PERS Health Insurance Program (PHIP) Benefit Guide

January 1 — December 31, 2026

PERS
HEALTH
INSURANCE PROGRAM
Public Employees Retirement System

CREDITABLE COVERAGE DISCLOSURE NOTICE

Important Notice from the Oregon PERS Health Insurance Program (PHIP) About Your Prescription Drug Coverage and Medicare

THIS SECTION APPLIES TO RETIREES AND DEPENDENTS WHO ARE NOT COVERED UNDER A MEDICARE ADVANTAGE PLAN

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PHIP and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PHIP has determined that the prescription drug coverage offered by the non-Medicare United Healthcare (Core Value and HDHP) and Kaiser (Core Value and HDHP) plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current PHIP coverage will be terminated.

Upon becoming eligible for Medicare, PHIP retirees must enroll in a PHIP provided Medicare Advantage (MA) plan or Medicare Supplement plan to continue receiving coverage in an PHIP provided health plan.

All PHIP's Medicare offerings provide medical and Part D prescription drug coverage. There is no need to enroll in a separate Medical or Part D drug plan and doing so will result in your being disenrolled from your PHIP plan and your Health Benefit Subsidy amount may be impacted.

Should this occur, please contact PHIP at 800-768-7377 if you wish to maintain coverage in the PHIP program.

If you do decide to join a Medicare drug plan and drop your current PHIP coverage, be aware that you and your dependents will not be able to get this coverage back unless you experience a new enrollment opportunity.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with PHIP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact information can be found on page 50 of this guide. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through PHIP changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

September 2025

Dear PERS Health Insurance Program (PHIP) member,

As we reflect on the past year, we'd like to be transparent about the very demanding 2026 health plan renewal cycle. Even though we faced several challenges beyond our control, we're proud to share that our teamwork in negotiations led to favorable agreements with our Contracted Health Plans (CHPs). Although some rates have gone up, we've worked hard to keep those increases as manageable as possible for you. These results mean PHIP can continue to offer affordable, high-quality health insurance plans for 2026.

In this guide you will find your benefit information for the 2026 PERS Health Insurance Program (PHIP) plan year. Please review the 2026 plan changes on pages 16-17 as well as the 2026 benefits and premium rates on pages 23-46.

If you are interested in changing your health insurance plan for the 2026 plan year, you may submit plan change requests October 1 through November 15. You will need to complete both a Disenrollment Form and a new Enrollment Request Form to submit no later than November 15, 2025.

If you do not want to make any changes to your health insurance plans for 2026, no action is required. Your current coverage will continue, and the 2026 premium rate and benefit changes will take effect January 1, 2026.

This year, plan change meetings begin September 8 and end September 25. A current schedule of the meetings is available at pershealth.com. Representatives from PHIP and the Contracted Health Plans (CHPs) will be there to answer your questions. Each meeting is approximately two hours long. Registration is required for the webinar, however no registration is required for in-person meetings.

Please bring your 2026 PHIP Benefit Guide with you.

For more information, visit our website at pershealth.com.

Sincerely,

PERS Health Insurance Program

Contents

Welcome *page 7*

2025 PHIP Plan Change Presentations *page 8*

Enrollment Opportunities *page 9*

After Enrollment *page 10*

Health Coverage While Traveling *page 14*

Changes to Plans *page 16*

Health Plan Enrollment Service Areas *page 18*

Plan Benefit Outlines & Rates *page 23*

- *2026 Medicare Benefit Outlines page 24*
- *2026 Core Value Plan Benefit Outlines page 36*
- *2026 High Deductible Health Plan Benefit Outlines page 40*
- *2026 Dental Benefit Outlines page 44*
- *2026 Medicare Rates page 45*
- *2026 Non-Medicare Rates page 46*

Required Notices *page 48*

Resources *page 49*

Contact Information *page 50*

Welcome

This guide provides an overview of PHIP benefits. For more details, please refer to your health plan member benefit handbook, Evidence of Coverage (EOC) or Annual Notice of Changes (ANOC).

Here's where you can find program specific information:

- PERS Health Insurance Program (PHIP) Medicare Enrollment Guide
- PERS Health Insurance Program (PHIP) Member Guide

To get these materials or other information regarding PHIP, visit pershealth.com or call Customer Service at 800-768-7377. To view the complete PHIP eligibility and enrollment Oregon Administrative Rules (OAR), visit sos.oregon.gov/archives.

Please note

The information provided in this guide is for general comparison only. Any error or omission is purely unintentional. Please refer to your individual health plan member benefit handbook, Evidence of Coverage (EOC) or Annual Notice of Changes (ANOC) for a full explanation of benefits including exclusions and limitations.

It is your responsibility as a PHIP member to review the PERS Health Insurance Program Member Guide and understand your obligation as a PHIP participant.

2025 PHIP Plan Change Presentations

Join PERS Health Insurance Program (PHIP) to learn more about 2026 benefit changes. Pre-registration is not required for in-person meetings and meetings last approximately 2 hours. For directions, you may contact the locations directly. For questions regarding the meeting schedule, contact PHIP at 800-768-7377.

Represented Plans: K = Kaiser Permanente, M = Moda Health, P = Providence, U = UnitedHealthcare

Area	Date	Time(s)	Location	Plans
Portland	9/08 Monday	9:30 a.m.	**Sheraton Portland Airport** 8235 NE Airport Way	ALL
Salem	9/09 Tuesday	9:30 a.m.	**Oregon State Fairgrounds** 2330 17th St. NE (Cascade Hall)	ALL
Hillsboro	9/10 Wednesday	9:30 a.m.	**Embassy Suites Hillsboro** 9355 NE Tanasbourne Drive	ALL
Corvallis	9/10 Wednesday	2:30 p.m.	**Corvallis Community Center** 2601 NW Tyler Ave	ALL
Bend	9/11 Thursday	9:30 a.m.	**Springhill Suites Bend** 551 SW Industrial Way	M, P, U
Webinar*	9/15 Monday	9:30 a.m.	**Webinar** https://attendee.gotowebinar.com/register	ALL
Keizer	9/16 Tuesday	9:30 a.m.	**Keizer Civic Center** 930 Chemawa Rd. NE	ALL
Oregon City	9/23 Tuesday	9:30 a.m.	**Willamette Falls Community Center** 519 15th Street (Auditorium)	ALL
Webinar*	9/25 Thursday	9:30 a.m.	**Webinar** https://attendee.gotowebinar.com/register	ALL

Please note: Due to unforeseen circumstances, the printed schedule may change. Any changes to the schedule can be found on pershealth.com.

* Registration is required. Use the link or copy and paste the URL to register. Once registered, an email with further instructions will be sent to you.

For questions regarding the meeting schedule, contact PHIP at (800) 768-7377.

Enrollment Opportunities

Current Member — Initial Medicare Eligibility

Eligibility for Medicare begins the first day of the month of your 65th birthday. You are required to retain both Medicare Part A and Part B to be enrolled in a PHIP Medicare plan.

Once you become eligible for Medicare, your non-Medicare plan will be terminated and you may not have another opportunity to enroll.

If you are currently enrolled in a PHIP non-Medicare plan and need to change to a PHIP Medicare plan, you will need to do the following within 30 days of becoming eligible for Medicare:

- Fill out a Disenrollment Form for your current PHIP non-Medicare plan.
- Fill out a new Enrollment Request Form for the PHIP Medicare plan, if enrolled in both Medicare Part A and Part B.

PHIP coverage will begin on the date your Medicare coverage becomes effective — as long as we receive your completed Enrollment Request Form before the date of your initial Medicare eligibility.

Current Member – Medicare Disability

Your eligibility to enroll in Medicare Part A and Part B due to Social Security Disability, becomes effective the first day of the 25th month after your Social Security Disability benefits began. In this case, becoming Medicare-eligible due to disability is considered your initial Medicare eligibility.

If you are currently enrolled in a PHIP non-Medicare plan, you must complete an Enrollment Request Form 30 days before becoming Medicare-eligible. If you do not submit a new Enrollment Request Form for Medicare coverage, your PHIP coverage will end. Also, you will not be able to enroll for PHIP once you are Medicare-eligible.

If you miss this opportunity, becoming Medicare-eligible at age 65 will not be a new opportunity to enroll in a PHIP health plan, unless you have had 24 months of continuous employer-sponsored coverage immediately before enrollment in PHIP.

