilitation services 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 co-pay for: – Medicare-covered cardiac rehabilitation services – Medicare-covered intensive cardiac rehabilitation services – Medicare-covered pulmonary rehabilitation services | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered cardiac rehabilitation services 20% of the cost for Medicare-covered intensive cardiac rehabilitation service 20% of the cost for Medicare-covered pulmonary rehabilitation services | General Authorization rules may apply In-Network 20% of the cost for Medicare-covered cardiac rehabilitation services 20% of the cost for Medicare-covered intensive cardiac rehabilitation service 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: – 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: – 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 | General \$0 co-pay for all preventive services covered under Original Medicare at zero cost sharing: – 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 | General \$0 co-pay for all preventive services covered under Original Medicare at zero cost sharing: – 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 Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|---|---|---|---|
| #23 Preventive services and wellness/ education programs (Continued) | <p>Continued</p> <ul style="list-style-type: none"> – Cervical and vaginal cancer screening. Covered once every two 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. Medicare covers one | <p>Continued</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>Authorization rules may apply In-Network</p> <p>The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> – Written health education materials, including newsletters – Nursing Hotline | <p>Continued</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>Authorization rules may apply In-Network</p> <p>The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> – Written health education materials, including newsletters – Nursing Hotline | <p>Continued</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>Authorization rules may apply In-Network</p> <p>The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> – Written health education materials, including newsletters – Nursing Hotline |
| | Continues | | | |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|---|----------------------------|-----------------------|--------------------|
| <p>#23 Preventive Services and Wellness/ Education Programs (Continued)</p> | <p>Continued</p> <hr/> <p>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. Covered once a year for all men with Medicare over age 50. <hr/> <p style="text-align: right;">Continues</p> | | | |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|--|---|---|---|
| <p>#23 Preventive services and wellness/ education programs (Continued)</p> | <p>Continued</p> <ul style="list-style-type: none"> - Smoking cessation (counseling to stop smoking). Covered 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. - 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> | <p>20% co-insurance for renal dialysis 20% co-insurance for kidney disease education services</p> | <p>General Authorization rules may apply In-Network 20% of the cost for renal dialysis \$0 co-pay for kidney disease education services</p> | <p>General Authorization rules may apply In-Network 20% of the cost for renal dialysis \$0 co-pay for kidney disease education services</p> | <p>General Authorization rules may apply In-Network 20% of the cost for renal dialysis \$0 co-pay for kidney disease education services</p> |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|--------------------------------------|--|---|--|---|
| #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>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 both you and a Part D plan. 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 Value Rx (HMO) for certain drugs.</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 that cannot be met by most pharmacies in</p> | <p>Drugs covered under Medicare Part B General</p> <p>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 both you and a Part D plan. 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 Choice Rx (HMO) for certain drugs.</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 that cannot be met by most pharmacies in</p> | <p>Drugs covered under Medicare Part B General</p> <p>Most drugs are not covered.</p> <p>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 does not offer prescription drug coverage.</p> |
| | | Continues | Continues | |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|-------------------|---|--|--------------------|
| #25 Outpatient prescription drugs (Continued) | | <p>Continued</p> <hr/> <p>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>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>If you request a formulary exception for a drug and PremierCare Value Rx (HMO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost-sharing for that drug.</p> <p>In-Network \$100 annual deductible.</p> <p>Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> – \$7 co-pay for a one-month (30-day) supply of drugs in this tier – \$21 co-pay for a three-month (90-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$30 co-pay for a one-month (30-day) supply of drugs in this tier – \$90 co-pay for a three-month (90-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$70 co-pay for a one-month (30-day) supply of drugs in this tier – \$210 co-pay for a three-month (90-day) supply of drugs in this tier <hr/> <p style="text-align: right;">Continues</p> | <p>Continued</p> <hr/> <p>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>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>If you request a formulary exception for a drug and PremierCare Choice Rx (HMO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost-sharing for that drug.</p> <p>In-Network \$190 annual deductible.</p> <p>Initial Coverage After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,930:</p> <p>Retail Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> – \$7 co-pay for a one-month (30-day) supply of drugs in this tier – \$21 co-pay for a three-month (90-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$30 co-pay for a one-month (30-day) supply of drugs in this tier – \$90 co-pay for a three-month (90-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$65 co-pay for a one-month (30-day) supply of drugs in this tier – \$195 co-pay for a three-month (90-day) supply of drugs in this tier <hr/> <p style="text-align: right;">Continues</p> | |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|-------------------|--|--|--------------------|
