

# PERS Health Insurance Program

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*Member Handbook and Benefit Guide*  
*January 1, 2006 – December 31, 2006*





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# Introduction

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We are a well respected organization that serves our members by enabling informed retirement and health decisions and delivering retirement and health benefits, effectively and efficiently.

## **PERS Health Insurance Program**

The PERS Health Insurance Program offers health insurance coverage for all retirees, their spouses and eligible dependents. If you are not yet Medicare eligible, the PERS health plans may not be your best option for health insurance coverage. Make sure you inquire about your employer's health plan options for non-Medicare eligible retirees, which often have better benefits and premiums.

**The PERS Health Insurance Program requires all Medicare-eligible members and eligible dependents to be enrolled in both Part A and Part B of Medicare. Enrollment in a PERS-sponsored medical plan includes enrollment in the Medicare Part D Pharmacy Plan. Be sure to contact Social Security three months prior to turning 65 to ensure proper enrollment in Medicare if you are NOT drawing Social Security or disability benefits at that time.**

**For Medicare Part A and B enrollment, contact the Social Security Administration at 1-800-772-1213 or online at [www.ssa.gov](http://www.ssa.gov).**

**To replace a lost Medicare card or get other general Medicare information, contact Medicare at 1-800-444-4606 or online at [www.medicare.gov](http://www.medicare.gov).**

**Please refer to the back of this handbook for other important phone numbers and website addresses.**

## **PERS Long Term Care Insurance**

Long term care is the type of care received either at home or in a facility when someone needs assistance with activities of daily living. Health insurance does not pay for the cost of long term care.

The PERS long term care insurance carrier is UNUM Life Insurance Company of America. All eligible PERS retirees, spouses and dependents may apply for long term care insurance by calling 1-800-227-4165 or by visiting UNUM at [w3.unumprovident.com/enroll/pers](http://w3.unumprovident.com/enroll/pers) for information on UNUM enrollment and eligibility.

# Your Health Plan Options

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The following is a description of the types of health plans available through the PERS Health Insurance Program. Additional health plan-specific information regarding these plans can be found in the Benefit Summaries and Premium Rates section in the back of this handbook.

## **Medicare Supplement — ODS**

Generally, this plan allows you to choose any physician covered by Medicare. You can also live anywhere in the United States, or travel outside the United States and still maintain coverage. Under this plan, you pay an annual deductible and then a percentage of the Medicare allowed benefits. The supplement will only reimburse for Medicare-allowed services.

## **Managed Care Plans**

Managed care plans contract with hospitals and physicians to provide care for their enrollees. With managed care plans, you usually pay a modest fixed charge, called a co-pay, at the time you receive care instead of a percentage of your medical bills. Generally, there are no claim forms to file from managed care doctors, hospitals or other healthcare providers who contract with these health plans. When you join a managed care plan, you must use the providers (hospital and physicians) who are part of that plan to be eligible for benefits, and you must live in a certain geographic area (known as a service area). You must also select a primary care physician and be referred by the primary care physician for most specialist care. The PERS Health Insurance Program offers managed care plans to both Medicare and non-Medicare retirees:

- **Medicare Advantage Managed Care Plans — Clear Choice Health Plan, Kaiser Permanente, Providence Health Plan**

When you enroll in a Medicare managed care plan, that health plan becomes the administrator of your Medicare Part A and Part B medical benefits. Your Medicare benefits are locked into the managed care plan you have chosen. If you do not use the managed care plan's physicians and hospitals, except for emergency and urgent care, neither the managed care plan nor Medicare will cover your services.

- **Non-Medicare Managed Care Plans — Clear Choice Health Plans and Kaiser Permanente.**

The non-Medicare plans also require that you use the managed care plans' physicians and hospitals except for emergency and/or urgent care.

## **Preferred Provider Organization Plans (PPO)**

PPO plans allow you to choose any physician you want. The PPO benefits are designed to save you money if you use providers who have signed "preferred" contracts. PPO plans do have specific service areas where preferred providers are available, although they usually cover wider geographic regions than managed care plans. The PERS Health Insurance Program now offers PPO plans to both Medicare and non-Medicare retirees:

- **Medicare Advantage PPO Plan — ODS**

When you enroll in a Medicare Advantage PPO plan, that health plan becomes the administrator of your Medicare Part A and Part B medical benefits. Your Medicare benefits are locked into the PPO plan you have chosen. To receive the higher benefit, you must use an ODS Advantage Medicare PPO provider.

- **Non-Medicare PPO Plan — ODS and Providence Health Plans**

The non-Medicare PPO plans also are designed to save you money when you use providers who have signed a preferred contract.

## Exclusions and Limitations

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All of the plans available have some limitations and exclusions. Please call the specific health plan for more information. The plan benefit brochure you receive after enrollment from your health plan will include complete information on the exclusions and limitations for the plan. Information will also be available on your health plan's website.

### **ESRD — End-Stage Renal Disease Enrollment Options**

End-stage renal disease means that stage of kidney impairment that appears irreversible and permanent, and requires a regular course of dialysis or a kidney transplant to maintain life. If you currently have ESRD, your ability to enroll in a Medicare Advantage Plan through the PERS Health Insurance Program may be limited. However, ODS will be available to you. Please contact the PERS Health Insurance Program for more information.



## Power of Attorney

The PERS Health Insurance Program requires a Power of Attorney or Authorization to Disclose Information be on file with the program office for anyone acting on a member's behalf. The PERS Health Insurance Program is unable to release information to anyone other than the spouse, son or daughter of a member.

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## Change of Address

The PERS Health Insurance Program accepts address changes from the member by written notification and by phone. **Failure to notify PERS may result in involuntary termination if you are enrolled in a managed care plan.** If you are moving out of your managed care service area, you will be able to select a new health plan from all the plans available in your new service area. Please include your Social Security number and signature on your written notice, and mail or fax it to the PERS Health Insurance Program.

You are also required to submit your change of address in writing to the PERS Pension Office at P.O. Box 23700, Tigard, OR 97281-3700.

Note: Mail is not forwarded even if there is a forward authorization on file with the U.S. Postal Service.

# Eligibility

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The information presented in this section is a summary of the Oregon PERS Administrative Rule OAR 459-035-0020 for enrolling in PERS-sponsored health plans. If you have any questions about your eligibility for enrollment, or RHIA and RHIPA contributions, or would like to obtain a copy of the complete eligibility rules, please call the PERS Health Insurance Program or visit [http://arcweb.sos.state.or.us/rules/OAR\\_default.html](http://arcweb.sos.state.or.us/rules/OAR_default.html).

## Eligible Persons

An "eligible person" includes an eligible retiree, an eligible spouse, an eligible dependent or an eligible surviving spouse or dependent. The PERS Health Insurance Program reviews eligibility upon receiving enrollment forms. The categories of "eligible persons" are as follows:

1. An eligible retiree means a PERS member who is receiving a service or disability retirement allowance or benefit under PERS or who received an optional lump sum payment.
2. An eligible spouse means the spouse of an eligible retiree.

3. An eligible Dependent Domestic Partner means a person who has a relationship with and resides with a PERS retiree, the PERS retiree is providing over one-half of the financial support for the person and qualifies as a dependent of the PERS retiree as determined under section 105(b) of the Internal Revenue Code, 26 USC 105(b), as amended by the Working Families Tax Relief Act of 2004, P.L. 108-311. For more detailed information regarding requirements for coverage, contact your tax consultant or legal advisor.
4. An eligible dependent means a dependent child who satisfies one of the requirements listed in sub-sections (a), (b), (c), (d) that follow:
  - a. The child is less than nineteen (19) years of age.
  - b. The child is less than twenty-four (24) years of age and is attending school full-time, such as an academic, trade or vocational school. You will be asked to submit documentation for proof of full-time status.
  - c. The child is nineteen (19) years of age or more and has either been continuously dependent upon the retiree since childhood due to disability or physical handicap, or has been covered under a healthcare insurance plan as the retiree's dependent for at least twenty-four (24) consecutive months immediately prior to enrollment in a PERS-sponsored health insurance plan. In either case, the following additional requirements must also be satisfied:
    - The child is not able to achieve self-support through his or her work due to developmental disability, mental retardation or physical handicap as verified by a physician and accepted by the carrier, and
    - The incapacity is continuous and began prior to the date the child would otherwise have ceased to be an eligible dependent.
  - d. The child is legally adopted or placed in the home pending adoption. Legal custody or guardianship does not apply.
5. An eligible surviving spouse or dependent means:
  - a. The surviving spouse or dependent of a deceased retired PERS member, or
  - b. The surviving spouse or dependent of a deceased PERS member who was not retired but who was eligible to retire at the time of death.
6. In no event shall an eligible person as defined in this rule be entitled to coverage as both a retiree and a spouse or dependent.

**Please note: Upon reaching age 65 or becoming Medicare eligible due to a disability, a retiree must be enrolled in Parts A and B of Medicare to be eligible for PERS-sponsored health coverage. Enrollment in a PERS-sponsored medical plan includes enrollment in Medicare Part D Pharmacy Plan. If you drop your Part B, you will no longer be eligible for the coverage through the PERS Health Insurance Program.**

# Enrollment Opportunities

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## Enrollment Periods

The following enrollment times are the only enrollment opportunities offered. Retirees and their spouses or dependents who do not choose to enroll in a PERS health plan during one of these enrollment periods will lose their opportunity to enroll into the PERS Health Insurance Program. Retirees and dependents must meet eligibility requirements. See pages 5 and 6.

- **New retiree.** New retirees may enroll up to 90 days after the effective date of their retirement. Coverage will be effective on your retirement date if you apply before your retirement date and on the first day of the month after your application is received if you apply after your retirement date.
- **Medicare Eligibility.** PERS retirees may enroll up to 90 days after the date of their initial Medicare eligibility if they are enrolled in both Medicare Parts A and B. Enrollment in a PERS-sponsored medical plan includes enrollment in the Medicare Part D Pharmacy Plan. Coverage will be effective on the date that your Medicare coverage becomes effective if you enroll before the date of your Medicare eligibility. Coverage will be effective on the first day of the month after your application is received if you apply after the date of your Medicare eligibility.
- **Medicare Disability.** PERS retirees and/or dependents who are disabled and receiving Social Security benefits will become eligible for Medicare approximately 24 months following the established date of disability. The 90-day Medicare eligibility enrollment opportunity also applies in these circumstances.
- **Continuous Group Coverage.** PERS retirees may enroll at any time if they have been covered under another group health plan for 24 consecutive months immediately preceding enrollment in a PERS health plan. The preceding coverage must have been with an employer-sponsored group health plan. Group coverage is defined in several ways:
  - Coverage you may have as an active or retired employee that is terminating;
  - Coverage continued through COBRA following termination of employment;
  - High Option Portability Plan, which includes a drug benefit that is comparable or better than the PERS Health Insurance drug plan.Coverage will be effective on the date that your other coverage ends. If you have any questions, call the PERS Health Insurance Program or visit the PERS Health Insurance Plan website.

