

6. Ending your Membership

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

PERS ODS Advantage PPORX is sponsored by PERS Health Insurance Program. Disenrolling from the PERS ODS Advantage PPORX may disenroll you from PERS. You may wish to call PERS Health Insurance Program at 503-224-7377 or toll free 1-800-768-7377 or TTY 1-800-433-6313, Monday through Friday from 7:30 a.m. to 5:30 p.m. Pacific time, to discuss your options. If you leave the PERS Health Insurance Program you may not be able to return to the PERS Health Insurance Program.

Until your membership ends, you must keep getting your Medicare services and/or prescription drug coverage through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care and/or prescription drugs as usual through our Plan. If you happen to be hospitalized on the day your membership ends, generally you will be covered by our Plan until you are discharged. Call Member Services for more information and to help us coordinate with your new plan.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy including our mail-order-pharmacy services, are listed on our formulary, and you follow other coverage rules.

We cannot ask you to leave the Plan because of your health

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- If you do not stay continuously enrolled in Medicare A and B
- If you move out of the service area or are away from the service area for more than 12 months you cannot remain a member of our Plan. And we must end your membership (“disenroll” you). If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan’s service area. Section 10 gives more information about getting care when you are away from the service area.
- If you knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

You have the right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

7. Definitions of Important Words Used in the EOC

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services and/or prescription drugs or payment for services and/or prescription drugs you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug/item/service you think you should be able to receive. Section 5 explains appeals, including the process involved in making an appeal.

Benefit period – For both our Plan and the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,350 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when drugs or services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs/services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific drugs/services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug/service.

Coverage Determination –A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the Plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you

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the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our Plan.

Covered services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

Custodial care -- Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 6 discusses disenrollment.

Durable medical equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the Plan.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

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Grievance - A type of complaint you make about us or one of our network providers/pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

Home health aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care -- Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 10 under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice care -- A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048)

Inpatient Care – Health care that you get when you are admitted to a hospital.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period after you have met your deductible and before your total drug expenses, have reached \$2,700 including amounts you've paid and what our Plan has paid on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

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Medically necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare supplement insurance) policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (A Medicare Advantage plan is not a Medigap policy.)

Member (member of our Plan, or “plan member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 8 for information about how to contact Member Services.

Network pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare

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and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare Plan – (“Traditional Medicare” or “Fee-for-service” Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network provider or out-of-network facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this EOC in Section 2.

Out-of-network pharmacy – A pharmacy that doesn’t have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – see “**Medicare Advantage (MA) Plan**”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs, such as benzodiazepines, barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see Section 10 for a listing of these drugs). These drugs are not considered Part D drugs.

Primary Care Physician (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing covered services while you are a plan member. Section 2 tells more about PCPs.

Preferred Provider Organization Plan – A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a

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specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing may be higher when plan benefits are received from out-of-network providers.

Prior authorization – Approval in advance to get certain services or drugs that may or may not be on our formulary. In a PPO plan you do not need prior authorization to obtain out-of-network services. However, you may want to check with your plan before obtaining services out-of-network to confirm that the service is covered by your plan and what your cost share responsibility is. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 8 for information about how to contact The QIO in your state and Section 5 for information about making complaints to The QIO.

Rehabilitation services – These services include physical therapy, speech and language therapy, and occupational therapy.

Quantity Limits - A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service area – “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

Skilled nursing facility (SNF) care - A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care – Section 2 explains about “urgently needed” services. These are different from emergency services.

8. Helpful Phone Numbers and Resources

Contact Information for our Plan Member Services

If you have any questions or concerns, please call or write to our Plan Member Services. We will be happy to help you.

CALL **1-877-299-9061** PERS ODS Advantage Member Services This number is also on the cover of this booklet for easy reference. Calls to this number are free.

PERS ODS Advantage Member Services business hours are Monday through Friday from 7:30 a.m. to 5:30 p.m. Pacific time

CALL **1-888-786-7509** ODS Advantage Pharmacy Customer Service This number is also on the cover of this booklet for easy reference. Calls to this number are free.