| #25 Outpatient prescription drugs (Continued) | | <p>Continued</p> <hr/> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> – 30% co-insurance for a one-month (30-day) supply of drugs in this tier – 30% co-insurance 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 plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> – \$7 co-pay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$30 co-pay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$70 co-pay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> – 30% co-insurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> – \$7 co-pay for a one-month (30-day) supply of drugs in this tier – \$14 co-pay for a three-month (90-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$30 co-pay for a one-month (30-day) supply of drugs in this tier – \$60 co-pay for a three-month (90-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$70 co-pay for a one-month (30-day) supply of drugs in this tier – \$140 co-pay for a three-month (90-day) supply of drugs in this tier <hr/> <p style="text-align: right;">Continues</p> | <p>Continued</p> <hr/> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> – 28% co-insurance for a one-month (30-day) supply of drugs in this tier – 28% co-insurance 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 plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> – \$7 co-pay for a one-month (31-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$30 co-pay for a one-month (31-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$65 co-pay for a one-month (31-day) supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> – 28% co-insurance for a one-month (31-day) supply of drugs in this tier <p>Mail Order</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> – \$7 co-pay for a one-month (30-day) supply of drugs in this tier – \$14 co-pay for a three-month (90-day) supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$30 co-pay for a one-month (30-day) supply of drugs in this tier – \$60 co-pay for a three-month (90-day) supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$65 co-pay for a one-month (30-day) supply of drugs in this tier – \$130 co-pay for a three-month (90-day) supply of drugs in this tier <hr/> <p style="text-align: right;">Continues</p> | |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|--|-------------------|---|--|--------------------|
| <p>#25 Outpatient prescription drugs (Continued)</p> | | <p>Continued</p> <hr/> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> – 30% co-insurance for a one-month (30-day) supply of drugs in this tier – 30% co-insurance 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 plan for more information.</p> <p>Coverage Gap</p> <p>After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay 86% of the plan’s costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p> <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> – 5% co-insurance, or – \$2.60 co-pay for generic (including brand drugs treated as generic) and a \$6.50 co-pay for all other drugs <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 Value Rx (HMO).</p> <hr/> <p style="text-align: right;">Continues</p> | <p>Continued</p> <hr/> <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> – 28% co-insurance for a one-month (30-day) supply of drugs in this tier – 28% co-insurance 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 plan for more information.</p> <p>Coverage Gap</p> <p>After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay 86% of the plan’s costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p> <p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> – 5% co-insurance, or – \$2.60 co-pay for generic (including brand drugs treated as generic) and a \$6.50 co-pay for all other drugs <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 Choice Rx (HMO).</p> <hr/> <p style="text-align: right;">Continues</p> | |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|---|-------------------|--|--|--------------------|
| #25 Outpatient prescription drugs (Continued) | | <p>Continued</p> <p>Out-of-Network Initial Coverage</p> <p>After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach \$2,930:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> – \$7 co-pay for a 10-day supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$30 co-pay for a 10-day supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$70 co-pay for a 10-day supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> – 30% co-insurance for a 10-day supply of drugs in this tier <p>Additional Out-of-Network Coverage Gap</p> <p>You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach \$4,700.</p> <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> – 5% co-insurance, or – \$2.60 co-pay for generic (including brand drugs treated as generic) and a \$6.50 co-pay for all other drugs. | <p>Continued</p> <p>Out-of-Network Initial Coverage</p> <p>After you pay your yearly deductible, you will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until your total yearly drug costs reach \$2,930:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> – \$7 co-pay for a 10-day supply of drugs in this tier <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$30 co-pay for a 10-day supply of drugs in this tier <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> – \$65 co-pay for a 10-day supply of drugs in this tier <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> – 28% co-insurance for a 10-day supply of drugs in this tier <p>Additional Out-of-Network Coverage Gap</p> <p>You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach \$4,700.</p> <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> – 5% co-insurance, or – \$2.60 co-pay for generic (including brand drugs treated as generic) and a \$6.50 co-pay for all other drugs. | |

