



Member Handbook and Benefit Guide

January 1, 2012, to
December 31, 2012



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Introduction

MISSION STATEMENT

PERS is a well-respected organization that serves our members by enabling informed retirement and health decisions. We deliver 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. In your retirement planning, make sure you inquire about options for non-Medicare eligible retirees from your employer's health plan, which often have better benefits and premiums.

PERS WEBSITE

On the PERS website (www.pershealth.com), you can download the forms necessary to make changes to your account or health plan, submit address changes, view the latest member handbook or view past issues of the quarterly HealthWise newsletter. The website is one method the PERS Health Insurance Program uses to communicate important information to members throughout the year.

PLAN CHANGE

PERS offers an annual plan change period from October 1 to November 15. Information about making changes will be mailed in September. During this time, you can change your medical plan to any plan that is available in your area. Plan changes made during this period become effective January 1. This period is not an opportunity to add dental coverage or dependents. If you are enrolled and do not want to change plans, no paperwork is required. If you do want to make a change, you must fill out

a Termination Form for the plan you are ending and an Enrollment Request Form for the new coverage, and submit them to the PERS Health Insurance Program office before the November 15 deadline. You may obtain forms online from the PERS website or by calling PERS Health Insurance Program customer service. If you do not submit a change during this period, you will be unable to change your enrollment midyear, unless you experience a family status change or new enrollment opportunity.

MEDICARE BASICS

The PERS Health Insurance Program requires all Medicare eligible members and eligible Medicare dependents to be enrolled and retain both Parts A and B of Medicare. If you turn down Part B when first eligible and request to enroll at a later date, you may be penalized. If you stop paying your Part B premium, you will lose your ability to continue any of the PERS Medicare health plans.

In most circumstances, if you do not enroll in the PERS Health Insurance Program when you are first eligible for Medicare Parts A and B, you will forfeit any future opportunity to enroll in a PERS-sponsored medical plan. Refer to enrollment opportunities on page 10 of this handbook.

Enrollment in a PERS-sponsored Medicare plan includes automatic enrollment in a Part D pharmacy plan.

MEDICARE ENROLLMENT

You will become eligible for Medicare at age 65, regardless of whether you are receiving a Social Security benefit at the time. You are entitled to Medicare the first day of the calendar month during which you turn 65, unless your birthday falls on the first day of the month. If your birthday falls on the first, you are entitled to Medicare the first day of the prior month.

Medicare eligibility could occur earlier than age 65 if you are awarded Social Security disability. Medicare eligibility because of disability would become effective the first day of the 25th month after your Social Security benefits begin.

If you receive Social Security benefits prior to age 65, you will automatically be enrolled in Medicare. You should receive your Medicare information, including your Medicare Parts A and B card, approximately three months prior to your birthday or when you become eligible for Medicare because of disability.

If you ARE NOT receiving your Social Security benefit prior to age 65, you will need to contact the Social Security Administration or visit your local Social Security office approximately three months prior to your birthday and apply for Medicare Parts A and B.

MEDICARE PARTS A, B AND D DESCRIPTION

Medicare consists of several “parts.” Part A and Part B cover hospital and medical expenses, respectively. Medicare Part D offers a pharmacy benefit.

- Part A covers inpatient hospital expenses. In most cases, you pay no premium to maintain this coverage.
- Part B covers outpatient (medical) expenses, such as doctor visits and lab and diagnostic services. You pay a premium each month to maintain this coverage. This premium is deducted monthly from your Social Security benefit check, or if you do not yet receive a benefit, you will be billed by Social Security. You must continue to pay your Part B premium to remain eligible for all PERS Medicare plans.

NOTE: As a member, it is your responsibility to ask your pharmacy or DME supplier if it is accredited with CMS and can bill Original Medicare for your Part B drugs and supplies (such as injectable and infusible prescription drugs, diabetic meters and test strips, oral cancer medications, albuterol used with a nebulizer and some vaccines).

For more information, contact your health plan customer service for clarification about which Part B drugs and supplies are covered by contracted or network providers.

For Medicare Parts A and B enrollment, contact the Social Security Administration. Contact information is on the back cover of this book.

- Part D covers approved prescription medication. You must pay a premium for this coverage; however, it is included in the premium you pay for coverage through the PERS Health Insurance Program. Enrolling in a PERS-sponsored medical plan automatically enrolls you in the PERS Medicare Part D plan. The PERS Medicare Part D plan does not have an up-front deductible or coverage gap (donut hole) like some individual Medicare plans sold in the commercial market. See pages 36-37 for detailed benefit information.

Caution: You cannot be enrolled in two Medicare Part D plans at the same time or have other retiree coverage that receives Medicare funding. Terminating your Medicare Part D coverage or enrolling in another Part D plan will disenroll you completely from the PERS Health Insurance Program, including your medical and optional dental coverage.

To replace a lost Medicare card or get other general Medicare information, please see the Medicare contact information on the back cover of this book.

CREDITABLE COVERAGE

If you or your dependent is already Medicare eligible when you enroll in a PERS-sponsored health plan, you may be required to show proof from your prior employer or health plan that the prior plan’s prescription drug coverage was equal to or exceeded that of the basic Medicare Part D prescription drug benefit. If the coverage was not creditable, Medicare could impose a one percent per month penalty for the months you did not have creditable coverage.

Your health plan options

Below are descriptions of the various types of health plans available through the PERS Health Insurance Program. Additional plan-specific information can be found in the benefit summaries, premium rates and definitions sections in this handbook.

MEDICARE SUPPLEMENT

The Medicare supplement plan allows you to choose any physician who is a Medicare participating provider. You can live anywhere in the United States or travel outside the United States and still maintain coverage as referred to on pages 18-20. You must meet your annual deductible first; then, Medicare pays its portion and the plan pays the balance of the Medicare-allowed benefits.

- Medicare supplement – ODS

MANAGED CARE PLANS

Managed care plans contract with hospitals and physicians to provide care for enrollees. With managed care plans, you usually pay a modest fixed charge, called a “copay,” at the time you receive care. Generally, you have no claim forms to file from managed care doctors, hospitals and other healthcare providers who contract with these health plans. When you join a managed care plan, you must use the providers (hospitals and physicians) that are part of the plan. You must live in a certain geographic area, known as a “service area,” to be eligible for benefits. You also must select a primary care physician and be referred by that physician for most specialist care. Some exceptions exist in newer Medicare Advantage plans as described later in this handbook.

Managed care plans for Medicare eligible participants are called Medicare Advantage (MA) plans. When you enroll in any MA plan, that plan becomes the administrator of your Medicare Parts A and B benefits, and you are locked into the managed care plan you have chosen until the plan change period or you move out of the plan’s service area. The PERS Health Insurance Program offers health maintenance organization (HMO), point-of-service (POS) and Preferred Provider Organization (PPO) Medicare Advantage plans to its Medicare participants:

- Medicare Advantage managed care HMO plans
 - > PacificSource Health Plans
 - > Kaiser Permanente
 - > Providence Health Plans (Providence Medicare Extra Group Plan)
- Medicare Advantage managed care HMO-POS plan
 - > Providence Health Plans (Providence Medicare Choice Group Plan)
- Medicare Advantage managed care PPO plan
 - > ODS (ODS Advantage PPORX Plan)

NON-MEDICARE PLANS

The PERS Health Insurance Program offers HMO, POS and PPO plans to its non-Medicare participants:

- Managed care plans
 - > HMO plan – Kaiser Permanente (refer to page 46 for more information)
 - > POS plan – PacificSource Health Plans (refer to page 47 for more information)
- Preferred Provider Organization (PPO) plans
 - > PPO plan – ODS and Providence Health Plans (Refer to pages 46-47 for a description of these services)

You may also refer to pages 53-55 for additional definitions.

Exclusions and limitations

All available plans have some limitations and exclusions. Please contact the specific health plan administrator for more information. The plan benefit brochure you receive from your chosen health plan after enrollment will include complete information on the exclusions and limitations for the plan. Information also will be available on your health plan's website. Please refer to the back of this handbook for phone numbers and website addresses.

Other important information

END-STAGE RENAL DISEASE ENROLLMENT OPTIONS

End-stage renal disease (ESRD) is defined as the 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, the ODS Medicare Supplement Plan is available to you. Please contact the PERS Health Insurance Program for more information.

If you are enrolled in another health plan in addition to the PERS Health Insurance Program, please provide that information for correct coordination of benefits.

POWER OF ATTORNEY/ AUTHORIZATION TO DISCLOSE INFORMATION

The PERS Health Insurance Program requires that 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 who is not authorized by the PERS member.

CHANGE OF ADDRESS

The PERS Health Insurance Program accepts address changes from members or an authorized party by written notification, or by online submission via the website. Failure to notify PERS can result in involuntary termination of coverage 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 submit via the website or mail, or fax it to the PERS Health Insurance Program.



You also are required to submit your change of address in writing to the PERS Pension Office at the address listed on the back cover.

You must maintain a residence and live in the United States in order to be eligible for the PERS program. If you reside in another country, you are not eligible to retain the PERS coverage.

Eligibility

The information presented in this section is a summary of the Oregon Administrative Rule (OAR 459-035-0020) for enrolling in PERS-sponsored health plans. If you have any questions about your eligibility for enrollment or Retirement Health Insurance Account (RHIA) and Retiree Health Insurance Premium Account (RHIPA) contributions (see pages 14-15), or if you would like to obtain a copy of the complete OAR eligibility rules, please call the PERS Health Insurance Program at 800-768-7377 or visit <http://arcweb.sos.state.or.us/banners/rules.htm>.

WHO'S ELIGIBLE?

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, and enrollment will be determined by the eligibility of the retiree. The categories of eligible persons are as follows:

- An eligible retiree is a PERS member who is receiving a service or disability retirement allowance or benefit under PERS or who received an optional lump sum payment.
- An eligible spouse refers to the spouse of an eligible retiree.
- An IRS-eligible, dependent domestic partner refers to a person who has a relationship with and resides with a PERS retiree; the PERS retiree is providing more than one-half the financial support for the person and has claimed that person on his or her most recent federal tax return. For more detailed information regarding requirements for coverage, contact the PERS Health Insurance Program.

- An eligible dependent refers to a dependent child who is less than 26 years of age.
- An eligible dependent may also be someone who is 26 years of age or older and has either been continuously dependent upon the retiree since childhood because of a disability or physical handicap or has been covered under a healthcare insurance plan as the retiree's dependent for at least 24 consecutive months immediately before 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 because of developmental disability, mental retardation or a physical handicap as verified by a physician and accepted by the carrier.
 - > The incapacity is continuous and began before the date the child would otherwise have ceased to be an eligible dependent.
 - > The child is legally adopted or placed in the home pending adoption. Legal custody or guardianship does not apply.
- An eligible surviving spouse or dependent refers to:
 - > The surviving spouse or dependent of a deceased retired PERS member
 - > 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
- In no event shall an eligible person as defined in this rule be entitled to coverage as both a retiree and as a spouse or dependent.
- Members and their dependents must reside in the United States in order to receive coverage.

