Addendum Updates – December 2006

Oregon Guide to

Medigap, Medicare Advantage & Prescription Drug Plans

2007

SHIBA
Senior Health Insurance Benefits Assistance

STATE OF OREGON
THE UNION
1859

Addendum

SHIBA has updated the guide with new information received after printing. Please print the following pages and insert into your guide.

Addendum pages

NEW Special needs plan

NEW Medicare Advantage only plans

NEW Medicare Advantage + prescription plans

Prescription drugs covered under Part B

Original Medicare makes payments to physicians for drugs or biologicals that are not usually self-administered. This means that coverage is usually limited to drugs or biologicals administered by someone in your provider's office.

Medicare will pay 80 percent of the approved amount for covered prescription drugs. You must satisfy the annual Part B deductible ($131 for 2007) before Medicare begins to pay its share.

The following classes of drugs are covered:

Durable Medical Equipment (DME) Supply Drugs: Drugs that are used in a covered DME item. These include inhalation drugs used in a nebulizer and some chemotherapeutic agents used in an infusion pump.

Immunosuppressive Drugs: Drugs used in immunosuppressive therapy for those patients who have received a covered organ transplant.

Hemophilia Clotting Factors: Drugs used to control bleeding. This coverage also includes the items needed for administration of the drug.

Oral Anti-Cancer Drugs: Drugs taken orally during cancer chemotherapy. Some restrictions apply to this class of drugs.

Oral Anti-Emetic Drugs: Oral anti-nausea drugs, given within 48 hours of cancer chemotherapy, that replace the intravenous drugs that would be given in the provider's office.

Pneumococcal and Influenza Vaccines: These are covered when ordered by a physician.

Hepatitis B Vaccine: This is covered for those individuals considered at moderate to high risk for contracting the disease.

Antigens: These drugs are administered in the provider's office, most often to treat some type of allergy.

Erythropoietin (EPO): Drug used for the treatment of anemia for persons with chronic renal failure who are on dialysis.

Parenteral Nutrition: Drugs used to treat individuals who cannot absorb nutrients through their intestinal tract.

Intravenous Immune Globulin (IVIG): Drugs used to treat primary immune deficiency disease. Certain conditions apply.

Injectable/Intravenous Drugs:

- Administered "incident to" a physician service ***and***
- considered by Part B carrier as "not usually self-administered."

If a beneficiary's claim for a particular drug is denied because the drug is subject to the "self-administered drug" exclusion, the beneficiary may appeal the denial.

Updated pages 22-25. Updates are in RED. Please replace these pages in the guide.

Medicare Advantage
Plan availability by county/service areas

Service Areas/ Company	Advantra Freedom	ATRIO	Care Source	Clear Choice	Family Care	Health Net	Humana	Kaiser	ODS	PacifiCare
All of Oregon								Contact Kaiser	X	
Azalea			X						X	
Baker	X						X		X	X
Benton	X					X	X		X	X
Clackamas	X				X	X	X		X	X
Clatsop					X				X	
Columbia	X					X	X		X	X
Coos		X					X		X	
Crook	X			X			X		X	X
Curry							X		X	
Deschutes	X			X			X		X	X
Douglas		X	X				X		X	X
Gilliam									X	
Glendale			X						X	
Gold Hill			X						X	
Grant				X			X		X	X
Harney							X		X	X
Hood River	X			X		X	X		X	X
Jackson			X			X			X	
Jefferson				X			X		X	X
Josephine			X			X			X	
Klamath	X	X		97731 97733 97737			X		X	X

Plan availability by county/service areas

Providence	Regence	Samaritan	Sierra Optima	Sterling	Today's Options	Trillium Advantage	Unicare	United Healthcare	WellCare
				X	X				
				X	X				
			X	X	X		X		X
	X	X	X	X	X		X	X	X
X	X		X	X	X		X	X	X
	X		X	X	X				
X	X		X	X	X		X		X
			X	X	X				
			X	X	X		X		
	X		X	X	X				
			X	X	X		X		
	X		X	X	X				
			X	X	X				
				X	X				
				X	X				
			X	X	X		X		
			X	X	X		X		
			X	X	X		X		X
	X		X	X	X				X
			X	X	X		X		
	X		X	X	X				
			X	X	X		X		X

Service Areas/ Company	Advantra Freedom	ATRIO	Care Source	Clear Choice	Family Care	Health Net	Humana	Kaiser	ODS	PacifiCare
Lake	X			97638 97641 97735			X		X	X
Lane						X			X	
Lincoln	X						X		X	X
Linn						X			X	
Malheur	X						X		X	X
Marion	X					X	X		X	X
Morrow					X				X	
Multnomah	X				X	X	X		X	X
Polk	X					X	X		X	X
Rogue River			X						X	
Sherman	X			X			X		X	X
Tillamook									X	
Umatilla	X				X		X		X	X
Union	X						X		X	X
Wallowa							X		X	X
Wasco	X			X			X		X	X
Washington	X				X	X	X		X	X
Wheeler				X			X		X	X
Yamhill						X	X		X	
Clark in WA						X				

Providence	Regence	Samaritan	Sierra Optima	Sterling	Today's Options	Trillium Advantage	Unicare	United Healthcare	WellCare
			X	X	X		X		
X	X		X	X	X	X		X	X
		X	X	X	X		X		X
	X	X	X	X	X			X	
			X	X	X				X
X	X		X	X	X		X	X	X
			X	X	X				
X	X		X	X	X		X	X	X
X	X		X	X	X		X	X	X
				X	X				
			X	X	X		X		X
	X		X	X	X				
			X	X	X		X		X
			X	X	X				X
			X	X	X		X		
			X	X	X		X		
X	X		X	X	X		X	X	X
			X	X	X		X		
X	X		X	X	X				
X	X								

Updated pages 110-111. Updates are in RED. Please replace these pages in the guide.

