

2021

# Summary of Benefits

## CareOregon Advantage **Plus** (HMO-POS SNP)

For Oregon counties: Clackamas, Columbia, Jackson,  
Multnomah, Tillamook and Washington



## CAREOREGON ADVANTAGE PLUS (HMO-POS SNP)

(A Medicare Advantage Health Maintenance Organization with Point of Service Option (HMO-POS) offered by HEALTH PLAN OF CAREOREGON, INC. with a Medicare contract.)

### SUMMARY OF BENEFITS

*January 1, 2021 - December 31, 2021*

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

To join **CareOregon Advantage Plus (HMO-POS SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and The Oregon Health Plan, and live in our service area.

Our service area includes the following counties in Oregon: Clackamas, Columbia, Jackson, Multnomah, Tillamook and Washington.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**CareOregon Advantage Plus (HMO-POS SNP)** has a network of doctors, hospitals, pharmacies, and other providers. For some services, you can use providers that are not in our network.

- You can see our plan's provider directory at our website ([careoregonadvantage.org/providersearch](http://careoregonadvantage.org/providersearch)).
- You can see our plan's pharmacy directory at our website ([careoregonadvantage.org/pharmacy](http://careoregonadvantage.org/pharmacy)).
- You can see our plan's formulary (list of Part D prescription drugs) and any restrictions on our website, ([careoregonadvantage.org/druglist](http://careoregonadvantage.org/druglist)).

Or, call us and we will send you a copy of the provider and pharmacy directories or the formulary.

This document is available in other formats such as braille or large print.

This document may be available in a non-English language.

*CareOregon Advantage Plus is an HMO-POS SNP with a Medicare/Medicaid contract.*

*Enrollment in CareOregon Advantage Plus depends on contract renewal.*

*Out-of-network/non-contracted providers are under no obligation to treat CareOregon Advantage Plus members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.*

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## Discrimination is Against the Law

CareOregon Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CareOregon Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CareOregon Advantage:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CareOregon Advantage Customer Service.

If you believe that CareOregon Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Coordinator

315 SW Fifth Ave

Portland, OR 97204

Toll-free: 888-712-3258

Fax: 503-416-1313 TTY/TDD: 711

Email: [MedicareEnrollmentServices@careoregon.org](mailto:MedicareEnrollmentServices@careoregon.org)

You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance, Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

<b>Premiums and Benefits</b>	<b>CareOregon Advantage Plus (HMO-POS SNP)</b>
<b>Monthly premium</b>	<p>You pay \$0 or \$36.00 per month</p> <p>In addition, you must keep paying your Medicare Part B premium.</p>
<b>Deductible</b>	<p>You pay <b>\$203</b>.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay <b>\$0</b>.</p>
<b>Maximum Out-of-Pocket Responsibility (does not include prescription drugs)</b>	<p>You pay \$3,450 per year</p> <p>You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. You will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<b>Inpatient Hospital Services</b>	<p>You pay:</p> <ul style="list-style-type: none"> <li>• \$1,484 deductible for each benefit period</li> <li>• Days 1-60: \$0</li> <li>• Days 61-90: \$371 copay per day</li> <li>• Days 91-150: \$742 copay per lifetime reserve day</li> </ul> <p>May require prior authorization. May require a referral from your doctor.</p>
<b>Outpatient Hospital Services</b>	<p>0% or 20% of the cost for each:</p> <ul style="list-style-type: none"> <li>• Medicare-covered ambulatory surgical center visit</li> <li>• Medicare-covered outpatient hospital facility visit</li> </ul> <p>May require prior authorization. May require a referral from your doctor.</p>
<b>Doctor's Office Visits</b>	<p>Primary care physician visit:</p> <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> <li>• Out-of-network: 20% of the cost</li> </ul> <p>Specialist visit:</p> <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> <li>• Out-of-network: 20% of the cost</li> </ul> <p>Routine physical:</p> <ul style="list-style-type: none"> <li>• In-network: \$0</li> <li>• Out-of-network: 20% of the cost</li> </ul> <p>There is a limit to how much our plan will pay for out-of-network services. Some services may require a referral from your primary care physician.</p>
<b>Preventive Care</b>	<p>In-network: You pay nothing</p>
<b>Emergency Care</b>	<p>0% or 20% of the cost (up to \$120)</p>