Current Member — Enrolling a Spouse or Dependent Child

You may enroll an eligible spouse or dependent during any enrollment opportunity available to retirees.

Adding a New Spouse or Dependent Child

You must enroll your new spouse or dependent within 30 days of the family status change (e.g., birth, marriage). If your spouse has a different last name, PHIP will require a copy of the marriage certificate.

To add a new spouse and/or dependent, please complete and submit a PHIP Enrollment Request Form.

The coverage will be effective on the first of the month after we receive the completed PHIP Enrollment Request Form.

Dental Plan Enrollment

To enroll in a PHIP dental plan, you must enroll in a PHIP medical plan during the same enrollment opportunities as the PHIP medical plan. Dependents' dental coverage must be with the same contracted dental plan as the retiree. However, the retiree can choose dental and medical plans from different Contracted Health Plans (CHP).

For Kaiser Permanente dental, you must live in the Kaiser Permanente dental plan service area.

Get a Complete List of Enrollment Opportunities

For a complete list of PHIP enrollment opportunities, please contact PHIP for a PERS Health Insurance Program Member Guide or visit pershealth.com.

After Enrollment

Annual Plan Change Period

From October 1 to November 15, you can submit paperwork to change your medical and/or dental plan to another PHIP plan available within your residing area. Changes made during this time become effective January 1 of the following year. If you're enrolled and don't want to change plans, you don't need to do anything.

You may not add dental coverage or dependents during the Plan Change Period unless you have an enrollment opportunity.

If you do need to make a change, you'll need to fill out a Disenrollment Form for the plan you are ending, and an Enrollment Request Form for the new plan. You'll need to submit both forms to PHIP before November 15.

Find forms at pershealth.com or by calling PHIP customer service.

If you do not submit a change during this period, you will be unable to change your enrollment mid-year, unless you experience a family status change or new enrollment opportunity.

Snow Bird

The Snow Bird option allows members enrolled in PHIP Medicare Advantage plans to change their health plan to the Moda Health Medicare Supplement Plan or UnitedHealthcare® Group Medicare Advantage (PPO) plan while temporarily living outside their Medicare Advantage plan's service area. Members must live outside the service area for more than 60 days to use this option.

After returning to Oregon, members will be eligible to change back to their prior Medicare Advantage plan.

The Snow Bird option also applies to non-Medicare members who are enrolled in Kaiser Permanente. You have the option to change to the same plan under UnitedHealthcare.

You must fill out a Disenrollment Form for the plan you are ending and an Enrollment Request Form for the new plan before leaving the area, and again upon returning. Please contact PHIP for more information.

Change of Address

If you change your address, you must notify PHIP in writing. Complete, sign, date, and submit a Change of Address Form to PHIP. Address changes may be sent via mail or fax. Email requests will not be accepted.

PHIP will notify the appropriate health plan.

If you do not notify PHIP within 30 days of moving outside a service area, you may lose coverage. You must maintain a permanent residence within the United States to be eligible for PHIP. If you reside in another country, you are not eligible to keep PHIP coverage.

Late Payments

Your premium payment is due on the first of each month. If your payment is not received by then, your account will be considered delinquent.

If you do not pay your premium, your health plan coverage will be canceled.

If your coverage is canceled, you may have to pay for all claims, unless they are covered under Original Medicare. Per OAR 459-035-0090 (3) If payment is by check or money order, the check or money order must be physically received by the Third Party Administrator on or before the due date. (4) Failure to make the payment by the due date shall result in termination of a person's PERS-sponsored health insurance coverage.

Disenrollment

Voluntary Disenrollment

If you would like to end your PHIP coverage, you will need to complete and send a PHIP Disenrollment Form. This is required by PHIP and Medicare.

This change will be effective on the first of the month after we receive your PHIP Disenrollment Form, unless you request a later date. If your spouse and/or dependent child age 18 and over are part of your plan, they will also need to sign the form.

If anyone in your family stops their dental coverage, the whole family will lose their dental coverage.

Involuntary Termination

PHIP may be required to end your coverage if you:

- Lose your Medicare Part A and/or Part B.
- Sign up for another non-PHIP Medicare Advantage or Medicare Part D Prescription Drug Plan.
- Fail to pay your monthly premium.
- Lose your retirement status by returning to work.

If your PHIP coverage ends, you may not sign up for PHIP again unless you get a new enrollment opportunity.

If you owe PHIP money, you will need to pay any outstanding balance before you can re-enroll.

Death Notification of PERS Retiree or Spouse

If you are the PERS retiree:

- If your spouse passes away, your PHIP coverage will continue as usual. To end your spouse's coverage, please mail a photocopy of their death certificate to PHIP and separately to the PERS Pension office.

If you are the surviving spouse or dependent child of a PERS retiree:

- If the PERS retiree passes away, your PHIP coverage will continue automatically. You will need to mail a copy of the retiree's death certificate to PHIP and also separately to the PERS Pension office. If you would like to end your coverage, please send PHIP a Disenrollment Form.

Enrollment Upon Death of the PERS Retiree

- 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 date of death, or by meeting other enrollment opportunities. However, if the spouse remarries, coverage cannot be extended to the new spouse.

Appeal Rights

For appeals related to PHIP enrollment or eligibility follow the instructions below. For appeals regarding claims, prescriptions or other benefit specific issues, please contact your health plan directly.

Pursuant to Oregon Administrative Rules (OAR) 459-001-0030, if you disagree with staff's determination you may request a review by writing to the PERS Director within 60 days after the date of this letter. Your request should include the following information:

(a) A description of the determination you want reviewed.

(b) A short statement describing how and why you think the determination is wrong.

(c) A statement of facts that you believe show the determination is wrong.

(d) A list of any statutes, rules, or court decisions that you believe support your position.

(e) A statement of the action you seek.

(f) A request for review.

Once disenrollment or termination occurs, you cannot re-enroll in PHIP unless you have a new enrollment opportunity.

Oregon Revised Statutes are available from the Office of Legislative Counsel, or can be located on the internet at oregonlegislature.gov/bills_laws.

Oregon Administrative Rules are available from the Oregon State Archives at http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_459/459_tofc.html.

Mail appeal to:

Public Employees Retirement System
Attn: PHIP Appeals
P.O. Box 23700
Tigard, OR 97281-3700

The Director may ask a Division Administrator to act on your appeal. Your request will either be granted or denied. You will be mailed a response letter within 45 days after we receive your request.

Health Plan Appeals

If you have appeals, complaints or grievances about your health plan benefits or claims, please send them to the health plan in which you are enrolled. Refer to your plan's Evidence of Coverage (EOC) or member benefit handbook for more information. To get a copy of these materials, please contact your health plan directly.

Contact information can be found in the resources section on page 49.

Health Coverage While Traveling

Health Coverage While Traveling

All PHIP health plans cover urgent and emergency care when you travel. Before you travel, contact your health plan to determine your travel benefits. If you receive medical services outside of the United States, ask for an itemized statement of care (in English if possible). Then submit to your health plan for reimbursement. Check with your health plan's Evidence of Coverage (EOC) for emergency and urgent care copay/coinsurance information. Limits and exclusions apply.

	Emergency/Travel Benefits (Medicare Plans Only[1])		
	Kaiser Permanente Senior Advantage	**Moda Health Supplement Plan**	**Providence Medicare Align Group Plan + Rx**
	Member pays		
Travel outside service area (within USA)	Urgent care: $15 copay Emergency: $50 copay Ambulance (air or ground to closest facility): $50 copay Visiting Member benefit[2] Additional travel benefit[3]	Covers all Medicare covered services in full	Urgent care: $25 copay Emergency: $50 copay Ambulance (air or ground to closest facility): $50 copay 20% to maximum allowance of $1,000 for follow-up services.
Emergency benefits outside service area travel (outside USA)	Urgent care: $15 copay Emergency: $50 copay Ambulance (air or ground): $50 copay	20% coinsurance for emergency, urgent care, and ambulance. Coverage limited to $50,000 per member (lifetime maximum).	Urgent care: $25 copay Emergency: $50 copay Ambulance (air or ground to closest facility): $50 copay
Time Frame	6 Months*	12 Months	6 Months*

* Per CMS guidelines for travel within and outside USA. Medicare members who permanently move outside a plan's service area or who are out of the service area for six consecutive months or more must disenroll from their Medicare Advantage plan.