## Dental Plan Enrollment

You are eligible to enroll in a PERS-sponsored dental plan only if you also have PERS medical coverage. In addition, if anyone in your family wants dental coverage, everyone in your family who is enrolled in a PERS medical plan must also be enrolled in a PERS dental plan.

Enrollment in a PERS dental plan is limited to when you first enroll in a PERS medical plan. You must apply for dental coverage at the time you enroll in a PERS medical plan or you will not be able to get PERS-sponsored dental coverage. The only exception to this is those members who have continuous dental coverage through a group retiree plan. There are no other dental coverage enrollment periods.

The Kaiser Permanente dental plan is only available if you are enrolling in the Kaiser Permanente medical plan. You may, however, enroll in the ODS dental plan and keep your Kaiser medical coverage.

If you are enrolling in Clear Choice, Providence Health Plan or ODS, the ODS dental plan is available. Limitations and exclusions apply to some services. Please refer to pages 40 and 41 for a description of these services.

## Dependent Enrollment

Dependents may be enrolled during any of the enrollment periods available to retirees, including the retiree's date of retirement, the dependent's eligibility for Medicare or after the dependent has had at least 24 consecutive months of coverage under another group health plan. New dependents may also be enrolled within 30 days of becoming a dependent.

Dependents must be enrolled in the same plan as the retiree. If the retiree has Medicare coverage and the dependent has non-Medicare coverage, their coverage must still be with the same health plans. A spouse or dependent may enroll in a PERS-sponsored health plan up to 90 days after their initial Medicare eligibility in both Medicare Parts A and B even though the retiree remains enrolled in his/her employer group plan. Enrollment in a PERS-sponsored medical plan includes enrollment in the Medicare Part D Pharmacy Plan. The dependent may also enroll in a PERS-sponsored health plan if enrolled in Medicare Parts A and B at the time of the PERS member's retirement.

**Divorced spouses of PERS retirees are not eligible for a PERS-sponsored health plan, even if receiving a PERS benefit check. If a spouse is enrolled at the time of divorce, COBRA continuation applies.**

The surviving spouse of a PERS member may continue enrollment as described on page 10. However, in the event of remarriage, coverage of the surviving spouse of the PERS retiree cannot be extended to the new spouse.

# To Enroll

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To enroll in any PERS sponsored health plan, you must:

1. Complete the Intent/Enrollment form. Be sure to include your personal information and any spouse or dependent information if applicable, your reason for applying for PERS Health Insurance coverage, the one medical and/or one dental plan you have chosen, and your signature and the date;
2. Make photocopies of the Medicare card of each Medicare-eligible individual applying;
3. Complete the Pay Option form, selecting only ONE option, and sign the form;
4. Mail all of the above to PERS Retiree Health Insurance Program. The office address can be found on the back cover.

Intent/Enrollment forms must be returned to the PERS Health Insurance Program within the enrollment periods described in the paragraph below:

- If you choose a managed care plan and are enrolled in Medicare Part A and Part B, an enrollment application will be sent to you for the specific managed care plan you have selected. Due to Medicare guidelines, managed care applications can only be signed within 90 days prior to the requested effective date.
- If you are currently enrolled in a PERS-sponsored non-Medicare plan, you will be required to fill out enrollment forms again 30 days prior to becoming Medicare eligible. Failure to submit required forms will result in cancellation of your health plan coverage.
- When enrolling in a PERS-sponsored plan, you will automatically be enrolled in the Medicare Part D Pharmacy Plan, if you are Medicare eligible.

## Plan Change

PERS offers an annual Plan Change from October 1 to November 15. Information will be mailed in September. During this time, you can change your medical plan to any that are available in your area. Plan changes made during this period take effect January 1. **This is not an opportunity to add dental coverage or dependents.** If you are enrolled and do not wish to change plans, no paperwork is required.



# After Enrollment

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## Making Monthly Payments

PERS Health Insurance Program members have three monthly payment options available:

1. Deduction from your PERS pension
2. Electronic fund transfer from your bank account
3. Monthly invoice

## Late Payments

Premium payments are due on or before the first of each month. There is no grace period. If payment is not received by the fifth of the month, the account is considered delinquent and health plan coverage will be canceled.

## Disenrollment

Written notice is required to terminate your health plan. Please include your name, Social Security number and signature on your written notice and mail or fax it to the PERS Health Insurance Program. The office address and fax number can be found on the back of this booklet. If you are on Medicare and enrolled with a managed care plan, Medicare guidelines require a written request for termination that is signed and dated within the month prior to the termination of coverage. Both the member and spouse must sign the written request for termination notice.

## Surviving Spouse

- **Retiree.** Upon the death of your spouse, your PERS Health Insurance coverage will continue as normal. You must mail a photocopy of the death certificate to terminate your spouse's coverage to the PERS Health Insurance Program. The office address and fax number can be found on the back cover.
- **Spouse or dependent of retiree.** Upon the death of the PERS member, your PERS Health Insurance coverage will continue automatically. You must mail a copy of the retiree's death certificate to the PERS Health Insurance Program for your account to be properly set up. If you wish to terminate your coverage, a written request will be required. The office address and fax number can be found on the back cover.

## Appeals

Appeals related to eligibility or enrollment opportunities should be directed in writing to the PERS Health Insurance Program at the mailing address on the back cover. Appeals related to claim and benefit payments or Medicare enrollment/disenrollment issues should be directed to the health insurance carriers.

# Premium Subsidies

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## **RHIA (Medicare) Subsidy**

Oregon Revised Statute (ORS) 238.420 established a trust fund called the Retirement Health Insurance Account (RHIA). RHIA pays a monthly contribution toward the cost of healthcare coverage for some PERS retirees. This contribution is applied automatically, if eligible, by verifying your pension service records, and is reflected in the monthly premium you pay.

Following are the requirements for a retired member enrolled in a PERS-sponsored plan to be eligible for contributions from the RHIA toward the costs of premiums for that plan. An “eligible retired member” includes:

1. A retiree who is enrolled in Parts A and B of Medicare and who:
  - a. Is retired, is receiving a PERS service or disability retirement allowance, and had eight or more years of qualifying service at the time of retirement, or
  - b. Is receiving a PERS disability retirement allowance computed as if he or she had eight or more years of creditable service.
2. A surviving spouse or dependent of a deceased “eligible retired member” as described in section 1 of this rule, who is enrolled in Parts A and B of Medicare, and who:
  - a. Is receiving a retirement allowance or benefit from PERS, or
  - b. Was covered under the “eligible retiree member’s” PERS-sponsored health insurance plan and the deceased retired member retired before May 1, 1991.



## RHIPA (State of Oregon Non-Medicare) Subsidy

ORS 238.415 established a trust fund called the Retiree Health Insurance Premium Account (RHIPA). RHIPA pays a monthly contribution toward the cost for healthcare coverage for some state of Oregon retirees who are not eligible for Medicare. This contribution applies **only** to PERS retirees who retired directly from a state agency such as ODOT, Department of Fish and Wildlife or any other agency of state government. The contribution will be applied automatically, if eligible, by verifying your pension service records, and is reflected in the monthly premium you pay.

Following are the requirements for a retired state employee enrolled in a PERS-sponsored health insurance plan. An “eligible retired state employee” includes:

1. A retiree who was a state employee at the time of retirement and who is not eligible for Medicare, and who:
  - a. Is receiving a PERS service or disability retirement allowance or benefit, and had eight or more years of qualifying service at the time of retirement, or
  - b. Is receiving a PERS disability retirement allowance computed as if the member had eight or more years of creditable service, and has attained the earliest service retirement age. Earliest Retirement Age means:
    - 1) Age 55 for members other than police officer and firefighter members.
    - 2) Age 50 for police officer and firefighter members.
    - 3) All members with 30 years of service regardless of age.
  
2. A surviving spouse or dependent of a deceased “eligible retired state employee,” as described in section 1 of this rule, who is not eligible for Medicare, and who:
  - a. Is receiving a retirement allowance or benefit from PERS, or
  - b. Was covered under a PERS-sponsored health insurance plan at the time of the retiree’s death and the eligible retired state employee retired on or after September 29, 1991.



### *RHIPA Subsidy Rates*

**PERS members eligible for the RHIPA subsidy may call the PERS Health Insurance Program office at 1-800-768-7377 or access the website at [www.pershealth.com](http://www.pershealth.com) for health plan premium rates applicable to RHIPA-eligible members.**

# Continuation of Coverage

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The Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law in 1986. Under the COBRA provision, PERS is required to offer qualified beneficiaries continuation of coverage on a self-pay basis. Qualified beneficiaries include retirees, their spouses and dependents who lose coverage under the group healthcare plan upon the occurrence of a “qualifying event.”

“Qualifying events” include the date coverage is lost due to:

- Termination of PERS retirement status
- The divorce or legal separation of a retiree’s covered spouse
- A dependent child losing eligibility for coverage under the PERS program because of the eligibility requirements (e.g., a child reaching the maximum age limit or marrying)

COBRA eligibility is limited as follows:

- Retirees are entitled to continue coverage for a period of 18 months following the occurrence of the qualifying event.
- If a qualified beneficiary is determined to be disabled by the Social Security Administration within the initial 60 days of coverage, he/she may be eligible for an additional 11 months of coverage, or up to 29 months from the qualifying event. The qualified beneficiary is responsible for providing written notification to the COBRA administrator within 18 months of the original qualifying event.
- Dependents who experience a qualifying event are entitled to continued coverage for up to 36 months.
- Additionally, Oregon law (ORS 743.600) provides that legally separated or divorced spouses age 55 or older and their eligible dependents may continue their coverage for up to 10 years. Coverage under this law will be subject to all other regulations governing COBRA administration, but is not considered a second qualifying event.