	Notes	Plan A	Plan B	Plan C	Plan D	Plan E
United World Life Insurance Company Mutual of Omaha Plaza Omaha, NE 68175 (877) 845-0892	*Does crossover* *Attained age rating* *Pre-existing look-back/ waiting period: 0/0* **For ZIP codes 970-972**	**65 & under** $55.08 **70** $62.60 **75** $72.83 **80** $79.42 **85** $85.24	**65 & under** $67.30 **70** $76.50 **75** $89.00 **80** $97.06 **85** $104.17			
United World Life Insurance Company Mutual of Omaha Plaza Omaha, NE 68175 (877) 845-0892	*Does crossover* *Attained age rating* *Pre-existing look-back/ waiting period: 0/0* **For ZIP codes 973-979**	**65 & under** $52.87 **70** $60.10 **75** $69.92 **80** $76.25 **85** $81.83	**65 & under** $64.61 **70** $73.44 **75** $85.44 **80** $93.18 **85** $100.00			
USAA Life Insurance Company 9800 Fredricksburg Road San Antonio, TX 78288 (800) 531-8000	*Not a crossover claim participant* *Attained age rating* *Pre-existing look-back/ waiting period: 0/0*	**65 & under** $87.89 **70** $97.07 **75** $104.21 **80** $110.67 **85** $117.98			**65 & under** $121.55 **70** $133.96 **75** $144.33 **80** $153.68 **85** $162.52	

MONTHLY rates shown are for women non-smokers

Plan F	Plan F High*	Plan G	Plan H	Plan I	Plan J	Plan J High*	Plan K	Plan L
65 & under $84.95 **70** $96.56 **75** $112.34 **80** $122.51 **85** $131.48		**65 & under** $72.76 **70** $82.70 **75** $96.22 **80** $104.93 **85** $112.61						
65 & under $81.55 **70** $92.70 **75** $107.85 **80** $117.61 **85** $126.23		**65 & under** $69.85 **70** $79.40 **75** $92.37 **80** $100.73 **85** $108.11						
65 & under $127.67 **70** $140.25 **75** $151.30 **80** $160.99 **85** $170.68		**65 & under** $125.12 **70** $137.87 **75** $148.41 **80** $157.93 **85** $167.45						

* High-deductible plan with $1,860 deductible.

Plan contact information

Trillium Advantage
Trillium Advantage
H2174-001 SNP (HMO)

1800 Millrace Dr.
Eugene, OR 97403

(800) 910-3906 or TTY (877) 600-5473

www.trilliumchp.com

Plan service areas and premiums

Lane

Monthly premium $28

Amount you pay

Annual deductible $138

Doctor's office visits
- Primary care physician 20%
- Specialist 20%

Inpatient hospital care
- Deductible $1,000
- Days 1-60, per day
- Medicare-covered hospital $0
- Days 61-90, per day $238
- 60 lifetime reserve days and 90 days each benefit period.

Inpatient mental health care
- Deductible $1,000
- Days 1-60, per day
- Medicare-covered hospital $0
- Days 61-90, per day $238
- 60 lifetime reserve days and 190 days in a psychiatric hospital in a lifetime.

Amount you pay

Skilled nursing facility
- Days 1-20, per day
- Medicare-covered $0
- Days 21-100, per day..... $119
- 100 days per benefit period and 3-day prior hospital stay required.

Home health care $0

Hospice..... $0

Chiropractic services 20%

Podiatry services 20%

Outpatient mental health care 50%

Outpatient substance abuse care 20%

Outpatient services/surgery 20%

Ambulance services 20%

Emergency care
- Medicare covered..20% of the cost up to $50 (waived if admitted)

Urgently needed care 20%

Outpatient rehabilitation 20%

Prosthetic devices..... 20%

Durable medical equipment 20%

Diabetes self-monitoring training and supplies 20%

Diagnostic tests, X-rays, and lab services 20%

Preventive services 20%
- Flu or pneumonia vaccines $0

Outpatient prescription drug
- Part B 20%
- Part D ..... $265 annual deductible

Amount you pay

After $265 deductible and until total drug costs reach $2,400, you pay 25%.

After total drug costs equal $2,400 you pay 100% of your drug costs, until your out-of-pocket expenses total $3,850.

Once your out-of-pocket drug costs reach $3,850 you pay:
- Generic..... $2.15 or 5%
- All others .....$5.35 or 5%

Dental services 20%
- Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams 20%
- Routine hearing exams and aids.....not covered

Vision services..... contact plan

Routine physical exams 20%

Health/ wellness education .....not covered

Transportation.....not covered

Acupuncture/ naturopathic.....not covered

Plan hospitals and pharmacies

Please contact the plan or visit their Web site.

Plan contact information

Advantra Freedom
Freedom 1 H0846-004 (PFFS)

14955 Healthrow Forest Parkway
Houston, TX 77032

(800) 711-1607 or TTY (866) 386-2335

www.advantrafreedom.com

Plan service areas and premiums

Baker, Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Klamath, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, Wasco, and Washington

Monthly premium $98

Amount you pay

Annual out-of-pocket max.....$1,000

Doctor's office visits
- Primary care physician..... $0
- Specialist..... $0

Inpatient hospital care..... $0
- No limit to number of days per benefit period.

Inpatient mental health care
- Medicare-covered hospital..... 50%
- 190 lifetime days in a psychiatric hospital.

Skilled nursing facility..... $0
- 100 days each benefit period and no prior hospital stay required.

Home health care $0

Hospice..... $0

Chiropractic services $15

Podiatry services $0

Amount you pay

Outpatient mental health care.....$15

Outpatient substance abuse care $15

Outpatient services/surgery..... $0

Ambulance services $150
- (waived if admitted)

Emergency care
- Worldwide Medicare covered.. $50
- (waived if admitted)

Urgently needed care
- Worldwide..... $0

Outpatient rehabilitation $15

Durable medical equipment $0

Prosthetic devices..... $0

Diabetes self-monitoring training and supplies $0

Diagnostic tests, X-rays, and lab svcs.
- Clinical/diagnostic lab/X-rays ... 0%
- Radiation therapy 20%

Preventive services..... $0

Outpatient prescription drugs
- Medicare covered (Part B) 20%
- Other .....not covered

Dental services 50%

Hearing services
- Diagnostic hearing exams and routine hearing test (1 yearly).. $20
- Hearing aid fitting and hearing aid..... 100% ($100 limit for routine hearing aids every year.)

Vision services..... contact plan

Routine physical exams $0

Amount you pay

Health/ wellness education ..... contact plan

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Advantra Freedom
Freedom 2 H0846-005 (PFFS)

14955 Healthrow Forest Parkway
Houston, TX 77032

(800) 711-1607 or TTY (866) 386-2335

www.advantrafreedom.com

Plan service areas and premiums

Baker, Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Klamath, Lake, Lincoln, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, Wasco, and Washington

Monthly premium $0

Amount you pay

Annual out-of-pocket max..... $3,000

Doctor's office visits
- Primary care physician $15
- Specialist $30

Inpatient hospital care
- Days 1-5, per day
- Medicare-covered hospital $180
- Days 6-90, per day $0
- Additional days $0
- No limit on days covered each benefit period.