	Emergency/Travel Benefits (Medicare Plans Only[1])	
	Providence Medicare Flex Group Plan + Rx	**UnitedHealthcare Group Medicare Advantage (PPO)**
	Member pays	
Travel outside service area (within USA)	Urgent care: $25 copay Emergency: $65 copay Ambulance (air or ground to closest facility): $50 copay $30 or $35 copay or 20% coinsurance for planned or follow-up services.	Urgent care: $20 copay Emergency: $65 copay Ambulance (air or ground to closest facility): $50 copay
Emergency benefits outside service area travel (outside USA)	Urgent care: $25 copay Emergency: $65 copay Ambulance (air or ground to closest facility): $50 copay	Emergency care or urgently needed care and emergency ambulance transportation to nearest facility: $65 copay
Time Frame	6 Months*	6 Months*

1 Medicare does not provide coverage outside of the United States. You may choose to buy a travel insurance policy to get health coverage abroad. Travel insurance might not include health insurance, so make sure to read your plan details carefully.

2 Members temporarily visiting other Kaiser Permanente regions may receive care from designated providers in those areas.

3 Covers routine, preventive, and follow-up care outside Kaiser network at 20% coinsurance as part of the $1,000 annual worldwide travel benefit maximum.

Changes to Plans

Important Notice for the 2026 Plan Year

For a full list of plan changes, refer to your health plan's Annual Notice Of Change (ANOC) and Evidence of Coverage (EOC) documents. For dental plan changes, refer to your plans dental handbook.

Medical and Prescription Drugs

Kaiser Permanente Northwest

Medicare

- The Prescription Drug out-of-pocket maximum per individual per calendar year is $2,100.

Non-Medicare — Core Value Plan

- Allergy serums are now subject to cost sharing.
- The birthing center is a covered Service.
- Members must use at least 80 percent of the quantity of a prescription before it can be refilled.

Non-Medicare HDHP Plan

- Allergy serums are now subject to cost sharing.
- The birthing center is a covered Service.
- Members must use at least 80 percent of the quantity of a prescription before it can be refilled.

Moda Health

Medicare Supplement

- The Prescription Drug out-of-pocket maximum per individual per calendar year is $2,100.
- The wellness fitness program is changing from Silver&Fit to One Pass.

Providence Health Plan

Medicare — Align Group Plan + RX (HMO) and Flex Group Plan + RX (HMO-POS)

- The Prescription Drug out-of-pocket maximum per person per calendar year is $2,100.

UnitedHealthcare®

Medicare — Group Medicare Advantage (PPO) Plan

- The Prescription drug calendar year out-of-pocket maximum is $2,100.

Non-Medicare Core Value

- No benefit changes for the 2026 plan year.

Non-Medicare HDHP Plan

- No benefit changes for the 2026 plan year.

Dental

Delta Dental Plan of Oregon

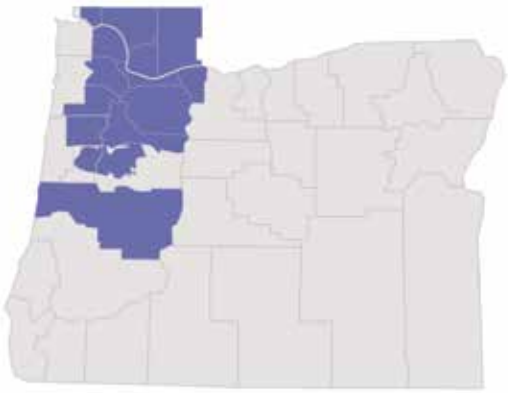
- No benefit changes for the 2026 plan year.

Kaiser Permanente

- Members pay the cost share that normally applies for non-emergency dental care services, plus amounts that exceed usual and customary charges.
- Limitations on routine fillings have been removed.
- Nitrous Oxide is covered for Children aged 12 years and younger with a $25 cost share.

Health Plan Enrollment Service Areas

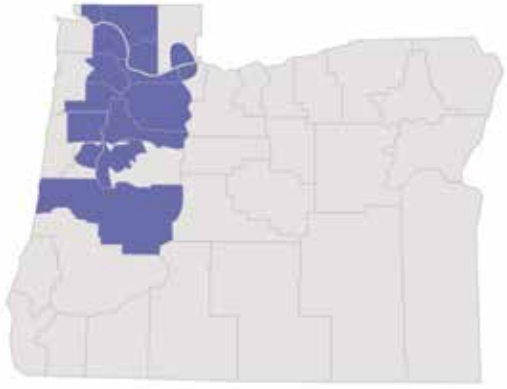
In selecting a PHIP health plan, you must reside in the United States and maintain a permanent residence (not mailing) within a health plan's service area in order to participate in PHIP.



Kaiser Foundation Health Plan of the NW — Medicare

Oregon — Benton: 97321, 97330, 97331, 97333, 97339, 97370; Clackamas; Columbia; Hood River; Lane; Linn: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97383, 97389; Marion; Multnomah; Polk; Washington; Yamhill

Washington — Clark; Cowlitz; Skamania; Wahkiakum: 98612, 98647



Non-Medicare Service Area

Oregon — Benton: 97321, 97330, 97331, 97333, 97339, 97370; Clackamas; Columbia; Hood River: 97014; Lane; Linn: 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389; Marion; Multnomah; Polk; Washington; Yamhill

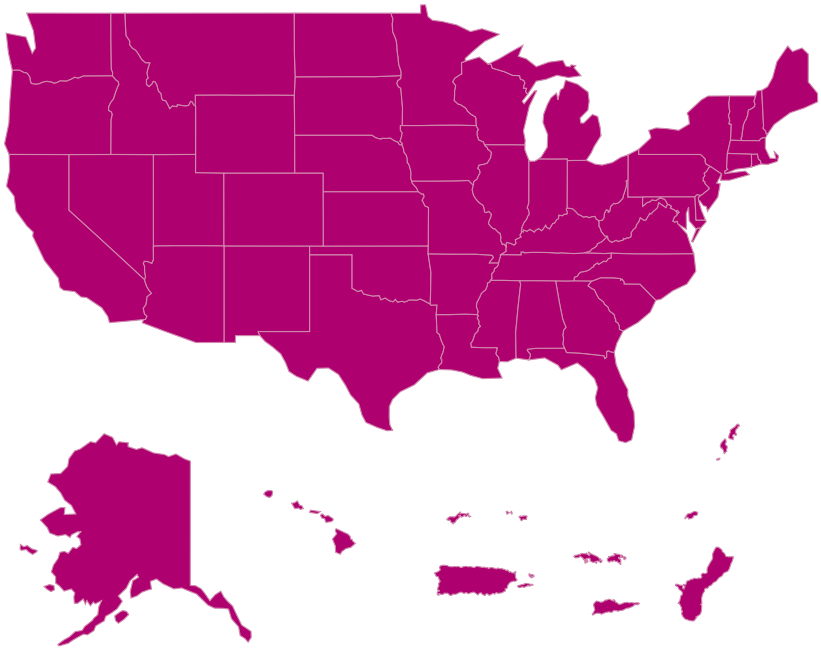
Washington — Clark; Cowlitz; Skamania: 98639, 98648; Wahkiakum: 98612, 98647

Dental Service Area

Oregon — Benton: 97330, 97331, 97333, 97339, 97370, 97456; Clackamas; Columbia; Hood River: 97014, 97031, 97041, 97044; Lane: 97401, 97402, 97403, 97404, 97405, 97408, 97409, 97419, 97424, 97426, 97431, 97437, 97438, 97440, 97446, 97448, 97451, 97452, 97454, 97455, 97461, 97475, 97477, 97478, 97487, 97489; Linn: 97321, 97322, 97335, 97348, 97355, 97358, 97360, 97374, 97377, 97389; Marion; Multnomah; Polk; Washington; Yamhill

Washington — Clark; Cowlitz; Lewis: 98591, 98593, 98596; Skamania: 98605, 98610, 98639, 98648, 98651; Wahkiakum: 98612, 98647