| Benefit Category | Original Medicare | PremierCare Value Rx (HMO) | PremierCare Choice Rx | PremierCare Choice |
|--------------------------|---|--|--|--|
| #26 Dental services | Preventive dental services (such as cleaning) not covered. | In-Network \$0 co-pay for Medicare-covered dental benefits In general, preventive dental benefits (such as cleaning) not covered. | In-Network \$0 co-pay for Medicare-covered dental benefits In general, preventive dental benefits (such as cleaning) not covered. | In-Network In general, preventive dental benefits (such as cleaning) not covered. \$0 co-pay for Medicare-covered dental benefits |
| #27 Hearing services | Supplemental routine hearing exams and hearing aids not covered. 20% co-insurance for diagnostic hearing exams | In-Network In general, supplemental routine hearing exams and hearing aids not covered. – \$30 co-pay for Medicare-covered diagnostic hearing exams | In-Network In general, supplemental routine hearing exams and hearing aids not covered. – \$30 co-pay for Medicare-covered diagnostic hearing exams | In-Network In general, supplemental routine hearing exams and hearing aids not covered. – \$30 co-pay for Medicare-covered diagnostic hearing exams |
| #28 Vision services | 20% co-insurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk | In-Network \$0 co-pay for – One pair of eyeglasses or contact lenses after cataract surgery – Up to 1 pair of glasses every two years – Up to 1 pair of contacts every two years – \$30 co-pay for exams to diagnose and treat diseases and conditions of the eye. – \$20 co-pay for up to 1 supplemental routine eye exam every year \$100 plan coverage limit for eyeglasses (lenses and frames) every two years \$65 plan coverage limit for contact lenses every two years | In-Network \$0 co-pay for – One pair of eyeglasses or contact lenses after cataract surgery – Up to 1 pair of glasses every two years – Up to 1 pair of contacts every two years – \$30 co-pay for exams to diagnose and treat diseases and conditions of the eye. – \$20 co-pay for up to 1 supplemental routine eye exam every year \$100 plan coverage limit for eyeglasses (lenses and frames) every two years \$65 plan coverage limit for contact lenses every two years | In-Network \$0 co-pay for – One pair of eyeglasses or contact lenses after cataract surgery – Up to 1 pair of glasses every two years – Up to 1 pair of contacts every two years – \$30 co-pay for exams to diagnose and treat diseases and conditions of the eye. – \$20 co-pay for up to 1 supplemental routine eye exam every year \$100 plan coverage limit for eyeglasses (lenses and frames) every two years \$65 plan coverage limit for contact lenses every two years |
| Over-the-counter items | Not covered | General The plan does not cover over-the-counter items. | General The plan does not cover over-the-counter items. | General The plan does not cover over-the-counter items. |
| Transportation (Routine) | Not covered | In-Network This plan does not cover supplemental routine transportation. | In-Network This plan does not cover supplemental routine transportation. | In-Network This plan does not cover supplemental routine transportation. |
| Acupuncture | Not covered | In-Network This plan does not cover acupuncture. | In-Network This plan does not cover acupuncture. | In-Network This 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 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 and Medicare Advantage. 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.