Inpatient mental health care
- Days 1-5, per day
- Medicare-covered hospital $180
- Days 6-90, per day $0
- 190 lifetime days in a psychiatric hospital.

Amount you pay

Skilled nursing facility
- Days 1-3, per day $0
- Days 4-100, per day $90
- 100 days each benefit period and no prior hospital stay required.

Home health care $0

Hospice..... $0

Chiropractic services $30

Podiatry services $30

Outpatient mental health care..... $30

Outpatient substance abuse care $30

Outpatient services/surgery..... 20%

Ambulance services ..... 20% (waived if admitted)

Emergency care
- Worldwide Medicare covered .. $50 (waived if admitted)

Urgently needed care
- Worldwide..... $50 (waived if admitted)

Outpatient rehabilitation 20%

Durable medical equipment 20%

Prosthetic devices..... 20%

Diabetes
- Self-monitoring training $0
- Supplies..... 20%

Diagnostic tests, X-rays, and lab services 20%

Preventive services..... $0

Amount you pay

Outpatient prescription drug
- Part B 20%
- Other .....not covered

Dental services 50%

Hearing services
- Diagnostic hearing exams and routine hearing test (1 yearly) .. $30
- Hearing aid fitting and hearing aid..... 100% ($100 limit for routine hearing aids every year.)

Vision services..... contact plan

Routine physical exams $0

Health/ wellness education ..... contact plan

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Sierra Optima
Sierra Optima H4449-004 (PFFS)

P.O. Box 15645
Las Vegas, NV 89114

(800) 274-6648 or TTY (800) 349-3538

www.sierraoptima.com

Plan service areas and premiums

Marion and Polk

Monthly premium $0

Amount you pay

Annual out-of-pocket max..... $3,000

Doctor's office visits
- Primary care physician.....$10
- Specialist..... $20

Inpatient hospital care
- Days 1-24, per day
- Medicare-covered hospital.....$125
- Days 25-90, per day..... $0
- 60 lifetime reserve days and 90 days each benefit period.

Inpatient mental health care
- Days 1-24, per day
- Medicare-covered hospital.....$125
- Days 25-90, per day..... $0
- 60 lifetime reserve days and 190 days in a psychiatric hospital in a lifetime.

Skilled nursing facility
- Days 1-24, per day $0
- Days 25-100, per day $125
- 100 days each benefit period and 3-day prior hospital stay required.

Amount you pay

Home health care $0

Hospice..... $0

Chiropractic services $20

Podiatry services $20

Outpatient mental health care..... $20

Outpatient substance abuse care $20

Outpatient services/surgery..... $50

Ambulance services $100

Emergency care
- Worldwide Medicare covered .. $50

Urgently needed care (worldwide) .....$10-20 or 20% of the cost

Outpatient rehabilitation $20

Durable medical equipment 20%

Prosthetic devices..... 20%

Diabetes self-monitoring training and supplies 20%

Diagnostic tests, X-rays, and lab services 20%

Preventive services..... 20%
- Flu and pneumonia vaccines..... $0

Outpatient prescription drugs
- Medicare covered (Part B) 20%
- Other .....not covered

Dental services $40
- Preventative dental benefits, such as cleaning, not covered.

Amount you pay

Hearing services
- Diagnostic hearing exams $40
- Routine hearing exams and aids.....not covered

Vision services..... contact plan

Routine physical exams ... contact plan

Health/ wellness education .....not covered

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Sierra Optima
Sierra Optima H4449-006 (PFFS)

P.O. Box 15645
Las Vegas, NV 89114

(800) 274-6648 or TTY (800) 349-3538

www.sierraoptima.com

Plan service areas and premiums

Baker, Benton, Crook, Deschutes, Jefferson, Klamath, Lincoln, Morrow, Umatilla, Union, Wallowa, and Wasco

Monthly premium $81.40

Amount you pay

Annual out-of-pocket max..... $3,000

Doctor's office visits
- Primary care physician.....$10
- Specialist..... $20

Inpatient hospital care
Days 1-24, per day
Medicare-covered hospital.....$125
Days 25-90, per day..... $0
60 lifetime reserve days and 90 days each benefit period.

Inpatient mental health care
Days 1-24, per day
Medicare-covered hospital.....$125
Days 25-90, per day..... $0
60 lifetime reserve days and 190 days in a psychiatric hospital in a lifetime.

Amount you pay

Skilled nursing facility
Days 1-24, per day $0
Days 25-100, per day $125
100 days each benefit period and 3-day prior hospital stay required.

Home health care $0

Hospice..... $0

Chiropractic services $20

Podiatry services $20

Outpatient mental health care..... $20

Outpatient substance abuse care $20

Outpatient services/surgery..... $50

Ambulance services $100

Emergency care
Worldwide Medicare covered .. $50

Urgently needed care (worldwide)
.....$10-20 or 20% of the cost

Outpatient rehabilitation $20

Durable medical equipment 20%

Prosthetic devices..... 20%

Diabetes self-monitoring training and supplies 20%

Diagnostic tests, X-rays, and lab services 20%

Preventive services..... 20%
Flu and pneumonia vaccines..... $0

Outpatient prescription drugs
Medicare covered (Part B) 20%
Other .....not covered

Amount you pay

Dental services $40
Preventative dental benefits, such as cleaning, not covered.

Hearing services
Diagnostic hearing exams $40
Routine hearing exams and aids.....not covered

Vision services.....contact plan

Routine physical exams ...contact plan

Health/ wellness education .....not covered

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Sierra Optima
Sierra Optima H4449-007 (PFFS)

P.O. Box 15645
Las Vegas, NV 89114

(800) 274-6648 or TTY (800) 349-3538

www.sierraoptima.com

Plan service areas and premiums

Clatsop, Coos, Curry, Douglas, Grant, Harney, Hood River, Jackson, Josephine, Lake, Lane, Linn, Sherman, Tillamook, Wheeler, and Yamhill

Monthly premium $218.20

Amount you pay

Annual out-of-pocket max..... $3,000

Doctor's office visits
- Primary care physician.....$10
- Specialist..... $20

Inpatient hospital care
- Days 1-24, per day
- Medicare-covered hospital.....$125
- Days 25-90, per day..... $0
- 60 lifetime reserve days and 90 days each benefit period.

Inpatient mental health care
- Days 1-24, per day
- Medicare-covered hospital.....$125
- Days 25-90, per day..... $0
- 60 lifetime reserve days and 190 days in a psychiatric hospital in a lifetime.