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

Enrollment opportunities

ENROLLMENT PERIODS

The following milestones mark the only enrollment opportunities. 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 in the PERS Health Insurance Program. Retirees and dependents must meet eligibility requirements (see pages 8-9).

- **New retiree.** New retirees can 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 or the date of your PERS disability approval letter) or on the first day of the month after your application is received (if you apply after your retirement date or the date of your PERS disability approval letter).
- **Working past Medicare eligibility.** If you are not drawing a Social Security benefit check and are still working when you turn 65, you will need to contact the Social Security Administration to sign up for Medicare Part A. Part A is free for most people. Because Medicare Part B has a premium, you might want to wait until three months before your retirement date to contact the Social Security Administration to sign up for Part B. The Medicare enrollment period is anytime during the active group coverage or anytime during the eight months after the active coverage ends. If you do not have Part B in place when you lose your employer coverage, you cannot enroll in a PERS health plan.
- **Medicare eligibility.** PERS retirees can 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 PERS Medicare Part D 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 who are disabled and receiving Social Security benefits will become eligible for Medicare 24 months after Social Security benefits begin. The 90-day Medicare eligibility enrollment opportunity also applies in these circumstances. If this enrollment opportunity is missed, becoming Medicare eligible at age 65 will not be a new opportunity to enroll in a PERS health plan unless you have had 24 months of continuous employer-sponsored coverage immediately preceding enrollment in a PERS health plan.
- **Continuous employer-sponsored coverage.** PERS retirees can enroll at any time if they have been covered under another employer-sponsored 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. Employer-sponsored group coverage is defined in several ways:
 - > Coverage you had as an active or retired employee that is terminating
 - > Coverage continued through COBRA following termination of employment
 - COBRA continuation coverage is secondary to Medicare, except when the Medicare beneficiary has end-stage renal disease.

- COBRA continuation coverage is primary to Medicare during the 30-month ESRD coordination period.
- > Coverage known as a High-Option Portability Plan, which includes a drug benefit that is comparable to or better than Basic Medicare Part D Plan

PERS coverage must begin the first of the month after employer-sponsored coverage ends, if loss of coverage is the reason for enrolling. If you have any questions, please contact the PERS Health Insurance Program office.

DENTAL PLAN ENROLLMENT

Enrollment in a PERS dental plan is limited to when you first enroll in a PERS medical plan or when you become Medicare eligible. You must apply for dental coverage at one of these enrollment opportunities or you will not be able to get PERS-sponsored dental coverage. The only exception is for members who have continuous dental coverage through an employer-sponsored health plan. There are no other dental coverage enrollment periods. There may be a 12-month waiting period for some services if you have not had 24 months of continuous employer-sponsored dental coverage immediately preceding enrollment into a PERS dental plan. (See page 50 for more information.)

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.

PERS offers two dental plans: Kaiser Permanente and ODS. You can enroll under either dental plan regardless of your medical plan selection. However, for Kaiser Permanente dental, you must reside in the Kaiser Permanente dental plan service area. Please refer to pages 50-51 for a description of these services.

DEPENDENT ENROLLMENT

Dependents can be enrolled during any of the enrollment periods available to retirees, including the retiree's date of retirement, Medicare-eligibility date or after the retiree has had at least 24 consecutive months of coverage under another employer. If a dependent experiences an enrollment opportunity after the retiree is enrolled, he or she will be eligible to enroll under the retiree's account. New dependents also can be enrolled within 30 days of becoming a dependent (e.g., through marriage).

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

If the retiree does not enroll in the PERS Health Insurance Program upon his or her enrollment opportunity, the dependent(s) will not be eligible for PERS-sponsored coverage.

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 in a PERS-sponsored health plan at the time of divorce, COBRA continuation applies. The spouse will need to send a copy of the divorce decree to the PERS Health Insurance Program within 60 days of the dissolution of marriage to continue coverage.

The surviving spouse and/or dependents of a PERS member may continue enrollment as described on page 13. If the surviving spouse or dependent is not enrolled at the time of the PERS retiree's death, the spouse/dependent may enroll within 90 days of the death or by meeting other enrollment opportunities as described on pages 10-11. However, in the event of remarriage, coverage of the surviving spouse of the PERS retiree cannot be extended to the new spouse.

How to enroll

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

- Complete the Enrollment Request Form. Be sure to include your personal information and any spousal or dependent information, if applicable; your reason for applying for PERS health insurance coverage; and the one medical or one dental plan you have chosen. Sign and date the form.
- Complete the Medicare card section for all Medicare eligible individuals and make photocopies of the Medicare card of each Medicare eligible individual applying. Send the copy with the Enrollment Request Form.

Enrollment Request Forms must be returned to the PERS Health Insurance Program office within the enrollment periods described in the paragraphs below:

- To insure that you receive the effective date you expect, your enrollment application must be received by the PERS Health Insurance Program prior to the month in which you are applying for coverage. If you are eligible for Medicare guidelines require that your application is signed no earlier than 90 days prior to your Medicare eligibility date but within 90 days following Medicare eligibility.

- If you are currently enrolled in a PERS-sponsored non-Medicare plan, you will be required to fill out the Enrollment Request Form 30 days prior to becoming Medicare eligible. Failure to submit a new Enrollment Request Form for the Medicare coverage will result in cancellation of your health plan coverage under PERS.

When enrolling in a PERS-sponsored Medicare plan, you will automatically be enrolled in a Part D drug plan.

- Complete the pay option section. Select only one option. (See "Making monthly premium payments" on page 13.)
- Provide a copy of a Certificate of Creditable Coverage if you are enrolling because of employer-sponsored health coverage ending.
- Submit the form to the PERS Health Insurance Program office. The address can be found on the back cover of this book.

Caution: You cannot be enrolled in two Medicare Part D plans at the same time or have other retiree coverage that receives Medicare funding. Terminating your Medicare Part D coverage or enrolling in another Part D plan will disenroll you completely from the PERS Health Insurance Program, including your medical and optional dental coverage.

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 of this book. Appeals related to claim and benefit payments or Medicare plan enrollment or disenrollment issues should be directed to the health insurance carriers of the plan in which you are enrolled.

After enrollment

MAKING MONTHLY PREMIUM PAYMENTS

PERS Health Insurance Program members have three monthly payment options:

- Deduction from your monthly PERS pension check. This option ensures timely premium payment and prevents a lapse in coverage.
- Electronic funds transfer from your bank account. This option also ensures timely premium payment and prevents a lapse in coverage.
- Monthly invoice. Untimely payments can cause a lapse in coverage or cancellation of coverage.

Only one payment option is allowed per PERS Health account.

LATE PAYMENTS

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

DISENGROLLMENT

The PERS Health Insurance Program and Medicare guidelines require a written request for termination of health insurance coverage that is signed and dated within the month prior to the termination of coverage. Termination will occur the first of the month after the signed request. Both the member and spouse must sign the written request for termination. 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.

Note: Once disenrollment has occurred, you may not re-enroll in the PERS Health Insurance Program unless you experience a new enrollment opportunity as described on pages 10-11.

DEATH NOTIFICATION

As a PERS retiree. Upon the death of your spouse, your PERS health insurance coverage will continue as usual. To terminate your spouse's coverage, you must mail a photocopy of the death certificate to the PERS Health Insurance Program AND the PERS Pension Office.

As a surviving spouse or dependent of a PERS retiree. Your PERS health insurance coverage will continue automatically following the retiree's passing. You must mail a copy of the retiree's death certificate to the PERS Health Insurance Program and the PERS Pension Office for your account to be properly set up. If you would like to terminate your coverage, a written request to do so is required.

Please note: If the surviving spouse is not enrolled at the time of the PERS retiree's death, the spouse may enroll within 90 days of the death or by meeting other enrollment opportunities described on pages 10-11.

The address, as well as the fax number for the PERS Health Insurance Program office, can be found on the back cover of this booklet.



Premium subsidies

RHIA (MEDICARE) SUBSIDY

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

To be eligible for RHIA contributions toward the costs of premiums for a PERS-sponsored plan, retired members must meet the following requirements:

- Be enrolled in Parts A and B of Medicare and also meet one of these requirements:
 - > Receive a PERS service or disability retirement allowance under Tier 1 or Tier 2 and have had eight or more years of qualifying service at the time of retirement
 - > Receive a PERS disability retirement allowance computed as if he or she had eight or more years of creditable service and was a Tier 1 or 2 retiree

- Be a surviving spouse or dependent of a deceased eligible retired member, as described in section one of this statute, who is enrolled in Parts A and B of Medicare, and who also meets these requirements:
 - > Receives a retirement allowance or benefit from PERS
 - > Was covered under an eligible retiree member's PERS-sponsored health insurance plan and the deceased member retired before May 1, 1991

Please note: If you are a surviving spouse and are no longer eligible for an ongoing pension benefit, you may no longer be eligible for the RHIA subsidy.

RHIPA (STATE OF OREGON NON-MEDICARE) SUBSIDY

ORS 238.415 established a trust fund called the Retiree Health Insurance Premium Account. RHIPA pays a monthly contribution toward the cost of healthcare coverage for some State of Oregon retirees who are not eligible for Medicare. This contribution applies only to PERS retirees who retire from a state agency, such as the Oregon Department of Transportation (ODOT), the Oregon Department of Fish and Wildlife or any other agency of state government, and who immediately apply for their pension. The contribution will be applied automatically, if you are eligible, by verifying your qualifying state service time. The monthly premium amount you pay will reflect the subsidy following verification.

To receive RHIPA contributions, retired state employees enrolled in a PERS-sponsored health plan must meet the following requirements:

- Be a Tier 1 or 2 retiree who is a state employee at the time of retirement and is not currently eligible for Medicare, and who also meets one of these requirements:
 - > Receives a PERS service or disability retirement allowance or benefit and has had eight or more years of qualifying state service at the time of retirement
 - > Receives a PERS disability retirement allowance computed as if the member had eight or more years of creditable state service and had attained the earliest service retirement age
- Be a surviving spouse or dependent of a deceased eligible retired state employee, as described in section one of this statute, who is not eligible for Medicare and who meets one of these requirements:
 - > Is receiving a retirement allowance or benefit from PERS

- > 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

Please note: If you are a surviving spouse and are no longer eligible for an ongoing pension benefit, you also may no longer be eligible for the RHIPA subsidy.

RHIPA SUBSIDY RATES

PERS members eligible for the RHIPA subsidy can call the PERS Health Insurance Program office for health plan premium rates applicable to RHIPA-eligible members. RHIPA subsidy rates will be available in November 2011.



Continuation of coverage

In accordance with Federal and State of Oregon guidelines, the PERS Health Insurance Program provides opportunities for the continuation of coverage following a Qualifying Event. If you experience one of the Qualifying Events listed below, please contact the PERS Health Insurance Program for additional information. A Qualifying Event will occur if eligibility for coverage is lost due to:

- 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)

Once continuation of coverage has been secured, timely payment of premiums is essential.