Health Plan Enrollment Service Areas



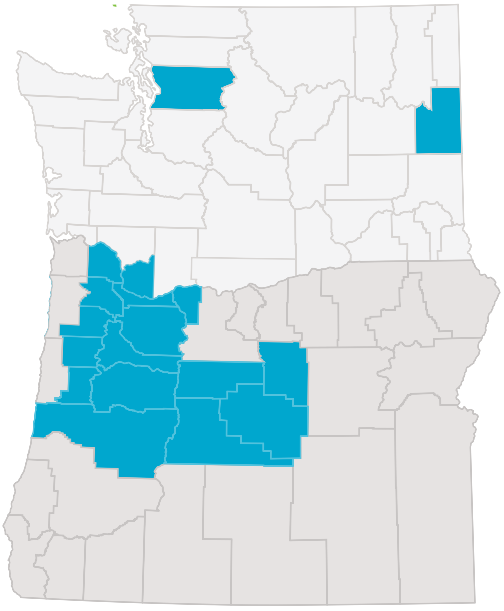
Moda Health

Nationwide including
the U.S. territories

Delta Dental of Oregon

Nationwide including
the U.S. territories

Health Plan Enrollment Service Areas

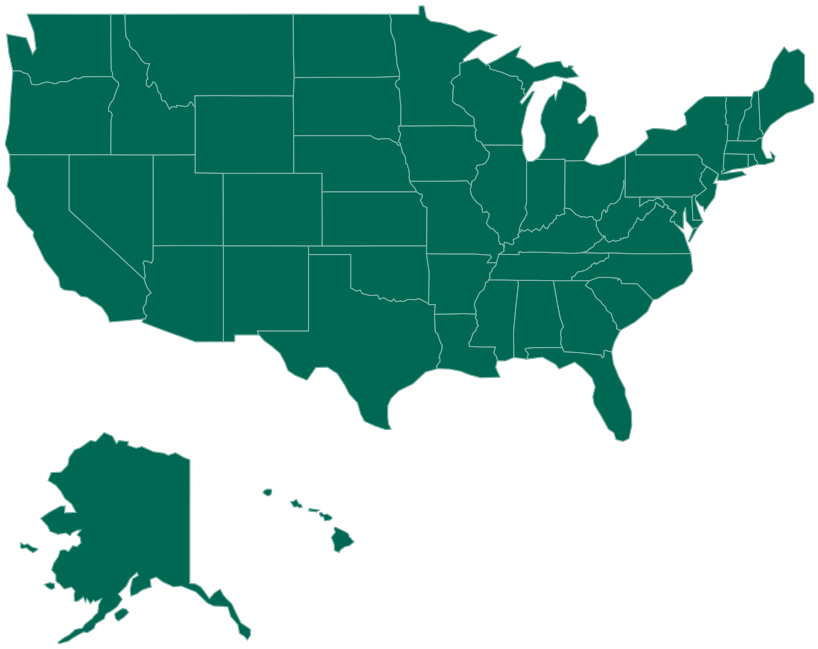


Providence Medicare Advantage Plans

Oregon — Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Lane, Linn, Marion, Multnomah, Polk, Washington, Wheeler and Yamhill

Washington — Clark, Snohomish and Spokane

Health Plan Enrollment Service Areas



United Healthcare Medicare

Nationwide including the U.S. territories

United Healthcare Non-Medicare

Nationwide

2026 Medicare Plan Benefit Outlines

For questions on plan benefits, exclusions and limitations:

Refer to your plan's Evidence of Coverage (EOC) or member benefit handbook. You can obtain either by contacting your health plan directly.

For the Moda Health Medicare Supplement Plan, you can also refer to the Medicare and You Handbook, which can be obtained through CMS.

Contact information is on page 50 of this publication.

When the retiree and spouse/dependent have Medicare, the coverage must be with the same contracted health plan.

Kaiser Foundation Health Plan of the NW — Medicare Senior Advantage

Medicare Enrollment Service Area: See map and listing of health plan enrollment service area on page 18.

Benefit Description	Medicare Senior Advantage
Eligible Providers	Kaiser Permanente facilities and affiliated providers. See kp.org/locations
	Member Pays:
Calendar Year Deductible	None
Calendar Year Medical Out-of-Pocket Maximum	$1,000 per individual
Preventive Care	Covered in full per Medicare guidelines
Inpatient Care:	
• Inpatient Hospital Care	• $200 copay per admit
• Skilled Nursing Facility	• Covered in full
Outpatient Care:	
• Primary Care Office Visits	• $15 copay
• Specialist Office Visits	• $15 copay
• Outpatient Surgery	• $15 copay
• Ambulance (air-ground)	• $50 copay
• Emergency Services	• $50 copay
• Urgent Care	• $15 copay
• DME	• 20%[1]
• Lab Test	• Covered in full
• X-ray	• Covered in full
• Diagnostic Procedures (CT/MRI/PET)	• Covered in full
• OT/PT/ST Therapies[2]	• Covered in full

Benefit Description	Medicare Senior Advantage
Other Services:	
• Chiropractic Care[3]	• $15 copay
• Acupuncture[4]	• $15 copay
• Routine Hearing	• Exam: Covered in full; Hardware (aids): $400 allowance per ear / $800 per calendar year
• Routine Vision	• Exam: $15 copay; Hardware: $200 credit every 2 years for lenses, frames and/or contacts
Calendar Year Pharmacy Out-of-Pocket Maximum	$2,100 per individual
Pharmacy[5]:	This is a Medicare Part D Prescription Drug Plan
• Tier 1	• Up to an $8 copay per 30-day supply
• Tier 2	• Up to a $15 copay per 30-day supply
• Tier 3	• 40% to $250 max per script/ 30-day supply
• Tier 4	• 40% to $250 max per script/ 30-day supply
• Tier 5	• 40% to $250 max per script/ 30-day supply
• Tier 6	• $0 cost share
Rates (per member, per month):	
• Adult	• $291.04
• Child	• $234.20

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 health plan document, the information in the health plan document shall prevail.

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

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

3 Medicare covered chiropractic services only.

4 Acupuncture for chronic low back pain per Medicare guidelines; up to 12 visits in 90 days are covered, no more than 20 acupuncture treatments can be given yearly. Specific medical criteria must be met. Physician referral required.

5 See Health Plan EOC for more details on each tier. EOC may contain expanded language.

Moda Health — Medicare Supplement

Medicare Enrollment Service Area: See map and listing of health plan enrollment service area on page 19.

Benefit Description	Medicare Supplement
Eligible Providers	Any licensed Medicare Provider
	Member Pays:
Part B Calendar Year Deductible	$257 per individual[1]
Calendar Year Medical Out-of-Pocket Maximum	N/A
Preventive Care	Covered in full per Medicare guidelines
Inpatient Care:	
• Inpatient Hospital Care	• Covered in full
• Skilled Nursing Facility	• Covered in full[2]
Outpatient Care:	
• Physician Office Visits	• Covered in full
• Specialist Office Visits	• Covered in full
• Outpatient Surgery	• Covered in full
• Ambulance (air-ground)	• Covered in full
• Emergency Services	• Covered in full
• Urgent Care	• Covered in full
• DME	• Covered in full
• Lab Test	• Covered in full
• X-ray	• Covered in full
• Diagnostic Procedures (CT/MRI/PET)	• Covered in full
• OT/PT/ST Therapies[3]	• Covered in full

Benefit Description	Medicare Supplement
Other Services: • Chiropractic Care[4] • Acupuncture[4] • Routine Hearing[5] • Routine Vision[6]	 • Covered in full per Medicare guidelines • Covered in full per Medicare guidelines • Exam: Covered in full; Hardware (aids): $399 or $699 options available • Exam: $15 copay; Hardware: $200 allowance every 2 calendar years for lenses, frames and/or contacts
Calendar Year Pharmacy Out-of-Pocket Maximum	$2,100 per individual
Pharmacy[7]: • Tier 1 • Tier 2 • Tier 3 • Tier 4 • Tier 5 • Tier 6	This is a Medicare Part D Prescription Drug Plan • Up to an $8 copay per 31-day supply • Up to a $15 copay per 31-day supply • 40% to $250 max per script/ 31-day supply • 40% to $250 max per script/ 31-day supply • 40% to $250 max per script/ 31-day supply • $0 cost share
Rates (per member, per month): • Adult • Child	 • $409.06 • $328.62

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1 2025 Part B Deductible. 2026 Part B Deductible is not available at this time.
2 Coverage applies to a Medicare certified facility for up to 100 days/Medicare benefit period.
3 Outpatient rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy
4 Medicare covered only. Contact Medicare or refer to the Medicare & You 2026 handbook and Medicare.gov website for more details
5 Must use TruHearing providers. One routine hearing exam and one hearing aid per ear per calendar year.
6 To receive the VSP benefit as listed, use VSP Advantage providers. For out-of-network reimbursement amounts, refer to your member handbook.
7 See Health Plan EOC for more details on each tier.