Amount you pay

Skilled nursing facility
- Days 1-24, per day $0
- Days 25-100, per day $125
- 100 days each benefit period and 3-day prior hospital stay required.

Home health care $0

Hospice..... $0

Chiropractic services $20

Podiatry services $20

Outpatient mental health care..... $20

Outpatient substance abuse care $20

Outpatient services/surgery..... $50

Ambulance services $100

Emergency care
- Worldwide Medicare covered .. $50

Urgently needed care (worldwide) .....$10-20 or 20% of the cost

Outpatient rehabilitation $20

Durable medical equipment 20%

Prosthetic devices..... 20%

Diabetes self-monitoring training and supplies 20%

Diagnostic tests, X-rays, and lab services 20%

Preventive services..... 20%
- Flu and pneumonia vaccines..... $0

Outpatient prescription drugs
- Medicare covered (Part B) 20%
- Other .....not covered

Amount you pay

Dental services $40
- Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams $40
- Routine hearing exams and aids.....not covered

Vision services..... contact plan

Routine physical exams ... contact plan

Health/ wellness education .....not covered

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Sierra Optima
Sierra Optima H4449-010 (PFFS)

P.O. Box 15645
Las Vegas, NV 89114

(800) 274-6648 or TTY (800) 349-3538

www.sierraoptima.com

Plan service areas and premiums

Clackamas, Columbia, Gilliam, Malheur, Multnomah, and Washington

Monthly premium $53.10

Amount you pay

Annual out-of-pocket max..... $3,000

Doctor's office visits
- Primary care physician $10
- Specialist $20

Inpatient hospital care
- Days 1-24, per day
- Medicare-covered hospital $125
- Days 25-90, per day..... $0
- 60 lifetime reserve days and 90 days each benefit period.

Inpatient mental health care
- Days 1-24, per day
- Medicare-covered hospital $125
- Days 25-90, per day..... $0
- 60 lifetime reserve days and 190 days in a psychiatric hospital in a lifetime.

Skilled nursing facility
- Days 1-24, per day $0
- Days 25-100, per day $125
- 100 days each benefit period and 3-day prior hospital stay required.

Amount you pay

Home health care $0

Hospice..... $0

Chiropractic services $20

Podiatry services $20

Outpatient mental health care..... $20

Outpatient substance abuse care $20

Outpatient services/surgery..... $50

Ambulance services $100

Emergency care
- Worldwide Medicare covered .. $50

Urgently needed care (worldwide) .....$10-20 or 20% of the cost

Outpatient rehabilitation $20

Durable medical equipment 20%

Prosthetic devices..... 20%

Diabetes self-monitoring training and supplies 20%

Diagnostic tests, X-rays, and lab services 20%

Preventive services..... 20%
- Flu and pneumonia vaccines..... $0

Outpatient prescription drugs
- Medicare covered (Part B) 20%
- Other .....not covered

Dental services $40
- Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams $40

Amount you pay

- Routine hearing exams and aids.....not covered

Vision services..... contact plan

Routine physical exams ... contact plan

Health/ wellness education .....not covered

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Sierra Optima
Sierra Optima Plus
H4449-002 (PFFS)

P.O. Box 15645
Las Vegas, NV 89114

(800) 274-6648 or TTY (800) 349-3538

www.sierraoptima.com

Plan service areas and premiums

Clackamas, Columbia, Gilliam, Malheur, Multnomah, and Washington

Monthly premium $121.20

Amount you pay

Annual out-of-pocket max. $500

Doctor's office visits
- Primary care physician $5
- Specialist $5

Inpatient hospital care $0
90 days each benefit period.

Inpatient mental health care $0
190 days in a psychiatric hospital in a lifetime.

Skilled nursing facility
- Days 1-19, per day $0
- Days 20-100, per day $50

100 days each benefit period and 3-day prior hospital stay required.

Home health care $0

Hospice $0

Chiropractic services $5

Podiatry services $5

Amount you pay

Outpatient mental health care $5

Outpatient substance abuse care $5

Outpatient services/surgery $0

Ambulance services $100

Emergency care
- Worldwide Medicare covered .. $50

Urgently needed care
- Worldwide $5-40

Outpatient rehabilitation $5

Durable medical equipment 20%

Prosthetic devices 20%

Diabetes
- Self-monitoring training $5
- Supplies 20%

Diagnostic tests, X-rays, and lab svcs.
- Clinical/diagnostic lab $0-200
- Radiation therapy $0
- X-rays $0-50

Preventive services $0

Outpatient prescription drugs
- Medicare covered (Part B) 20%
- Other ..... not covered

Dental services $5
Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams $5
- Routine hearing exams and aids ..... not covered

Vision services ..... contact plan

Amount you pay

Routine physical exams ... contact plan

Health/ wellness education ..... not covered

Transportation ..... not covered

Acupuncture ..... not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Sierra Optima
Sierra Optima Plus
H4449-003 (PFFS)

P.O. Box 15645
Las Vegas, NV 89114

(800) 274-6648 or TTY (800) 349-3538

www.sierraoptima.com

Plan service areas and premiums

Baker, Benton, Crook, Deschutes, Jefferson, Klamath, Lincoln, Morrow, Umatilla, Union, Wallowa, and Wasco

Monthly premium $149.20

Amount you pay

Annual out-of-pocket max..... $500

Doctor's office visits
- Primary care physician..... $5
- Specialist..... $5

Inpatient hospital care..... $0
90 days each benefit period.

Inpatient mental health care..... $0
190 days in a psychiatric hospital in a lifetime.

Skilled nursing facility
- Days 1-19, per day..... $0
- Days 20-100, per day $50

100 days each benefit period and 3-day prior hospital stay required.

Home health care $0

Hospice..... $0

Chiropractic services $5

Amount you pay

Podiatry services $5

Outpatient mental health care..... $5

Outpatient substance abuse care $5

Outpatient services/surgery..... $0

Ambulance services $100

Emergency care
Worldwide Medicare covered .. $50

Urgently needed care
Worldwide $5-40

Outpatient rehabilitation $5

Durable medical equipment..... 20%

Prosthetic devices..... 20%

Diabetes
- Self-monitoring training $5
- Supplies..... 20%

Diagnostic tests, X-rays, and lab svcs.
- Clinical/diagnostic lab..... $0-200
- Radiation therapy $0
- X-rays $0-50

Preventive services..... $0

Outpatient prescription drugs
- Medicare covered (Part B) 20%
- Other .....not covered

Dental services $5
Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams $5
- Routine hearing exams and aids.....not covered

Amount you pay

Vision services..... contact plan

Routine physical exams ... contact plan

Health/ wellness education .....not covered

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Sierra Optima
Sierra Optima Plus
H4449-009 (PFFS)

P.O. Box 15645
Las Vegas, NV 89114

(800) 274-6648 or TTY (800) 349-3538

www.sierraoptima.com

Plan service areas and premiums

Marion and Polk

Monthly premium $53.10

Amount you pay

Annual out-of-pocket max..... $500

Doctor's office visits
- Primary care physician..... $5
- Specialist..... $5

Inpatient hospital care..... $0
90 days each benefit period.