Continuation rights will end prior to the COBRA provisions described here, if a covered individual:

- Fails to make a timely premium payment. See next page for explanation;
- Becomes covered under another group health plan (including Medicare) that does not contain limitations or exclusions with respect to their specific pre-existing condition(s); or
- Is no longer considered disabled by the Social Security Administration.

Continuation rights will also end if PERS ceases to maintain any group health plan.

In general, continuation rights will be the same as that provided to similarly situated persons who have not experienced a qualifying event. In practice, this means continuants under the PERS plan have the following rights afforded active group members:

- They may add newborns, new spouses and adopted children as covered dependents in accordance with the administrative rules.
- Continuants covered by a managed care plan are required to change plans when they move out of the managed care plan's service area.

However, there are some exceptions to the general guidelines of treating beneficiaries the same as active employees:

- Continuants may be charged a premium equal to 102 percent of the cost of coverage incurred by the group health plan. In the case of a beneficiary qualifying for the additional 11-month continuation period due to disability, premiums will be set at 150 percent of the active group rate from months 19 through 29.
- Each beneficiary is entitled to a separate election for whether or not to continue dental coverage, but they must continue health coverage in order to continue dental benefits. Beneficiaries who elect continuation must continue the health plan (and dental plan, if elected) in which they were enrolled prior to the qualifying event.

When your continuation coverage ends, you may be eligible for a medical portability plan without a medical examination. Please call your health plan for more information and an application form.

**If you have any continuation of coverage questions, call the PERS Health Insurance Program or visit the PERS Health Insurance Program website.**

### *Timely Premium Payments*

*The initial premium payment must be paid within 45 days of the date continued coverage is elected. Thereafter, premiums are due the first of each month, for that month's coverage. If payment is not postmarked or received on or before the 45th day (for the initial premium) and/or the 30th day following the monthly due date, coverage will be terminated and cannot be reinstated.*

# PERS Health Insurance Plans

*Benefit Changes, Health Plan Service Areas*



This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

# Changes to Plans

## Effective January 1, 2006

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### 1. Prescription Drug Plan (this change affects all members enrolled in the PERS health insurance plans)

#### Medicare and Non-Medicare

- Members prescription drug co-insurance portion will now be 40 percent to a maximum of \$150 per prescription
- A \$3,600 out-of-pocket maximum per person, per calendar year has been added

### 2. Clear Choice Health Plans

#### Medicare

- Referral from primary care physician to see a contracted specialist is no longer required
- Durable medical equipment will be covered in full

#### Non-Medicare

- Orthotics, post-cataract eye-wear, TMJ disorder and Tobacco Addiction services will be covered in full. Benefit maximums still apply

### 3. Kaiser Permanente Health Plan

#### Medicare and Non-Medicare

- Coverage provided under the student out-of-area benefit will be limited to services received within the United States

#### Medicare

- There are no contract changes to the Kaiser Medicare plan

#### Non-Medicare

- Post-mastectomy breast prosthesis is now covered at 80 percent;
- Outpatient X-ray, lab and special diagnostic procedures are now covered at a \$10 co-pay per visit.
- Inpatient X-ray, lab and special diagnostic procedures will be provided under the \$200 inpatient hospital co-pay per admission benefit

#### Dental

- Replacement of temporary removable appliances within five years of the date appliance is received is now excluded

# Changes to Plans Effective January 1, 2006

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## 4. ODS

### Medicare

- Medicare Advantage PPO is a new statewide option. The plan works similar to the non-Medicare PPO plan. Co-pays vary whether an In-Plan or Out-of-Plan provider is used.

### Non-Medicare

- Family deductible and out-of-pocket maximum (3x Individual) no longer applies.

### Dental

- There are no changes to the ODS Dental plan.

## 5. Providence Health Plans

### Medicare

- Providence Health Plans' Medicare service area has expanded into Clark County, Washington.

### Non-Medicare

- The out-of-plan emergency room visit benefit will mirror the In-Plan emergency room benefit of \$100 co-pay, then 20 percent; waived if admitted.

# Health Plans Offered

## Clear Choice Health Plans (CCHP)

Clear Choice Health Plans is a provider-sponsored organization that is owned and operated by local doctors and hospitals. It offers cost-effective, extended coverage to PERS retirees.



**If you have questions about Clear Choice Health Plans, call:**

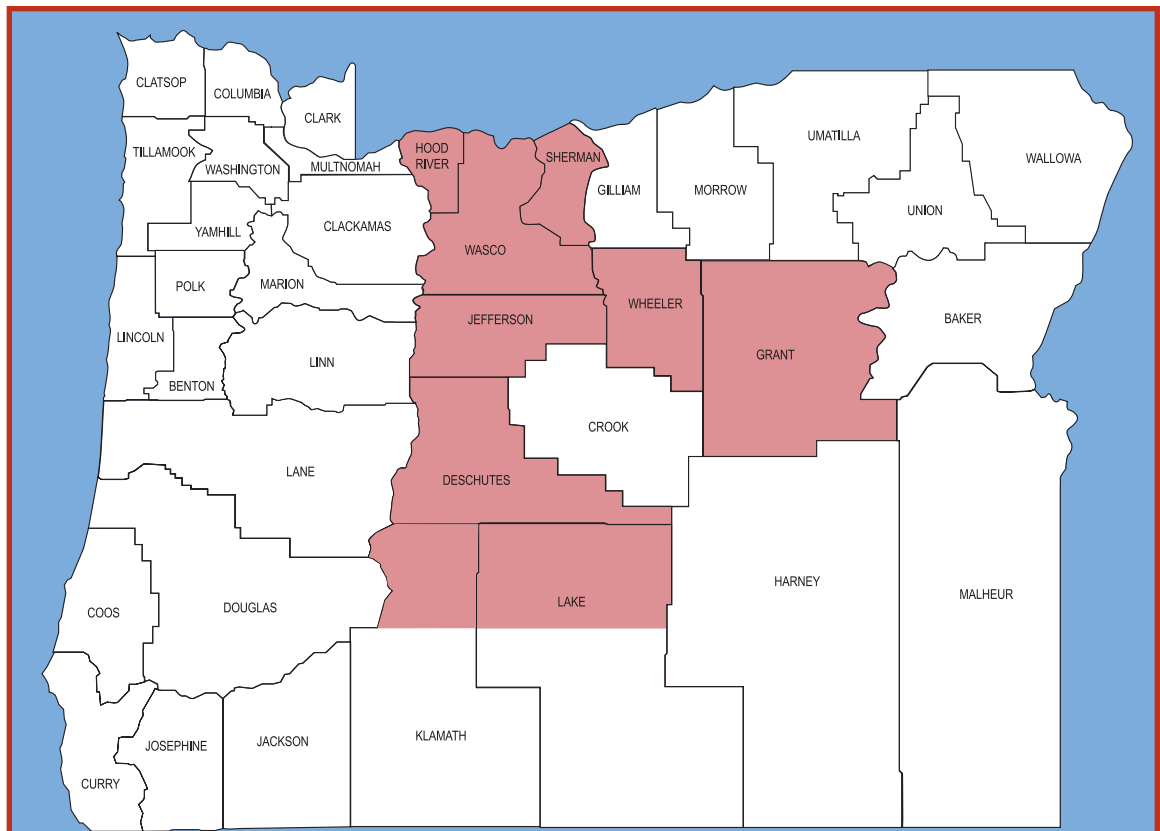
In Oregon: 541-385-5315

Toll-free: 1-888-863-3637

Teletypewriter (TTY): 1-800-735-2900

On the web: [www.clearchoicehp.com](http://www.clearchoicehp.com)

**Clear Choice Health Plans Service Area**



**Service Areas**

To be eligible for Clear Choice Health Plans, your permanent street address (not a mailing address) must be located in one of the following Oregon counties (or in one of the listed Zip codes of Lake or Klamath counties). Counties and Zip codes include Deschutes, Grant, Hood River, Jefferson, Sherman, Wasco, Wheeler, Klamath (97731, 97733, 97737) and Lake (97638, 97641, 97735).

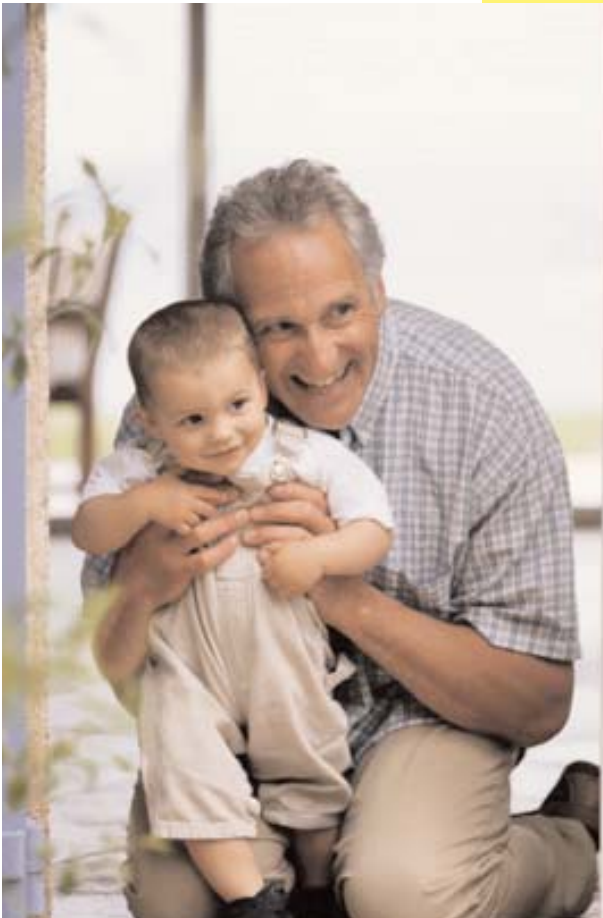
**Coverage Outside of the Service Areas**

Clear Choice Health Plans provides worldwide coverage for the following four services: emergency services, urgently needed services, ambulance services and out-of-area dialysis services. These do not require prior authorization.

Clear Choice Health Plans also provides routine maintenance care to treat or monitor an existing medical condition. Examples of covered services include blood pressure checks, diabetes monitoring or routine monitoring of blood thinner medications. Prior authorization is required.

