### PERS HEALTH INSURANCE PROGRAM
#### 2021 Medicare Benefit/Rate Comparison

<table>
<thead>
<tr>
<th>Supplement Plan</th>
<th>Medicare Advantage Plan</th>
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<tbody>
<tr>
<td>Mosaiqué Medicare Supplement Plan</td>
<td>Kaiser Permanente Senior Advantage</td>
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<tr>
<td>Kaiser Permanente Clinic Physicians and Hospitals</td>
<td>Plan Physicians and Hospitals</td>
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<td>Plan Physicians and Hospitals</td>
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<tr>
<td>Medicare Advantage Network Providers</td>
<td>Any licensed Medicare Provider</td>
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#### Eligible Providers
- Any licensed Medicare Provider
- Kaiser Permanente and The Portland Clinic Physicians and Hospitals
- Plan Physicians and Hospitals
- Any licensed Medicare Provider

#### Cost Share
- **Preventive Care**: $0 per individual
- **Outpatient Care**: $0 per individual
- **Inpatient Care**: $0 per individual
- **Other Services**: $0 per individual
- **Prescription Drugs**: $0 per 31-day supply

#### In-Network/Out-of-Network
- **In-Network**
- **Out-of-Network**

#### Out-of-Pocket Maximum
- N/A
- $1,000 per individual
- $3,400 per individual

#### Summary
- **16 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.**
- **15 See Health Plan EOC for more details on each pharmacy tier. EOC may contain expanded language.**
- **10 Must use TruHearing providers. One routine hearing exam and one aid per ear per calendar year.**
- **8 If no referral is in place when seeing an In-network specialist, $35 copay applies.**

#### Provider List
- **Tier 1**
- **Tier 2**
- **Tier 3**
- **Tier 4**
- **Tier 5**
- **Tier 6**

#### Calendar Year Deductible
- **$198 per individual**

#### Calendar Year Maximum
- **Out-of-Pocket Maximum**
- N/A
- $1,000 per individual
- $3,400 per individual

#### Conclusion
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.

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1. Out-of-network Medicare providers are paid at the Medicare limit charge.
2. 2020 Part B deductible. 2021 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 100 days/Medicare benefit period.
5. Days 1-20 are covered in full; days 21-100: member pays $15 copay per day.
6. Outpatient Rehab: OT/1 Occupational Therapy, PT/1 Physical Therapy, ST/1 Speech Therapy
7. Applies to Medicare approved supplies/equipment only and may require Pre-Authorization. Some diabetic supplies are covered in full.
8. If referral is in place when seeing an in-network specialist, $35 copay applies.
9. Medicare covered services only.
10. Must use TruHearing providers. One routine hearing exam and one aid per ear per calendar year.
11. To receive the VSF-benefit as listed, use VSF Advantage providers. For out-of-network reimbursement amounts, refer to the member handbook.
12. Acupuncturist for low back pain per Medicare guidelines, up to 12 visits in 90 days are covered if specific circumstances are met. Physician referral may be required.
13. Any licensed provider.
15. See Health Plan EOC for more details on each pharmacy tier. EOC may contain expanded language.
16. 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.