Inpatient mental health care..... $0
190 days in a psychiatric hospital in a lifetime.

Skilled nursing facility
- Days 1-19, per day..... $0
- Days 20-100, per day $50

100 days each benefit period and 3-day prior hospital stay required.

Home health care $0

Hospice..... $0

Chiropractic services $5

Podiatry services $5

Outpatient mental health care..... $5

Amount you pay

Outpatient substance abuse care $5

Outpatient services/surgery..... $0

Ambulance services $100

Emergency care
- Worldwide Medicare covered .. $50

Urgently needed care
- Worldwide $5-40

Outpatient rehabilitation $5

Durable medical equipment 20%

Prosthetic devices..... 20%

Diabetes
- Self-monitoring training $5
- Supplies..... 20%

Diagnostic tests, X-rays, and lab svcs.
- Clinical/diagnostic lab.....$0-200
- Radiation therapy $0
- X-rays $0-50

Preventive services..... $0

Outpatient prescription drugs
- Medicare covered (Part B) 20%
- Other .....not covered

Dental services $5
Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams $5
- Routine hearing exams and aids.....not covered

Vision services ..... contact plan

Routine physical exams ... contact plan

Amount you pay

Health/ wellness education .....not covered

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Unicare Life & Health Ins. Co.
SecurityChoice Classic
H0540-001 (PFFS)

P.O. Box 9092
Oxnard, CA 93031

(800) 949-5384 or TTY (800) 297-1538

www.unicare.com

Plan service areas and premiums

Baker, Benton, Clackamas, Columbia, Crook, Deschutes, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Lincoln, Marion, Multnomah, Polk, Sherman, Umatilla, Wallowa, Wasco, Washington, and Wheeler

Monthly premium $0

Amount you pay

Doctor's office visits
- Primary care physician $10
- Specialist $10

Inpatient hospital care
- Annual out-of-pocket limit $750
- Days 1-5, per day
- Medicare-covered hospital $150
- Days 6-90, per day $0
- No limit to days covered each benefit period. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Inpatient mental health care
- Annual out-of-pocket limit $300
- Medicare-covered hospital $300
- 190 lifetime days in a psychiatric hospital. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Amount you pay

Skilled nursing facility
- Days 1-20, per day $0
- Days 21-100, per day..... $25
- 100 days each benefit period and no prior hospital stay required. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Home health care 15%

Hospice..... $0

Chiropractic services $10

Podiatry services $10

Outpatient mental health care.... 50%

Outpatient substance abuse care $10

Outpatient services/surgery
- Ambulatory surgical center $100
- Outpatient hospital facility ..$10-100

Ambulance services $100

Emergency care
- Worldwide Medicare covered .. $50 (waived if admitted)

Urgently needed care
- Worldwide.....$10 (waived if admitted)

Outpatient rehabilitation $10

Durable medical equipment 30%
- If item costs more than $750, you must notify plan. If you don't, you will pay 70% of the bill.

Prosthetic devices..... 30%
- If item costs more than $750, you must notify plan. If you don't, you will pay 70% of the bill.

Amount you pay

Diabetes
- Self-monitoring training $0
- Supplies.....$10 or 30% of cost

Diagnostic tests, X-rays, and lab services $0-25

Preventive services..... $0

Outpatient prescription drug .....not covered

Dental services .....not covered

Hearing services
- Diagnostic hearing exams $10
- Routine hearing test .....$10 (every two years)
- Hearing aids .....not covered

Vision services ..... contact plan

Routine physical exams.. contact plan

Health/ wellness education .....not covered

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Unicare Life & Health Ins. Co.
SecurityChoice Enhanced
H0540-010 (PFFS)

P.O. Box 9092
Oxnard, CA 93031

(800) 949-5384 or TTY (800) 297-1538

www.unicare.com

Plan service areas and premiums

Baker, Benton, Clackamas, Columbia, Crook, Deschutes, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Lincoln, Marion, Multnomah, Polk, Sherman, Umatilla, Wallowa, Wasco, Washington, and Wheeler

Monthly premium $25

Amount you pay

Doctor's office visits
- Primary care physician $10
- Specialist $10

Inpatient hospital care
- Medicare-covered hospital $50
- Additional hospital days..... $0
- No limit to days covered each benefit period. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Inpatient mental health care
- Medicare-covered hospital $50
- 190 lifetime days in a psychiatric hospital. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Amount you pay

Skilled nursing facility..... $0
- 100 days each benefit period and no prior hospital stay required. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Home health care $0

Hospice..... $0

Chiropractic services $10

Podiatry services $10

Outpatient mental health care.... 50%

Outpatient substance abuse care $10

Outpatient services/surgery
- Ambulatory surgical center $25
- Outpatient hospital facility ... $10-25

Ambulance services $25

Emergency care
- Worldwide Medicare covered .. $25 (waived if admitted)

Urgently needed care
- Worldwide.....$10 (waived if admitted)

Outpatient rehabilitation $10

Durable medical equipment 20%
- If item costs more than $750, you must notify plan. If you don't, you will pay 70% of the bill.

Prosthetic devices..... 20%
- If item costs more than $750, you must notify plan. If you don't, you will pay 70% of the bill.

Amount you pay

Diabetes
- Self-monitoring training $0
- Supplies.....$10 or 20% of cost

Diagnostic tests, X-rays, and lab services $0-25

Preventive services..... $0

Outpatient prescription drug .....not covered

Dental services .....not covered

Hearing services
- Diagnostic hearing exams $10
- Routine hearing test .....$10 (every two years)
- Hearing aids .....not covered

Vision services ..... contact plan

Routine physical exams.. contact plan

Health/ wellness education .....not covered

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

WellCare – Duet H1340-004 (PFFS)

8735 Henderson Rd.
Tampa, FL 33634

(866) 238-9898 or TTY (866) 239-6265

www.wellcarepffs.com

Plan service areas and premiums

Clackamas, Jackson, Klamath, Lane, Lincoln, Marion, Multnomah, Umatilla, and Washington

Monthly premium $0

Amount you pay

Annual deductible $124

Doctor's office visits
- Primary care physician 20%
- Specialist 20%

Inpatient hospital care
- Deductible $952
- Days 1-60, per day Medicare-covered hospital $0
- Days 61-90, per day $238
- 60 lifetime reserve days and 90 days each benefit period.