TIMELY COBRA 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 day 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) or the 30th day following the monthly due date, coverage will be terminated and cannot be reinstated.



Coverage outside the service areas

PacificSource Health Plans

MEDICARE AND NON-MEDICARE PLANS

PacificSource provides worldwide coverage for the following four services:

- Emergency services
- Urgently needed services
- Ambulance services
- Out-of-area dialysis services

These services do not require prior authorization.

Kaiser Permanente

Kaiser Permanente members temporarily outside the service area are covered for emergency care, urgent care and medically necessary ground or air ambulance service worldwide. Medicare members also have a limited travel benefit that covers routine and follow-up care worldwide.

Currently enrolled Medicare members who permanently move outside the Kaiser Permanente Northwest service area or who are out of the service area for six consecutive months or more must disenroll from their Medicare Advantage plan.

Members temporarily visiting other Kaiser Permanente regions may receive visiting member care from designated providers in those areas. For information about service areas and facility locations in other regions, please call Membership Services in the Northwest region and ask for the member travel brochure.

With Kaiser Permanente, health plans are available in California and Hawaii for PERS retirees who relocate to those areas. Please call the PERS Health Insurance Program office for more information. Premiums and benefits will differ from those noted in this handbook.

EMERGENCY/TRAVEL BENEFITS FOR MEDICARE PLANS	PacificSource Medicare Essentials 801	Providence Medicare Extra	Providence Medicare Choice
Emergency room (ER) (worldwide)	\$50 copay	\$50 copay	\$50 copay
Urgent care (worldwide)	\$15 copay	\$25 copay	\$25 copay
Ambulance (worldwide; air/ground)	\$50 copay	\$50 copay	\$50 copay
Outside service area travel – in U.S.	Covers ER, urgent care & ambulance	Member pays 20% to maximum allowance of \$1,000 for follow-up services	Member pays 20%
Outside service area travel – outside U.S.	Covers ER, urgent care & ambulance	Covers ER, urgent care & ambulance	Covers ER, urgent care & ambulance

If you do not use Kaiser Permanente’s physicians and hospitals, neither Kaiser Permanente nor Medicare will cover your services, except for emergency and urgent care, authorized referrals, renal dialysis outside the service area per Medicare criteria, and travel benefits.

KAISER PERMANENTE DENTAL PLAN

If you have a dental emergency while traveling outside the service area, you may go to the nearest dental office. You have limited coverage for qualifying emergency dental care. See the dental plan section on page 50.

ODS

You must maintain a residence and reside in the United States in order to participate in the PERS program.

ODS ADVANTAGE PPORX

Members can travel for up to 12 months anywhere in the United States with the ODS Advantage PPORX Plan. The travel benefit provides members the flexibility of using an in-network provider or any out-of-network Medicare provider while paying the same copayment or coinsurance. For members enrolled in the ODS Advantage PPORX Plan and traveling outside the United States, emergency care is covered worldwide.

ODS MEDICARE SUPPLEMENT PLAN

Coverage is limited to eligible emergency medical care expenses incurred outside of the U.S.

NON-MEDICARE PLAN

Members traveling outside of the primary service area may receive the in-network benefit level by using a Travel Network provider. The in-network benefit level only applies to a Travel Network provider if members are outside the primary service area and the travel is not for the purpose of receiving treatment or benefits.

Treatments of emergency medical conditions are covered worldwide. All emergency services will be reimbursed at the in-network benefit level. However, benefits are subject to our contracted rates for in-network physicians and providers. Members may be responsible for any amounts outside the maximum plan allowance.

ODS DENTAL PLAN

The ODS dental plan gives you the freedom to choose any licensed dentist. As part of the Delta Dental Plan, the largest dental network in the country, you can visit any of the 134,000 Delta Dental dentists in America and still be covered as in-network.

ODS Supplement	ODS Advantage PPORX	Kaiser Permanente Senior Advantage
20% coinsurance	\$50 copay	\$50 copay
20% coinsurance	\$20 copay	\$15 copay
20% coinsurance	\$50 copay	\$50 copay
Covers ER, urgent care & ambulance	Out-of-network copay applies	Care in other KP regions or Group Health Cooperative service area. Covers ER, urgent care & ambulance worldwide. Covers routine, preventive & follow-up care outside Kaiser network at 20% coinsurance as part of \$1,000 annual worldwide travel benefit maximum.
Covers ER, urgent care & ambulance at 20% coinsurance. Coverage limited to \$50,000 lifetime per member	Covers ER, urgent care & ambulance at out-of-network copay	Covers ER, urgent care & ambulance worldwide. Covers routine, preventive & follow-up care outside Kaiser network at 20% coinsurance, up to \$1,000 annual worldwide plan-paid travel benefit maximum.

Providence Health Plans

All plans have worldwide coverage for urgent and emergency care including ambulance (air and ground), as well as travel benefits.

MEDICARE PLANS

The Providence Medicare Extra Group Plan includes a travel benefit that covers necessary follow-up care from any Medicare-approved provider. The Providence Medicare Choice Group Plan with the out-of-network option allows you to see any Medicare-approved provider.

NON-MEDICARE PLAN

Providence uses the First Choice Health Network in Washington and Alaska and MultiPlan/PHCS for all other states. If you are traveling and use a national network provider under the First Choice Health Network or MultiPlan/PHCS network, it is paid at the in-network level. Whether you are in or out of the service area, if you choose an out-of-network provider, benefits are paid at the out-of-network level.

PERS Snow Bird option

For members who are enrolled in PacificSource Health Plans, Providence Medicare Extra Group Plan or Kaiser Permanente 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 outside their managed care plan's service area. Members must plan on living outside the service area for more than 60 days for this option to apply.

Before leaving, members should contact the PERS Health Insurance Program to request an application to change to either the ODS Medicare Supplement Plan or the ODS Advantage PPORX 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.

Please note: Members will need to fill out a Termination Form and Enrollment Request 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.

Benefit changes, health plan service areas and plan features



Changes to plans

EFFECTIVE JANUARY 1, 2012

Prescription Drug Program

KAISER PERMANENTE

Medicare and non-Medicare

- The Prescription Drug out-of-pocket maximum per person per calendar year will now be \$4,700.
- No other benefit changes for 2012 at this time.

ODS

Medicare and non-Medicare

- The Prescription Drug out-of-pocket maximum per person per calendar year will now be \$4,700.
- One early refill for prescription eye drops to treat glaucoma is now covered.
- Drugs dispensed in higher dosages which must be split to attain the correct dosage, are not covered unless medically necessary.
- Claims arising from ionizing radiations, pollution or contamination by radioactivity from any nuclear waste will be excluded.
- Drugs/medications purchased from a foreign country are excluded.
- Members must reside in the USA in order to receive coverage.
- Select brand medications with a generic equivalent are not covered.
- At retail, brand drugs are covered up to a 31 day supply and generic drugs up to a 93 day supply.
- Prescription medications for which there is an OTC equivalent or alternative are excluded.
- No other benefit changes for 2012 at this time.

Medical

KAISER PERMANENTE

Medicare

- Routine physical exam and the personalized prevention plan services will be consolidated into an Annual Wellness Exam as defined by Medicare. This exam will be covered in full.
- Injectable Part D immunization serum will be covered at no charge.
- Physician referred acupuncture services are excluded.
- No other benefit changes for 2012 at this time.

Non-Medicare

- Emergency room copay increasing from \$75 per visit to \$100.
- Travel related services, including travel-only immunizations, are excluded.
- Physician referred acupuncture services are limited to 12 visits per calendar year.
- No other benefit changes for 2012 at this time.

ODS

All medical and dental plans

- Members must reside in the U.S. in order to receive coverage.

Medicare Supplement

- Emergency care received in a foreign country now has a lifetime benefit limit of \$50,000.
- Skilled nursing facility stay begins within 30 days after an inpatient hospital stay of three or more days.
- No other benefit changes for 2012 at this time.



Medicare Advantage PPO

- No changes for 2012 at this time.

Non-Medicare

- Annual benefit limit for essential benefits (medical and prescription drug) will increase from \$750,000 to \$2,000,000.
- Preventive services will be covered at no charge in-network in accordance with PPACA guidelines (change took effect January 1, 2011, but was not noted in handbook).
- Hearing aid benefit maximum is expected to increase in 2012 based on consumer price index data that will be available in January 2012.
- Eliminating visit limits for medically necessary outpatient rehabilitative services for mental health and chemical dependency.
- Emergency room copay will increase from \$100 per visit to \$200.
- Adding travel network for members traveling outside primary network service area or for children residing outside the service area; will not apply to members traveling primarily to obtain treatment or benefits.
- Services that accumulate toward the **out-of-network** out-of-pocket maximum can no longer be used to satisfy the in-network out-of-pocket maximum.
- Services that accumulate toward the **in-network** out-of-pocket maximum can no longer be used to satisfy the out-of-network out-of-pocket maximum.
- Non-emergent care in a foreign country is excluded.
- Claims arising from ionizing radiations, pollution or contamination by radioactivity from any nuclear waste will be excluded.
- Specific coverage of telemedical health service provided in connection with treatment of diabetes is now covered.
- No other benefit changes for 2012 at this time.

Changes to plans *(continued)*

PACIFICSOURCE COMMUNITY HEALTH PLANS (FORMERLY CLEAR ONE HEALTH PLANS)

Medicare

- Annual routine physical exams are now covered in full.
- Annual Wellness Visit as defined by Medicare will be covered in full.
- No other benefit changes for 2012 at this time.

Non-Medicare

- Pre-Existing Conditions Waiting Period will no longer apply to eligible dependent children under age 19.
- Emergency room copay will increase from \$100 per visit to \$200.
- Outpatient rehabilitation benefit limit has changed from \$3,000 per calendar year to 30 visits per calendar year.
- Inpatient Mental Health benefit limit of \$2,500 per calendar year has been removed.
- Air ambulance benefit limit of \$3,500 per calendar year has been removed.
- Ground ambulance benefit limit of \$2,500 per calendar year has been removed.
- Tobacco addiction services lifetime limit of \$500 has been replaced by a limit of two quit attempts per lifetime.
- Transplant services \$500,000 lifetime limit has been removed.
- Alternative care out-of-network providers are now covered after 30% coinsurance.
- No other benefit changes for 2012 at this time.

PROVIDENCE HEALTH PLAN

Medicare Choice Plan

- Out-of-pocket maximum will be reduced from \$3,500 to \$3,400.
- In-network preventive services copay reduced from \$20 to \$0.
- Medical eye exam copay reduced from \$20 to \$0.
- No other benefit changes for 2012 at this time.

Medicare Extra Plan

- In-network preventive services copay reduced from \$15 to \$0.
- Medical eye exam copay reduced from \$15 to \$0.
- No other benefit changes for 2012 at this time.

