OREGON PERS HEALTH INSURANCE PROGRAM
2017 MEDICARE BENEFIT COMPARISON

	SUPPLEMENT PLAN	MEDICARE ADVANTAGE PLANS						
	Moda Health Medicare Supplement Plan [1]	**PERS Moda Health PPORX (PPO)**		**Kaiser Permanente Senior Advantage (HMO)**	**PacificSource Medicare Essentials RX 803**	**Providence – Medicare Flex Group Plan + Rx (HMO-POS) [2]**		**Providence – Medicare Align Group Plan + Rx (HMO)**
		In – Network [3]	**Out – of – Network [4]**			**In – Network**	**Out – of – Network**	
Eligible Providers	Any licensed Medicare Provider	Medicare Advantage Network Providers	Any licensed Medicare Provider	Kaiser Permanente and The Portland Clinic Physicians and Hospitals	Plan Physicians and Hospitals	Plan Physicians and Hospitals	Any licensed Medicare Provider	Plan Physicians and Hospitals
	MEMBER PAYS:	**MEMBER PAYS:**		**MEMBER PAYS:**	**MEMBER PAYS:**	**MEMBER PAYS:**		**MEMBER PAYS:**
Calendar Year Deductible	$166 per individual [5]	None		None	None	None		None
Calendar Year Medical Out-of-Pocket Maximum	None	$2,500 per individual		$1,000 per individual	$3,400 per individual	$3,000 per individual		$1,500 per individual
INPATIENT CARE								
▪ Inpatient Hospital Care	▪ Covered in full	▪ $100 copay/day; $300 max. per admit	▪ 20%	▪ $200 copay per admit	▪ $125 copay/day (days 1-4 only); $500 max. per admit	▪ $125 copay/day; $500 max. per admit	▪ 20%	▪ $100 copay/day; $500 max. per admit
▪ Skilled Nursing Facility	▪ Covered in full	▪ Covered in full	▪ 20%	▪ Covered in full	▪ Covered in full	▪ Covered in full	▪ 20%	▪ Covered in full
OUTPATIENT CARE								
▪ Physician Office Visits	▪ Covered in full	▪ $15 copay	▪ $25 copay	▪ $15 copay	▪ $15 copay	▪ $20 copay	▪ $30 copay	▪ $15 copay
▪ Specialist Office Visits	▪ Covered in full	▪ $20 copay	▪ $30 copay	▪ $15 copay	▪ $20 copay	▪ $25 copay [8]	▪ $35 copay	▪ $20 copay
▪ Outpatient Surgery	▪ Covered in full	▪ $125 copay	▪ 20%	▪ $15 copay	▪ $125 copay	▪ $150 copay	▪ 20%	▪ $75 copay
▪ Ambulance	▪ Covered in full	▪ $50 copay (one-way)	▪ $50 copay (one-way)	▪ $50 copay	▪ $50 copay	▪ $50 copay (one-way)	▪ $50 copay (one-way)	▪ $50 copay (one-way)
▪ Emergency Services	▪ Covered in full	▪ $65 copay	▪ $65 copay	▪ $50 copay	▪ $50 copay	▪ $65 copay	▪ $65 copay	▪ $50 copay
▪ Urgent Care	▪ Covered in full	▪ $20 copay	▪ $20 copay	▪ $15 copay	▪ $20 copay	▪ $25 copay	▪ $25 copay	▪ $25 copay
▪ DME	▪ Covered in full	▪ 20% [7]	▪ 30% [7]	▪ 20% [7]	▪ 20% [7]	▪ 20% [7]	▪ 20% [7]	▪ 20% [7]
▪ Lab Test	▪ Covered in full	▪ Covered in full	▪ 20%	▪ Covered in full	▪ Covered in full	▪ Covered in full	▪ 20%	▪ Covered in full
▪ Diagnostic Imaging (X-ray/CT/MRI)	▪ Covered in full	▪ 10%	▪ 20%	▪ Covered in full	▪ 10%	▪ 10%	▪ 20%	▪ 10%
▪ OT/PT/ST Therapies [6]	▪ Covered in full	▪ $20 copay	▪ $30 copay	▪ $15 copay	▪ $20 copay	▪ $25 copay	▪ $35 copay	▪ $20 copay
PREVENTIVE CARE								
▪ Annual Wellness Exam	▪ Covered in full [1]	▪ Covered in full	▪ Covered in full	▪ Covered in full	▪ Covered in full [9]	▪ Covered in full	▪ Covered in full	▪ Covered in full
▪ Women's Preventive	▪ Covered in full [1]	▪ Covered in full	▪ Covered in full	▪ Covered in full	▪ Covered in full [9]	▪ Covered in full	▪ Covered in full	▪ Covered in full
▪ Prostate Cancer Screening	▪ Covered in full [1]	▪ Covered in full	▪ Covered in full	▪ Covered in full	▪ Covered in full [9]	▪ Covered in full	▪ Covered in full	▪ Covered in full
▪ Immunizations	▪ Covered in full [1]	▪ Covered in full	▪ Covered in full	▪ Covered in full	▪ Covered in full [9]	▪ Covered in full	▪ Covered in full	▪ Covered in full
OTHER SERVICES								
▪ Chiropractic Care [10]	▪ Covered in full	▪ $20 copay	▪ $30 copay	▪ $15 copay	▪ $15 copay	▪ $20 copay	▪ $30 copay	▪ $20 copay
▪ Vision Routine Eye Exam	▪ Discounts available, contact Moda Health	▪ $20 copay	▪ $20 copay	▪ $15 copay	▪ $15 copay	▪ $20 copay	▪ Discounts available, contact Providence Health Plan	▪ $15 copay
▪ Vision Hardware		▪ $100 credit every 24 months for lenses, frames and/or contacts	▪ $100 credit every 24 months for lenses, frames and/or contacts	▪ $100 credit every 2 calendar years for lenses, frames and/or contacts	▪ $100 credit every 24 months for lenses, frames and/or contacts	▪ $100 credit every 2 years for frames and/or contacts		▪ $100 credit every 2 years for frames and/or contacts
PRESCRIPTION DRUGS	**THIS IS A MEDICARE PART D PRESCRIPTION DRUG PLAN included with all Medicare medical plans**							
▪ Brand & Generic	40% of charge up to a $250 maximum per prescription for a 31-day supply			40% of charge up to a $250 maximum per prescription for a 30-day supply	40% of charge up to a $250 maximum per prescription for a 31-day supply	40% of charge up to a $250 maximum per prescription for a 31-day supply		
Calendar Year Prescription Drug Out-of-Pocket Maximum	$4,950 out-of-pocket maximum per member per calendar year			$4,950 out-of-pocket maximum per member per calendar year	$4,950 out-of-pocket maximum per member per calendar year	$4,950 out-of-pocket maximum per member per calendar year		