Inpatient mental health care
- Deductible $952
- Days 1-60, per day Medicare-covered hospital $0
- Days 61-90, per day $238
- 60 lifetime reserve days.

Skilled nursing facility
- Days 1-20, per day $0
- Days 21-100, per day.....$119
- 100 days each benefit period and 3-day prior hospital stay required.

Amount you pay

Home health care $0

Hospice..... $0

Chiropractic services 20%

Podiatry services 20%

Outpatient mental health care.... 50%

Outpatient substance abuse care 50%

Outpatient services/surgery..... 20%

Ambulance services 20%

Emergency care
- Medicare covered..20% of the cost up to $50 (waived if admitted)

Urgently needed care 20%

Outpatient rehabilitation 20%

Durable medical equipment 20%

Prosthetic devices..... 20%

Diabetes
- Self-monitoring training $0
- Supplies..... 20%

Diagnostic tests, X-rays, and lab svcs.
- Clinical/diagnostic lab.....0-20%
- Radiation therapy/X-rays..... 20%

Preventive services..... $0

Outpatient prescription drugs
- Medicare covered (Part B) 20%
- Other .....not covered

Dental services ..... contact plan

Hearing services..... contact plan

Vision services..... contact plan

Routine physical exams.. contact plan

Amount you pay

Health/ wellness education ..... contact plan

Transportation.....not covered

Acupuncture.....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

Trillium Advantage
Trillium Advantage
H2174-002 (HMO)

1800 Millrace Dr.
Eugene, OR 97403

(800) 910-3906 or TTY (877) 600-5473

www.trilliumchp.com

Plan service areas and premiums

Lane

Monthly premium $104

Amount you pay

Annual out-of-pocket max.....$1,500

Doctor's office visits
- Primary care physician 20%
- Specialist 20%

Inpatient hospital care
- Days 1-8, per day
  Medicare-covered hospital $100
- Days 9-90, per day $0

90 days each benefit period and $800 out-of-pocket limit per stay.

Inpatient mental health care
- Days 1-8, per day
  Medicare-covered hospital $100
- Days 9-90, per day $0

60 lifetime reserve days and 190 days in a psychiatric hospital in a lifetime.

Skilled nursing facility..... $0
100 days per benefit period and 3-day prior hospital stay required.

Home health care $0

Hospice..... $0

Amount you pay

Chiropractic services 20%

Podiatry services 20%

Outpatient mental health care
- 1-6 individual/group therapy..... $20
- 7 or more..... $25

Outpatient substance abuse care
- 1-6 individual/group therapy..... $20
- 7 or more..... $25

Outpatient services/surgery
- Ambulatory surgical center $50
- Outpatient hospital facility $0

Ambulance services $50

Emergency care
- Medicare covered..... $50
  (waived if admitted)

Urgently needed care $20
(waived if admitted)

Outpatient rehabilitation $20

Durable medical equipment 20%

Prosthetic devices..... $0

Diabetes
- Self-monitoring training $20
- Supplies..... $0

Diagnostic tests, X-rays, and lab services $0

Preventive services..... $0

Outpatient prescription drug
- Part B $0
- Part D ..... $0 annual deductible

Until total drug costs reach $2,400, you pay the following:

Retail pharmacy (31-day supply):
- Generic..... $7
- Preferred brand $30
- Non-preferred brand..... $60

Amount you pay

Retail pharmacy and mail order (90-day supply):
- Generic.....$14
- Preferred brand $60
- Non-preferred brand.....$120

Gap coverage ("donut hole"):
- Generic (31-day)..... $7
- Generic (90-day) $14

After total drug costs equal $2,400 you pay 100% of your drug costs, until your out-of-pocket expenses total $3,850.

Once your out-of-pocket drug costs reach $3,850 you pay:
- Generic..... $2.15 or 5%
- All others .....$5.35 or 5%

Dental services $20
Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams $20
- Routine hearing exams and aids.....not covered

Vision services.....contact plan

Routine physical exams $20

Health/ wellness education ..... contact plan

Transportation.....not covered

Acupuncture/ naturopathic.....not covered

Plan hospitals and pharmacies

Please contact the plan or visit their Web site.

Plan contact information

Unicare Life & Health Ins. Co.
SecurityChoice Plus
H0540-020 (PFFS)

P.O. Box 9092
Oxnard, CA 93031

(800) 949-5384 or TTY (800) 297-1538

www.unicare.com

Plan service areas and premiums

Baker, Benton, Clackamas, Columbia, Crook, Deschutes, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Lincoln, Marion, Multnomah, Polk, Sherman, Umatilla, Wallowa, Wasco, Washington, and Wheeler

Monthly premium $11

Amount you pay

Doctor's office visits
- Primary care physician $10
- Specialist $25

Inpatient hospital care
- Annual out-of-pocket limit $1,000
- Days 1-5, per day
- Medicare-covered hospital $200
- Days 6-90, per day $0
- No limit to days covered each benefit period. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Inpatient mental health care
- Annual out-of-pocket limit $900
- Medicare-covered hospital $900
- 190 lifetime days in a psychiatric hospital. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Amount you pay

Skilled nursing facility
- Days 1-20, per day $0
- Days 21-100, per day $100
- 100 days each benefit period and no prior hospital stay required. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Home health care 15%

Hospice $0

Chiropractic services $25

Podiatry services $25

Outpatient mental health care 50%

Outpatient substance abuse care $10

Outpatient services/surgery
- Ambulatory surgical center $100
- Outpatient hospital facility $10-100

Ambulance services $150

Emergency care
- Worldwide Medicare covered $50
- (waived if admitted)

Urgently needed care
- Worldwide $25
- (waived if admitted)

Outpatient rehabilitation $25

Durable medical equipment 30%
- If item costs more than $750, you must notify plan. If you don't, you will pay 70% of the bill.

Prosthetic devices 30%
- If item costs more than $750, you must notify plan. If you don't, you will pay 70% of the bill.

