

**PERS HEALTH INSURANCE PROGRAM
2021 MEDICARE BENEFIT/RATE COMPARISON**

	SUPPLEMENT PLAN		MEDICARE ADVANTAGE PLANS					
	MODA HEALTH MEDICARE SUPPLEMENT PLAN	KAISER PERMANENTE SENIOR ADVANTAGE	PACIFICSOURCE MEDICARE ESSENTIALS RX 803	PROVIDENCE – MEDICARE FLEX GROUP PLAN + RX		PROVIDENCE – MEDICARE ALIGN GROUP PLAN + RX	UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE (PPO)	
				IN-NETWORK	OUT-OF-NETWORK		IN-NETWORK	OUT-OF-NETWORK ¹
ELIGIBLE 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	Medicare Advantage Network Providers	Any licensed Medicare Provider
	MEMBER pays:	MEMBER pays:	MEMBER pays:	MEMBER pays:		MEMBER pays:	MEMBER pays:	
CALENDAR YEAR DEDUCTIBLE	\$198 per individual ²	None	None	None		None	None	
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM	N/A	\$1,000 per individual	\$3,400 per individual	\$3,000 per individual		\$1,500 per individual	\$2,500 per individual	
PREVENTIVE CARE³	Covered in full	Covered in full	Covered in full	Covered in full		Covered in full	Covered in full	
INPATIENT CARE								
▪ Inpatient Hospital Care	Covered in full	\$200 copay per admit	\$125 copay/day; \$500 max. per admit	\$125 copay/day; \$500 max. per admit	20%	\$100 copay/day; \$500 max. per admit	\$100 copay/day; \$300 max. per admit	\$100 copay/day; \$300 max. per admit
▪ Skilled Nursing Facility	Covered in full ⁴	Covered in full	Covered in full	Covered in full ⁵	20%	Covered in full	\$0 copay ⁴	\$0 copay ⁴
OUTPATIENT CARE								
▪ Physician Office Visits	Covered in full	\$15 copay	\$15 copay	\$20 copay	\$30 copay	\$15 copay	\$15 copay	\$15 copay
▪ Specialist Office Visits	Covered in full	\$15 copay	\$20 copay	\$25 copay ⁸	\$35 copay	\$20 copay	\$20 copay	\$20 copay
▪ Outpatient Surgery	Covered in full	\$15 copay	\$125 copay	\$150 copay	20%	\$75 copay	\$125 copay	\$125 copay
▪ Ambulance (air/ground)	Covered in full	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay
▪ Emergency Services	Covered in full	\$50 copay	\$50 copay	\$65 copay	\$65 copay	\$50 copay	\$65 copay	\$65 copay
▪ Urgent Care	Covered in full	\$15 copay	\$20 copay	\$25 copay	\$25 copay	\$25 copay	\$20 copay	\$20 copay
▪ DME	Covered in full	20% ⁷	20% ⁷	20% ⁷	20% ⁷	20% ⁷	20% ⁷	20% ⁷
▪ Lab Test	Covered in full	Covered in full	Covered in full	Covered in full	20%	Covered in full	\$0 copay	\$0 copay
▪ X-ray	Covered in full	Covered in full	10%	10%	20%	10%	10%	10%
▪ Diagnostic Imaging (CT/MRI/PET)	Covered in full	Covered in full	10%	10%	20%	10%	10%	10%
▪ OT/PT/ST Therapies ⁶	Covered in full	Covered in full	\$20 copay	\$25 copay	\$35 copay	\$20 copay	\$20 copay	\$20 copay
OTHER SERVICES								
▪ Chiropractic Care ⁹	Covered in full	\$15 copay	\$15 copay	\$20 copay	\$35 copay	\$20 copay	\$20 copay	\$20 copay
▪ Acupuncture	Covered in full ⁹	\$15 copay ¹²	\$15 copay ¹²	\$25 copay ¹²	\$35 copay ¹²	\$20 copay ¹²	\$20 copay ¹²	\$20 copay ¹²
▪ Routine Hearing Exam	\$45 copay ¹⁰	\$15 copay	\$45 copay ¹⁰	\$45 copay ¹⁰	Not covered	\$45 copay ¹⁰	\$2,400 allowance ¹⁴	\$2,400 allowance ¹⁴
▪ Hearing Hardware (aids)	\$699 or \$999 options ¹⁰	\$200 allowance/ear, \$400/year	\$699 or \$999 options ¹⁰	\$699 or \$999 options ¹⁰	Not covered	\$699 or \$999 options ¹⁰	\$2,400 allowance ¹⁴	\$2,400 allowance ¹⁴
▪ Vision Routine Eye Exam	\$15 copay	\$15 copay	\$15 copay	\$20 copay ¹³	\$20 copay ¹³	\$15 copay ¹³	\$20 copay	\$20 copay
▪ Vision Hardware (lenses, frames and/or contacts)	\$100 allowance every 2 calendar years ¹¹	\$100 credit every 2 calendar years	\$100 credit every 2 calendar years	\$100 credit every 2 years ¹³	\$100 credit every 2 years ¹³	\$100 credit every 2 years ¹³	\$100 allowance every 24 months	\$100 allowance every 24 month
PRESCRIPTION DRUGS¹⁵	THIS IS A MEDICARE PART D PRESCRIPTION DRUG PLAN that is included with all Medicare medical plans							
▪ Tier 1	\$8 copay per 31-day supply	\$8 copay per 30-day supply	\$8 copay per 31-day supply	\$8 copay per 31-day supply	\$8 copay per 31-day supply	\$8 copay per 31-day supply	\$8 copay per 31-day supply	\$8 copay per 31-day supply
▪ Tier 2	\$15 copay per 31-day supply	\$15 copay per 30-day supply	\$15 copay per 31-day supply	\$15 copay per 31-day supply	\$15 copay per 31-day supply	\$15 copay per 31-day supply	\$15 copay per 31-day supply	\$15 copay per 31-day supply
▪ Tier 3	40% to \$250 max/script/31-day	40% to \$250 max/script/30-days	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day
▪ Tier 4	40% to \$250 max/script/31-day	40% to \$250 max/script/30-days	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day
▪ Tier 5	40% to \$250 max/script/31-day	40% to \$250 max/script/30-days	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day	40% to \$250 max/script/31-day
▪ Tier 6	\$0 cost share	\$0 cost share	\$0 cost share	\$0 cost share	\$0 cost share	\$0 cost share	N/A	N/A
CALENDAR YEAR PHARMACY OUT-OF-POCKET MAXIMUM	\$6,550 per member	\$6,550 per member	\$6,550 per member	\$6,550 per member		\$6,550 per member	\$6,550 per member	
RATES (PER MEMBER, PER MONTH)¹⁶								
▪ Adult	\$313.17	\$239.38	\$264.41	\$241.33	\$194.06	\$278.19	\$252.29	\$202.83
▪ Child	\$251.53	\$192.50	\$212.53			\$223.56		

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.

¹ Out-of-network Medicare providers are paid up to the Medicare limiting 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 a 100 days/Medicare benefit period.

⁵ Days 1-20 are covered in full; days 21-100 member pays a \$50 copay per day.

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 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 VSP benefit as listed, use VSP Advantage providers. For out-of-network reimbursement amounts, refer to the member handbook.

¹² Acupuncture 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.

¹⁴ Allowance is shared between in and out-of-network. Combined ear allowance.

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.