Providence Medicare Advantage Plans — Medicare Advantage HMO

Medicare Enrollment Service Area: See map and listing of health plan enrollment service area on page 20.

Benefit Description	Medicare Advantage Align Group Plan + Rx (HMO)
Eligible Providers	Plan Physicians and Hospitals
	Member Pays:
Calendar Year Deductible	None
Calendar Year Medical Out-of-Pocket Maximum	$1,500 per individual
Preventive Care	Covered in full per Medicare guidelines
Inpatient Care:	
• Inpatient Hospital Care	• $100 copay/day; $500 max. per admit
• Skilled Nursing Facility[1]	• Covered in full
Outpatient Care:	
• Physician Office Visits	• $15 copay
• Specialist Office Visits	• $20 copay
• Outpatient Surgery	• $75 copay
• Ambulance (air-ground)	• $50 copay
• Emergency Services	• $50 copay
• Urgent Care	• $25 copay
• DME[2]	• 20%
• Lab Test	• Covered in full
• X-ray	• 10%
• Diagnostic Procedures (CT/MRI/PET)	• 10%
• OT/PT/ST Therapies[3]	• $20 copay

Benefit Description	Medicare Advantage Align Group Plan + Rx (HMO)
Other Services: • Chiropractic Care[4] • Acupuncture[5] • Routine Hearing[6] • Routine Vision[7]	 • $20 copay • $20 copay • Exam: Covered in full; Hardware (aids): $399 or $699 options available • Exam: $15 copay; Hardware: $200 allowance every 2 years for lenses, frames and/or contacts
Calendar Year Pharmacy Out-of-Pocket Maximum	$2,100 per member
Pharmacy[8]: • Tier 1 • Tier 2 • Tier 3 • Tier 4 • Tier 5	This is a Medicare Part D Prescription Drug Plan • Up to an $8 copay per 31-day supply • Up to a $15 copay per 31-day supply • 40% to $250 max per script/31-day supply • 40% to $250 max per script/31-day supply • 40% to $250 max per script/31-day supply
Rates (per member, per month): • Adult • Child	 • $372.54 • $299.40

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 health plan document, the information in the health plan document shall prevail.

1 Days 1-100, covered in full.

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

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

4 Medicare covered chiropractic services only.

5 Acupuncture for low back pain per Medicare guidelines; up to 12 visits in 90 days are covered if specific circumstances are met.

6 Must use TruHearing providers. One routine hearing exam and up to two hearing aids per calendar year, one per ear.

7 Any licensed Medicare provider.

8 See Health Plan EOC for more details on each tier. EOC may contain expanded language.

Providence Medicare Advantage Plans — Medicare Advantage HMO-POS

Medicare Enrollment Service Area: See map and listing of health plan enrollment service area on page 20.

Benefit Description	Medicare Advantage Flex Group Plan + Rx (HMO-POS)	
	In-Network	**Out-of-Network**
Eligible Providers	Plan Physicians and Hospitals	Any Licensed Medicare Provider
	Member Pays:	
Calendar Year Deductible	None	
Calendar Year Medical Out-of-Pocket Maximum	$3,000 per individual	
Preventive Care	Covered in full per Medicare guidelines	Covered in full per Medicare guidelines
Inpatient Care:		
• Inpatient Hospital Care	• $125 copay/day; $500 max. per admit	• 20%
• Skilled Nursing Facility	• Covered in full[1]	• 20%
Outpatient Care:		
• Physician Office Visits	• $20 copay	• $30 copay
• Specialist Office Visits	• $25 copay	• $35 copay
• Outpatient Surgery	• $150 copay	• 20%
• Ambulance (air-ground)	• $50 copay	• $50 copay
• Emergency Services	• $65 copay	• $65 copay
• Urgent Care	• $25 copay	• $25 copay
• DME[2]	• 20%	• 20%
• Lab Test	• Covered in full	• 20%
• X-ray	• 10%	• 20%
• Diagnostic Procedures (CT/MRI/PET)	• 10%	• 20%
• OT/PT/ST Therapies[3]	• $25 copay	• $35 copay

Benefit Description	Medicare Advantage Flex Group Plan + Rx (HMO-POS)	
	In-Network	Out-of-Network
Other Services: • Chiropractic Care[4] • Acupuncture[5] • Routine Hearing[6]	 • $20 copay • $25 copay • Exam: Covered in full; Hardware (aids): $399 or $699 options available	 • $35 copay • $35 copay • Not covered
• Routine Vision[7]	• Exam: $20 copay; Hardware: $200 allowance every 2 years for lenses, frames and/or contacts	• Exam: $20 copay; Hardware: $200 allowance every 2 years for lenses, frames and/or contacts
Calendar Year Pharmacy Out-of-Pocket Maximum	$2,100 per individual	
Pharmacy[8]: • Tier 1 • Tier 2 • Tier 3 • Tier 4 • Tier 5	This is a Medicare Part D Prescription Drug Plan • Up to an $8 copay per 31-day supply • Up to a $15 copay per 31-day supply • 40% to $250 max per script/31-day supply • 40% to $250 max per script/31-day supply • 40% to $250 max per script/31-day supply	
Rates (per member, per month): • Adult • Child	 • $340.69 • $273.92	

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1 Days 1-20, covered in full; Days 21-100, $50 copay per day.
2 Applies to Medicare approved supplies/equipment only and may require pre-authorization. Some diabetic supplies are covered in full.
3 Outpatient Rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy.
4 Medicare covered chiropractic services only.
5 Acupuncture for low back pain per Medicare guidelines; up to 12 visits in 90 days are covered if specific circumstances are met.
6 Must use TruHearing providers. One routine hearing exam and up to two hearing aids per calendar year, one per ear.
7 Any licensed Medicare provider.
8 See Health Plan EOC for more details on each tier. EOC may contain expanded language.

UnitedHealthcare — Medicare Advantage PPO

Medicare Enrollment Service Area: See map and listing of health plan enrollment service area on page 21.

Benefit Description	Group Medicare Advantage (PPO)	
	In-Network	**Out-of-Network**[1]
Eligible Providers	Medicare Advantage (PPO) Providers	Any Licensed Medicare Provider
	Member Pays:	
Calendar Year Deductible	None	
Calendar Year Medical Out-of-Pocket Maximum	$2,500 per individual	
Preventive Care	Covered in full per Medicare guidelines	Covered in full per Medicare guidelines
Inpatient Care:		
• Inpatient Hospital Care	• $100 copay/day; $300 max. per admit	• $100 copay/day; $300 max. per admit
• Skilled Nursing Facility	• $0 copay per day up to 100 days	• $0 copay per day up to 100 days
Outpatient Care:		
• Physician Office Visits	• $15 copay	• $15 copay
• Specialist Office Visits[2]	• $20 copay	• $20 copay
• Outpatient Surgery	• $125 copay	• $125 copay
• Ambulance (air-ground)	• $50 copay	• $50 copay
• Emergency Services	• $65 copay	• $65 copay
• Urgent Care	• $20 copay	• $20 copay
• DME[3]	• 20%	• 20%
• Lab Test	• $0 copay	• $0 copay
• X-ray	• 10%	• 10%
• Diagnostic Procedures (CT/MRI/PET)	• 10%	• 10%
• OT/PT/ST Therapies[4]	• $20 copay	• $20 copay

Benefit Description	Group Medicare Advantage (PPO)	
	In-Network	Out-of-Network
Other Services: • Chiropractic Care[5] • Acupuncture[6] • Routine Hearing Exam/Aid Hardware[7] • Routine Vision	 • $20 copay • $20 copay • Exam: Covered in full; Hardware (aids): $2400 allowance per year • Exam: $20 copay; Hardware: $200 combined allowance every 24 months for lenses, frames and contacts	 • $20 copay • $20 copay • Exam: Covered in full; Hardware (aids): not covered • Exam: $20 copay; Hardware: $200 combined allowance every 24 months for lenses, frames and contacts
Calendar Year Pharmacy Out-of-Pocket Maximum	$2,100 per individual	
Pharmacy[8]: • Tier 1 • Tier 2 • Tier 3 • Tier 4 • Tier 5	This is a Medicare Part D Prescription Drug Plan • Up to an $8 copay per 31-day supply • Up to a $15 copay per 31-day supply • 40% to $250 max per script/31-day supply • 40% to $250 max per script/31-day supply • 40% to $250 max per script/31-day supply	
Rates (per member, per month): • Adult • Child	 • $310.69 • $249.92	

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

2 Referrals not required.

3 Applies to Medicare approved supplies/equipment only and may require pre-authorization. Some diabetic supplies are covered in full.