Medicare requires that Medicare Advantage members who permanently move outside of the service area or who are out of the service area for six months or more, must disenroll from their Medicare Advantage plan.

For members who are enrolled in Clear Choice Health Plans and who reside inside Oregon part of the year and outside of Oregon part of the year, the PERS Health Insurance Program offers a “Snow Bird” option. The Snow Bird option allows members to change their health plan to ODS while living or traveling out of their managed care plan’s service area. Members must plan on living out of the service area for more than 60 days for this option to apply. See page 26 for more information on the PERS Snow Bird option.



## Kaiser Permanente

Kaiser Permanente wants you to have a doctor who is right for you and your family. Someone you feel comfortable with. Someone who listens and takes time to get to know you and your concerns so you get the healthcare that is right for you.



Therefore, we encourage you to choose a Primary Care Physician in family practice or internal medicine with whom you can build a long-term relationship to help you achieve and maintain good health and good spirits. Membership Services can help you choose your physician by calling them at the numbers listed below. They can also tell you about the providers who are currently taking new patients. Additional information about our providers is on our website.

### The SilverSneakers Fitness Program

The Kaiser Permanente Medicare Advantage plan includes free membership in the SilverSneakers Fitness Program, which is offered through modern, fully equipped fitness centers conveniently located and sensitive to the needs of seniors. You may participate in SilverSneakers classes or other senior-friendly classes offered at these fitness centers, or you may use the facility's equipment on your own. Call the Membership Services numbers below for a brochure listing the participating fitness centers. SilverSneakers is an excellent way to maintain or improve your fitness. It is also a great opportunity to have fun and make new friends.

**If you have questions about the Kaiser Permanente Health Plan, call Membership Services Monday through Friday 8:00 a.m. to 6:00 p.m.**

In Portland: 503-813-2000

Toll-free in other areas: 1-800-813-2000

Teletypewriter (TTY) toll-free: 1-800-735-2900

On the web: [www.kaiserpermanente.org](http://www.kaiserpermanente.org)

### Service Areas

In order to be eligible to enroll with Kaiser Permanente, your home address must fall within the Zip codes listed below. Kaiser Permanente areas are not indicated on a map.

#### OREGON

**Benton County:** 97330, 97331, 97333, 97339, 97370. **Clackamas County:** 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034, 97035, 97036, 97038, 97042, 97045, 97055, 97067, 97068, 97070, 97222, 97267, 97268 (97049 non-Medicare only). **Columbia County:** All Zip codes. **Hood River County:** 97014 non-Medicare only. **Linn County:** 97321, 97322, 97335, 97355, 97358, 97374, 97389, 97360. **Marion County:** 97002, 97020, 97026, 97032, 97071, 97137, 97301, 97302, 97303, 97305, 97306, 97307, 97308, 97309, 97310, 97311, 97312, 97313, 97314, 97325, 97352, 97362, 97375, 97381, 97383, 97384, 97385, 97392 (97342, 97346, 97373 non-Medicare only). **Multnomah County:** All Zip codes. **Polk County:** All zip codes.

**Washington County:** All Zip codes. **Yamhill County:** All Zip codes.

## WASHINGTON

**Clark County:** All Zip codes. **Cowlitz County:** All Zip codes. **Lewis County:** 98591, 98593, 98596. **Skamania County:** 98639, 98648 non-Medicare only. **Wahkiakum County:** 98612, 98647.

## CALIFORNIA and HAWAII

For PERS retirees who live in California or Hawaii and are interested in enrollment in a Kaiser Permanente Health Plan located in your area, please call the PERS Health Insurance Program office for more information. Premium rates will differ from those noted in this handbook.

## Coverage Outside of the Service Area

When you enroll in Kaiser Permanente’s Medicare Advantage plan, Kaiser becomes the administrator of your Medicare benefits. Your Medicare benefits are locked into the managed care plan you have chosen. **If you do not use Kaiser Permanente’s physicians and hospitals, neither Kaiser nor Medicare will cover your services, except for emergency, urgent care authorized referrals and travel benefits.**

When temporarily out of the service area for up to 90 days, members may also receive routine and follow-up care at Kaiser Permanente facilities in other areas of the country and at group health facilities in Washington and Idaho.

Non-Medicare members who permanently move to another Kaiser Permanente service area will have their health plan membership terminated. Members may be able to apply for membership in the new service area where they reside. Medicare requires that Kaiser Permanente Medicare Advantage members who permanently move outside of the service area or who are out of the service area for six months or more must disenroll from their Medicare Advantage plan.

For members who are enrolled in Kaiser Permanente and who reside inside the Kaiser Permanente Northwest service area part of the year and outside of Oregon part of the year, the PERS Health Insurance Program offers a “Snow Bird” option. The option allows members to change their health plan to ODS while living or traveling out of their managed care plan’s service area. Members must plan on living out of the service area for more than 60 days for this option to apply. See page 26 for more information on the PERS Snow Bird option.

The Kaiser Permanente Medicare Advantage plan offers a \$1,000 travel benefit per year for routine care and preventive services provided by physicians and hospitals not contracting with Kaiser Permanente for those members who are traveling outside the service area. Members are responsible for a 20 percent co-insurance on the \$1,000 travel benefit.

Kaiser Permanente members who are temporarily outside the service area are covered for emergency and urgent care outside the service area worldwide.

## ODS

ODS offers a full line of dental and medical insurance products to PERS members. Based in Portland, Oregon, ODS makes health insurance easy for its customers by offering exceptional, personalized customer service. You may live anywhere in the United States and maintain coverage.



### Medicare Supplement Plan

ODS offers a Medicare supplement plan to all eligible PERS retirees who are enrolled in Medicare Parts A and B. This is a traditional medical supplement insurance program that pays secondary to Medicare. Members can choose any available provider that accepts Medicare as a primary payer. Members may also live anywhere in the United States. Coverage outside of the United States is limited to six months per year.

### ODS Medicare Advantage PPO Plan

ODS offers a Medicare PPO plan to all eligible PERS retirees who are enrolled in Medicare Parts A and B and reside in the state of Oregon. Members can choose any available provider that accepts Medicare; however, members may receive a better benefit if an ODS Advantage Network Provider is selected. If you would like to know whether or not your physician is included in the ODS Advantage Network, please contact ODS or visit their website.

### Non-Medicare PPO Plan

ODS offers a Preferred Provider Organization Plan (PPO) for non-Medicare retirees and/or dependents. There are four networks available to members: the ODS Network, First Choice Health Network, Idaho Physicians Network and Private Healthcare Systems (PHCS) Network. The state in which you reside will determine the PPO network. The PPO plan premium rate is the same for all networks. To determine your network, please refer to the following.

**ODS Network** - Members living in Oregon or one of the following counties in Washington state: Benton, Clark, Cowlitz, Klickitat, Pacific, Skamania, Wahkiakum or Walla Walla counties.

**First Choice Health Network** - If you reside in Washington state and do not live in Benton, Clark, Cowlitz, Klickitat, Pacific, Skamania, Wahkiakum and Walla Walla counties.

**Idaho Physicians Network** - Members who reside in the state of Idaho.

**PHCS Network** - Members who reside in a state other than Oregon, Washington or Idaho.

If you would like to know whether or not your physician is included in the PPO network, please call or visit the ODS website.

**If you have questions about ODS, call:**

In Portland: 503-243-3880

Toll-free (Oregon only): 1-800-962-1533

Toll-free (outside Oregon): 1-800-852-5195

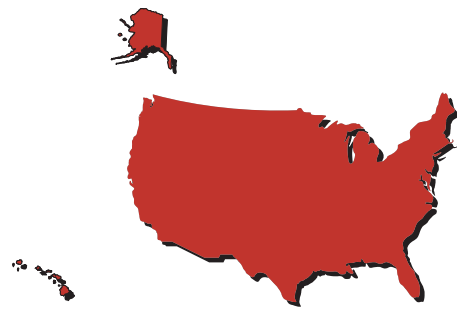
Teletypewriter (TTY): 1-800-433-6313

Dental: 1-800-452-1058

Pharmacy: 503-265-4709 or 1-888-786-7509

Monday through Friday 7:30 a.m. to 5:30 p.m. (PST)

On the web: [www.odscompanies.com](http://www.odscompanies.com)

**Coverage Outside the State of Oregon Service Area****Medicare Supplement Plan**

For persons eligible under the Medicare Supplement Plan, coverage is limited to a total of six months per year outside the United States **beginning** on the date expense is first incurred.

**ODS Medicare Advantage PPO Plan**

For members enrolled in the ODS Medicare Advantage PPO plan, coverage may continue up to 12 months when the member is temporarily traveling or visiting outside of Oregon. Coverage is limited to care in the United States only.

Emergency and urgent care are covered worldwide. The out-of-network co-pays apply for services received outside of Oregon, except for emergency and urgent services.

**Non-Medicare PPO Plan**

While temporarily outside the service area, benefits received by those covered by the non-Medicare PPO Plan will be paid at the out-of-plan benefit level. Treatment of emergency medical conditions are covered worldwide and will be reimbursed at the rate we reimburse PPO physicians and providers. However, benefits are subject to our contracted rates for PPO physicians and providers, and the maximum plan allowance for non-PPO physician and providers.

**eDocAmerica**

eDocAmerica provides personal and confidential access to board certified physicians from any computer with Internet access. The service is free. You can access eDocAmerica at [www.odscompanies.com/members/edoc/](http://www.odscompanies.com/members/edoc/). **eDocAmerica is not meant to replace your primary physician.**

**24-Hour Registered Nurse Advice Line**

Nurse Advice Line, offered by eDocAmerica, is a free telephone service that is available 24 hours a day, seven days a week. A nurse will discuss your medical concern and then advise you on a recommended course of action. To speak with a nurse, please call 1-866-321-7580.

# Providence Health Plan (PHP)

We've been caring for people in the Northwest for almost 150 years. We are part of Providence Health System, established by the Sisters of Providence, the pioneers who established the area's first hospital.