Diabetes
- Self-monitoring training $0
- Supplies ..... $10 or 30% of cost

Diagnostic tests, X-rays, and lab services $0-25

Preventive services $0

Amount you pay

Outpatient prescription drug
- Part B 20%
- Part D $0
- Until total drug costs reach $2,400, you pay:
- 30-day supply:
- Generics $10
- Preferred brand $30
- Non-preferred brand $60
- Non-specialty and specialty injectable drugs ..... 30% coinsurance
- 90-day supply:
- Generics $30
- Preferred brand $90
- Non-preferred brand $180
- Non-specialty and specialty injectable drugs ..... 30% coinsurance
- Mail order ..... contact plan
- After total drug costs equal $2,400 you pay 100% of your drug costs, until your out-of-pocket expenses total $3,850.
- Once your out-of-pocket drug costs reach $3,850 you pay:
- Generic ..... greater of $2.15 or 5%
- All others ..... greater of $5.35 or 5%

Dental services ..... not covered

Hearing services
- Diagnostic hearing exams $25
- Routine hearing test $25
- (every two years)
- Hearing aids ..... not covered

Vision services ..... contact plan

Routine physical exams ..... contact plan

Health/wellness education ..... not covered

Transportation ..... not covered

Acupuncture ..... not covered

Plan hospitals

Please visit their Web site.

Plan contact information

Unicare Life & Health Ins. Co.
SecurityChoice Enhanced Plus
H0540-032 (PFFS)

P.O. Box 9092
Oxnard, CA 93031

(800) 949-5384 or TTY (800) 297-1538

www.unicare.com

Plan service areas and premiums

Baker, Benton, Clackamas, Columbia, Crook, Deschutes, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Lincoln, Marion, Multnomah, Polk, Sherman, Umatilla, Wallowa, Wasco, Washington, and Wheeler

Monthly premium $56

Amount you pay

Doctor's office visits
- Primary care physician $10
- Specialist.....$10

Inpatient hospital care
- Medicare-covered hospital..... $50
- Additional days..... $0

No limit to days covered each benefit period. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Inpatient mental health care
- Medicare-covered hospital..... $50

190 lifetime days in a psychiatric hospital. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Skilled nursing facility $0

100 days each benefit period and no prior hospital stay required. Notify plan before being admitted or pay $50 per day, max. to $500 until notified.

Amount you pay

Home health care $0

Hospice..... $0

Chiropractic services $10

Podiatry services $10

Outpatient mental health care..... 50%

Outpatient substance abuse care.....$10

Outpatient services/surgery
- Ambulatory surgical center.....$25
- Outpatient hospital facility.....$10-25

Ambulance services $25

Emergency care
- Worldwide Medicare covered ..... $25 (waived if admitted)

Urgently needed care
- Worldwide .....$10 (waived if admitted)

Outpatient rehabilitation $10

Durable medical equipment..... 20%

If item costs more than $750, you must notify plan. If you don't, you will pay 70% of the bill.

Prosthetic devices..... 20%

If item costs more than $750, you must notify plan. If you don't, you will pay 70% of the bill.

Diabetes
- Self-monitoring training $0
- Supplies .....$10 or 20% of cost

Diagnostic tests, X-rays, and lab services.....$0-25

Preventive services..... $0

Outpatient prescription drug
- Part B..... 20%
- Part D..... $0

Amount you pay

Until total drug costs reach $2,400, you pay:

30-day supply:
- Generics $10
- Preferred brand..... $30
- Non-preferred brand $60
- Non-specialty and specialty injectable drugs.....30% coinsurance

90-day supply:
- Generics $30
- Preferred brand..... $90
- Non-preferred brand $180
- Non-specialty and specialty injectable drugs.....30% coinsurance

Mail order..... contact plan

Gap coverage ..... contact plan

After total drug costs equal $2,400 you pay 100% of your drug costs, until your out-of-pocket expenses total $3,850.

Once your out-of-pocket drug costs reach $3,850 you pay:
- Generic ..... greater of $2.15 or 5%
- All others.....greater of $5.35 or 5%

Dental services.....not covered

Hearing services
- Diagnostic hearing exams.....$10
- Routine hearing test.....$10 (every two years)
- Hearing aids.....not covered

Vision services ..... contact plan

Routine physical exams..... contact plan

Health/wellness education...not covered

Transportation.....not covered

Acupuncture .....not covered

Plan hospitals

Please visit their Web site.

Plan contact information

WellCare – Concert
H1340-013 (PFFS)

8735 Henderson Rd.
Tampa, FL 33634

(866) 238-9898 or TTY (866) 239-6265

www.wellcarepffs.com

Plan service areas and premiums

Baker, Benton, Clackamas, Columbia, Hood River, Jackson, Klamath, Lane, Lincoln, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, and Washington

Monthly premium $0

Amount you pay

Annual out-of-pocket max..... $3,650

Doctor's office visits
- Primary care physician $10
- Specialist..... $35

Inpatient hospital care
- Days 1-5, per day
- Medicare-covered hospital..... $225
- Days 6-90, per day $0
- 60 lifetime reserve days and 90 days each benefit period.

Inpatient mental health care
- Days 1-5, per day
- Medicare-covered hospital..... $225
- Days 6-90, per day $238
- 60 lifetime reserve days and 190 days in a psychiatric hospital in a lifetime.

Skilled nursing facility
- Days 1-15, per day $0
- Days 16-60, per day $90
- Days 61-100, per day $0
- 100 days each benefit period and no prior hospital stay required.

Amount you pay

Home health care $0-35

Hospice..... $0

Chiropractic services $35

Podiatry services $35

Outpatient mental health care
- Individual.....$35
- Group.....$25

Outpatient substance abuse care
- Individual.....$35
- Group.....$25

Outpatient services/surgery
- Ambulatory surgical center.....$75
- Outpatient hospital facility.....$120

Ambulance services 20%

Emergency care
- Worldwide Medicare covered ..... $50 (waived if admitted)

Urgently needed care ..... $25 (waived if admitted)

Outpatient rehabilitation
..... $35 or 20% of cost

Durable medical equipment..... 25%

Prosthetic devices..... 25%

Diabetes
- Self-monitoring training $0
- Supplies 25%

Diagnostic tests, X-rays, and lab services
- Clinical/diagnostic lab/ X-rays..... $10-35 or 20% of cost
- Radiation therapy..... 25%

Preventive services..... $0

Outpatient prescription drug
- Part B..... 25%
- Part D..... $0

Amount you pay

Until total drug costs reach $2,400, you pay:

30-day supply:
- Tier 1..... $0
- Tier 2..... $28
- Tier 3..... $58
- Tier 4.....33% coinsurance

90-day supply and mail order:
- Tier 1..... $0
- Tier 2..... $84
- Tier 3..... $174
- Tier 4.....33% coinsurance

After total drug costs equal $2,400 you pay 100% of your drug costs, until your out-of-pocket expenses total $3,850.