ODS Advantage Pharmacy Customer Service business hours are seven days a week, from 7:00 a.m. to 8:00 p.m. Pacific time, from November 15, 2008 to March 1, 2009. (After March 1, 2009, your call will be handled by our automated phone system, Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a Customer Service representative will return your call the next business day.)

TTY/TDD **1-800-433-6313** This number requires special telephone equipment. Calls to this number are free.

FAX **503-948-5577** ODS Advantage Member Services

FAX **503-382-5361** ODS Advantage Pharmacy Customer Service

WRITE ODS Health Plan, Inc. **Attn: ODS Advantage PPORX**, P.O. Box 40384
Portland, OR 97240-0384

VISIT ODS Health Plan, Inc. **Attn: ODS Advantage PPORX**, 601 S.W. Second
Ave. Suite 700 Portland, OR 97204-3156

WEBSITE **www.odscompanies.com/odsadvantage**

Contact Information for Grievances, Organizations Determinations, Coverage Determinations and Appeals

Part C Organization Determinations (about your Medicare Care and Services)

- CALL** **1-800-592-8283** Calls to this number are free.
- TTY/TDD** **1-800-433-6313** This number requires special telephone equipment. Calls to this number are free.
- FAX** **503-243-5105** Attn: ODS Advantage PPORX Organization Determination
- WRITE** ODS Health Plan, Inc. **Attn: ODS Advantage PPORX Organization Determinations**, P.O. Box 40384 Portland, OR 97240-0384

For information about Part C organization determinations, see Section 5.

Part C Grievances (about your Medical Care and Services)

- CALL** **1-877-299-9061** When leaving a message, please include your name, number and the time that you called, and a Member Services representative will return your call the next business day. Calls to this number are free.
1-800-592-8283 For expedited grievances. Calls to this number are free.
- TTY/TDD** **1-800-433-6313** This number requires special telephone equipment. Calls to this number are free.
- FAX** **503-243-5105** Attn: ODS Advantage PPORX Grievances
- WRITE** ODS Health Plan, Inc. **Attn: ODS Advantage PPORX Grievances**, P.O. Box 40384 Portland, OR 97240-0384

For information about Part C grievances, see Section 4.

Part C Appeals (about your Medical Care and Services)

- CALL** **1-877-299-9061** When leaving a message, please include your name, number and the time that you called, and a Member Services representative will return your call the next business day. Calls to this number are free.
1-800-592-8283 For expedited appeals. Calls to this number are free.
- TTY/TDD** **1-800-433-6313** This number requires special telephone equipment. Calls to this number are free.

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FAX **503-243-5105** Attn: ODS Advantage PPORX Appeals

WRITE ODS Health Plan, Inc. **Attn: ODS Advantage PPORX Appeals**, P.O. Box
40384 Portland, OR 97240-0384

For information about Part C appeals, see Section 5.

Part D Coverage Determinations (about your Part D Prescription Drugs)

CALL **1-888-786-7509** When leaving a message, please include your name, number
and the time that you called, and a Customer Service representative will return
your call the next business day. Calls to this number are free.

TTY/TDD **1-800-433-6313** This number requires special telephone equipment. Calls to this
number are free.

FAX **1-800-207-8235** or **503-382-5361**

WRITE ODS Health Plan, Inc. **Attn: ODS Advantage PPORX Coverage
Determination**, P.O. Box 40327 Portland, OR 97240-0327

For information about Part D coverage determinations, see Section 5.

Part D Grievances (about your Part D Prescription Drugs)

CALL **1-888-786-7509** When leaving a message, please include your name, number
and the time that you called, and a Customer Service representative will return
your call the next business day. Calls to this number are free.

TTY/TDD **1-800-433-6313** This number requires special telephone equipment. Calls to this
number are free.

FAX **503-243-5105** Attn: ODS Advantage PPORX Grievances

WRITE ODS Health Plan, Inc. **Attn: ODS Advantage PPORX Grievances**, P.O. Box
40384 Portland, OR 97240-0384

For information about Part D grievances, see Section 4.