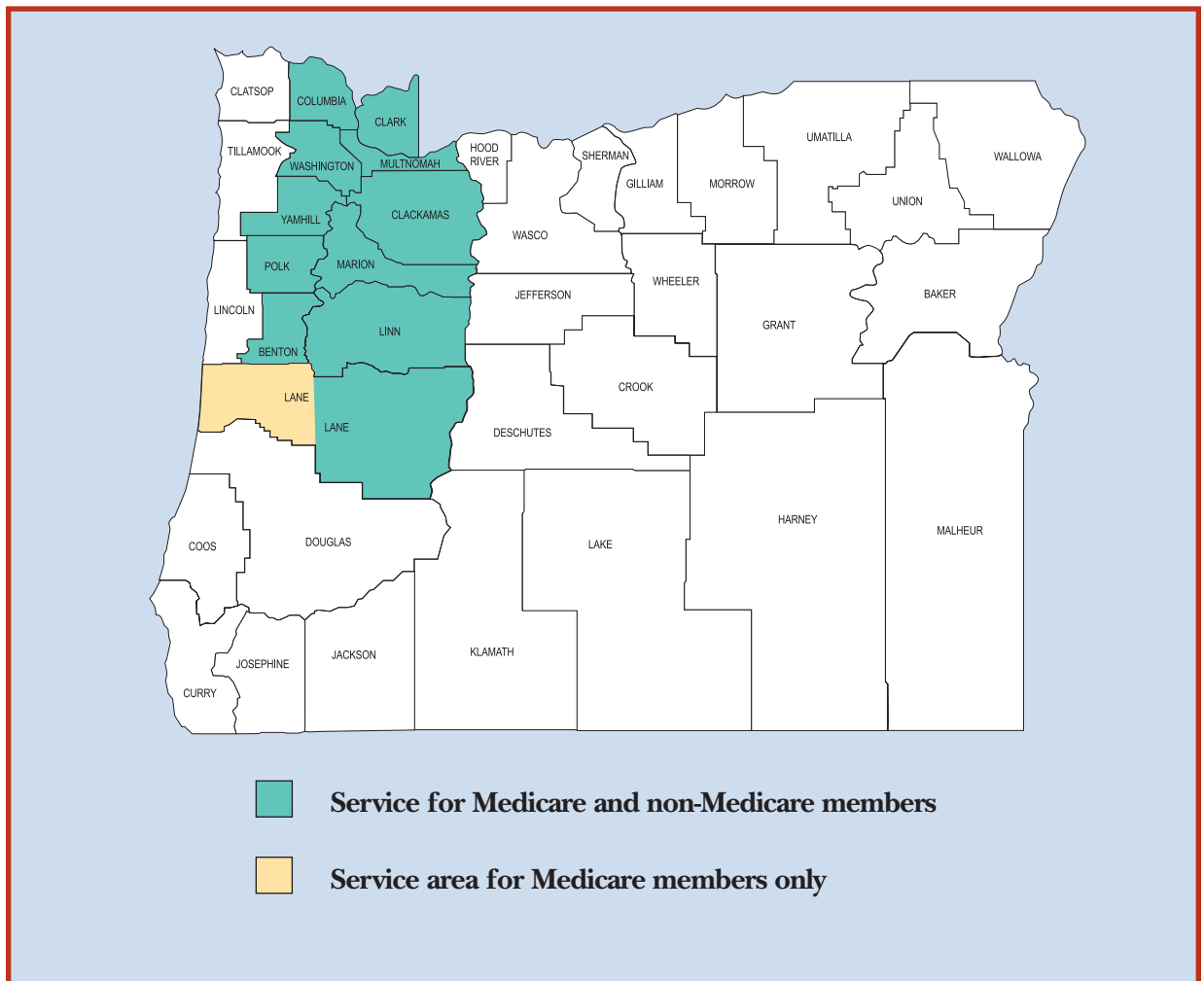
## Medicare Members

Providence offers retirees a managed care plan that focuses on prevention and quality. With managed care, members choose a primary care physician from the Providence Health Plan network and receive all care from their chosen physician, unless they are given a specialist referral.

## Non-Medicare Members

Providence offers in-plan and out-of-plan benefits with a common deductible. Non-Medicare retirees and/or dependents must reside in one of the service areas listed

### Providence Health Plan Service Area



below. Members who use the Providence Health Plan network providers generally pay less for medical care after their deductible has been met.

Call Providence Health Plan or visit the Providence Health Plan website to verify if your physician is included in the network. Please refer to page 38 for non-Medicare and Medicare members plan Summary of Benefits.

**If you have questions about Providence Health Plan, call:**

For Medicare members in Oregon: 503-574-8000

Toll-free: 1-800-603-2340

Non-Medicare members in Oregon: 503-574-7500

Toll-free: 1-800-878-4445

Teletypewriter (TTY): 503-574-8702

Teletypewriter (TTY) toll-free: 1-888-244-6642

On the web: [www.providence.org/healthplans](http://www.providence.org/healthplans)

**Service Areas**

**OREGON:** Benton, Clackamas, Columbia, Lane, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties. Coverage in Zip codes 97430, 97439, 97453, 97480 and 97493 are for Medicare members only.

**WASHINGTON:** Clark County. Coverage in Zip codes 98601, 98604, 98606, 98607, 98622, 98629, 98642, 98660, 98668, 98675 and 98682 through 98687.

**Medicare Members Coverage Outside of the Service Area**

Providence Health Plan members are covered for emergency and urgent care worldwide. When you enroll in the Providence Health Plan's Medicare Advantage plan, called Providence Medicare Extra, Providence becomes the administrator for your Medicare benefits. Your Medicare benefits are locked into the managed care plan you have chosen. **If you do not use a Providence Health Plan physician or hospital, except for the above listed benefits, neither Providence nor Medicare will cover your services.**

Medicare requires that Medicare Advantage members who permanently move outside of the service area or who are out of the service area for six months or more must disenroll from their Medicare Advantage plan.

For members who are enrolled in Providence Health Plan and who reside inside the Providence Service Area part of the year and outside part of the year, the PERS Health Insurance Program offers a Snow Bird option. The Snow Bird option allows members to change their health plan to ODS while living or traveling out of their managed care plan's service area. Members must plan on living out of the service area for more than 60 days for this option to apply. See page 26 for more information on the PERS Snow Bird option.

The Providence Medicare Extra plan offers a travel benefit of \$1,000 per calendar year for necessary follow-up care services with providers who do not contract with Providence for those members who are traveling outside the service area. Members are responsible for a 20 percent co-insurance on the \$1,000 travel benefit.

## PERS Snow Bird Option

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For members who are enrolled in Clear Choice Health Plans, Providence Health Plan or Kaiser Permanente Health Plan and who reside inside Oregon part of the year and outside of Oregon part of the year, the PERS Health Insurance Program offers a “Snow Bird” option. The Snow Bird option allows members to change their health plan to ODS Medicare Supplement while living or traveling out of their managed care plan’s service area. Members must plan on living out of the service area for more than 60 days for this option to apply.

Before leaving the service area for more than 60 days, members should contact a PERS Member Specialist, who will provide them with an Intent/Enrollment form to change to the ODS Medicare Supplement Plan for the time outside the managed care service area. Upon return to Oregon, members will be eligible to change back to their managed care plan. For members enrolled in the ODS Medicare Advantage PPO Plan, coverage may continue up to 12 months when the member is temporarily traveling or visiting outside of Oregon. Coverage is limited to care in the United States only. The out-of-network co-pays apply for services received outside of Oregon, except for emergency and urgent services.

**Please note: Members will need to fill out an Intent/Enrollment form to change their plan when leaving the area and when returning. Please contact the PERS Health Insurance Program to receive more information about this option.**



# PERS Health Insurance Plans

## *Benefit Summaries and Premium Rates*



This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

# Prescription Drug Benefit

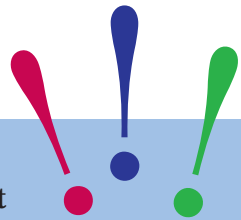
The PERS Health Insurance Program plans, including the prescription drug benefit, are among the most cost-effective benefit plans available to retirees. Each of the health plans available through the PERS Health Insurance Program includes a comprehensive prescription drug benefit plan.

## **PERS Prescription Drug Benefit for: Clear Choice Health Plans, ODS and Providence Health Plan**

This program is administered by ODS for all three health plans. For information or questions about this program, contact ODS at the numbers listed on the back cover. PERS has negotiated discounted prices for prescriptions through in-network pharmacies. These include all major chain pharmacies in Oregon and throughout the United States. Most independent pharmacies in Oregon are also in-network. ODS, Providence Health Plan and Clear Choice Health Plans members who purchase prescription drugs at an out-of-network pharmacy may have a greater out-of-pocket cost above the 40 percent benefit because negotiated discounts are not applied and the out-of-network pharmacy may bill for any excess charges.

### **Remember:**

**You must present your prescription card to the pharmacist when purchasing prescription drugs to receive the PERS discounted price.**



- **Out-of-Pocket Maximum**

This program has a calendar year out-of-pocket maximum. Once a member has paid \$3,600 for eligible prescription drugs, the plan will pay 100 percent for covered prescription drugs for the remainder of the calendar year.

- **Prescription Drugs Purchased at the Pharmacy**

The prescription drug co-insurance for brand name drugs is 40 percent of the discounted prescription charge, up to a maximum co-insurance of \$150 per prescription for a 30-day supply. A 90-day supply of generic drugs may be obtained for a maximum co-insurance of \$150.

- **Mail Order Prescription Drugs**

Prescription drug benefits and co-pays for these plans are the same as described above. This benefit is offered through Walgreens Mail Order Pharmacy and provides a convenient way to order medications and have them delivered directly to your home. Prescriptions may be ordered by mail, by visiting [www.whphi.com](http://www.whphi.com) or by calling Walgreens at 1-800-635-3070, Monday through Friday from 8 a.m. to 5 p.m. Pacific Time.

- **Prescriptions for ODS Members Residing in Long Term Care Facilities**

Patients residing in nursing home facilities or other long-term care facilities will pay 40 percent of the prescription charge at the time of dispensing or upon receiving a bill from the institutional pharmacy servicing the facility. The institutional pharmacy will bill ODS for the remainder of the prescription charge.

## **PERS Prescription Drug Benefit for: Kaiser Permanente**

Members enrolled with Kaiser Permanente through PERS are covered under the Kaiser prescription drug benefit. Kaiser members must use Kaiser facilities and pharmacies to obtain prescriptions. The Kaiser prescription drug benefit covers those drugs that have been approved through the Kaiser formulary process.