Non-Medicare

- Preventive services will be covered in full.
- Emergency room visit copay (in- and out-of-network) will increase from \$100 copay, then 20% to \$200 copay, then 20% per visit. The deductible does not apply to this benefit.
- No other benefit changes for 2012 at this time.

Dental

KAISER PERMANENTE

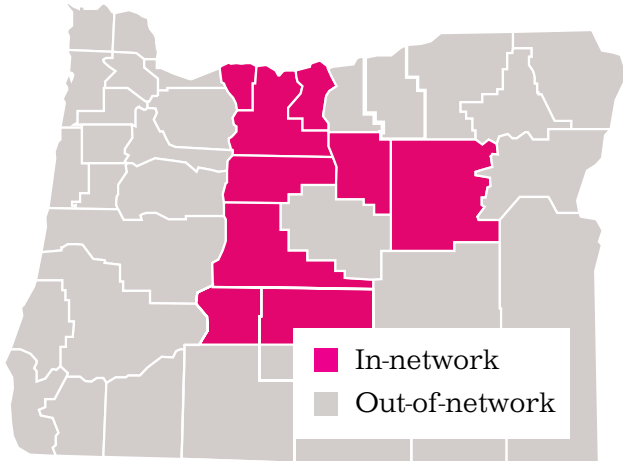
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns that were not placed by a Kaiser dental provider will be excluded.
- “Hospital call fees”, “call fees”, or similar charges associated with dentally necessary services that are performed at ambulatory service centers or hospitals are excluded.
- No other benefit changes for 2012.

ODS

- Implants are now covered. Placement and removal is now covered once per lifetime per tooth space.
- Frequency for bitewing X-rays reduced from two times per year to once per calendar year.
- Frequency for complete series X-rays reduced from once every three years to once every five years.
- Non-Emergent care in a foreign country is excluded.
- No other benefit changes for 2012.

Health plan service areas

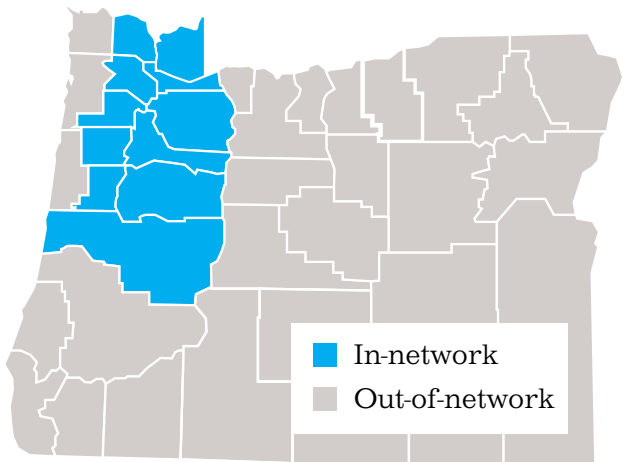
To be eligible for the PERS-sponsored health plans, your main residence address (not a mailing address) must be located within the plan's service area.



PacificSource Health Plans

SERVICE AREA:

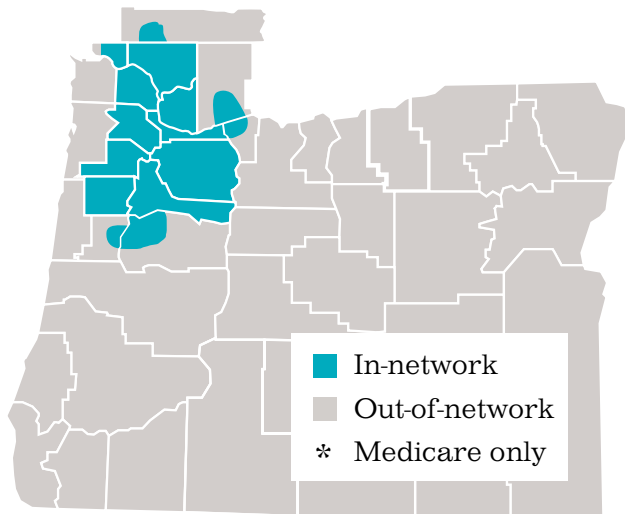
Deschutes; Grant; Hood River; Jefferson;
Klamath: 97731, 97733, 97737, 97739; Lake: 97638,
97641, 97735, 97739; Sherman; Wasco; Wheeler



Providence Health Plans

SERVICE AREA:

Benton, Clackamas, Clark, Columbia, Lane,
Linn, Marion, Multnomah, Polk, Washington,
Yamhill

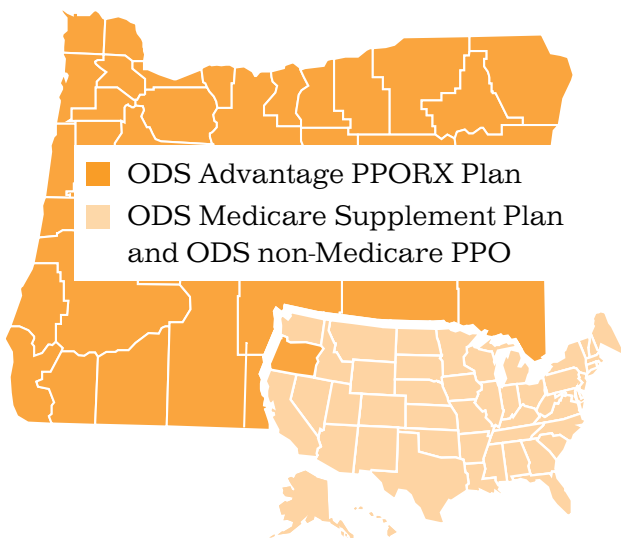


Kaiser Permanente

SERVICE AREA:

Benton: 97330, 97331, 97333, 97339, 97370; Clackamas; Clark; Columbia; Cowlitz; Hood River: 97014, 97031*, 97041*, 97044*; Lewis: 98591, 98593, 98596; Linn: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389; Marion; Multnomah; Polk; Skamania: 98605*, 98610*, 98639, 98648, 98651*, 98671*; Wahkiakum: 98612, 98647; Washington; Yamhill

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



ODS

NATIONWIDE

SERVICE AREA:

All Oregon counties plus extended nationwide coverage for ODS Medicare Supplement Plan and ODS non-Medicare PPO.



PacificSource Health Plans

PacificSource Community Health Plans, Inc., (formerly Clear One Health Plans) offers Medicare Advantage plans under the name PacificSource Medicare. Our parent company, PacificSource Health Plans, is an independent not-for-profit community health plan founded by a group of physicians in Oregon with the goal of improving healthcare quality and access in the community.

With a 78-year reputation for taking great care of people, we are known for building relationships and making the extra effort to get to know customers one on one. As a member of your local community, we're right here to help you get the healthcare you need to live the life you want.

MEDICARE ADVANTAGE PLAN

The **PacificSource Medicare Essentials 801 Plan** is a Medicare Advantage, managed care plan. Members will use in-network providers for most services. You can see any Medicare-approved provider in the PacificSource Medicare network, you will choose your own primary care provider, and you have the freedom to see specialists without a referral. Our Medicare Advantage plan covers more than Medicare alone and travelers have the added protection of worldwide coverage for ambulance services, urgent and emergent care, and dialysis services. This plan includes the ODS prescription drug benefit.

NON-MEDICARE POINT OF SERVICE (POS) PLAN

The **PacificSource Choice POS Plan** gives you the freedom to see either in-network or out-of-network providers for covered services. Your PacificSource non-Medicare plan includes access to participating providers nationwide through the First Health Network. You will generally pay less for services from providers in the PacificSource network. And you have the freedom to see specialists without a referral.

Travelers have the added protection of worldwide coverage for ambulance services, urgent and emergency care, and dialysis services. For more details, see the 2012 non-Medicare benefit summary on pages 46-47.

PACIFICSOURCE VALUE-ADDED SERVICES

MEDICARE ADVANTAGE PLAN

Our Medicare Advantage plan includes additional benefits not covered by Medicare:

- **Annual routine physicals** - \$0 copay
- **Routine vision exam** - \$0 copay
- **Eyeglasses and contacts** - \$100 benefit for eyeglasses or contact lenses every two calendar years
- **Discounts on weight management programs** - Jenny Craig

NON-MEDICARE POINT OF SERVICE (POS) PLAN

- **In Touch** - online access to coverage and benefit information
- **Health Manager** - online health and wellness center powered by WebMD
- **Discounts on weight management programs** - Jenny Craig





Kaiser Permanente

MEDICARE AND NON-MEDICARE PLANS

In 1945, Henry Kaiser's Portland and Vancouver shipyard health plan opened to the public as a community health plan. Our doctors, specialists, nurses and staff work together, sharing information to create a seamless care experience for you and your family. As a Kaiser Permanente member, you can choose a primary care provider that is right for you.

Kaiser Permanente has 31 medical offices in our Northwest service area. Because most of our medical offices offer multiple healthcare services under one roof, you can often save time by taking care of various health needs in one trip. In addition to providing the care you need, we offer the resources, tools and expertise to help you get and stay healthy.

DENTAL PLAN

The Kaiser Permanente dental plan offers 17 dental offices in the Northwest region to choose from. This plan brings together a team of experienced dental professionals committed to providing you with high-level, preventive dental care and treatment planning based on the latest dental research. We believe that establishing a dentist-patient relationship is essential to providing consistent, high-quality care.

Your first examination with your own personal dentist will include the following:

- Diagnostic X-rays
- Gum disease test
- Tooth decay assessment
- Head and neck cancer screening
- Blood pressure check

Your dentist will work with you to plan your treatment and identify any needed follow-up appointments, including cleanings. Any future care that you need will be under the direction of your personal dentist.

For more details, see the 2012 medical and dental plan comparisons on pages 40-51. Medicare Membership Services is available by telephone seven days a week, from 8 a.m. to 8 p.m.

- Non-Medicare Membership Services is available Monday through Friday, 8 a.m. to 6 p.m.
- You also can visit Membership Services at most medical offices and at Kaiser Sunnyside Medical Center.

KAISER PERMANENTE ADDITIONAL BENEFITS

- **24-hour advice nurse benefit.** Contact a Kaiser Permanente advice nurse if you're not sure when to go in for care or where to be seen. Call 503-813-2000 in Portland or 800-813-2000 from elsewhere.
- **Health fitness benefit.** We offer the Silver&Fit® program as part of your Senior Advantage HMO Plan. With the Silver&Fit benefit, you can choose a membership at one of many contracted fitness clubs or exercise facilities, or you can choose the Silver&Fit Home Fitness program.

KAISER PERMANENTE VALUE-ADDED SERVICES*

- **kp.org.** Access information and take care of healthcare-related tasks online.
 - > E-mail your doctor's office, check lab results, order prescription refills, make primary care appointments and more.
 - > Take a Total Health Assessment online and get a personalized online health improvement program.
 - > Select the option to share the results of your Total Health Assessment with your primary care provider, and they will be automatically included in your electronic medical file.