Part D Appeals (about your Part D Prescription Drugs)

CALL **1-888-786-7509** When leaving a message, please include your name, number
and the time that you called, and a Customer Service representative will return
your call the next business day. Calls to this number are free.
1-800-592-8283 For expedited appeals. Calls to this number are free.

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TTY/TDD **1-800-433-6313** This number requires special telephone equipment. Calls to this number are free.

FAX **503-243-5105** Attn: ODS Advantage PPORX Appeals

WRITE ODS Health Plan, Inc. **Attn: ODS Advantage PPORX Appeals**, P.O. Box
40384 Portland, OR 97240-0384

For information about Part D appeals, see Section 5.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You* Handbook, visit www.medicare.gov and choose “Find Helpful Phone Numbers and Resources,” or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

Oregon – Senior Health Insurance Benefits Assistance Program (SHIBA)

SHIBA is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. SHIBA can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. SHIBA has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact the SHIBA at 1-800-722-4134 Monday through Friday from 8:00 a.m. to 5:00 p.m. Pacific time (Oregon TTY 1-800-735-2900) Write SHIBA at Oregon SHIBA 250 Church Street SE, Suite 200, Salem, OR 97301-3921. The SHIBA web site is www.oregonshiba.org . You may also find the website for SHIBA at www.medicare.gov under “Search Tools” by selecting “Helpful Phone Numbers and Webstites.”

Oregon - Acumentra Health (QIO)

“QIO” stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIO’s have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 4 and 5 for more information about complaints, appeals and grievances.

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You may contact Acumentra Health at (503) 279-0100 from 8:00 a.m. to 5:00 p.m. Monday through Friday Pacific time. You can fax Acumentra Health at (503) 279-0190 or write Acumentra Health 2020 S.W. Fourth Ave. Suite 520, Portland, OR 97201-4960. The Acumentra Health web site is www.acumentra.org.

How to contact the Medicare program

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov for information. This is the official government website for Medicare. This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under “Search Tools” for Medicare contacts in your state. Select “Helpful Phone Numbers and Websites.” If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, call to apply for Oregon Health Plan coverage 1-800-359-9517 or TTY 1-800-621-5260 from 8:00 a.m. to 5:00 p.m. Monday through Friday, Pacific time. You can write to Division of Medical Assistance Programs, Oregon Department of Human Services (DHS) 500 Summer St. NE, Salem, OR 97301. The DHS web site is www.oregon.gov/DHS

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors’ benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit www.ssa.gov on the Web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or “Group”) Coverage

If you get, or your spouse gets, benefits from your current or former employer or union, or from your spouse’s current or former employer or union, call the employer/union benefits administrator or Member Services if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouse’s) employer/union benefits may change, or you (or your spouse) may lose the benefits, if you enroll in Medicare Part D. Call your employer/union benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

9. Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

10. How Much You Pay for Your Part C Medical Benefits and/or Part D Prescription Drugs

Your Monthly Premium for Our Plan

Your premium is collected by the PERS Health Insurance Program and forwarded to ODS Health Plan, Inc. If you qualify for extra help from Medicare, called the Low-Income Subsidy or LIS, you may not have to pay for part of your monthly premium.

If you have any questions about your plan premiums or the payment program, please call the PERS Health Insurance Program Customer Service at 1-800-768-7377 or TTY 1-800-433-6313 Monday through Friday from 7:30 a.m. to 5:30 p.m. Pacific time.

Note: If you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP at the phone number listed in determine what benefits are available to you.

How Much You Pay for Part C Medical Benefits

This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. These are the benefits and coverage you get as a member of our Plan. Later in this section under “General Exclusions” you can find information about services that are not covered. Information about how much you pay for your Part D Prescription Drug Benefits is later in this section

What do you pay for covered services?

“Copayments” and “coinsurance” are the amounts you pay for covered services.

- A **“copayment”** is a payment you make for your share of the cost of certain covered services you get. A copayment is a set amount per service. You pay it when you get the service.
- **“Coinsurance”** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. You pay your coinsurance when you get the service.