The Kaiser Permanente formulary is developed in an ongoing process whereby Kaiser Permanente physicians and pharmacists evaluate scientific literature to identify the drugs best suited to treat specific medical conditions. Drugs are added to or subtracted from the formulary whenever new drugs or new information warrants this change. Kaiser Permanente physicians remain responsible for deciding which drugs meet the individual needs of each patient. For information about the Kaiser Permanente drug formulary and covered drugs, please contact Kaiser Permanente Membership Service. The Kaiser phone number can be found on the back cover.

- **Out-of-Pocket Maximum**

This program has a calendar year out-of-pocket maximum. Once a member has paid \$3,600 for eligible prescription drugs, the plan will pay 100 percent for covered prescription drugs for the remainder of the calendar year.

- **Prescription Drugs Purchased at the Kaiser Permanente Pharmacy**

The prescription drug co-insurance is 40 percent of the charge of the prescription for covered drugs, up to a maximum co-insurance of \$150 per prescription for up to a 30-day supply. Up to a 90-day supply may be purchased at the pharmacy; however, the co-insurance of 40 percent and co-insurance limit of \$150 applies up to each 30-day supply of covered drugs.

- **Kaiser Permanente Mail Order**

Kaiser Permanente Mail Order can save a trip to the pharmacy. The service is free, easy to use and fast. Orders arrive within seven to 10 days. Members can order prescription refills by phone, by using the website at [www.kaiserpermanente.org](http://www.kaiserpermanente.org) or by mail. For covered maintenance drugs\*, up to a 90-day supply can be ordered. Co-insurance for up to a 90-day supply of covered maintenance drugs is 40 percent of the prescription charge with a maximum co-insurance limit of \$300 per prescription.

To order by telephone or check on a home-delivery, call the 24-hour service at 503-778-2678 in the Portland area or 1-800-548-9809 in other areas. To order prescriptions using the Internet, visit [www.kaiserpermanente.org](http://www.kaiserpermanente.org) and go to the “For Our Members” section. Prescriptions can also be refilled by mail.

- **Prescriptions for Kaiser Permanente Members Residing in Long-Term Care Facilities**

Patients residing in nursing homes or other long-term care facilities will pay 40 percent of the prescription charge for covered drugs up to a maximum co-insurance of \$150 per prescription for up to a 30-day supply. Specialty packaging costs are not covered.

\* A maintenance drug is one that is appropriate for chronic use as prescribed and for which evidence suggests that it is safe and effective when used for a chronic condition. For example, certain drugs for high blood pressure or diabetes are considered maintenance drugs.

# Clear Choice Health Plans

## Summary of Benefits

	<i>Medicare</i>	<i>Non-Medicare</i>	
		<b>In-Plan</b>	<b>Out-of-Plan</b>
SERVICE AREA	See service information on pages 18 and 19		
PROVIDERS	Plan physicians and hospitals		
LIFETIME MAXIMUM	Unlimited	\$2,000,000	
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM	None	\$2,000 per Individual does not include deductible	\$6,000 per Individual does not include deductible
CALENDAR YEAR DEDUCTIBLE	None	\$200 per Individual \$600 per Family	\$1,000 per Individual \$3,000 per Family
OFFICE VISIT	\$10 co-pay	*\$15 PCP/\$25 specialist (no deductible)	30% co-insurance after deductible
PREVENTIVE CARE	\$10 co-pay	\$15 PCP/\$25 specialist (no deductible)	30% co-insurance after deductible
LAB, X-RAY & DIAGNOSTIC PROCEDURES	Covered in full	20% co-insurance after deductible	30% co-insurance after deductible
HOSPITAL CARE	Covered in full	20% co-insurance after deductible	30% co-insurance after deductible
EMERGENCY <ul style="list-style-type: none"> <li>• Urgent Care</li> <li>• Ambulance</li> <li>• Emergency Room</li> </ul>	<ul style="list-style-type: none"> <li>• \$10 co-pay</li> <li>• \$50 co-pay, waived if admitted</li> <li>• \$50 co-pay, waived if admitted</li> </ul>	<ul style="list-style-type: none"> <li>• \$25 co-pay (no deductible)</li> <li>• 20% co-insurance (no deductible)</li> <li>• \$100 co-pay, waived if admitted</li> </ul>	<ul style="list-style-type: none"> <li>• 30% co-insurance after deductible</li> <li>• 20% co-insurance (no deductible)</li> <li>• \$100 co-pay, waived if admitted</li> </ul>
SKILLED NURSING	Covered in full in a Medicare-certified facility for up to 100 days	20% co-insurance after deductible	30%co-insurance after deductible
ROUTINE EYE EXAM & EYE GLASSES	\$120 combined benefit every 24 months for eye exam and glasses	Not covered	Not covered
ALTERNATIVE CARE	\$10 co-pay Medicare-covered chiropractic services only	\$25 co-pay (no deductible)	
PRESCRIPTION DRUGS	See pages 28 and 29		

This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

\* Must select a Primary Care Physician (PCP)

## Revised Premium Rates

### RHIA Contribution Premium Rates

The monthly premiums shown below are after the \$60 Retirement Health Insurance Account (RHIA) contribution. More information on the RHIA contribution and eligibility can be found on page 11 of this handbook.

RETIREE WITH MEDICARE	\$89.17
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$231.76
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$727.78

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

### Non-Contribution Premium Rates

The monthly premiums shown below are without the contribution from RHIA or Retiree Health Insurance Premium Account (RHIPA). More information on RHIA and RHIPA contributions and eligibility can be found on pages 11 and 12 of this handbook.

RETIREE WITHOUT MEDICARE	\$594.57
RETIREE WITHOUT MEDICARE FAMILY* WITHOUT MEDICARE	\$1,233.18
RETIREE WITHOUT MEDICARE FAMILY* WITH MEDICARE	\$737.16
RETIREE WITH MEDICARE	\$149.17
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$291.76
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$787.78

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

# Kaiser Permanente

## Summary of Benefits

	<i>Medicare</i>	<i>Non-Medicare</i>
SERVICE AREA	See service information on pages 20 and 21	
PROVIDERS	Kaiser Permanente physicians and hospitals	
LIFETIME MAXIMUM	Unlimited	Unlimited
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM	\$1,000 per Individual \$2,000 per Family	\$1,000 per Individual \$2,000 per Family
CALENDAR YEAR DEDUCTIBLE	None	None
OFFICE VISIT	\$15 co-pay	\$15 co-pay
PREVENTIVE CARE	\$15 co-pay	\$15 co-pay
LAB, X-RAY & DIAGNOSTIC PROCEDURES	Covered in full	\$10 co-pay per visit
HOSPITAL CARE	\$200 co-pay per admission	\$200 co-pay per admission
EMERGENCY CARE <ul style="list-style-type: none"> <li>• Urgent Care</li> <li>• Ambulance</li> <li>• Emergency Care</li> </ul>	<ul style="list-style-type: none"> <li>• \$15 co-pay</li> <li>• \$50 co-pay</li> <li>• \$50 co-pay at plan and non-plan facilities. Co-pay waived if admitted</li> </ul>	<ul style="list-style-type: none"> <li>• \$15 co-pay</li> <li>• \$75 co-pay</li> <li>• \$75 co-pay plus any supplemental charges at Kaiser Permanente Plan and at non-plan facilities. Co-pay waived if admitted</li> </ul>
SKILLED NURSING	Covered in full in a Medicare-certified facility for up to 100 days per Medicare benefit period	Covered in full in a Medicare-certified facility for up to 100 days per calendar year
ROUTINE EYE EXAM & EYE GLASSES	\$15 co-pay for eye exam. \$100 allowance every 24 months toward the purchase of lenses, frames and/or contact lenses	\$15 co-pay for eye exams. (eye glasses/contact lenses not covered)
ALTERNATIVE CARE	Discounts available (in addition to Medicare covered chiropractic benefit). Contact Kaiser Customer Service	Discounts available. Contact Kaiser Customer Service
PRESCRIPTION DRUGS	See pages 28 and 29	

This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

*Premium Rates***RHIA Contribution Premium Rates**

The monthly premiums shown below are after the \$60 Retirement Health Insurance Account (RHIA) contribution. More information on the RHIA contribution and eligibility can be found on page 11 of this handbook.

RETIREE WITH MEDICARE	\$74.70
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$207.40
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$551.00

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

**Non-Contribution Premium Rates**

The monthly premiums shown below are without the contribution from RHIA or Retiree Health Insurance Premium Account (RHIPA). More information on RHIA and RHIPA contributions and eligibility can be found on pages 11 and 12 of this handbook.

RETIREE WITHOUT MEDICARE	\$478.30
RETIREE WITHOUT MEDICARE FAMILY* WITHOUT MEDICARE	\$954.60
RETIREE WITHOUT MEDICARE FAMILY* WITH MEDICARE	\$611.00
RETIREE WITH MEDICARE	\$134.70
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$267.40
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$611.00

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

# ODS Medicare Plans

## Summary of Benefits

	<i>Medicare Supplement</i>	<i>Medicare Advantage PPO</i>	
		<b>In-Plan</b>	<b>Out-of-Plan</b>
SERVICE AREA	See service information on pages 22 and 23		
PROVIDERS	Any licensed Medicare participating provider	Advantage Network Medicare providers	Any licensed Medicare participating provider
LIFETIME MAXIMUM	\$1,000,000 (annual automatic reinstatement of \$5,000)	None	
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM	None	\$1,000 per Individual	
CALENDAR YEAR DEDUCTIBLE	\$110 per Individual*	None	
OFFICE VISIT	20%*	\$15 co-pay	\$30 co-pay
PREVENTIVE CARE	Medicare covered services only	Routine physical covered in full	Routine physical \$30 co-pay
LAB, X-RAY & DIAGNOSTIC PROCEDURES	20%*	Lab: Covered in full X-ray: \$10 co-pay Diag.: 10% to \$100 co-pay	Lab: Covered in full X-ray: \$20 co-pay Diag.: 20% to \$200 co-pay
HOSPITAL CARE	Current Medicare Part A deductible covered in full	\$250 co-pay per admit	\$500 co-pay per admit
EMERGENCY <ul style="list-style-type: none"> <li>• Urgent Care</li> <li>• Ambulance</li> <li>• Emergency Room</li> </ul>	<ul style="list-style-type: none"> <li>• 20%*</li> <li>• 20%*</li> <li>• 20%*</li> </ul>	<ul style="list-style-type: none"> <li>• \$35 co-pay</li> <li>• \$50 co-pay one way</li> <li>• \$50 co-pay</li> </ul>	<ul style="list-style-type: none"> <li>• \$35 co-pay</li> <li>• \$50 co-pay one way</li> <li>• \$50 co-pay</li> </ul>
SKILLED NURSING	Medicare covers first 20 days. ODS covers from 21st to 100th	1-20 days: Covered in full 21-100 Days: \$40 co-pay per day	1-20 days: Covered in full 21-100 Days: \$80 co-pay per day
ROUTINE EYE EXAM & EYE GLASSES	Discounts available through Binyon's and EyeMed. Contact ODS Customer Service	Exam: \$15 co-pay Hardware: Not covered	Exam: \$30 co-pay Hardware: Not covered
ALTERNATIVE CARE	20% chiropractic services only	\$15 co-pay chiropractic services only	\$30 co-pay chiropractic services only
PRESCRIPTION DRUGS	See pages 28 and 29		

This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

\* Deductible and co-insurance applies to all Medicare Part B approved amounts.