- **Healthy living classes.** Learn about weight management, dealing with ongoing medical conditions (such as osteoarthritis), caregiver support, meditation techniques and more. (Some classes require a fee.)
- **CHP Active and Healthy.** Medicare and non-Medicare members receive discounts on hundreds of activities, including gym memberships (more than 270 clubs to choose from), tickets for live theater, symphony and first-run movies, sporting events and more.
- **Alternative and chiropractic care.** Receive discounts on self-referred chiropractic care, acupuncture, naturopathic care and massage therapy.
- **Talk with a health coach.** Get one-on-one help setting health goals and developing a wellness plan. Coaching consultations are at no charge to members.

Go to kp.org to learn more about Kaiser Permanente.

*The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Kaiser Permanente grievance process.





ODS

ODS has had roots in Oregon’s communities for more than 55 years. We proudly hold a place in Oregon’s history as a pioneer in dental insurance. Over time, we’ve evolved our lines of business to provide healthcare plans that offer our members a range of coverage, including medical, dental and pharmacy products.

ODS ADVANTAGE PPORX

ODS Advantage PPORX is a Medicare Advantage plan that is offered to all eligible PERS retirees and their dependents who reside in the State of Oregon. Members can choose any Medicare provider or a provider from the ODS Advantage statewide network. You are not required to select a primary care provider, and you can seek care from a specialist without a referral.

ODS MEDICARE SUPPLEMENT PLAN

ODS offers a Medicare supplement plan to all eligible PERS retirees. This is a traditional Medicare supplement insurance program that pays secondary to Medicare. Members can choose any Medicare provider. Members also can live anywhere in the United States.

NON-MEDICARE PPO PLAN

ODS offers a Preferred Provider Organization (PPO) plan for non-Medicare retirees and dependents. Four networks are available to members; the state in which you reside will determine the PPO network as follows:

- **ODS Plus Network.** Members living in Oregon, Idaho or one of the following counties in Washington State: Benton, Clark, Cowlitz, Klickitat, Pacific, Skamania, Wahkiakum and Walla Walla.
- **First Choice Health Network.** Members who reside in Washington State and do not live in Benton, Clark, Cowlitz, Klickitat, Pacific, Skamania, Wahkiakum or Walla Walla counties.
- **PHCS Network.** Members who reside in a state other than Oregon, Washington or Idaho.
- **ODS Travel Network.** Medical plan members can receive care outside of their primary service area while traveling.

If you are wondering whether your physician is included in the PPO network, please call us at 503-243-3880 or toll-free at 800-962-1533, or visit the ODS website at www.odscompanies.com and click on the “Find Care” box.

DENTAL PLAN

Wherever you go, ODS goes with you. As a Delta Dental Plan member, ODS provides you with access to the nation's largest dental network, including 134,000 dentists nationwide.

TOTAL COST CONTROL

At ODS, we do things differently. Because we require dentists to file fees for services that fall below our fee ceiling, we provide total cost control for you, our member. The highest potential for savings exists when you visit a provider participating in our ODS Delta Dental network because these dentists have agreed to accept ODS-contracted fees as full payment for services. This arrangement means you usually pay less for each visit and are protected from balance billing – the difference between what ODS pays and the dentist's fee – which will cut down on out-of-pocket costs.

ORAL HEALTH, TOTAL HEALTH

Oral health research has shown a strong link between oral health and overall health. ODS believes that when you see a dentist regularly and maintain a healthy mouth, it can help keep the rest of your body healthy, too. Through our Oral Health, Total Health program, ODS offers additional preventive benefits to diabetics and pregnant women in their third trimester.

ODS also provides other evidence-based dental benefits, including routine oral cancer screenings with every exam.

ODS WELL

ODS Well™ provides tools and individualized health support, and is available through myODS, a personalized, secure website.

- **Condition and disease management — ODS Advantage PPORX.** ODS health coaches use evidence-based practices to help patients across the continuum of care, addressing chronic medical needs, healthy lifestyle management and everything in between. You and your eligible dependents receive one-on-one support from an ODS health coach, including customized guidance and help with goal setting.
- **Care coordination and case management — ODS Advantage PPORX.** Registered nurses, physicians, coaches and behavioral healthcare coordinators at ODS help you and your caregivers navigate the complexities of the healthcare system. Our care coordination staff focuses on optimizing your clinical outcomes.
- **Registered Nurse Advice Line.** Speak with a nurse 24/7. Call 866-321-7580.
- **Vision and hearing discounts.** Discounts are available through TruVision and Binyon's in Oregon and Southwest Washington. TruVision offers discounts on laser vision correction and contact lenses. Binyon's offers discounts on eyeglasses, including frames and lenses. Please call TruVision at 877-330-2020 for information and participating locations.

TruHearing digital hearing aids are also available at a reduced price for members and their family. For more information, please call 800-334-1807.

Please contact ODS PERS customer service with provider or benefit questions.

Also available in myODS:

- > Treatment Cost Navigator
- > Dental Optimizer
- > Prescription price check tool (pharmacy members only)
- > Everywhere Care
- > Electronic Explanation of Benefits
- > View claims status, view benefits and eligibility history





Providence Health Plans

Providence Health Plans (PHP) is part of Providence Health & Services, Oregon's largest network of health services.

PROVIDENCE MEDICARE ADVANTAGE PLANS

When you enroll in one of our Medicare Advantage plans, Providence Health Plans works with Medicare for you. To meet your needs, we offer two types of Medicare plans. **Providence Medicare Extra™ Group Plan** is a managed care plan in which you use in-network providers.

Providence Medicare Choice™ Group Plan is a managed care plan with a point-of-service option that allows you to see any Medicare-approved provider, or in-network providers for lower out-of-pocket costs. It's up to you.

Both plans offer the same benefits, but with different out-of-pocket costs. With Providence Medicare Choice Group, you pay a lower premium and may pay a little more when you use services. With Providence Medicare Extra Group, you pay a little higher premium with lower out-of-pocket costs when you use services.

Thousands of providers participate with Providence Health Plans. Contact us for help finding a provider near you.

With Providence Medicare Extra Group Plan, you must use a participating provider or have a referral from your primary care provider to see another provider or specialist – except for emergency or urgent care. Providence Medicare Choice Group Plan covers you when you see any Medicare-approved provider. If you are on the Providence Medicare Choice Group Plan and you receive a referral from your primary care provider, you pay lower out-of-pocket costs. Without a referral on the Providence Medicare Choice Group Plan, you pay the out-of-network copay.

NON-MEDICARE PLAN

This plan offers in-network and out-of-network benefits with a common deductible.

Members who use the in-network providers generally pay less for medical care after their deductible has been met.

For details on the medical plans, please refer to pages 40-49 for Medicare and non-Medicare 2012 benefit comparisons. If you have questions about Providence Health Plans, call Monday through Friday, from 8 a.m. to 5 p.m.

PROVIDENCE VALUE-ADDED SERVICES

- **Providence RN.** Get free 24-hour medical advice and speak to a registered nurse, any time day or night, seven days a week by calling 800-700-0481.
- **Recreational activities.** The LifeBalance program provides exclusive discounts on a variety of recreational services, activities and events throughout the Northwest. Save on fitness, entertainment, travel, rentals, cultural and sporting events, and more. Call 888-754-5433.
- **Alternative care (ChooseHealthy).** Access discounts for acupuncture, chiropractic care, massage therapy and dietitian services. ChooseHealthy provides a network of providers offering 25 percent off their usual and customary fees.
- **Hearing.** TruHearing offers digital hearing aids at a reduced price for members and their family. Call 877-315-2020.
- **Vision.** Discounts are available through Northwest Vision Associates (NVA), TruVision and Binyon's in Oregon and Southwest Washington. NVA offers a 20 percent discount from usual fees on vision exams and vision hardware for all members who do not have a vision benefit. TruVision offers discounts on laser vision correction and contact lenses. Binyon's offers discounts on eyeglass, frames and lenses.
- **Classes.** Stay healthy and receive discounts on classes through Providence Health & Services to help you lose weight, stop smoking or just have fun.

THE SILVERSNEAKERS® FITNESS PROGRAM

- Fitness membership benefits
 - > A basic membership at a participating location - at no additional cost
- Includes use of amenities such as treadmills, weights, heated pool and fitness classes

- > Use any of the more than 9,000 participating locations in the nation
- > No restrictions on days and times you can visit
- > Program AdvisorsSM at each location
- > Additional classes and programs available at many locations
- SilverSneakers classes
 - > Group exercise classes focus on cardiovascular health, muscular strength, balance and coordination
 - > Classes are designed to improve activities for daily living and help maintain independence and are appropriate for all fitness levels
 - > Certified instructors teach SilverSneakers classes
- Fun social and educational activities
- Online tools and support
 - > Members can create exercise and nutrition plans, track goals and progress, find health articles and recipes
 - > Post on message boards and be part of the online community

PROVIDENCE HEALTHCARE SERVICES

Quality medical care programs are available to help you control complicated health conditions through a planned partnership between you, your healthcare provider and your plan.



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 PACIFICSOURCE, ODS AND PROVIDENCE HEALTH PLANS

This program is administered by ODS for all three health plans. For information or questions about this program, contact ODS at the pharmacy number listed on the back cover of this book. PERS has negotiated discounted prices for prescriptions through participating pharmacies, including all major chain pharmacies in Oregon and throughout the United States. Most independent pharmacies in Oregon are also participating. ODS, Providence Health Plan and PacificSource Health Plan members who purchase prescription drugs at a nonparticipating pharmacy may be reimbursed for less than 40 percent of the amount paid because negotiated discounts are not applied.

If you are Medicare eligible, you are automatically enrolled in the PERS Part D plan, which is ODS Advantage Rx (PDP). You cannot be enrolled in two Medicare Part D plans. If you terminate your Medicare Part D coverage directly through Medicare or enroll in another Part D plan, this will disenroll you completely from the PERS Health Insurance Program, including your medical and optional dental coverage.

Out-of-pocket maximum

This program has a calendar year out-of-pocket maximum. Once a member has paid \$4,700 out of pocket 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 member's prescription drug coinsurance for brand name drugs is 40 percent of the discounted prescription charge, up to a maximum coinsurance of \$150 for each prescription filled for up to a 31-day supply (even if the prescription is written for less than a 31-day supply). A 93-day supply of generic drugs may be obtained for up to a maximum coinsurance of \$150.

Mail-order prescription drugs

Prescription drug benefits and copayments for these plans are the same as described above.

Claims for foreign mail-order pharmacies are not covered. ODS does not cover medications imported from foreign countries as this practice is in violation of the Federal Food, Drug, and Cosmetic Act. Medications obtained from foreign sources that are represented as U.S.-approved prescription drugs may be of unknown origin and quality and may create a potential safety risk to individuals. Mail-order prescriptions can be obtained through Walgreen's mail-order service.

Prescriptions for ODS members residing in long-term care facilities

Patients residing in nursing home 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.