<b>Premiums and Benefits</b>	<b>CareOregon Advantage Plus (HMO-POS SNP)</b>	
<b>Urgently Needed Services</b>	0% or 20% of the cost (up to \$65)	
<b>Diagnostic Services, Labs and Imaging</b>	Diagnostic radiology services (such as MRIs, CT scans): <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> </ul> Diagnostic tests and procedures: <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> </ul> Lab services: <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> </ul> Outpatient X-rays: <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> </ul> Therapeutic radiology services (such as radiation treatment for cancer): <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> </ul>	May require prior authorization. May require a referral from your doctor.
<b>Hearing Services</b>	In-network: 0% or 20% of the cost If ordered by a physician as a diagnostic test, some exams are covered by our plan.	
<b>Dental Services</b>	In-network: 0% or 20% of the cost Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth)	
<b>Vision Services</b>	<b>Standard</b> You pay 0% or 20% of the cost for: <ul style="list-style-type: none"> <li>- Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk.</li> <li>- one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.</li> </ul> <b>Supplemental</b> <ul style="list-style-type: none"> <li>- \$0 copay for up to 1 supplemental eye exam every year.</li> <li>- \$0 copay for up to 1 pair of eyeglass frames or contact lenses every year. (\$175 plan coverage limit for frames/\$100 limit for contacts)</li> </ul> You pay nothing for: <ul style="list-style-type: none"> <li>- up to 1 pair of basic eyeglass lenses per year (including standard progressive lenses)</li> </ul>	
<b>Mental Health Services</b>	<b>Inpatient services</b> You pay: <ul style="list-style-type: none"> <li>• \$1,484 deductible for each benefit period</li> <li>• Days 1-60: \$0</li> <li>• Days 61-90: \$371 copay per day</li> <li>• Days 91-150: \$742 copay per lifetime reserve day</li> </ul> May require prior authorization. May require a referral from your doctor.	<b>Outpatient services</b> Outpatient group therapy visit: <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> </ul> Outpatient individual therapy visit: <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> </ul>

<b>Premiums and Benefits</b>	<b>CareOregon Advantage Plus (HMO-POS SNP)</b>
<b>Skilled Nursing Facility (SNF)</b>	<p>You pay:</p> <p>In-network: you pay \$0 or:</p> <ul style="list-style-type: none"> <li>• You pay nothing for days 1-20</li> <li>• \$185.50 copay per day for days 21-100</li> </ul> <p>May require prior authorization. May require a referral from your doctor.</p>
<b>Physical Therapy</b>	<p>In-network, you pay 0% or 20% of the cost.</p> <p>May require prior authorization. May require a referral from your doctor.</p>
<b>Ambulance</b>	<p>In-network: 0% or 20% of the cost</p>
<b>Ambulatory Surgical Center</b>	<p>In-network: 0% or 20% of the cost</p> <p>May require prior authorization. May require a referral from your doctor.</p>
<b>Transportation</b>	<p>Not covered</p>
<b>Medicare Part B Drugs</b>	<p>0% or 20% of the cost for Medicare Part B chemotherapy drugs and other Part B drugs.</p>
<b>Foot Care (podiatry services)</b> -Foot exams and treatment -Routine foot care	<p>You pay:</p> <ul style="list-style-type: none"> <li>• In-network: 0% or 20% of the cost</li> <li>• In-network: You pay nothing for unlimited visits</li> </ul> <p>May require a referral from your doctor</p>
<b>Diabetes Supplies and Services</b>	<p>You pay nothing for:</p> <ul style="list-style-type: none"> <li>• Diabetes self-management training</li> </ul> <p>You pay 0% or 20% of the cost for:</p> <ul style="list-style-type: none"> <li>• Therapeutic shoes or inserts</li> <li>• Diabetes monitoring supplies</li> </ul> <p>May require prior authorization.</p>
<b>Meal Delivery Program (for post-discharge only)</b>	<p>There is no cost to use this benefit.</p> <p>After your discharge from an inpatient stay in a hospital, rehab or skilled nursing facility, you are eligible to receive up to 14-days of meals delivered to your home (maximum 28 meals, or two meals per day).</p> <p>A referral is required.</p>