# ODS Medicare Plans

## Revised Premium Rates

### RHIA Contribution Premium Rates

The monthly premiums shown below are after the \$60 Retirement Health Insurance Account (RHIA) contribution. More information on the RHIA contribution and eligibility can be found on page 11 of this handbook.

	ODS MEDICARE SUPPLEMENT NON-MEDICARE PPO	ODS MEDICARE ADVANTAGE PPO NON-MEDICARE PPO
RETIREE WITH MEDICARE	\$96.52	\$83.91
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$242.12	\$224.87
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$761.54	\$731.01

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

### Non-Contribution Premium Rates

The monthly premiums shown below are without the contribution from RHIA or Retiree Health Insurance Premium Account (RHIPA). More information on RHIA and RHIPA contributions and eligibility can be found on pages 11 and 12 of this handbook.

RETIREE WITHOUT MEDICARE	\$696.89	\$696.89
RETIREE WITHOUT MEDICARE FAMILY* WITHOUT MEDICARE	\$1,255.66	\$1,255.66
RETIREE WITHOUT MEDICARE FAMILY* WITH MEDICARE	\$833.67	\$737.33
RETIREE WITH MEDICARE	\$156.52	\$143.91
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$302.12	\$284.87
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$831.54	\$791.01

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

# ODS Non-Medicare PPO Plan

## Summary of Benefits

	<i>Non-Medicare</i>	
	<b>In-Plan</b>	<b>Out-of-Plan</b>
SERVICE AREA	See service information on pages 22 and 23	
PROVIDERS	Preferred physicians and providers	Non-preferred physicians and providers
LIFETIME MAXIMUM	\$2,000,000	
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM	\$2,000 per Individual Does not include deductible	\$6,000 per Individual Does not include deductible
CALENDAR YEAR DEDUCTIBLE	\$200 per Individual deductible	
OFFICE VISIT	\$20 co-pay (no deductible)	30% co-insurance after deductible
PREVENTIVE CARE	\$20 co-pay (no deductible)	30% co-insurance after deductible
LAB, X-RAY & DIAGNOSTIC PROCEDURES	20% co-insurance after deductible	30% co-insurance after deductible
HOSPITAL CARE	20% co-insurance after deductible	30% co-insurance after deductible
EMERGENCY <ul style="list-style-type: none"> <li>• Urgent Care</li> <li>• Ambulance</li> <li>• Emergency Room</li> </ul>	<ul style="list-style-type: none"> <li>• \$20 co-pay (no deductible)</li> <li>• 20% co-insurance after deductible</li> <li>• \$100 co-pay, then 20%; co-pay waived if admitted</li> </ul>	<ul style="list-style-type: none"> <li>• 30% co-insurance after deductible</li> <li>• 30% co-insurance after deductible</li> <li>• \$100 co-pay, then 30%; co-pay waived if admitted</li> </ul>
SKILLED NURSING	20% co-insurance after deductible	30% co-insurance after deductible
ALTERNATIVE CARE	Out-of-pocket costs vary by type of services received. Contact ODS Customer Service.	
PRESCRIPTION DRUGS	See pages 28 and 29	

This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

*Revised Premium Rates (include ODS Medicare Supplement Plan described on page 34)*

## RHIA Contribution Premium Rates

The monthly premiums shown below are after the \$60 Retirement Health Insurance Account (RHIA) contribution. More information on the RHIA contribution and eligibility can be found on page 11 of this handbook.

	ODS NON-MEDICARE PPO MEDICARE SUPPLEMENT	ODS NON-MEDICARE PPO MEDICARE ADVANTAGE PPO
RETIREE WITH MEDICARE	\$96.52	\$83.91
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$242.12	\$224.87
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$761.54	\$731.01

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

## Non-Contribution Premium Rates

The monthly premiums shown below are without the contribution from RHIA or Retiree Health Insurance Premium Account (RHIPA). More information on RHIA and RHIPA contributions and eligibility can be found on page 11 and 12 of this handbook.

RETIREE WITHOUT MEDICARE	\$696.89	\$696.89
RETIREE WITHOUT MEDICARE FAMILY* WITHOUT MEDICARE	\$1,255.66	\$1,255.66
RETIREE WITHOUT MEDICARE FAMILY* WITH MEDICARE	\$833.67	\$737.33
RETIREE WITH MEDICARE	\$156.52	\$143.91
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$302.12	\$284.87
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$821.54	\$791.01

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

# Providence Health Plan

## Summary of Benefits

	<i>Medicare</i>		<i>Non-Medicare</i>	
			<b>In-Plan</b>	<b>Out-of-Plan</b>
SERVICE AREA	See service information on pages 24 and 25			
PROVIDERS	Plan physician's and hospitals			
LIFETIME MAXIMUM	None		\$2,000,000	
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM	None		\$2,000 per Individual \$6,000 per Family does not include deductible	\$6,000 per Individual \$18,000 per Family does not include deductible
CALENDAR YEAR DEDUCTIBLE	None		\$200 per Individual / \$600 per Family	
OFFICE VISIT	\$15 co-pay		\$20 co-pay (no deductible)	30% co-insurance after deductible
PREVENTIVE CARE	\$15 co-pay		\$20 co-pay (no deductible)	Not covered
LAB, X-RAY & DIAGNOSTIC PROCEDURES	Covered in full		20% co-insurance after deductible	30% co-insurance after deductible
HOSPITAL CARE	\$250 per admission. \$500 maximum per calendar year		20% co-insurance after deductible	30% co-insurance after deductible
EMERGENCY <ul style="list-style-type: none"> <li>• Urgent Care</li> <li>• Ambulance</li> <li>• Emergency Room</li> </ul>	<ul style="list-style-type: none"> <li>• \$25 co-pay</li> <li>• \$50 co-pay</li> <li>• \$50 co-pay, waived if admitted</li> </ul>		<ul style="list-style-type: none"> <li>• 20% co-insurance (no deductible)</li> <li>• 20% co-insurance after deductible</li> <li>• \$100 co-pay, then 20%; waived if admitted</li> </ul>	<ul style="list-style-type: none"> <li>• 20% co-insurance (no deductible)</li> <li>• 30% co-insurance after deductible</li> <li>• \$100 co-pay, then 20%; waived if admitted</li> </ul>
SKILLED NURSING	Covered in full in a Medicare facility for up to 100 days		20% co-insurance after deductible	30% co-insurance after deductible
ROUTINE EYE EXAM & EYE GLASSES	\$15 co-pay for eye exam. Hardware discounts available through Tru-Vision		Not covered	Not covered
ALTERNATIVE CARE	Discounts available. Contact Providence Customer Service		\$15 co-pay — \$1,500 calendar year maximum Contact Providence Customer Service for a list of contracted providers.	
PRESCRIPTION DRUGS	See pages 28 and 29			

This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

*Premium Rates***RHIA Contribution Premium Rates**

The monthly premiums shown below are after the \$60 Retirement Health Insurance Account (RHIA) contribution. More information on the RHIA contribution and eligibility can be found on page 11 of this handbook.

RETIREE WITH MEDICARE	\$77.37
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$213.00
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$662.58

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

**Non-Contribution Premium Rates**

The monthly premiums shown below are without the contribution from RHIA or Retiree Health Insurance Premium Account (RHIPA). More information on RHIA and RHIPA contributions and eligibility can be found on pages 11 and 12 of this handbook.

RETIREE WITHOUT MEDICARE	\$554.49
RETIREE WITHOUT MEDICARE FAMILY* WITHOUT MEDICARE	\$1,139.70
RETIREE WITHOUT MEDICARE FAMILY* WITH MEDICARE	\$681.30
RETIREE WITH MEDICARE	\$137.37
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$273.00
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$722.58

Rates are effective January 1, 2006 through December 31, 2006.

\* Family includes spouse and/or dependents enrolled in the PERS plan.

# Kaiser Permanente Dental Plan

## Summary of Benefits

SERVICE AREA	See service area information on pages 20 and 21
DEDUCTIBLE (per calendar year)	None
COVERED PROVIDERS	Dentists associated with Kaiser Permanente Dental Associates
DIAGNOSTIC & PREVENTIVE SERVICES	100% after \$10 co-pay. Limit of two cleanings per year
MAINTENANCE CARE FOR TEETH & GUMS (Including root canal therapy, pulp capping, fillings and gum treatment)	Member pays 20% after \$10 co-pay
ORAL SURGERY (Including extractions and surgical removal of impacted teeth)	Member pays 20% after \$10 co-pay
PROSTHETIC DEVICE (Includes crowns, bridges and dentures)	Member pays 50% after \$10 co-pay
ORTHODONTIC SERVICES	Not covered
OUT-OF-AREA COVERAGE	\$100 for emergency services for relief of pain, acute infection, hemorrhage or injury
CALENDAR YEAR BENEFIT MAXIMUM	\$1,500 per person
EXCLUSIONS & LIMITATIONS	Certain services are limited or not covered at all. Some exclusions included congenital or developmental malformations, dental implants, cosmetic services and experimental procedures. Also, there may be limitations for procedures for which you might receive payment from other insurance or government programs.

### Premium Rates

*Retiree only*

**\$45.97**

*Retiree and family*

**\$85.55**

Rates are effective January 1, 2006 through December 31, 2006.

Family includes spouse and/or dependents enrolled in the PERS plan.