4 Outpatient rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy.

5 Medicare covered chiropractic services only.

6 Acupuncture for low back pain per Medicare guidelines; up to 12 visits in 90 days are covered if specific circumstances are met. Prior authorization is not required.

7 Combined ear allowance. In-network coverage only.

8 See Health Plan EOC for more details on each tier. EOC may contain expanded language.

2026 Non-Medicare Plan Benefit Outlines

A Note About Qualified High Deductible Health Plans

The PHIP qualified High Deductible Health Plan (HDHP) can be used with a Health Savings Account (HSAs). If you have other health insurance coverage such as Medicare, or private health insurance, you are not eligible for this type of plan. You are also not eligible if you are claimed on someone else's tax return.

Health Savings Account (HSA) Basics

An HSA is a special savings account that you contribute money to, then withdraw funds to be used for qualified medical, pharmacy, dental and vision expenses. HSAs are funded by individual post-tax contributions and have annual contribution limits set by the IRS. Additionally, HSAs allow you to carry over your balance from year-to-year.

If you are 55 or older an additional annual catch-up contribution may be available. If you change plans or become Medicare eligible you can keep the HSA account and the money in it, which you can continue to use for qualified expenses.

The HSA belongs to you and you are responsible for setting one up through a financial institution.

Contributions cannot be automatically deducted from your PERS pension benefit.

HSA and Medicare

Once you become Medicare eligible, you are no longer eligible to contribute to your HSA. You may be able to cover some expenses with HSA funds including Medicare premiums and long-term care.

Contact a tax advisor for specific rules regarding HSAs.

When the retiree and spouse/dependents are enrolling in non-Medicare coverage, the coverage must be with the same Contracted Health Plan.

Kaiser Foundation Health Plan of the NW — Traditional Core Value Plan

Non-Medicare Enrollment Service Area: See map and listing of health plan enrollment service area on page 18.

Benefit Description	Non-Medicare Traditional Core Value
Eligible Providers	Kaiser Permanente facilities and affiliated providers. See kp.org/locations
	Member Pays:
Calendar Year Deductible	None
Calendar Year Medical Out-of-Pocket Maximum	$2,000 per individual $4,000 per family (2 or more)
Preventive Care	Covered in full per ACA guidelines
Inpatient Care:	
• Inpatient Hospital Care	• $200 copay/day; $1,000 max per admit
• Skilled Nursing Facility	• Covered in full
Outpatient Care:	
• Primary Care Office Visits[1]	• $30 copay
• Specialist Office Visits	• $40 copay
• Outpatient Surgery	• $200 copay
• Ambulance (air-ground)	• $100 copay
• Emergency Services	• $200 copay
• Urgent Care	• $30 copay
• DME	• 20%
• Lab Test[2]	• $30 copay
• X-ray	• $30 copay
• Diagnostic Procedures (CT/MRI/PET)	• 20%
• OT/PT/ST Therapies[3]	• $40 copay

Benefit Description	Non-Medicare Traditional Core Value
Other Services: • Alternative Care[4] • Vision	 • $30 copay • Exam: $30 copay; Hardware: $100 allowance every 2 years for lenses, frames and/or contacts
Calendar Year Pharmacy Out-of-Pocket Maximum	$5,000 per individual
Pharmacy[5]: • Tier 1 • Tier 2 • Tier 3 • Tier 4 • Tier 5 • Tier 6	 • Up to an $8 copay per 30-day supply • Up to a $15 copay per 30-day supply • 40% to $250 max per script/ 30-day supply • 40% to $250 max per script/ 30-day supply • 40% to $250 max per script/ 30-day supply • $0 cost share
Rates (per member, per month): • Adult • Child	 • $1,188.05 • $361.21

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 health plan document, the information in the health plan document shall prevail.

1 One annual preventative primary care visit per year at $0. First three primary care or primary care-related visits per year at $5 per visit. This includes any combination of in-person or virtual care.

2 Certain diagnosis-based screening and lab tests available at $0 cost-share per IRS guidelines.

3 Outpatient rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy. Benefit is limited to 20 visits per therapy per calendar year.

4 Spinal manipulation is limited to 20 visits and acupuncture is limited to 12 visits per calendar year. Naturopathy, no visit limit. Massage therapy not covered.

5 See Health Plan EOC for more details on each tier. EOC may contain expanded language.

UnitedHealthcare — Core Value Plan

Non-Medicare Enrollment Service Area: See map and listing of health plan enrollment service area on page 21.

Benefit Description	Non-Medicare Select Plus Core Value	
	In-Network	Out-of-Network
Eligible Providers	Preferred physicians and facilities	Any Licensed Physician or facility
	Member Pays:	
Calendar Year Deductible	$1,000 per Individual/$2,000 per Family	
Calendar Year Medical/Pharmacy Out-of-Pocket Maximum	$6,350 + $1,000 Deductible = $7,350/Individual; $12,700 + $2,000 Deductible = $14,700/Family	
Preventive Care	Covered in full per ACA guidelines	40% after deductible per ACA guidelines
Inpatient Care:		
• Inpatient Hospital Care	• 20% after deductible	• 40% after deductible
• Skilled Nursing Facility	• 20% after deductible	• 40% after deductible
Outpatient Care:		
• Physician Office Visits[1]	• $20 copay, no deductible	• 40% after deductible
• Specialist Office Visits	• $20 copay, no deductible	• 40% after deductible
• Outpatient Surgery	• 20% after deductible	• 40% after deductible
• Ambulance (air-ground)	• 20% after deductible	• 20% after deductible
• Emergency Services	• $200 copay, then 20%, no deductible	• $200 copay, then 20%, no deductible
• Urgent Care	• $20 copay, no deductible	• 40% after deductible
• DME	• 20% after deductible	• 40% after deductible
• Lab Test	• 20%, no deductible	• 40% after deductible
• X-ray	• 20%, no deductible	• 40% after deductible
• Diagnostic Procedures (CT/MRI, PET)	• 20%, no deductible	• 40% after deductible
• Physical Therapy[2]	• $20 copay, no deductible	• 40% after deductible
• OT/ST Therapies[2]	• $20 copay, no deductible	• 40% after deductible

Benefit Description	Non-Medicare Select Plus Core Value	
	In-Network	Out-of-Network
Other Services: • Alternative Care[3]	• $30 copay, no deductible	• 40% after deductible
Calendar Year Pharmacy Out-of-Pocket Maximum	Combined with Medical	
Prescription Drugs: • Brand • Generic • Specialty	 • 40%, no deductible • 40%, no deductible • 40%, no deductible	
Rates (per member, per month): • Adult • Child	 • $1,665.09 • $504.32	

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1 One annual preventative primary care visit per year at $0. First three primary care or primary care-related visits per year at $5 per visit. This includes any combination of in-person or virtual care.

2 Outpatient rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy. Limited to 20 visits per therapy, per calendar year.

3 Spinal Manipulation is limited to 20 visits and acupuncture is limited to 12 visits per calendar year. Massage therapy not covered.

Kaiser Foundation Health Plan of the NW — High Deductible Health Plan

Non-Medicare Enrollment Service Area: See map and listing of health plan enrollment service area on page 18.