What is the maximum amount you will pay for covered medical services?

There is a limit to how much you have to pay out-of-pocket for covered health care services each year. The maximum amount you will pay for covered medical services including all in and out-of-network copayments and coinsurance is \$1,500. For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Your cost once a benefit limit has been reached will not count toward an out-of-pocket maximum.

Benefits Chart

The benefits chart on the following pages lists the services our Plan covers and what you pay for each service. The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.

See Section 2 for information on requirements for using network providers.

Benefits chart – your covered services

What you must pay when you get these covered services for both In and Out of Network

Inpatient Services

Inpatient hospital care

Covered services include:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion as well as ensuring post-transplant continuity of care where there is a closer facility.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.
- Physician Services

\$200 copayment per admission is applied once during each benefit period

You are covered for 90 days each benefit period

If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a plan hospital

Benefits chart – your covered services

What you must pay when you get these covered services for both In and Out of Network

Inpatient mental health care

Covered services include mental health care services that require a hospital stay. 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.

\$200 copayment per admission is applied once during each benefit period

Skilled nursing facility (SNF) care

A 2-day prior hospital stay is required for each SNF stay. Covered services include:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Regular nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors)
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician services

Days 1-20 \$0 copayment for each day

Days 21-100 \$40 copayment for each day

A 2-day prior hospital stay is required for each SNF stay

You are covered for 100 days each benefit period

Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our Plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you

Benefits chart – your covered services

What you must pay when you get these covered services for both In and Out of Network

went to the hospital (as long as it provides skilled nursing facility care).

- A SNF where your spouse is living at the time you leave the hospital.

Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered

Covered services include:

- | | |
|---|--|
| • Physician services | \$15 copayment |
| • Tests (like X-ray or lab tests) | \$10 copayment per x-ray \$0 lab |
| • X-ray, radium, and isotope therapy including technician materials and services | \$35 Radiation therapy |
| • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations | 10% up to a maximum copayment of \$100 for MRI, CT and PET scans |
| • Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices | \$0 copayment |
| • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition | \$10 copayment |
| • Physical therapy, speech therapy, and occupational therapy | \$15 copayment |

Benefits chart – your covered services	What you must pay when you get these covered services for both In and Out of Network
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Home health agency care

Covered services include:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and 35 or fewer hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies | <p>\$0 copayment</p> <p>\$15 copayment</p> <p>\$0 copayment</p> <p>10% coinsurance</p> |
|--|--|

Hospice care

You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include:

- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan
- Home care

When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan.

Benefits chart – your covered services

What you must pay when you get these covered services for both In and Out of Network

Outpatient Services

Physician services, including doctor office visits

Covered services include:

- Office visits, including medical and surgical care in a physician’s office or certified ambulatory surgical center \$15 copayment
- Consultation, diagnosis, and treatment by a specialist \$15 copayment
- Hearing and balance exams, if your doctor orders it to see if you need medical treatment. \$15 copayment
- Telehealth office visits including consultation, diagnosis and treatment by a specialist \$15 copayment
- Second opinion prior to surgery \$15 copayment
- Outpatient hospital services 10% up to a maximum \$200 copay

- Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor) \$15 copayment for office visit with a Specialist or 10% up to a maximum \$200 for Out-patient and \$200 copayment for In-Patient Surgery

Chiropractic services

Covered services include: \$15 copayment
Manual manipulation of the spine to correct subluxation

Podiatry services

Covered services include: \$15 copayment

- Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).
- Routine foot care for members with certain medical conditions affecting the lower limbs.

