# Medicare Covered Services Only

Medicare covered services only.

# Applies to Medicare Approved Supplies/Equipment Only and May Require Pre-Authorization

Applies to Medicare approved supplies/equipment only and may require Pre-Authorization. Some diabetic supplies are covered in full.

# Outpatient Rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy

Outpatient Rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy

# Part B Deductible, Required by Medicare, Listed in Above Comparison Is the 2017 Part B Deductible; 2018 Part B Deductible Was Not Available When This Went to Print

Part B deductible, required by Medicare, listed in above comparison is the 2017 Part B deductible; 2018 Part B deductible was not available when this went to print.

# Out-Of-Network Medicare Providers Are Paid Up to the Medicare Limiting Charge

Out-of-network Medicare providers are paid up to the Medicare limiting charge.

# Prior Authorization Required for Hospital Inpatient Services, Skilled Nursing, Home Health Care, Outpatient Surgery, Outpatient Rehab, DME, Prosthetic Services and Diagnostic Procedures

Prior Authorization required for hospital inpatient services, skilled nursing, home health care, outpatient surgery, outpatient rehab, DME, prosthetic services and diagnostic procedures.

---

## Oregon PERS Health Insurance Program

### 2018 Medicare Comparison

<table>
<thead>
<tr>
<th>Supplement Plan</th>
<th>PERS Moda Health PPORX (PPO)</th>
<th>Kaiser Permanente</th>
<th>Medicare Advantage Plans</th>
<th>Providence – Medicare Flex Group Plan C Rx</th>
<th>Providence – Medicare AIGON Group Plan C Rx (HMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moda Health Medicare Supplement Plan</td>
<td>Medicare Advantage Network Providers</td>
<td>Kaiser Permanente and The Portland Clinic Physicians and Hospitals</td>
<td>Plan Physicians and Hospitals</td>
<td>Plan Physicians and Hospitals</td>
<td>Plan Physicians and Hospitals</td>
</tr>
<tr>
<td>Eligible Providers</td>
<td>Medical Advantage Network Providers</td>
<td>Medical Advantage Network Providers</td>
<td>Medical Advantage Network Providers</td>
<td>Medical Advantage Network Providers</td>
<td>Medical Advantage Network Providers</td>
</tr>
</tbody>
</table>

### Calendar Year Medical Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

### Inpatient Care

- Inpatient Hospital Care: Covered in full
- Skilled Nursing Facility: Covered in full

### Outpatient Care

- Physician Office Visits: $15 copay
- Specialist Office Visits: $20 copay
- Outpatient Surgery: $125 copay
- Ambulance: $50 copay
- Emergency Services: $65 copay
- Urgent Care: $20 copay
- Diagnostic Imaging (CT/MRI): Covered in full
- DME: Covered in full
- Lab Test: $10 per visit
- X-ray: Covered in full
- PT/OT/ST Therapies: $20 copay

### Preventive Care

- Follows USPSTF/AQA Guidelines

### Other Services

- Chiropractic Care: $20 copay
- Vision Routine Eye Exam: $100 credit every 24 months for lenses, frames and/or contacts
- Vision Hardware: $100 credit every 24 months for lenses, frames and/or contacts

### Prescription Drugs

- Brand and Generic: 40% of charge up to a $250 maximum per prescription for a 30-day supply
- RX Out-of-Pocket Maximum: $5,000 out-of-pocket maximum per member per calendar year

### This Is a Medicare Part D Prescription Drug Plan Included with all Medicare Medical Plans

Brand and Generic: 40% of charge up to a $250 maximum per prescription for a 30-day supply

RX Out-of-Pocket Maximum: $5,000 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 comparison and the plan document, the information in the plan document shall prevail.

---

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, 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 above comparison is the 2017 Part B deductible; 2018 Part B deductible was not available when this went to print. Please refer to Medicare.gov/your-Medicare-costs/costs-at-a-glance for the 2018 Part B deductible. Deductible and coinsurance applies to all Medicare Part B approved services only.
6. Days 1-20 care covered in full; days 21-100 member pays a $50 copay per day.
7. Outpatient Rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy
8. Applies to Medicare approved supplies/equipment only and may require Pre-Authorization. Some diabetic supplies are covered in full.
9. Prior authorization is required.
10. If no referral is in place when seeing an in-network specialist, $35 copay applies.
11. An office visit copayment may apply if non-preventive issues and services are managed during a scheduled preventive visit.
12. Medicare covered chiropractic services only.

---

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