Once your out-of-pocket drug costs reach $3,850 you pay:

- Generic ..... greater of $2.15 or 5%
- All others.....greater of $5.35 or 5%

Dental services..... 20%
Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams..... $20
- Routine hearing tests (1 yearly) ... $20
- Hearing aids.....not covered

Vision services $0-20

Routine physical exams..... contact plan

Health/wellness education.. contact plan

Transportation.....not covered

Acupuncture .....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

WellCare – Freedom
H1320-012 (PFFS)

8735 Henderson Rd.
Tampa, FL 33634

(866) 238-9898 or TTY (866) 239-6265

www.wellcarepffs.com

Plan service areas and premiums

Benton

Monthly premium $0

Amount you pay

Annual out-of-pocket max..... $3,650

Doctor's office visits
- Primary care physician $15
- Specialist..... $40

Inpatient hospital care
- Days 1-5, per day
- Medicare-covered hospital..... $250
- Days 6-90, per day $0
- 60 lifetime reserve days and 90 days each benefit period.

Inpatient mental health care
- Days 1-5, per day
- Medicare-covered hospital..... $250
- Days 6-90, per day $0
- 60 lifetime reserve days and 190 days in a psychiatric hospital in a lifetime.

Skilled nursing facility
- Days 1-20, per day..... $0
- Days 21-100, per day $119
- 100 days each benefit period and no prior hospital stay required.

Home health care $0-40

Hospice..... $0

Chiropractic services $40

Podiatry services $40

Amount you pay

Outpatient mental health care
- Individual.....$40
- Group.....$30

Outpatient substance abuse care
- Individual.....$40
- Group.....$30

Outpatient services/surgery
- Ambulatory surgical center.....$75
- Outpatient hospital facility.....$150

Ambulance services 20%

Emergency care
- Worldwide Medicare covered ..... $50 (waived if admitted)

Urgently needed care ..... $25 (waived if admitted)

Outpatient rehabilitation
..... $40 or 20% of cost

Durable medical equipment..... 30%

Prosthetic devices..... 30%

Diabetes
- Self-monitoring training $0
- Supplies 30%

Diagnostic tests, X-rays, and lab services
- Clinical/diagnostic lab/ X-rays..... $15-40 or 20% of cost
- Radiation therapy..... 20%

Preventive services..... $0

Outpatient prescription drug
- Part B..... 30%
- Part D..... $0

Until total drug costs reach $2,400, you pay:

30-day supply:
- Tier 1..... $0
- Tier 2..... $54
- Tier 3..... $64
- Tier 4.....33% coinsurance

Amount you pay

90-day supply and mail order:
- Tier 1..... $0
- Tier 2.....$162
- Tier 3.....$192
- Tier 4.....33% coinsurance

After total drug costs equal $2,400 you pay 100% of your drug costs, until your out-of-pocket expenses total $3,850.

Once your out-of-pocket drug costs reach $3,850 you pay:

- Generic ..... greater of $2.15 or 5%
- All others.....greater of $5.35 or 5%

Dental services..... 20%
Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams..... $20
- Routine hearing tests (1 yearly) ... $20
- Hearing aids.....not covered

Vision services ..... contact plan

Routine physical exams..... contact plan

Health/wellness education.. contact plan

Transportation.....not covered

Acupuncture .....not covered

Plan hospitals

Please contact the plan or visit their Web site.

Plan contact information

WellCare – Summit
H1340-006 (PFFS)

8735 Henderson Rd.
Tampa, FL 33634

(866) 238-9898 or TTY (866) 239-6265

www.wellcarepffs.com

Plan service areas and premiums

Baker, Benton, Clackamas, Columbia, Hood River, Jackson, Klamath, Lane Lincoln, Malheur, Marion, Multnomah, Polk, Sherman, Umatilla, Union, and Washington

Monthly premium $91

Amount you pay

Doctor's office visits
- Primary care physician $0
- Specialist..... $0

Inpatient hospital care
- Days 1-90, per day
- Medicare-covered hospital..... $0
- Additional days..... $0
- 60 lifetime reserve days and no limit on days covered each benefit period.

Inpatient mental health care
- Days 1-90, per day
- Medicare-covered hospital..... $0
- 60 lifetime reserve days and 190 days in a psychiatric hospital in a lifetime.

Skilled nursing facility
- Days 1-100, per day $0
- 100 days each benefit period and no prior hospital stay required.

Home health care $0

Hospice..... $0

Chiropractic services $0

Amount you pay

Podiatry services $0

Outpatient mental health care
- 1-50 visits 0%
- 51 or more 50%

Outpatient substance abuse care
- 1-50 visits 0%
- 51 or more 50%

Outpatient services/surgery $0

Ambulance services $0

Emergency care
- Worldwide Medicare covered ..... $0 (waived if admitted)

Urgently needed care ..... $0 (waived if admitted)

Outpatient rehabilitation..... $0

Durable medical equipment..... 20%

Prosthetic devices..... 20%

Diabetes
- Self-monitoring training $0
- Supplies 20%

Diagnostic tests, X-rays, and lab services
- Clinical/diagnostic lab/ X-rays..... 0-20% of cost
- Radiation therapy..... 20%

Preventive services..... $0

Outpatient prescription drug
- Part B..... 30%
- Part D..... $0

Until total drug costs reach $2,400, you pay:

30-day supply:
- Tier 1..... $0
- Tier 2..... $28
- Tier 3..... $58
- Tier 4.....33% coinsurance

Amount you pay

90-day supply and mail order:
- Tier 1..... $0
- Tier 2..... $84
- Tier 3..... $174
- Tier 4.....33% coinsurance

After total drug costs equal $2,400 you pay 100% of your drug costs, until your out-of-pocket expenses total $3,850.

Once your out-of-pocket drug costs reach $3,850 you pay:

- Generic ..... greater of $2.15 or 5%
- All others.....greater of $5.35 or 5%

Dental services..... $0
Preventative dental benefits, such as cleaning, not covered.

Hearing services
- Diagnostic hearing exams..... $0
- Routine hearing exams and aids .....not covered

Vision services .....contact plan

Routine physical exams..... contact plan

Health/wellness education.. contact plan

Transportation.....not covered

Acupuncture .....not covered

Plan hospitals

Please contact the plan or visit their Web site.