Benefits chart – your covered services	What you must pay when you get these covered services for both In and Out of Network
<p>Outpatient mental health care (including Partial Hospitalization Services) Covered services include:</p> <ul style="list-style-type: none"> • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization. 	<p>\$15 for each individual or group therapy visit</p>
<p>Outpatient substance abuse services</p>	<p>\$15 for each individual or group therapy visit</p>
<p>Outpatient surgery (including services provided at ambulatory surgical centers)</p>	<p>10% up to a maximum copayment of \$200 for each Medicare-covered visit to an ambulatory or outpatient hospital facility</p>
<p>Ambulance services Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health). The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required.</p>	<p>You pay \$50 for Medicare-covered ambulance services. \$50 copayment applies to each one-way trip</p>

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Benefits chart – your covered services	What you must pay when you get these covered services for both In and Out of Network
<p>Emergency care Available Worldwide</p>	<p>\$50 copayment Your copayment is waived if you are admitted to the hospital within 24 hours of being seen for the same condition</p> <p>If you need inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a plan hospital</p>
<p>Urgently needed care Available Worldwide</p>	<p>\$15 copayment</p>
<p>Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy</p>	<p>\$15 copayment</p>
<p>Durable medical equipment and related supplies Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in Section 7.)</p>	<p>\$10 copayment</p>
<p>Prosthetic devices and related supplies – (other than dental) that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>\$10 copayment</p>

Benefits chart – your covered services

What you must pay when you get these covered services for both In and Out of Network

Diabetes self-monitoring, training and supplies

– for all people who have diabetes (insulin and non-insulin users). Covered services include:

- Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors \$0
- One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts \$10 copayment
- Self-management training is covered under certain conditions \$10 copayment
- For persons at risk of diabetes: Fasting plasma glucose tests. Up to 2 tests per year not less than 6 months apart \$0 copayment

Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor. \$10 copayment

Outpatient diagnostic tests and therapeutic services and supplies

Covered services include:

- X-rays \$10 copayment
- Radiation therapy \$35 copayment
- Surgical supplies, such as dressings \$0 copayment
- Supplies, such as splints and casts \$0 copayment
- Laboratory tests \$0 copayment
- Blood - Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need. \$0 copayment
- Other outpatient diagnostic tests such as MRI, CT and PET scans 10% up to maximum \$100 copayment per procedure

Benefits chart – your covered services

What you must pay when you get these covered services for both In and Out of Network

Vision care

Covered services include:

- Outpatient physician services for eye care. \$15 copayment
office visit copayment applies
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. \$0 copayment
- One routine eye exam covered each year \$15 copayment
- Hardware Discount available through
Binyons

Preventive Care and Screening Tests

Abdominal Aortic Aneurysm Screening

\$0 copayment

A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.

Bone-mass measurements

\$15 copayment

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.

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Benefits chart – your covered services	What you must pay when you get these covered services for both In and Out of Network
<p>Colorectal screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy 	<p>\$0</p> <p>Office visit or outpatient surgery copayment applies to each procedure</p>
<p>Immunizations</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk <p>We also cover some vaccines under our outpatient prescription drug benefit.</p>	<p>\$0 copayment</p> <p>\$0 copayment</p> <p>10% coinsurance</p> <p>10% coinsurance</p>
<p>Mammography screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline exam between the ages of 35 and 39 • One screening every 12 months for women age 40 and older 	<p>\$10 copayment</p> <p>\$10 copayment</p>
<p>Pap tests, pelvic exams, and clinical breast exam</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months 	<p>\$0 copayment</p> <p>Office visit or outpatient surgery copayment applies to each procedure</p>

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Benefits chart – your covered services	What you must pay when you get these covered services for both In and Out of Network
<p>Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>\$0 copayment</p> <p>Office visit or outpatient surgery copayment applies to each procedure</p>
<p>Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Covered once every five years.</p>	<p>\$0 copayment</p> <p>Office visit or outpatient surgery copayment applies to each procedure</p>
<p>Physical exams One exam per year. Includes measurement of height, weight, body mass index and blood pressure; end-of-life planning; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.</p>	<p>\$0 copayment</p>
Other Services	
Dialysis (Kidney)	
Covered services include:	
<ul style="list-style-type: none"> • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2) 	10% coinsurance
<ul style="list-style-type: none"> • Inpatient dialysis treatments (if you are admitted to a hospital for special care) 	\$200 copayment
<ul style="list-style-type: none"> • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) 	\$15 copayment
<ul style="list-style-type: none"> • Home dialysis equipment and supplies 	10% coinsurance
<ul style="list-style-type: none"> • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) 	
<p>Medicare Part B Prescription Drugs These drugs are covered under Part B of the Original Medicare Plan. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the 	10% coinsurance

Benefits chart – your covered services

What you must pay when you get these covered services for both In and Out of Network

- patient and are injected while you are getting physician services
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan
 - Clotting factors you give yourself by injection if you have hemophilia
 - Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
 - Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
 - Antigens
 - Certain oral anti-cancer drugs and anti-nausea drugs
 - Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
 - Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Section 2 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed later in this section.