This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

## Summary of Benefits



SERVICE AREA	Worldwide
DEDUCTIBLE (per calendar year)	\$25 per person
COVERED PROVIDERS	All licensed dentists and certified denturists to the extent that he or she is operating under the scope of his or her license*
DIAGNOSTIC & PREVENTIVE SERVICES	Paid in full (no deductible). Available twice in a calendar year
MAINTENANCE CARE FOR TEETH & GUMS (Including root canal therapy, pulp capping, fillings and gum treatment)	Member pays 20% after deductible
ORAL SURGERY (Including extractions and surgical removal of impacted teeth)	Member pays 20% after deductible
PROSTHETIC DEVICE (Including crowns, bridges and dentures)	Member pays 50% after deductible
ORTHODONTIC SERVICES	Not covered
OUT-OF-AREA COVERAGE	Worldwide
CALENDAR YEAR BENEFIT MAXIMUM	\$1,500 per person
EXCLUSIONS & LIMITATIONS	Some services are limited or not covered at all, including congenital or developmental malformations, cosmetic services and experimental procedures. Also there may be limitations for procedures for which you might receive payment from other insurance or government programs. Oral surgery, restorative, periodontic, prosthodontic and endodontic services will not be covered for the first 12 months following enrollment unless you have had continuous dental coverage for the previous 24 months.

***Premium Rates***

*Retiree only*  
**\$46.22**

*Retiree and family*  
**\$92.27**

Rates are effective January 1, 2006 through December 31, 2006.

Family includes spouse and/or dependents enrolled in the PERS plan.

This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

\* A higher level of benefits are paid to providers who participate in the ODS Premier Dental Network. As the Delta Dental Plan of Oregon, members who live or travel outside Oregon have access to more than 114,000 dental professionals nationwide through the Delta Dental Network. Services provided by licensed dentist and certified denturists not participating with ODS or Delta Dental are paid at the out-of-network fee.

# Definitions

**AAPCC** — Area Adjusted Per Capita Cost - refers to Medicare funding and is regional based. This cost basis is used to determine the amount paid to MA plans for each member.

**Benefit Period** — The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or SNF. The benefit period ends when you haven't received any hospital (or skilled care) for 60 days in a row.

**Capitation** — Refers to a prepaid amount per person paid to a physician group or organization to cover healthcare services.

**Care Management** — Sometimes also called Case Management or Disease State Management. Generally refers to working with people who have either chronic or catastrophic conditions to ensure the best possible care and coordination of care.

**Coinsurance** — Other than the deductible, coinsurance, which is usually expressed as a percentage, is the portion of cost that the member will pay for health care services.

**Co-pay** — A fixed amount that the member pays at the time of service. Generally the co-pay is the only cost the member will have for a particular service.

**Deductible** — Generally applied on a calendar year basis. This is the amount of money each year that members pay out of their own pocket before the benefit plan begins to pay. Usually expressed as a per person amount.

**FFS** — Fee for Service is another form of reimbursement to physicians. Under this scenario, a physician is not paid until they submit a bill for a service rendered. Essentially, this is the opposite of capitation.

**Lifetime Maximum** — This is the maximum amount that a plan will pay out in a member's lifetime.

**Maximum Out-of-Pocket** — If a member uses all PPO or Participating providers (depending on the contract) this is the maximum amount of money one would be responsible for paying in any one calendar year.

**Medicare Advantage** — Previously known as Medicare + Choice or Medicare Part C.

**Medicare Assignment** — Doctors and suppliers that agree to accept Medicare's approved amount as full payment. Doctors or suppliers who agree to accept assignment from Medicare cannot try to collect more than the proper Medicare deductible and coinsurance amounts from anyone. Members still pay their share of the cost, in addition to what Medicare pays.

**Medicare Approved Amount** — In the original Medicare Supplement plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare, your supplement and/or you for a service or supply. It may be less than the actual amount charged by the doctor or supplier.

**Medicare Limiting Charge** — Doctors and providers that do not accept assignment may charge you more than the Medicare-approved amount. The limit on the amount over the Medicare-approved amount these providers can charge is 15 percent. The limiting charge applies only to certain services and doesn't apply to supplies and equipment. In addition, you may have to pay the entire charge at the time of service.

**Medicare Participating Provider** — A provider that accepts Medicare patients; provider may or may not accept Medicare Assignment.

**PBM** — Pharmacy Benefits Manager refers to the type of firms that manage pharmacy benefits for insurance companies and larger groups that are self-insured. PBMs make it possible for members to use prescription drug cards and to have their pharmacy benefit adjudicated at the point of sale at the pharmacy.

**PPO Plan** — Preferred Provider Organization is a type of benefit design that includes different levels of benefits depending upon whether or not services are received from a preferred provider.

**PPO Provider** — Preferred Provider Organization relates to a panel of doctors. Similar to participating providers,

PPO providers sign contracts and cannot charge members over the contracted fee. These providers agree to discount their charges.

**Participating Provider** — Providers are contracted to provide services for specific fees. The fees may or may not be discounted but the providers are bound to not charge the member for anything above the contracted fee even if they would generally charge someone with other coverage more. This is often referred to as Hold Harmless because the member is “held harmless” for charges over the contracted fee.

**Usual and Customary / Maximum Allowable Cost** — These are two very similar concepts. Both limit the amount a carrier will pay for a specific service. These are generally used in the absence of “participating” or “preferred” contracts. In the case of most carriers, a national data clearinghouse is used. The clearinghouse collects fee data by Zip code and procedure and then publishes the information. Fees are usually updated every six months.

## Acronyms

**Cap** — Capitation

**CD** — Chemical Dependency

**CMS** — Centers for Medicare and Medicaid Services

**COB** — Coordination of Benefits

**COC** — Certificate of Coverage

**COBRA** — Consolidated Omnibus Budget Reconciliation Act (federal act)

**DAW** — Dispense as Written

**DME** — Durable Medical Equipment

**DO** — Doctor of Osteopath

**DRGs** — Diagnostic Related Groups

**DUR** — Drug Utilization Review

**DX** — Diagnosis

**DXL** — Diagnostic X-ray and Lab

**E & I** — Experimental & Investigational

**EDI** — Electronic Data Interchange

**EFT** — Electronic Funds Transfer

**EOB** — Explanation of Benefits

**EOMB** — Explanation of Medicare Benefits

**ESRD** — End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

**FFS** — Fee for Service

**HCFA** — Health Care Financing Administration (Now CMS, a federal Agency)

**HIPAA** — Health Insurance Portability and Accountability Act (federal act and state law)

**HMO** — Health Maintenance Organization

**IBNR** — Incurred But Not Reported

**LCSW** — Licensed Clinical Social Worker

**LTC** — Long-Term Care

**MA** — Medicare Advantage

**MPA** — Maximum Plan Allowable

**MCO** — Managed Care Organization

**Medicare Part A** — Hospital Insurance hospital stays, Skilled Nursing Facility Care, Hospice

**Medicare Part B** — Medical Insurance doctor services, outpatient hospital care

**Medicare Part C** — Refers to Medicare + Choice health plans; now referred to as Medicare Advantage Plans

**Medicare Part D** — Prescription Drug Plan

**Medigap** — Medicare Supplement Insurance that conforms to one of the 10 Medicare-approved plans

**Medsupp** — Medicare Supplement Insurance

**MH** — Mental Health

**MM** — Major Medical

**MOP** — Maximum Out-of-Pocket

**MSP** — Medicare Second Payer

**Non-par** — Non-participating Provider

**OOA** — Out-of-Area

**OOP** — Out-of-Pocket

**OV** — Office Visit

**Par** — Participating Provider

**PCP** — Primary Care Physician

**PDL** — Preferred Drug List

**PDP** — Prescription Drug Plan

**PHI** — Protected Health Information

**POS** — Point of Service

**PPO** — Preferred Provider Organization

**QA** — Quality Assurance

**Rx** — Prescription Drug

**SB** — Senate Bill

**SHIBA** — Senior Health Insurance Benefits Assistance Program (a State of Oregon agency)

**SNF** — Skilled Nursing Facility

**TMJ** — Temporomandibular Joint (Jaw)

**U & C (R&C) (UCR)** — Usual and Customary, Reasonable and Customary, Usual Customary and Reasonable

**UR** — Utilization Review

**WHCRA** — Women's Health and Cancer Rights Act

**YTD** — Year-To-Date

## Notes

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# Important Telephone Numbers

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## PERS Health Insurance Program

In Portland: 503-224-7377

Toll-free (nationwide): 1-800-768-7377

Teletypewriter (TTY) for hearing and speech impaired: 1-800-433-6313

PERS website: [www.pershealth.com](http://www.pershealth.com)

Mailing address: P.O. Box 40187, Portland, OR 97240-0187

Fax: 503-765-3452 or 1-888-393-2943



## PERS Pension Office

(does not answer health insurance-related questions or accept any enrollment forms)

In Portland: 503-603-7777

Toll-free: 1-888-320-7377

[www.oregon.gov/pers](http://www.oregon.gov/pers)

## Clear Choice Health Plan

Phone: 541-385-5315

Toll-free: 1-888-863-3637

Teletypewriter (TTY) 1-800-735-2900

[www.clearchoicehp.com](http://www.clearchoicehp.com)



## Kaiser Permanente

In Portland: 503-813-2000

Toll-free from all other areas: 1-800-813-2000

Teletypewriter (TTY) for hearing and speech impaired: 1-800-735-2900

[www.kaiserpermanente.org](http://www.kaiserpermanente.org)



## The ODS Companies

In Portland: 503-243-3880

Toll-free (Oregon only): 1-800-962-1533

Toll-free (outside Oregon): 1-800-852-5195

Teletypewriter (TTY) for hearing and speech impaired: 1-800-433-6313

Dental: 1-800-452-1058



PERS Pharmacy Program (ODS, Clear Choice and Providence): 503-243-3960 or 1-888-361-1610

[www.odskompanies.com](http://www.odskompanies.com)

## Providence Health Plan

Medicare members in Oregon: 503-574-8000

Medicare members toll-free: 1-800-603-2340

Non-Medicare members in Oregon: 503-574-7500

Non-Medicare members toll-free: 1-800-878-4445

Teletypewriter (TTY) for hearing and speech impaired: 503-574-8702 or 1-888-244-6642

[www.providence.org/healthplans](http://www.providence.org/healthplans)