PERS PRESCRIPTION DRUG BENEFIT FOR KAISER PERMANENTE

Members enrolled with Kaiser Permanente through PERS are covered under the Kaiser prescription drug benefit. Kaiser Permanente members must use Kaiser facilities and pharmacies to obtain prescriptions. The Kaiser Permanente prescription drug benefit covers drugs that have been approved through the Kaiser Permanente formulary process. The Kaiser Permanente formulary is developed in an ongoing process; 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 warrant 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 Services at the number found on the back cover.

Out-of-pocket maximum

This plan has a calendar year out-of-pocket maximum. Once a member has paid \$4,700 out of pocket 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

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

Kaiser Permanente Mail Delivery

Kaiser Permanente Mail Delivery Pharmacy can save you a trip to the medical office.

The service is free, easy to use and fast. Orders arrive within seven to 10 days.

Members can order prescription refills by phone, via the website or by mail. For covered Part D maintenance drugs,* you can order up to a 90-day supply for 40 percent of the prescription charge with a maximum limit of \$300 per prescription.

Prescriptions for 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 Part D covered drugs, up to a maximum of \$150 per prescription for up to a 31-day supply. Specialty packaging costs are not covered.

*See page 53 for a definition of “maintenance drug.”

Notice about the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or

other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Plan benefit summaries and rate comparisons



2012 Medicare benefit summary

SUPPLEMENT PLAN		
	ODS Medicare Supplement Plan	ODS Advantage PPORX In-network ²
Service area	Refer to page 27	Refer to
Eligible providers	Any licensed Medicare provider	Advantage network providers
Calendar year deductible	\$162 per individual ⁴	None
Calendar year medical out-of-pocket maximum	None	\$2,500 per
	PLAN pays:	INSURED pays:
PHYSICIAN SERVICES		
<ul style="list-style-type: none"> ■ Office visits ■ Specialist visits ■ Preventive visits 	<ul style="list-style-type: none"> ■ 20% after deductible ■ 20% after deductible ■ Covered in full⁵ 	<ul style="list-style-type: none"> ■ \$15 copay ■ \$20 copay ■ Covered in full
LAB & X-RAY		
<ul style="list-style-type: none"> ■ Routine lab test ■ Routine X-ray procedures ■ Diagnostic procedures 	<ul style="list-style-type: none"> ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible 	<ul style="list-style-type: none"> ■ Covered in full ■ 10% ■ 10%
INPATIENT HOSPITAL SERVICES		
<ul style="list-style-type: none"> ■ Covered services 	<ul style="list-style-type: none"> ■ Current Medicare Part A covered in full 	<ul style="list-style-type: none"> ■ \$100 copay per day; \$300 maximum per admit
MISCELLANEOUS SERVICES		
<ul style="list-style-type: none"> ■ Chiropractic care⁸ ■ Ambulance ■ DME ■ Emergency services⁹ ■ Outpatient surgery ■ Skilled nursing ■ Urgent care 	<ul style="list-style-type: none"> ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible ■ Covered in full¹⁰ ■ 20% after deductible 	<ul style="list-style-type: none"> ■ \$20 copay ■ \$50 copay (one-way) ■ 10%¹² ■ \$50 copay ■ \$125 copay ■ Covered in full¹¹ ■ \$20 copay
VISION		
<ul style="list-style-type: none"> ■ Routine eye exam ■ Hardware 	<ul style="list-style-type: none"> ■ Discounts available; contact ODS 	<ul style="list-style-type: none"> ■ \$20 copay ■ Discounts available; contact ODS
PRESCRIPTION DRUGS¹⁵		
<ul style="list-style-type: none"> ■ Generic and brand ■ Rx out-of-pocket maximum 	<ul style="list-style-type: none"> ■ Refer to pages 36-37 ■ 40% of charge, up to a \$150 maximum for each prescription, ■ \$4,700 out-of-pocket maximum per member, per calendar 	

1 Member must select a primary care physician in order to receive in-network benefits. Certain out-of-network services may require prior authorization; please contact Providence Health Plans for a list of those services. If services received from out-of-network provider, excess charges may apply if the provider does not accept Medicare assignment. **2** Prior authorization required for hospital inpatient services, skilled nursing, home healthcare, outpatient surgery, chiropractic, outpatient rehab, DME, prosthetic services and diagnostic procedures. **3** Out-of-network Medicare providers are paid up to the Medicare limiting charge. **4** Part B deductible, required by Medicare, listed in comparison is the 2011 Part B deductible; 2012

This is a summary of benefits only, for general comparison. Any errors or omissions are purely unintentional. document shall prevail.

			MANAGED CARE PLANS	
Out-of-network³	Kaiser Permanente Senior Advantage	PacificSource Medicare Essentials 801		
page 27	Refer to page 27	Refer to page 26		
Any licensed Medicare provider	Kaiser Permanente physicians and hospitals	Plan physicians and hospitals		
	None	None		
individual	\$1,000 per individual	\$3,400 per individual		
	INSURED pays:	INSURED pays:		
<ul style="list-style-type: none"> ■ \$15 copay ■ \$20 copay ■ Covered in full 	<ul style="list-style-type: none"> ■ \$15 copay ■ \$15 copay ■ Covered in full⁶ 	<ul style="list-style-type: none"> ■ \$10 copay ■ \$15 copay ■ Covered in full 		
<ul style="list-style-type: none"> ■ Covered in full ■ 10% ■ 10% 	<ul style="list-style-type: none"> ■ Covered in full ■ Covered in full ■ Covered in full 	<ul style="list-style-type: none"> ■ Covered in full ■ Covered in full ■ Covered in full 		
<ul style="list-style-type: none"> ■ \$100 copay per day; \$300 maximum per admit 	<ul style="list-style-type: none"> ■ \$200 copay per admit 	<ul style="list-style-type: none"> ■ \$125 copay per day (days 1-4 only); \$500 maximum per stay 		
<ul style="list-style-type: none"> ■ \$20 copay ■ \$50 copay (one-way) ■ 10%¹² ■ \$50 copay ■ \$125 copay ■ Covered in full¹¹ ■ \$20 copay 	<ul style="list-style-type: none"> ■ \$15 copay ■ \$50 copay ■ 20%¹² ■ \$50 copay ■ \$15 copay ■ Covered in full¹⁰ ■ \$15 copay 	<ul style="list-style-type: none"> ■ \$15 copay ■ \$50 copay ■ Covered in full¹³ ■ \$50 copay ■ \$125 copay ■ Covered in full¹⁰ ■ \$15 copay 		
<ul style="list-style-type: none"> ■ \$20 copay ■ Discounts available; contact ODS 	<ul style="list-style-type: none"> ■ \$15 copay ■ \$100 credit every 24 months for lenses, frames and/or contacts 	<ul style="list-style-type: none"> ■ \$15 copay; once every 2 calendar years ■ \$100 credit every 2 calendar years for lenses, frames and/or contacts 		
<p>up to a 30-day supply year</p>				

Part B deductible was not available when this guide went to print. Please refer to your 2012 Medicare & You handbook, when available, for the new Part B deductible. Deductible and coinsurance applies to all Medicare Part B-approved services only. **5** Medicare-covered services only. **6** An office visit copayment may apply if non-preventive issues and services are managed during a scheduled preventive visit. **7** If no referral is in place when seeing an in-network specialist, \$30 copay applies. **8** Medicare-covered chiropractic services only. Kaiser and Providence offer discounts for other alternative care services. Contact health plan customer service for more details. **9** ER copays and coinsurance waived if admitted; applies to all health plans. **10** Coverage applies

Should any discrepancies be found between this guide and the plan document, the information in the plan

Providence — Medicare Choice Group ¹		Providence — Medicare Extra Group
In-network	Out-of-network	
Refer to page 26		Refer to page 26
Plan physicians and hospitals	Any licensed Medicare provider	Plan physicians and hospitals
None		None
\$3,400 per individual		Not applicable based on plan design
INSURED pays:		INSURED pays:
<ul style="list-style-type: none"> ■ \$20 copay ■ \$20 copay⁷ ■ Covered in full 	<ul style="list-style-type: none"> ■ \$30 copay ■ \$30 copay ■ 20% 	<ul style="list-style-type: none"> ■ \$15 copay ■ \$15 copay ■ Covered in full
<ul style="list-style-type: none"> ■ Covered in full ■ 10% ■ 10% 	<ul style="list-style-type: none"> ■ 20% ■ 20% ■ 20% 	<ul style="list-style-type: none"> ■ Covered in full ■ Covered in full ■ Covered in full
<ul style="list-style-type: none"> ■ \$350 copay per admit 	<ul style="list-style-type: none"> ■ 20% 	<ul style="list-style-type: none"> ■ \$250 copay per admit; \$500 max. per calendar year
<ul style="list-style-type: none"> ■ \$20 copay ■ \$50 copay (one-way) ■ 10%¹³ ■ \$50 copay ■ \$100 copay ■ Covered in full¹⁴ ■ \$25 copay 	<ul style="list-style-type: none"> ■ 20% ■ \$50 copay (one-way) ■ 20%¹³ ■ \$50 copay ■ 20% ■ 20% ■ \$25 copay 	<ul style="list-style-type: none"> ■ \$15 copay ■ \$50 copay (one-way) ■ Covered in full¹³ ■ \$50 copay ■ Covered in full ■ Covered in full ■ \$25 copay
<ul style="list-style-type: none"> ■ \$20 copay ■ Discounts available through Binyon's and TruVision 	<ul style="list-style-type: none"> ■ \$30 copay ■ Discounts available through Binyon's and TruVision 	<ul style="list-style-type: none"> ■ \$15 copay ■ Discounts available through Binyon's and TruVision

to a Medicare-certified facility for up to 100 days/Medicare benefit period. **11** Skilled nursing: in-network:1-20 days: covered in full; 21-100 days: \$40 copay per day; out-of-network:1-20 days: covered in full; 21-100 days: \$40 copay per day. No prior hospitalization required. **12** Applies to Medicare-approved supplies/equipment only. Some diabetic supplies are covered in full. **13** Applies to Medicare-approved supplies/equipment only and requires preauthorization. Some diabetic supplies are covered in full. **14** Skilled nursing: in-network; 1-20 days: covered in full; 21-100 days: \$50 copay per day. **15** Under ODS, at retail, brand drugs are covered up to a 31-day supply and generic drugs up to a 93-day supply.



2012 Medicare rate comparison

MEDICAL & PRESCRIPTION DRUG MONTHLY PREMIUM RATES

Retirement Health Insurance Account (RHIA) contribution premium rates (applies to all health plans)

The monthly premiums shown below are AFTER the \$60 Retirement Health Insurance Account contribution. More information on the RHIA contribution and eligibility can be found on page 14 of this handbook.