Additional Benefits

Health and wellness education programs	\$0 copayment
Asthma Care Program	
Depression Care Program	
Diabetes Care Program	
Cardiac Care Program	
General Disease Management Program	
ODS Advantage Health Coaches provide individual support to those members who have chronic conditions.	

Getting care using our Plan’s traveler benefit

Our plan offers traveler benefits to members who are out of our service area for up to 12 months. You may see any Medicare provider that will bill our plan for your care.

You may get care when you are outside the service area. You may need to pay higher cost sharing for routine care from non-network providers, but you won’t pay extra in a medical emergency or if your care is urgently needed. If you have questions about your medical costs when you travel, please call Member Services.

How Much You Pay for Part D Prescription Drugs

This section has a chart that tells you what you must pay for covered drugs. These are the benefits you get as a member of our Plan. (Covered Part B drugs were described earlier in this section, and later in this section under “General Exclusions” you can find information about drugs that are not covered.) For more detailed information about your benefits, please refer to our Summary of Benefits. If you do not have a current copy of the Summary of Benefits you can view it on our website or contact Member Services to request one.

How much do you pay for drugs covered by this Plan?

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in i.e., initial coverage period, the period after you reach your initial coverage limit, and catastrophic level, the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below. Refer to your plan formulary to see what drugs we cover and what tier they are on. (More information on the formulary is included later in this section.)

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see the “Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs.” If you do not already qualify for extra help, see “Do you qualify for extra help?” in Section 1 for more information.

Initial Coverage Period

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the coinsurance. Your coinsurance will vary depending on the drug and where the prescription is filled.

You will pay the following for your covered prescription drugs:

Drug Tier	Network Retail Cost-Sharing (30 day supply)	Network Retail Cost-Sharing (90 day supply)	Network Mail-Order Cost-Sharing (30 day supply)	Network Mail-Order Cost-Sharing (90 day supply)
Tier 1 Generic	40% to \$150*	40% to 150*	40% to 150*	40% to 150*
Tier 2 Brand	40% to \$150*	40% to \$450*	40% to \$150*	40% to \$450*

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*The prescription drug coinsurance for drugs is 40% of the discounted prescription charge, up to a maximum coinsurance of \$150 for each prescription filled up to a 30-day supply (even if the prescription is written for less than a 30-day supply). A 90-day supply of generic drugs may be obtained for a maximum coinsurance of \$150.00.

*Note: Our plan uses reference based pricing for certain drugs on our formulary. If you request a brand name drug when a generic drug is available, and your physician has not specifically prohibited use of a generic medication, you are required to pay the coinsurance plus the difference in cost between the brand name drug and its generic equivalent. Your additional expense to cover the difference in cost between the brand and the generic medication will not apply toward your \$150 (30-day supply) or \$450 (90-day supply) out of pocket maximum for each prescription you have filled. Unless you or your physician requires the use of a brand name drug, your prescription will be filled with a generic when available and permissible by state law. Please see the PERS ODS Advantage Comprehensive Formulary for a list of those formulary drugs impacted by reference based pricing. You can call Customer Service for more information on reference based pricing and the impact it may have on drugs you are taking.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs. To find out which drugs our plan covers, refer to your formulary.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$4,350 out-of-pocket for the year. When the total amount you have paid toward coinsurance or copayments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches \$4,350, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: \$0 coinsurance and PERS ODS Advantage Rx pays in full for covered drugs.

As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your, initial coverage limit, or total out-of-pocket costs (that is, the amount you pay does not help you move through the benefit or qualify for catastrophic coverage).