Benefit Description	Non-Medicare Qualified HDHP Plan
Eligible Providers	Kaiser Permanente facilities and affiliated providers. See kp.org/locations
	Member Pays:
Calendar Year Medical/ Pharmacy Deductible	$3,000 per individual If enrolled as a family, a total of $6,000 for all members combined.[1]
Calendar Year Medical/Pharmacy Out-of-Pocket Maximum	$6,650 per individual $13,300 per family
Preventive Care	Covered in full per ACA guidelines
Inpatient Care:	
• Inpatient Hospital Care	• 20% after deductible
• Skilled Nursing Facility	• 20% after deductible
Outpatient Care:	
• Primary Care Office Visit[2]	• 20% after deductible
• Specialist Office Visits	• 20% after deductible
• Outpatient Surgery	• 20% after deductible
• Ambulance (air-ground)	• 20% after deductible
• Emergency Services	• 20% after deductible
• Urgent Care	• 20% after deductible

Benefit Description	Non-Medicare Qualified HDHP Plan
Outpatient Care:	
• DME[3]	• 20% after deductible
• Lab Test[4]	• 20% after deductible
• X-ray	• 20% after deductible
• Diagnostic Procedures (CT/MRI/PET)	• 20% after deductible
• OT/PT/ST Therapies[5]	• 20% after deductible
Other Services:	
• Alternative Care[6]	• 20% after deductible
Calendar Year Pharmacy Out-of-Pocket Maximum	Combined with Medical
Prescription Drugs:	
• Brand	• 20% after deductible
• Generic	• 20% after deductible
• Specialty	• 20% after deductible
Rates (per member, per month):	
• Adult	• $709.84
• Child	• $217.75

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Once enrolled in the Qualified HDHP plan, you cannot switch to the Core Value plan at any time in the future.

1 A family has to meet the entire family deductible before covered expenses are paid at the plan coinsurance level for any of the family members.

2 One annual preventive primary care visit per year at $0. First three primary care or primary care-related visits per year at $5 per visit. This includes any combination of in-person or virtual care.

3 Certain DME are covered prior to deductible per IRS guidelines.

4 Certain diagnosis-based screening and lab tests available at $0 cost-share and prior to deductible per IRS guidelines.

5 Outpatient rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy. Limited to 20 visits per therapy per calendar year.

6 Spinal manipulation is limited to 20 visits and acupuncture is limited to 12 visits per calendar year. Naturopathy, no visit limit. Massage therapy not covered.

UnitedHealthcare — High Deductible Health Plan

Non-Medicare Enrollment Service Area: See map and listing of health plan enrollment service area on page 21.

Benefit Description	Non-Medicare Qualified HDHP Plan	
	In-Network	Out-of-Network
Eligible Providers	Preferred physicians and facilities	Any Licensed Physician or facility
	Member Pays:	
Calendar Year Deductible	$3,000 per individual. If enrolled as a family, a total of $6,000 for all members combined.[1]	
Calendar Year Medical/Pharmacy Out-of-Pocket Maximum	$6,650 per individual $13,300 per family	
Preventive Care	Covered in full per ACA guidelines	40% after deductible per ACA guidelines
Inpatient Care:		
• Inpatient Hospital Care	• 20% after deductible	• 40% after deductible
• Skilled Nursing Facility	• 20% after deductible	• 40% after deductible
Outpatient Care:		
• Physician Office Visits[2]	• 20% after deductible	• 40% after deductible
• Specialist Office Visits	• 20% after deductible	• 40% after deductible
• Outpatient Surgery	• 20% after deductible	• 40% after deductible
• Ambulance (air-ground)	• 20% after deductible	• 20% after deductible
• Emergency Services	• 20% after deductible	• 20% after deductible
• Urgent Care	• 20% after deductible	• 40% after deductible
• DME	• 20% after deductible	• 40% after deductible
• Lab Test	• 20% after deductible	• 40% after deductible
• X-ray	• 20% after deductible	• 40% after deductible
• Diagnostic Procedures (CT/MRI/PET)	• 20% after deductible	• 40% after deductible
• OT/PT/ST Therapies[3]	• 20% after deductible	• 40% after deductible

Benefit Description	Non-Medicare Qualified HDHP Plan	
Other Services: • Alternative Care[4]	• $30 copay after deductible	• 40% after deductible
Calendar Year Pharmacy Out-of-Pocket Maximum	Combined with Medical	
Prescription Drugs: • Brand • Generic • Specialty	• 20% after deductible • 20% after deductible • 20% after deductible	
Rates (per member, per month): • Adult • Child	• $1,200.90 • $365.07	

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Once enrolled in the Qualified HDHP plan, you cannot switch to the Core Value plan at any time in the future.

1 A family has to meet the entire family deductible before covered expenses are paid at the plan coinsurance level for any of the family members.

2 One annual preventative primary care visit per year at $0. First three primary care or primary care-related visits per year at $5 per visit. This includes any combination of in-person or virtual care.

3 Outpatient rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy. Limited to 20 visits per therapy, per calendar year.

4 Spinal manipulation is limited to 20 visits and acupuncture is limited to 12 visits per calendar year. Massage therapy not covered.

2026 Dental Benefit Outlines

You can enroll in either dental plan regardless of your medical plan selection.

	Kaiser Permanente*	Delta Dental of Oregon
Providers/Network	Kaiser Permanente Dental Associates	Delta Dental Premier, PPO and Non-Participating Providers[1]
	Member Pays:	**Member Pays:**
Calendar Year Deductible	None	$25 per individual[2]
Calendar Year Benefit Maximum (plan pays)	$1,750 per individual[3]	$1,750 per individual[3]
Preventive Care		
	Limit of two cleanings per calendar year	Available twice in a calendar year
• Exams	• $10 copay per visit[3]	• Covered in full[3]
• Cleanings	• $10 copay per visit[3]	• Covered in full[3,6]
• X-rays	• $10 copay per visit[3]	• Covered in full[3,4]
Basic Services		
• Restorative	• $10 copay, then 20%	• 20% after deductible[5]
• Oral Surgery (extractions)	• $10 copay, then 20%	• 20% after deductible[5]
• Endodontic/periodontic	• $10 copay, then 20%	• 20% after deductible[5]
Major Services		
• Crowns	• $10 copay, then 50%	• 50% after deductible[5]
• Cast Restorations	• $10 copay, then 50%	• 50% after deductible[5]
• Dentures/bridge work	• $10 copay, then 50%	• 50% after deductible[5]
• Implants	• $10 copay, then 50%	• 50% after deductible[5]
Travel Benefits		
Out-of-Area Coverage	Members pay the cost share that normally applies for non-emergency dental care services, plus amounts that exceed usual and customary charges.	Worldwide for emergency services only
Rates (per member, per month)		
• Adult	• $70.79	• $73.01
• Child	• $28.71	• $29.59

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 health plan document, the information in the health plan document shall prevail.

* To be enrolled in the Kaiser Permanente dental plan, you must live in the Kaiser Permanente dental service area.

1 The amounts payable for services of a non-participating provider are limited to the amount in the PPO Fee Schedule. Non-participating providers may balance bill.

2 Deductible waived on preventive services.

3 Charges for preventive services do not apply to the calendar year benefit maximum.

4 Some limitations apply.

5 There is a 12-month waiting period for basic and major services following enrollment unless member has had continuous dental coverage for the previous 12 months immediately preceding PHIP dental enrollment.

6 Additional cleanings may be covered through the Oral Health, Total Health program or Health through Oral Wellness® program. Contact customer service for additional details.

2026 Medicare Rates

Medical and Prescription Drug Monthly Premium Rate Comparison

The monthly premiums shown below are **without** the $60 RHIA premium subsidy contribution.

More information on the RHIA premium subsidy contribution eligibility is located on our website at pershealth.com/new-member/phip-subsidies/.

Health Plan	Adult rate*	Child Rate**
Kaiser Permanente Senior Advantage	$291.04	$234.20
Moda Health Medicare Supplement Plan	$409.06	$328.62
Providence Medicare Align Group Plan + Rx (HMO)	$372.54	$299.40
Providence Medicare Flex Group Plan + Rx (HMO-POS)	$340.69	$273.92
UnitedHealthcare Group Medicare Advantage (PPO)	$310.69	$249.92

Oregon Administrative Rules (OAR): 459-035-001(1) and 459-035-0020 describe PERS Health Insurance Program (PHIP) eligibility requirements. If you have questions about your eligibility, or if you would like a copy of the complete OAR eligibility rules, please call PHIP at the number listed in the back of this guide or visit https://sos.oregon.gov/archives/.

Non-Medicare rates are available on page 46. To calculate your premium rates, use the Rate Calculation Worksheet on page 47.

* Per member, per month adult rate includes retiree, spouse and dependent domestic partner.

** Per member, per month child rate includes dependent child regardless of age. Eligibility requirements apply for dependents over the age of 26, to view dependent eligibility refer to pershealth.com. No additional premium (cost) for more than two children.