Premiums and Benefits	CareOregon Advantage Plus (HMO-POS SNP)
<b>Health and Wellness Education Programs</b>	<p>There are no costs for these services  <b>Nurse Advice Line:</b> 866-209-0905            Available 24 hours a day, 7 days a week.  <b>Fitness Program:</b> Includes gym membership at participating Silver&amp;Fit® locations. At-home fitness kits are offered for members who can't get to a fitness location.</p>
<b>Help with Certain Chronic Conditions</b>	<p>For people with diabetes who have copays (low-income copay level 1 or 2) and who take at least one of the following drugs, you are eligible for \$0 copays when you fill a three-month supply (84-90-days). These drugs include:</p> <ul style="list-style-type: none"> <li>• Diabetes drugs, including insulin</li> <li>• Drugs to lower your blood pressure</li> <li>• Drugs to lower your cholesterol</li> </ul> <p><b>If you fill for less than a three-month supply, your normal cost-sharing amount will apply.</b> Ask your prescriber to write a three-month supply of your prescription(s). If you need help converting to a three-month supply of your medication, we can help by contacting your prescriber.</p>
<b>OTC <i>plus</i> Debit Card</b>	<p>There is no cost to use this benefit</p> <p>You get \$190 every three months (quarterly) to purchase health related over-the-counter items and/or Healthy Foods using a pre-loaded debit card at participating retailers.</p>

## Outpatient Prescription Drugs

<b>Initial Coverage Stage</b>	<p>Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> <li>•\$0 copay; or</li> <li>•\$1.30 copay; or</li> <li>•\$3.70 copay</li> </ul> <p>For brand drugs, either:</p> <ul style="list-style-type: none"> <li>•\$0 copay; or</li> <li>•\$4.00 copay; or</li> <li>•\$9.20 copay</li> </ul>	<p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy but may pay more than at an in-network pharmacy.</p>
<b>Catastrophic Coverage Stage</b>	<p>You pay nothing for all drugs, after your yearly out-of-pocket drug costs reach \$6,550</p>	



## Medicaid Covered Services

In this section, you can see a summary of the Medicaid benefits you may receive through the Oregon Health Plan. As long as you are eligible for the Oregon Health Plan and Medicare Parts A and B, the Medicaid Benefits Packages you can have through the Oregon Health Plan are the QMB + OHP Limited Drug Benefit Package, or the OHP with Limited Drug Benefit Package.

Please contact your State Medicaid case worker if you do not know which benefit package you have through the Oregon Health Plan.

This section does not list every Medicaid service covered or list every limitation or exclusion. To get a complete list of Medicaid benefits, please contact your Medicaid health plan Customer Service.

**You must be eligible for the Oregon Health Plan, Medicaid in order to receive the benefits listed in this section.**

### **Oregon Health Plan (OHP) Medicaid Benefit Packages:**

#### **QMB + OHP with Limited Drug Benefit Package**

This benefit package is for people who qualify to have their Medicare Parts A and B cost sharing paid for by Medicaid. If you receive the QMB + OHP with Limited Drug Benefit Package you get the benefits listed in the chart below.

The cost sharing amounts listed in Section II for the Medicare Parts A and B covered services are paid for you by your Medicaid health plan. Your provider cannot bill you for any amounts beyond what your Medicare and Medicaid plans pay.

You will still have to pay your Medicare Part D prescription drug cost sharing.

#### **OHP with Limited Drug Benefit Package**

This benefit package is for people who only qualify to have their Medicare Parts A and B cost sharing paid for by Medicaid for services normally covered by the Oregon Health Plan. If you receive the OHP with Limited Drug Benefit Package you get the benefits listed in the chart below.

The cost sharing amounts listed in Section II for Medicare Parts A and B covered services will be covered only for services that the Oregon Health Plan would normally cover. Your provider cannot balance bill you for any amounts beyond what your Medicare and Medicaid plans pay for services normally covered by the Oregon Health Plan.

If you receive a Medicare-covered service that is not normally covered by the Oregon Health Plan you will have to pay the Medicare Parts A and B cost sharing yourself. See page 14 for more information on services not covered by the Oregon Health Plan.

You will still have to pay your Medicare Part D prescription drug cost sharing.