Vaccine Coverage (including administration)

Our Plan's prescription drug benefit covers a number of vaccines, including vaccine administration. The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may

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have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, following our out-of-network paper claims policy (see Section 2), and then you will be reimbursed up to our normal coinsurance or copayment for that vaccine. In some cases you will be responsible for the difference between what we pay and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

The most cost effective way for you to receive covered vaccines is at an in-network pharmacy. You can call Customer Service for help finding an in-network pharmacy that can administer vaccines.

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay your normal coinsurance or copayment for the vaccine.
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the Doctor charges and what we normally pay. *
The Pharmacy	Your Doctor	You pay your normal coinsurance or copayment for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less any applicable in-network charge for administering the vaccine less any difference between what the Doctor charges for administering the vaccine and what we normally pay.*

*If you receive extra help, we will reimburse you for this difference.

We can help you understand the costs associated with vaccines (including administration) available under our Plan before you go to your doctor. For more information, please contact Member Services.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage as long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- Your coinsurance up to the initial coverage limit
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan

When you have spent a total of \$4,350 for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories
- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

- Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:
 - Family members or other individuals;
 - Medicare programs that provide extra help with prescription drug coverage; and
 - Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.
- Payments made by the following don't count toward your out-of-pocket costs:
 - Group Health Plans;

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- Insurance plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must let us know.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan’s benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, for every month in which you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Sample plan membership card

Here is an example of what your plan membership card looks like. See Section 1 for more information on using your plan membership card.

 <p style="text-align: center;">PERS ODS ADVANTAGE PPORX</p> <p>Subscriber ID #</p> <p>[] ODS Advantage PPORX Medical Plan#</p> <p>Medicare Limiting Charges Apply Medical: ODS Advantage Network CMS-H3813 801</p>	<p style="text-align: center;">PERS ODS ADVANTAGE PPORX</p>  <p>MedImpact BIN #: 003585 MedImpact PCN #: 38600 ODS Group #: Issuer: 80840</p> <p style="text-align: right;">MedicareRx <small>Prescription Drug Coverage</small></p> <p>ID: Name: CMS-S5975 801</p>
 <p style="text-align: center;">Provider Billing Instruction Card</p> <p style="text-align: center;">PERS ODS Advantage PPORX A PPO with a Medicare contract</p> <p style="text-align: center;">This plan covers in and out of network Medicare providers. No referral, no prior authorization and no PCP required.</p> <p style="text-align: center;">All Medicare providers are eligible to submit claims to ODS Health Plan, Inc. for processing.</p> <p style="text-align: center;">“Medicare Assignment and Limiting Charge rules apply”</p>	<p>Physician, Hospital, DME, etc. Claims Address: ODS Advantage Claims P.O. Box 4030 Portland, OR 97208-4030</p> <p>For eligibility and benefits providers call: 877-337-0650</p> <p style="text-align: center;">“Medicare Assignment and Limiting Charge rules apply” Web site: www.odscompanies.com</p>

General Exclusions

Introduction

The purpose of this part of Section 10 is to tell you about medical care and services, items, and drugs that aren't covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items, and drugs that aren't covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services).

If you get services, items or drugs that are not covered, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items, or drugs that we should have paid or covered (appeals are discussed in Section 5).

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this EOC, **the following items and services aren't covered under the Original Medicare Plan or by our plan:**

1. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determinations that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
9. Homemaker services.

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10. Charges imposed by immediate relatives or members of your household.
11. Meals delivered to your home.
12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines.
16. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Hearing aids and routine hearing examinations.
20. Eyeglasses (except after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
23. Acupuncture.
24. Naturopath services.
25. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
26. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Excluded Drugs

This part of Section 10 talks about drugs that are “excluded,” meaning they aren’t normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We won’t pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 5).

- A Medicare Prescription Drug Plan can’t cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can’t cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug’s label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction

If you receive extra help, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

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This document may be available in alternative formats.

PERS ODS Advantage PPO_{Rx} is a PPO and prescription drug plan with a Medicare contract.

www.odskompanies.com/odsadvantage



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