	ODS Supplement Plan	ODS Advantage PPORX	Kaiser Permanente Senior Advantage	PacificSource Medicare Essentials 801	Providence Medicare Choice	Providence Medicare Extra
Retiree with Medicare	\$169.46	\$181.85	\$155.46	\$163.74	\$143.77	\$163.77
Retiree with Medicare, family with Medicare	\$385.19	\$421.45	\$368.92	\$385.48	\$345.86	\$385.92
Retiree with Medicare, family without Medicare	\$948.17	\$951.32	\$832.17	\$1,157.48	\$906.47	\$926.47

Non-contribution premium rates (applies to all health plans)

The monthly premiums shown below are WITHOUT contribution from RHIA or Retiree Health Insurance Premium Account (RHIPA). More information on RHIA and RHIPA contributions and eligibility can be found on pages 14 and 15 of this handbook.

	ODS Supplement Plan	ODS Advantage PPORX	Kaiser Permanente Senior Advantage	PacificSource Medicare Essentials 801	Providence Medicare Choice	Providence Medicare Extra
Retiree with Medicare	\$229.46	\$241.85	\$215.46	\$223.74	\$203.77	\$223.77
Retiree with Medicare, family with Medicare	\$445.19	\$481.45	\$428.92	\$445.48	\$405.86	445.92
Retiree with Medicare, family without Medicare	\$1,008.17	\$1,011.32	\$892.17	\$1,217.48	\$966.47	\$986.47

DENTAL MONTHLY PREMIUM RATES

See benefit comparison for more detailed benefit information.

	ODS	Kaiser Permanente
Retiree only	\$59.97	\$51.62
Retiree and family	\$120.25	\$103.14

PERS Long-Term Care Insurance

(Detailed information not included in this guide.)

Long-term care is the type of care received either at home or in a facility when someone needs assistance with the 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. Information on Unum enrollment and eligibility is available online. All eligible PERS retirees, spouses and dependents may apply for long-term care insurance by contacting Unum at the numbers listed on the back of the booklet.

2012 non-Medicare benefit summary

	Kaiser Permanente	ODS Health Plan, Inc.	
		IN-NETWORK	OUT-OF-NETWORK
Service area	Refer to page 27	Refer to page 27	
Eligible providers	Kaiser Permanente physicians and hospitals	Preferred physicians and providers	Any licensed physician or facility
Calendar year essential benefit plan maximum (medical & Rx)	None	\$2,000,000	
Calendar year deductible	None	\$200 per individual	
Calendar year medical out-of-pocket maximum	\$1,000 per individual	\$2,000+ deductible per individual	\$6,000+ deductible per individual
	INSURED pays:	INSURED pays:	
PHYSICIAN SERVICES			
<ul style="list-style-type: none"> ■ Office visits ■ Specialist visits ■ Preventive visits² 	<ul style="list-style-type: none"> ■ \$15 copay ■ \$15 copay ■ Covered in full 	<ul style="list-style-type: none"> ■ \$20 copay, no deductible ■ \$20 copay, no deductible ■ Covered in full 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible
LAB & X-RAY			
<ul style="list-style-type: none"> ■ Routine lab test ■ Routine X-ray procedures ■ Diagnostic procedures 	<ul style="list-style-type: none"> ■ \$10 copay per visit ■ \$10 copay per visit ■ \$10 copay per visit 	<ul style="list-style-type: none"> ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible
INPATIENT HOSPITAL SERVICES			
<ul style="list-style-type: none"> ■ Covered services 	<ul style="list-style-type: none"> ■ \$200 copay per admit 	<ul style="list-style-type: none"> ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible
MISCELLANEOUS SERVICES			
<ul style="list-style-type: none"> ■ Alternative care ■ Ambulance ■ DME ■ Emergency services ■ Outpatient surgery ■ Skilled nursing ■ Urgent care 	<ul style="list-style-type: none"> ■ Discounts available ■ \$75 copay ■ 20% ■ \$100 copay⁶ ■ \$15 copay ■ Covered in full⁴ ■ \$15 copay 	<ul style="list-style-type: none"> ■ Costs vary by service ■ 20% after deductible ■ 20% after deductible ■ \$200 copay, then 20%⁵ ■ 20% after deductible ■ 20% after deductible ■ \$20 copay, no deductible 	<ul style="list-style-type: none"> ■ Costs vary by service ■ 30% after deductible ■ 30% after deductible ■ \$200 copay, then 20%⁵ ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible
VISION			
<ul style="list-style-type: none"> ■ Routine eye exam ■ Hardware 	<ul style="list-style-type: none"> ■ \$15 copay ■ Not covered 	<ul style="list-style-type: none"> ■ Discounts available; contact ODS 	
PRESCRIPTION DRUGS⁹			
<ul style="list-style-type: none"> ■ Generic and brand ■ Rx out-of-pocket maximum 	<ul style="list-style-type: none"> ■ Refer to pages 36-37 ■ 40% of charge, up to a \$150 maximum for each prescription, up to a 30-day ■ \$4,700 out-of-pocket maximum per member, per calendar year 		

1 Must select a primary care physician (PCP). Six-month waiting period for pre-existing conditions apply.
 2 Preventive services will be covered in accordance with PPACA guidelines. This applies to in-network services under ODS, PacificSource and Providence. 3 Pre-natal, delivery & postnatal physician services require a \$200 copay; deductible does not apply. 4 Covered in full in a Medicare-certified facility for up to 100 days per calendar year. 5 ER copay waived if admitted. Coinsurance is still required. 6 ER copay waived if admitted.

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

PacificSource Health Plans ¹		Providence Health Plans	
IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Refer to page 26		Refer to page 26	
Plan physicians and hospitals	Any licensed physician or facility	Plan physicians and hospitals	Any licensed physician or facility
None		None	
\$200 per individual	\$1,000 per individual	\$200 per individual	
\$2,000+ deductible per individual	\$6,000+ deductible per individual	\$2,000+ deductible per individual	\$6,000+ deductible per individual
INSURED pays:		INSURED pays:	
<ul style="list-style-type: none"> ■ \$15 copay, no deductible³ ■ \$25 copay, no deductible ■ Covered in full 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible 	<ul style="list-style-type: none"> ■ \$20 copay, no deductible ■ \$20 copay, no deductible ■ Covered in full 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible
<ul style="list-style-type: none"> ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible 	<ul style="list-style-type: none"> ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible
<ul style="list-style-type: none"> ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible 	<ul style="list-style-type: none"> ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible
<ul style="list-style-type: none"> ■ \$25 copay, no deductible ■ 20%, no deductible ■ 20% after deductible ■ \$200 copay, no deductible⁶ ■ 20% after deductible ■ 20% after deductible ■ \$25 copay, no deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 20%, no deductible ■ 30% after deductible ■ \$200 copay, no deductible⁶ ■ 30% after deductible ■ 30% after deductible ■ 30%, no deductible 	<ul style="list-style-type: none"> ■ \$15 copay⁷ ■ 20% after deductible ■ 20% after deductible ■ \$200 copay, then 20%⁶ ■ 20% after deductible ■ 20% after deductible ■ 20%, no deductible⁸ 	<ul style="list-style-type: none"> ■ Not covered ■ 20% after deductible ■ 30% after deductible ■ \$200 copay, then 20%⁶ ■ 30% after deductible ■ 30% after deductible ■ 20%, no deductible⁸
<ul style="list-style-type: none"> ■ Not covered ■ Not covered 	<ul style="list-style-type: none"> ■ Discounts available through Binyon's and TruVision 		

supply

⁷ \$1,500 calendar year maximum; contact Providence customer service for a list of contracted providers.
⁸ Urgent/immediate care – ancillary charges billed separately will be subject to the applicable cost share. The deductible will apply to diagnostics (lab, X-rays, etc.) received during the visit. ⁹ Under ODS, at retail, brand drugs are covered up to a 31-day supply and generic drugs up to a 93-day supply.

2012 non-Medicare rate comparison

MEDICAL & PRESCRIPTION DRUG MONTHLY PREMIUM RATES

Non-contribution premium rates (applies to all health plans)

The monthly premiums shown below are WITHOUT contribution from RHIA or Retiree Health Insurance Premium Account (RHIPA). More information on RHIA and RHIPA contributions and eligibility can be found on pages 14-15.

	Kaiser Permanente	ODS PPO Plans	PacificSource Choice POS	Providence Health Plans
Retiree without Medicare	\$678.71	\$827.55	\$919.49	\$720.90
Retiree without Medicare, family without Medicare	\$1,355.42	\$1,516.04	\$1,913.23	\$1,483.60
Retiree without Medicare, family with Medicare	\$892.17	N/A	\$1,127.15	N/A
Retiree without Medicare, family with Medicare (ODS Supplement)	N/A	\$1,029.20	N/A	N/A
Retiree without Medicare, family with Medicare (ODS Advantage PPORX)	N/A	\$963.08	N/A	N/A
Retiree without Medicare, family with Medicare (PHP Medicare Extra)	N/A	N/A	N/A	\$928.93
Retiree without Medicare, family with Medicare (PHP Medicare Choice)	N/A	N/A	N/A	\$908.91

DENTAL MONTHLY PREMIUM RATES

See benefit comparison for more detailed benefit information.

	ODS	Kaiser Permanente
Retiree only	\$59.97	\$51.62
Retiree and family	\$120.25	\$103.14


PERS Long-Term Care Insurance

(Detailed information not included in this guide.)

Long-term care is the type of care received either at home or in a facility when someone needs assistance with the 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. Information on Unum enrollment and eligibility is available online. All eligible PERS retirees, spouses and dependents may apply for long-term care insurance by contacting Unum at the numbers listed on the back of the booklet.

2012 dental benefit summary

	ODS ¹ 	Kaiser Permanente
Medical plan enrollment	PacificSource, Kaiser Permanente, ODS, Providence Health Plans	Kaiser Permanente, ODS, Providence Health Plans
Providers	Any licensed dentist, hygienist and certified denturist working within the scope of their license	Kaiser Permanente dental associates
Calendar year deductible	\$25 per individual	None
Calendar year benefit maximum (plan pays)	\$1,500 per individual	\$1,500 per individual
	INSURED pays:	INSURED pays:
PREVENTIVE CARE		
<ul style="list-style-type: none"> ■ Exams ■ Cleanings ■ Diagnostic 	Available twice in a calendar year <ul style="list-style-type: none"> ■ Covered in full ■ Covered in full ■ Covered in full² 	Limit of two cleanings per year <ul style="list-style-type: none"> ■ \$10 copay per visit ■ \$10 copay per visit ■ \$10 copay per visit
BASIC SERVICES		
<ul style="list-style-type: none"> ■ Restorative (fillings/root canal therapy) ■ Oral surgery (extractions) ■ Endodontic/periodontic 	<ul style="list-style-type: none"> ■ 20% after deductible³ ■ 20% after deductible³ ■ 20% after deductible³ 	<ul style="list-style-type: none"> ■ \$10 copay, then 20% ■ \$10 copay, then 20% ■ \$10 copay, then 20%
MAJOR SERVICES		
<ul style="list-style-type: none"> ■ Crowns ■ Cast restorations ■ Dentures/bridge work ■ Implants 	<ul style="list-style-type: none"> ■ 50% after deductible³ ■ 50% after deductible³ ■ 50% after deductible³ ■ 50% after deductible³ 	<ul style="list-style-type: none"> ■ \$10 copay, then 50% ■ \$10 copay, then 50% ■ \$10 copay, then 50% ■ Not covered
Orthodontic services	Not covered	Not covered
Out-of-area coverage	Worldwide for emergency services only	Kaiser Permanente allows a benefit of up to \$100 of reimbursement on an approved out-of-area emergency claim.
Exclusions and 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.	Certain services are limited or not covered at all. Some exclusions include 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.
RATES		
Retiree only	■ \$59.97	■ \$51.62
Retiree and family	■ \$120.25	■ \$103.14

1 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 134,000 dental professionals nationwide through the Delta Dental Network. Services provided by licensed dentists and certified denturists not participating with ODS or Delta Dental are paid at the out-of-network fee.