Below is a list of services that are covered by the Oregon Health Plan Medicaid and your Medicaid-managed care plan (does not include every service available):

Benefit Category	Oregon Health Plan Medicaid (member costs)	Your Medicaid-Managed Care Plan (member costs)
<b>Premium and Other Important Information</b>	This is a brief summary. Please refer to OHP member handbook for a detailed description of Medicaid benefits available to eligible Oregonians.	This is a brief summary. Please refer to your Medicaid member handbook for a detailed description of Medicaid benefits available to eligible Oregonians.  All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.
<b>Doctor and Hospital Choice</b> <i>(For more information, see the Emergency and Urgently Needed Care sections)</i>	Allows Fee-for-Service patients to go to any provider that accepts Medicaid.	Allows patients to go to any provider that accepts Medicaid.  You must go to network doctors, specialists, and hospitals.  Referral required for network hospitals and specialists (for certain benefits).

### Inpatient Care

Benefit Category	Oregon Health Plan Medicaid (member costs)	Your Medicaid-Managed Care Plan (member costs)
<b>Inpatient Hospital Care</b>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.
<b>Inpatient Mental Health Care</b>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.
<b>Skilled Nursing Facility</b> <i>(In a Medicare-certified skilled nursing facility)</i>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.
<b>Home Health Care</b> <i>(Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.
<b>Hospice</b>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.

## Outpatient Care

<b>Benefit Category</b>	<b>Oregon Health Plan Medicaid (member costs)</b>	<b>Your Medicaid-Managed Care Plan (member costs)</b>
<b>Doctor Office Visits</b>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.
<b>Chiropractic Services</b>	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.
<b>Podiatry Services</b>	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.
<b>Outpatient Mental Health Care</b>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.
<b>Outpatient Substance Abuse Care</b>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.
<b>Outpatient Services/Surgery</b>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.
<b>Ambulance Services</b> <i>(Medically necessary ambulance services)</i>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.
<b>Emergency Care</b> <i>(You may go to any emergency room if you reasonably believe you need emergency care.)</i>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.
<b>Urgently Needed Care</b> <i>(This is NOT emergency care, and in most cases, is out of the service area.)</i>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.
<b>Outpatient Rehabilitation Services</b> <i>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</i>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other health care provider for Medicaid-covered outpatient services.

## Outpatient Medical Services and Supplies

<b>Benefit Category</b>	<b>Oregon Health Plan Medicaid (member costs)</b>	<b>Your Medicaid-Managed Care Plan (member costs)</b>
<b>Durable Medical Equipment</b>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.
<b>Prosthetic Devices</b>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.
<b>Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</b>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.
<b>Diagnostic Tests, X-Rays, and Lab Services</b>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.

## Preventive Services

<b>Bone Mass Measurement</b>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.*	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.
<b>Colorectal Screening Exams</b>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.*	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.
<b>Routine Immunizations</b>	\$0 copayment for Medicaid-covered services, except immunizations given for travel and other reasons.	\$0 copayment for Medicaid-covered services.
<b>Mammograms (Annual Screening)</b> <i>Covered annually under Medicaid</i>	\$0 copayment for Medicaid-covered services.	\$0 copayment for Medicaid-covered services.
<b>Pap Smears and Pelvic Exams</b> <i>Covered annually under Medicaid</i>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for Medicaid-covered pap smears services.
<b>Prostate Cancer Screening Exams</b>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.
<b>End-Stage Renal Disease</b>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.

*\*Some services may not include a copayment if accessed in settings such as outpatient diagnostic settings at a hospital.*

<b>Benefit Category</b>	<b>Oregon Health Plan Medicaid (member costs)</b>	<b>Your Medicaid-Managed Care Plan (member costs)</b>
<b>Prescription Drugs</b>	<p>\$0 copayment for drugs</p> <p>Mental health drugs are covered by the state and not your Medicaid managed care health plan.</p>	<p><b>Part D medications</b> - Covered by your Medicare health plan <i>(See page 7 for details)</i></p> <p><b>Part B Medications</b> - You pay \$0 yearly deductible for Part B-covered drugs.</p> <p>In-Network \$0 copayment for Medicaid covered service (not including Part B-covered chemotherapy drugs). Prior Authorization rules may apply</p> <p>In-Network \$0 copayment for Medicaid covered service for Part B-covered chemotherapy drugs. Prior Authorization rules may apply</p> <p><b>Medicaid-covered Medications</b> -</p> <ul style="list-style-type: none"> <li>• Select over-the-counter drugs when accompanied by a prescription</li> <li>• Select vitamins and minerals when accompanied by a prescription</li> </ul> <p>Mental Health Drugs are not covered by your Medicaid Managed Care Plan.</p> <p>Your Medicaid Managed Care Plan uses a drug list (formulary). You can see the formulary on the web site of your Managed Care Plan.</p>
<b>Dental Services</b>	<p>\$0 copayment for restorative treatment.</p> <p>\$0 copayment for Medicaid covered Dental diagnostic and preventative routine checkup services.</p>	<p>\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p>
<b>Hearing Services</b>	<p>\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p>	<p>\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p>
<b>Vision Services</b>	<p>\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p>	<p>\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p>