2026 Non-Medicare Rates

Medical and Prescription Drug Monthly Premium Rate Comparison

The monthly premiums shown below are **without** the RHIPA premium subsidy contribution.

More information on the RHIPA premium subsidy contribution eligibility is located on our website at pershealth.com/new-member/phip-subsidies/.

Health Plan	Adult rate*	Child Rate**
Kaiser Permanente Core Value Plan	$1,188.05	$361.21
United Healthcare Core Value Plan	$1,665.09	$504.32
Kaiser Permanente Qualified HDHP	$709.84	$217.75
United Healthcare Qualified HDHP	$1,200.90	$365.07

Oregon Administrative Rules (OAR): 459-035-001(1) and 459-035-0020 describe PERS Health Insurance Program (PHIP) eligibility requirements. If you have questions about your eligibility, or if you would like a copy of the complete OAR eligibility rules, please call PHIP at the number listed in the back of this guide or visit https://sos.oregon.gov/archives/.

Medicare rates are available on page 45. To calculate your premium rates, use the Rate Calculation Worksheet on page 47.

* Per member, per month adult rate includes retiree, spouse and dependent domestic partner.

** Per member, per month child rate includes dependent child regardless of age. Eligibility requirements apply for dependents over the age of 26, to view dependent eligibility refer to pershealth.com. No additional premium (cost) for more than two children.

Premium Calculation Worksheet

1. Medicare Health Plan (Enter monthly Medicare premium rate from page 45)	**2026 Medicare Rates**
a. Retiree Premium Amount (Adult Rate[1])	1a. $
b. Spouse Premium Amount (Adult Rate[1])	1b. $
c. Dependent Premium Amount (Child Rate[2])	1c. $
d. Total Medicare Premium Amount (add 1a through 1c)	1d. $

2. Non-Medicare Health Plan (Enter monthly non-Medicare premium rate from page 46)	**2026 Non-Medicare Rates**
a. Retiree Premium Amount (Adult Rate[1])	2a. $
b. Spouse Premium Amount (Adult Rate[1])	2b. $
c. Dependent Premium Amount (Child Rate[2])	2c. $
d. Total Non-Medicare Premium (add 2a through 2c)	2d. $

3. Dental Plan (Enter monthly dental premium rate from page 44)	**2026 Dental Rates**
a. Retiree Premium Amount (Adult Rate[1])	3a. $
b. Spouse Premium Amount (Adult Rate[1])	3b. $
c. Dependent Premium Amount (Child Rate[2])	3c. $
d. Total Dental Premium (add 3a through 3c)	3d. $

4. This is your total monthly premium rate[1]	**2026 Total Rate**
add 1d+2d+3d	$

1 The monthly premium calculated does not include the Retirement Health Insurance Account (RHIA) nor the Retiree Health Insurance Premium Account (RHIPA) premium subsidy contribution. A premium subsidy contribution will be applied automatically, if eligible. More information on the PHIP premium subsidies eligibility is located on our website at pershealth.com.

2 If more than one dependent (child) multiply rate by 2. No additional cost for more than two children.

Required Notices

Women's Health and Cancer Rights Act

Beginning in 1999, federal law requires group health plans to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction on the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and coverage for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles, coinsurance amounts and copayments that are consistent with those that apply to other benefits under the plan.

Power of Attorney or Authorization to Disclose Information

PHIP requires that a Power of Attorney or Authorization to Disclose Information be on file at the PERS Health Insurance Office for anyone acting on a member's behalf. PHIP is unable to release information to anyone who is not authorized by the PHIP member. To disclose or change information after the death of a member, please provide one of the following: executor, letter of probate or trustee documentation, or Last Will and Testament.

COBRA Continuation of Coverage

If you experience one of these qualifying events you or your dependent may be eligible for continuation of coverage through COBRA. In accordance with federal and state of Oregon guidelines, PHIP provides opportunities for the continuation of coverage through COBRA following specific qualifying events. If you experience one of the qualifying events listed below, please contact PHIP for additional information. A qualifying event will occur if eligibility for coverage is lost because of:

- Cancelation of PERS retirement status.
- The divorce or legal separation of a retiree's covered spouse; PHIP must be notified within 60 days from the signed Dissolution of Marriage document.
- A spouse or dependent child no longer meeting eligibility requirements (e.g., a child reaches the maximum age limit, or a spouse loses coverage because the retiree does not enroll in PHIP upon the last enrollment opportunity).

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

Timely COBRA Premium Payments

Once you elect COBRA coverage, you have 45 days to pay the initial premium. After that, premiums are due the first day of each month. If your initial payment is not (postmarked or received) by the due date, your coverage will be terminated and cannot be reinstated. You have a 30-day grace period for monthly payments, after which your policy will be canceled and cannot be reinstated. The initial premium must be paid within 45 days of the date COBRA is elected. Thereafter, premiums are due the first day of each month for that month's coverage. If payment is not postmarked 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.

Resources

Getting Assistance With Your PHIP Plan

For general eligibility and enrollment questions you can contact PHIP in the following ways:

Online
pershealth.com

By Phone

In Portland: 503-224-7377
Toll-free: 800-768-7377
TTY: 711
Monday through Friday, 7:00 a.m. to 7:00 p.m.

By Mail

PERS Health Insurance Program
P.O. Box 231299
Tigard, OR 97281-1299

By Fax

In Portland: 503-765-3452
Toll-free: 888-393-2943

In Person

Call to make an appointment

Additional Member Resources

Centers for Medicare and Medicaid Services (CMS)

Toll-free: 800-633-4227
TTY: 877-486-2048

medicare.gov

Social Security Administration (SSA)

Toll-free: 800-772-1213
TTY: 800-325-0778

ssa.gov

PERS Pension Office
Pension questions only

Online

oregon.gov/pers

By Phone
Toll-free: 888-320-7377
TTY: 503-603-7766
Monday through Friday, 8:30 a.m. to 5:00 p.m.

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

Contacting Your Health Plan

For questions on plan benefits, limitations and exclusions, deductibles (if applicable) refer to your plan's EOC or benefit handbook. You can obtain either by contacting your health plan directly or from pershealth.com. **Note: For Medicare Supplement members, refer to your Traditional Medicare Supplement handbook and Medicare & You handbook for medical plan benefits, limits and exclusions.**

Medical

Kaiser Foundation Health Plan of the NW

(Medicare and non-Medicare) In Portland: 503-813-2000
Toll-free: 800-813-2000
TTY: 711
Medicare Members: 877-221-8221
my.kp.org/pers

Moda Health Plan, Inc.

Toll-free: 800-962-1533
TTY: 711
modahealth.com/pers

Providence Medicare Advantage Plans

Prospective members:
In Portland: 503-574-8403
Toll-free: 855-210-1587
TTY: 711

Enrolled Medicare members:
In Portland: 503-574-8000
Toll-free: 800-603-2340
TTY: 711
providencehealthassurance.com/PHIP

UnitedHealthcare

(Medicare and non-Medicare)

Medicare plan:
Toll-free: 844-884-1850
TTY: 711
uhc.com/pers

Non-Medicare plans:
Toll-free: 844-554-5498
TTY: 711
uhc.com/pers

Contact information for Dental and Pharmacy are located on the following page.

Contacting Your Health Plan (cont.)

Pharmacy

Kaiser Foundation Health Plan of the NW
(Medicare and non-Medicare)
Mail-order pharmacy:
Toll-free: 800-548-9809
TTY: 711
my.kp.org/pers

Moda Health Plan, Inc.
Toll-free: 888-786-7509
TTY: 711
modahealth.com/pers

Providence Medicare Advantage Plans
In-Portland: 503-574-8000
Toll-free: 800-603-2340
TTY: 711
providencehealthassurance.com/PHIP

UnitedHealthcare
(Medicare and non-Medicare)

Medicare plan:
Toll-free: 844-884-1850
TTY: 711
uhc.com/pers

Non-Medicare plans:
Toll-free: 844-554-5498
TTY: 711
uhc.com/pers

Dental

Kaiser Foundation Health Plan of the NW
In Portland: 503-813-2000
Toll-free: 800-813-2000
TTY: 711
my.kp.org/pers

Delta Dental of Oregon
Toll-free: 844-827-7379
TTY: 711
modahealth.com/pers

PERS
HEALTH
INSURANCE PROGRAM
Public Employees Retirement System

P.O. Box 231299
Tigard, OR 97281-1299

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Important plan information about your enrollment