\$0 medical deductible

There is no yearly deductible for either outpatient or inpatient care.

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 plans protect 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. All you pay are your monthly premiums.

Prescription for convenience

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

- Locally owned neighborhood drugstores 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 prescrip-

tion 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 and other medical professionals with clinical experience.

Proactive health

Staying healthy is the best medicine. PremierCare plan covers annual physicals, flu and pneumonia vaccinations, breast, cervical and prostate cancer screening, and smoking cessa-

tion—all with no co-pay.

Travel with confidence

Travel without worry knowing that PremierCare covers emergency and urgent care anywhere in the world.

Vision coverage included

Beginning in 2012, PremierCare plans cover routine vision care and annual eye exams, plus a \$100 prescription eyewear credit each two years, when you see a VSP doctor or supplier.

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.

PremierCare

Medicare Advantage Plans to fit your needs and your wallet

All three PremierCare plans meet or exceed Medicare Advantage requirements, but are available with different premiums, co-pays and co-insurance. PremierCare Value Rx and PremierCare Choice Rx include Medicare Part D prescription drug coverage. PremierCare Choice offers the same medical benefits as Choice Rx, but without prescription coverage.

PremierCare Value Rx

Pay just \$15 for a routine doctor appointment or \$0 for lab tests. If you're hospitalized, you'll pay \$160 a day for the first six days and \$0 for

the rest of your hospital stay.

After meeting the Part D prescription drug deductible of \$100, you'll pay a \$7 co-pay for up to a 30-day generic prescription, \$30 for preferred brand and some generic drugs and \$70 for non-preferred brand drugs.

Value Rx may be a good choice if:

- You see a doctor regularly.
- You could be hospitalized at least once in the coming year.

PremierCare Choice Rx

PremierCare Choice Rx covers the same medical services and prescription drugs as Value Rx, but with a lower monthly premium.

Pay \$20 for a routine doctor appointment and 20% of the cost of lab tests. If you're hospitalized, you'll pay \$295 a day for the first six days and \$0 for the rest of your hospital stay.

After meeting the Part D prescription drug deductible of \$190, you'll pay a \$7 co-pay for up to a 30-day generic prescription, \$30 for preferred brand and some generic drugs, and \$65 for non-preferred brand drugs.

Choice Rx may be a good choice if:

- You want to save on premiums but still want prescription drug coverage

- You don't expect to see a doctor regularly.
- You're fairly confident you won't need hospitalization in the coming year.

PremierCare Choice

With the lowest premium of our three Medicare Advantage plans, PremierCare Choice covers the same medical benefits at the same co-pays as Choice Rx, but without prescription drug coverage.

Choice may be a good choice if:

- You have a stand-alone Part D plan that you want to stay with.
- You don't expect to see a doctor regularly.
- You're fairly confident you won't need hospitalization in the coming year.

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 analyze all of your prescriptions and how they work together. It can recommend specific drugs or drug combinations that will treat your conditions more effectively.

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 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 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 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.

Frequently asked questions

How do I make an appointment?

Call the provider's office and let them know that you are a PremierCare 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, or you can browse our online directory at www.familycarehealthplans.org

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

If your PCP is not in our network (or if you don't have a PCP), 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 location.

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 get outpatient care from an in-network provider.

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

PremierCare 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 Service for help finding a provider.

What do I do in an emergency?

PremierCare covers urgent and emergency care anywhere in the world.

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 an in-network or out-of-network urgent care center.

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?

If your plan includes Medicare Part D prescription benefits, you can fill your prescriptions at any pharmacy in our network. Present your PremierCare member ID to the pharmacist.

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

See your *Provider/Pharmacy Directory* for a list of in-network pharmacies.

Does PremierCare cover chiropractic or alternative care?

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

PremierCare 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 | \$20 | Covered in full when you use a VSP provider |
| Prescription eyewear—Your choice of glasses <i>OR</i> contact lenses | | | |
| Frames & lenses | Every 24 months | \$0 | Single vision, lined bifocal and lined trifocal lenses are covered up to \$100. |
| Contacts | Every 24 months | \$0 | One pair of lenses covered up to \$65 in lieu of eyeglasses lenses & frames* |
| Extra discounts and savings through your VSP vision benefit | | | |
| Laser vision correction | | | |
| – Get a discount on laser vision correction through VSP network doctors and contracted laser surgery centers. | | | |
| Contacts | | | |
| – Get 15% off the cost of contact lens exam (fitting and evaluation)* | | | |
| *Available from the same VSP doctor who provided your eye exam within the last 12 months. | | | |
| 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.

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: 866-798-CARE (2273) **TTY:** 800-735-2900