2 Some limitations apply.

3 12-month waiting period for basic and major services following enrollment unless member has had continuous dental coverage for the previous 24 months.

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 worksheets

Monthly premium payments for Part B Medicare coverage are automatically deducted from your monthly Social Security payment, if you are receiving those benefits. Otherwise, you will be billed quarterly by Medicare for your Part B premium.

Medicare retiree

(use rates on pages 44 and 45)

I am a:	
<input type="checkbox"/>	Retiree with Medicare
<input type="checkbox"/>	Retiree with Medicare, family with Medicare
<input type="checkbox"/>	Retiree with Medicare, family without Medicare
Medical plan:	
Medical monthly premium:	
Dental plan:	
Dental monthly premium:	
Premium total:	

Monthly premium payments for Part D Medicare coverage are included in the monthly premium rates listed in this handbook.

Non-Medicare retiree

(use rates on pages 48 and 49)

I am a:	
<input type="checkbox"/>	Retiree without Medicare
<input type="checkbox"/>	Retiree without Medicare, family without Medicare
<input type="checkbox"/>	Retiree without Medicare, family with Medicare
<input type="checkbox"/>	Retiree without Medicare, family with Medicare (ODS Supplement)
<input type="checkbox"/>	Retiree without Medicare, family with Medicare (ODS Advantage PPORX)
<input type="checkbox"/>	Retiree without Medicare, family with Medicare (PHP Medicare Extra)
<input type="checkbox"/>	Retiree without Medicare, family with Medicare (PHP Medicare Choice)
Medical plan:	
Medical monthly premium:	
Dental plan:	
Dental monthly premium:	
Premium total:	

Definitions

Area-adjusted per capita cost (AAPCC).

Medicare funding that is region-based. This cost basis is used to determine the amount paid to Medicare Advantage plans for each member.

Benefit period. The way 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. A prepaid amount paid per person to a physician group or organization to cover healthcare services.

Care management. Sometimes also called “case management” or “disease state management,” these services help ensure the best possible care and coordination of care for people who have either chronic or catastrophic conditions.

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

Community plans. Commercial Medicare plans offered to the general public.

Copayment. A fixed amount that the member pays at the time of service. Generally the copayment is the only cost the member will have for a particular service.

Deductible. Generally applied on a calendar-year basis, the deductible 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.

Durable medical equipment (DME). Medicare-approved, medically necessary durable medical equipment is reusable medical equipment such as walkers, wheelchairs, hospital beds, etc.

Employer-sponsored health plan. A plan sponsored by an employer, or by an employer in partnership with a union, that provides medical care to two or more employees.

Fee for service (FFS or private FFS). Another form of reimbursement to physicians. Under this scenario, a physician is not paid until he or she submits a bill for a service rendered. Essentially, this is the opposite of capitation.

Health maintenance organization (HMO). Covers only care rendered by those doctors and other professionals who have agreed to treat patients in accordance with the HMO's guidelines and restrictions. Most HMOs require members to select a primary care physician (PCP). Except for a medical emergency, patients need a referral from the PCP in order to see a specialist or other doctor.

Lifetime maximum. The maximum amount that a plan will pay out in a member's lifetime.

Limiting charge. See “Medicare limiting charge.”

Maintenance drug. A drug that is appropriate for chronic use as prescribed and is supported by evidence 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.

Maximum allowable cost. See “Usual and customary.”

Maximum out-of-pocket. This is the maximum amount of money that a member is responsible for paying in any one calendar year, when a member uses only PPO or participating providers (depending on the contract).

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

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.

Definitions *(continued)*

Medicare limiting charge. Doctors and providers who 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 Part A. Hospital insurance that covers hospital stays, skilled nursing facility care and hospice.

Medicare Part B. Medical insurance that covers doctors' services and outpatient hospital care.

Medicare Part C. Medicare + Choice health plans, which are now referred to as Medicare Advantage plans.

Medicare Part D. Prescription drug plan.

Medicare participating provider. A provider who accepts Medicare patients; this provider may or may not accept Medicare assignment.

Medigap. Medicare supplement insurance that conforms to one of the 10 Medicare-approved plans.

Medsupp. Medicare supplement insurance.

Nonpar. Nonparticipating provider.

Par. Participating provider.

Participating provider. Providers that 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.

Pharmacy benefits manager (PBM). Refers to the type of firms that manage pharmacy benefits for insurance companies and larger self-insured

groups. PBMs make it possible for members to use prescription drug cards and to have their pharmacy benefit processed at the point of sale at the pharmacy.

Point of Service (POS) plan. A type of benefit design that requires members to choose a primary care physician to receive in-network benefits. This type of plan also offers lower benefits (or the same benefits, depending on the contract) to members who receive benefits out of network.

PPO provider. Preferred Provider Organization (PPO) relates to a panel of doctors. Similar to participating providers, PPO providers sign contracts and cannot charge members more than the contracted fee. These providers agree to discount their charges.

Preferred Provider Organization (PPO) plan. A type of benefit design that includes different levels of benefits depending on whether or not services are received from a preferred provider. These plans have specific service areas where preferred providers are available, although they usually cover wider geographic regions than managed care plans.

Retiree Health Insurance Premium Account (RHIPA). A monthly subsidy that PERS contributes toward the cost of a non-Medicare State of Oregon retiree's health insurance premium. A retiree must have eight or more years of creditable service with a PERS employer and must have retired directly from a state agency. City, county and district employers, including schools, are not considered state agencies. See page 15 for further explanation.

Retirement Health Insurance Account (RHIA).

A monthly subsidy that PERS contributes toward the cost of a retiree's health insurance premiums. A retiree must be enrolled in Medicare Parts A and B and have eight or more years of creditable service with a PERS employer. See page 14 for further explanation.

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 designations 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 and abbreviations

Cap – capitation	MCO – managed care organization
CD – chemical dependency	MH – mental health
CMS – Centers for Medicare and Medicaid Services	MM – major medical
COB – coordination of benefits	MOP – maximum out-of-pocket
COBRA – Consolidated Omnibus Budget Reconciliation Act (Federal act)	MPA – maximum plan allowance
COC – certificate of coverage	MSP – Medicare secondary payer
DAW – dispense as written	OOA – out-of-area
DME – durable medical equipment	OOP – out-of-pocket
DO – doctor of osteopathic medicine	OV – office visit
DRGs – diagnostic-related groups	PCP – primary care physician (provider)
DUR – drug utilization review	PDL – preferred drug list
DX – diagnosis	PDP – prescription drug plan
DXL – diagnostic X-ray and lab	PHI – protected health information
E&I – experimental and investigational	POS – point of service
EDI – electronic data interchange	PPACA - Patient Protection and Affordable Care Act
EFT – electronic funds transfer	PPO – Preferred Provider Organization
EOB – explanation of benefits	QA – quality assurance
ESRD – end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant)	Rx – prescription drug
FFS – fee for service	SB – Senate Bill
HCFA – Health Care Financing Administration (now CMS, a Federal agency)	SHIBA – Senior Health Insurance Benefits Assistance Program (a State of Oregon agency)
HIPAA – Health Insurance Portability and Accountability Act (Federal act and state law)	SNF – skilled nursing facility
HMO – health maintenance organization	TMJ – temporomandibular joint (jaw)
IBNR – incurred but not reported	U&C, R&C, UCR – usual and customary; reasonable and customary; usual, customary and reasonable
LCSW – licensed clinical social worker	UR – utilization review
LTC – long-term care	WHCRA – Women’s Health and Cancer Rights Act
MA – Medicare Advantage	YTD – year-to-date

Contact information

PERS Health Insurance Program

www.pershealth.com

In Portland: 503-224-7377 / Toll-free: 800-768-7377

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

Mailing address:

P.O. Box 40187, Portland, OR 97240-0187

PERS Pension Office

(Pension questions only)

www.oregon.gov/pers

In Portland: 503-598-7377 / Toll-free: 888-320-7377

Mailing address:

P.O. Box 23700, Tigard, OR 97281-3700

PERS Long-Term Care Insurance

Unum Life Insurance Company of America

<http://w3.unum.com/enroll/PERS>

Toll-free: 800-227-4165

Social Security Administration

www.ssa.gov

Toll-free: 800-772-1213

Medicare

(Centers for Medicare and Medicaid Services)

www.medicare.gov

Toll-free: 800-Medicare (800-633-4227)

Other websites noted within

<http://arcweb.sos.state.or.us/banners/rules.htm>

Kaiser Permanente

www.kp.org

Medicare members:

877-221-8221

Non-Medicare members:

In Portland: 503-813-2000 / Toll-free: 800-813-2000

Teletypewriter (TTY): 800-735-2900

Mail-order pharmacy:

In Portland: 503-778-2678 / Toll-free: 800-548-9809

ODS

www.odscompanies.com

Medical questions:

(Medicare supplement and non-Medicare PPO)

In Portland: 503-243-3880 / Toll-free: 800-962-1533

ODS Advantage PPORX (Medicare):

www.odscompanies.com/odsadvantage

In Portland: 503-265-4761 / Toll-free: 877-299-9061

Teletypewriter (TTY): 711

Dental questions:

In Portland: 503-243-4494 / Toll-free: 800-452-1058

PERS Pharmacy Program

(PacificSource, ODS and Providence members only)

In Portland: 503-265-4709 / Toll-free: 888-786-7509

PacificSource Health Plans

www.pacificsource.com

Medicare:

Direct: 541-385-5315 / Toll-free: 888-863-3637

Teletypewriter (TTY): 800-735-2900

www.medicare.pacificsource.com

Non-Medicare:

Direct: 541-686-1242 / Toll-free: 800-624-6052

Providence Health Plans

www.providencehealthplan.com

Medicare members:

In Oregon: 503-574-8000 / Toll-free: 800-603-2340

Non-Medicare members:

In Oregon: 503-574-7500 / Toll-free: 800-878-4445

Teletypewriter (TTY): 503-574-8702 or 888-244-6642