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

## PERS HEALTH INSURANCE PROGRAM

### 2022 MEDICARE BENEFIT-RATE COMPARISON

<table>
<thead>
<tr>
<th>SUPPLEMENT PLAN</th>
<th>MODA HEALTH MEDICARE SUPPLEMENT PLAN</th>
<th>KAISER PERMANENTE SENIOR ADVANTAGE</th>
<th>PACIFIC SOURCE MEDICARE ESSENTIALS RX 803</th>
<th>PROVIDENCE – MEDICARE FLEX GROUP PLAN + Rx</th>
<th>PROVIDENCE – MEDICARE ALIGN GROUP PLAN + Rx</th>
<th>UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE (PPO)</th>
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<td><strong>IN-NETWORK</strong></td>
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<td><strong>OUT-ON-NETWORK</strong></td>
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### ESSENTIAL PROVIDERS

- Kaiser Permanente, PeaceHealth, and The Portland Clinic
- Plan Physicians and Hospitals
- Any licensed Medicare Provider
- Plan Physicians and Hospitals
- Any licensed Medicare Provider
- Medicare Advantage Network Providers
- Any licensed Medicare Provider

### PREVENTIVE CARE

- **Inpatient Care**
  - Covered in full
  - $200 copay per admission
  - **Skilled Nursing Facility**
  - Covered in full
  - **Diagnostic Imaging (CT/MRI/PET)**
  - Covered in full
  - **Lab Test**
  - Covered in full
  - **Eye Exam**
  - Covered in full
  - **Drug Therapy**
  - Covered in full

### 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
  - **Inpatient Hospital Care**
  - Covered in full
  - **Vision Routine Eye Exam**
  - Covered in full
  - **X-ray**
  - Covered in full
  - **Diagnostic Imaging (CT/MRI/PET)**
  - Covered in full
  - **PT/OT/ST Therapies**
  - Covered in full

### OTHER SERVICES

- **Chiropractic Care**
  - Covered in full
  - **Acupuncture**
  - Covered in full
  - **Routine Hearing Exam**
  - Covered in full
  - **Hearing Aids ( aids)**
  - $399 or $699 options
  - **Vision Routine Exam**
  - $200 allowance every 2 calendar years
  - **Vision Hardware (lenses, frames and/ or contacts)**
  - $200 credit every 2 calendar years

### PRESCRIPTION DRUGS

- **Tier 1**
  - Up to $8 copay per 31-day supply
  - **Tier 2**
  - Up to $15 copay per 31-day supply
  - **Tier 3**
  - 40% to $250 max/script/31-day
  - **Tier 4**
  - 40% to $250 max/script/31-day
  - **Tier 5**
  - 40% to $250 max/script/31-day
  - **Tier 6**
  - 0% copay share

### CALENDAR YEAR PHARMACY OUT-OF-POCKET MAXIMUM

- Tier 1: $7,050 per member
- Tier 2: $7,050 per member
- Tier 3: $7,050 per member
- Tier 4: $7,050 per member
- Tier 5: $7,050 per member
- Tier 6: $7,050 per member

### BATES FOR MEMBERS, PER MONTH

- **Adult**
  - $324.78
  - $260.83
- **Child**
  - $246.13
  - $197.90
  - $252.54
  - $203.03
  - $232.20
  - $186.75
  - $267.34
  - $214.87
  - $252.29
  - $202.83

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1. Out-of-network Medicare providers are paid up to the Medicare limiting charge.
2. 2022 Part B deductible; 2022 Part B deductible is not available at this time.
3. Medicare covered services only.
4. Coverage applies to a Medicare-certified facility for up to a 100-day/Medicare benefit period.
5. Days 1-30 are covered in full; days 31-100; member pays $150 per day.
7. Outpatient Rehab: OT/OC, Occupational Therapy, PT, Physical Therapy, ST, Speech Therapy
8. Applies to Medicare-approved suppliers/equipment only and may require Pre-Authorization. Some diabetic supplies are covered in full.
9. If no referral is in place when seeing an in-network specialist, $250 copay applies.
10. Medicare covered services only.
11. Must use Truelinking program. One routine hearing exam and one per ear per calendar year.
12. To receive the VSP benefit as listed, use VSP Advantage providers. For out-of-network reimbursement amounts, refer to the member handbook.
13. Acupuncture for chronic low back pain per Medicare guidelines; up to 12 visits in 90 days are covered. Specific medical criteria must be met. Physician referral may be required.
15. Combined our allowance for hearing aids.
16. See Health Plan EOC for more details on each pharmacy tier. EOC may contain expanded language.
17. Apply the adult rate to the PERS retiree, Spouse and Dependent Domestic Partner. Apply the Child rate to a dependent child regardless of their age. No additional premium (cost) for more than two children.