<b>Physical Exams</b>	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.	\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.
<b>Health/Wellness Education</b>	Not covered	Not covered
<p><b>Other Non-Covered Medicare services that will be covered by the Oregon Health Plan:</b></p> <p>Preventative Services</p> <ul style="list-style-type: none"> <li>• Maternity Case Management, including nutritional counseling.</li> <li>• Maternity and newborn care</li> <li>• Well-child exams and immunizations</li> </ul> <p>Family Planning Services:</p> <ul style="list-style-type: none"> <li>• Including birth control pills, condoms, contraceptive implants, and Depo-Provera</li> <li>• Sterilizations</li> </ul> <p>Other Oregon Health Plan Services:</p> <ul style="list-style-type: none"> <li>• Death with dignity services*</li> <li>• Abortions*</li> </ul> <p><b>*Please Note:</b> these services are covered by the state and not by your Medicaid Managed Care health plan.</p>	<p>\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p> <p>\$0 copayment for Medicaid-covered X-ray, lab, routine immunization and family planning services.</p>	<p><b>In-Network</b></p> <p>\$0 copayment for visits to a doctor or other healthcare provider for Medicaid-covered outpatient services.</p> <p>\$0 copayment for Medicaid-covered X-ray, lab, routine immunization and family planning services.</p> <p><b>In-Network</b></p> <p>\$0 copayment for Medicaid-covered Preventative and Family Planning services.</p> <p>Prior Authorization rules may apply</p> <p>Services not covered by your Medicaid Managed Care Plan:</p> <ul style="list-style-type: none"> <li>• Death with dignity services*</li> <li>• Abortions*</li> </ul>

## **Services That Are Not Covered by the Oregon Health Plan Medicaid (Exclusions):**

Not all medical treatments are covered. When you need medical treatment, contact your Primary Care Provider. These are some of the exclusions (does not include every exclusion):

- Medicare Part D covered prescription drugs
- Conditions where a “home” treatment is effective, such as applying an ointment, resting a painful joint, drinking plenty of fluids, or a soft diet. Such conditions include:
  - Canker sores
  - Diaper rash
  - Corns/calluses
  - Sunburn
  - Food poisoning
  - Sprains
- Personal comfort or convenience items (radios, telephones, hot tubs, treadmills, etc.)
- Services that are primarily cosmetic, such as:
  - Benign skin tumors
  - Cosmetic surgery
  - Removal of scars
- Conditions where treatment is not normally effective, such as:
  - Some back surgery
  - TMJ surgery
  - Some transplants
- Services performed by an immediate relative or member of your household
- Any services received outside the United States
- Non-emergency care if you go to a provider who is not a network provider
- Other non-covered services include, but are not limited to, the following:
  - Circumcision (routine)
  - Weight loss program
  - Infertility services

If you have questions about covered or non-covered services, contact your Medicaid Managed Health plan Customer Service.

**Hours of Operation:**

- From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m., Pacific time.
- From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m., Pacific time.

**CareOregon Advantage Plus (HMO-POS SNP) Phone Numbers and Website:**

- If you are a member of this plan, call 503-416-4279 or toll-free at 888-712-3258. TTY/TDD users can call 711.
- If you are **not** a member of this plan, call 503-416-4279 or toll free at 888-712-3258. TTY/TDD users can call 711.
- Our website: [careoregonadvantage.org](http://careoregonadvantage.org)

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, [careoregonadvantage.org/druglist](http://careoregonadvantage.org/druglist).

Or, call us and we will send you a copy of the formulary.



**CareOregon Advantage Customer Service**

**CALL:** 503-416-4279 or toll-free 888-712-3258

**TTY/TDD:** 711

**HOURS OF OPERATION:** every day, 8 a.m. to 8 p.m.



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