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.

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[1] Medicare covered services only.
[2] Member must select a Primary Care Physician (PCP) from network in order to receive In-Network benefits. Certain out-of-network services may require prior-authorization. If services received from out-of-network provider, excess charges may apply if the provider does not accept Medicare assignment.
[3] Prior Authorization required for hospital inpatient services, skilled nursing, home health care, outpatient surgery, chiropractic, outpatient rehab, DME, prosthetic services and diagnostic procedures.
[4] Out-of-network Medicare providers are paid up to the Medicare limiting charge.
[5] Part B deductible, required by Medicare, listed in the comparison is the 2016 Part B deductible; 2017 Part B deductible was not available when this handbook went to print. *Please refer to Medicare.gov/your-Medicare-costs/costs-at-a-glance for the 2017 Part B deductible.* Deductible and coinsurance applies to all Medicare Part B approved services only.
[6] Outpatient Rehab: OT= Occupational Therapy, PT= Physical Therapy, ST= Speech Therapy
[7] Applies to Medicare approved supplies/equipment only and may require Pre-Authorization. Some diabetic supplies are covered in full.
[8] If no referral is in place when seeing an In-network specialist, $35 copay applies.
[9] An office visit copayment may apply if non-preventive issues and services are managed during a scheduled preventive visit.
[10] Medicare covered chiropractic services only.