Clackamas County 2017 Medicare Retirees	ORIGINAL MEDICARE : PART A (2017)*** PART A: No additional premium for most participants.	ORIGINAL MEDICARE: PART B (2017)*** PART B standard monthly premium: Variable depending on year retired; income. *2017 premium: $134.00*	Kaiser Senior Advantage	Providence*** Medicare Align
	INPATIENT HOSPITAL SERVICES	DOCTOR SERVICES AND OTHER MEDICAL CARE	IN-PLAN COVERAGE ONLY	IN-PLAN COVERAGE ONLY
Deductible: Individual/Family Maximum	No annual deductible	$183; first three pints of blood (if hospital has to purchase and it is not donated by blood bank)	$0	$0
Annual Out-of-Pocket Maximum: Individual	None	None	$600	$1,500
Lifetime Maximum Benefit	None	None	N/A	N/A
PREVENTIVE HEALTH SERVICES				
Periodic health exams (maximum once per year)	Covered under Part B	One routine physical exam within 12 months of enrollment in Part B ("Welcome to Medicare" Physical Exam"); if have Part B longer than 12 months, yearly wellness visit covered at 100% every 12 months.	$0	$0
Preventive screening test (colon, pap smears, prostate, etc.)	Generally, covered under Part B	Cardiovascular, diabetes, glaucoma screening-frequency varies by test and physical history.	Covered in full within limits set by Medicare	Covered in full within limits set by Medicare
Mammograms		Once every 12 months for women age 40 and older, or as ordered by doctor; one baseline for women between 35-39		
PHYSICIAN/PROVIDER SERVICES				
Office visits to a Personal Physician/Provider	Generally, covered under Part B	Generally, 80% of Medicare-approved amounts; 45% for outpatient mental health care	$10 co pay	Primary Care: $15 co pay Specialty Care: $20 co pay
Podiatry Services (medically necessary foot care)		Generally, 80% of Medicare-approved amounts		
Office visits to all other providers		Generally, 80% of Medicare-approved amounts		
Allergy shots		Covered at 80% of Medicare-approved charge if required to be administered by professionals (limited coverage for self-injectibles)	$0	No charge if required to be administered by professional; see prescription formulary for self-injectibles
Routine immunizations		Annual flu shot; pneumonia shot and Hepatitis B as ordered by doctor.		No co pay for flu, pneumonia, or Hepatitis B vaccines; others generally covered
INPATIENT HOSPITAL SERVICES				
Inpatient care (per Medicare benefit period)	Per spell of illness for the same medical condition: All except $1316 for a stay of 1-60 days; all except $329 per day for days 61-90 per benefit period; all except $658 per day for each of 60 lifetime reserve days (usable one-time only); no coverage for additional inpatient care until new benefit period ; inpatient psychiatric hospital services is limited to 190 days in a lifetime	Covered under Part A	No charge	$100 per day/$500 maximum per admission
Provider visits while hospitalized	Covered under Part B	Generally, 80% of Medicare-approved amounts for doctors' services provided while hospitalized		
Surgery & anesthesia	Costs for use of facilities and nursing services for inpatients paid under Part A			
Rehabilitative care	Physical therapy, speech therapy, and occupational therapy for inpatients covered under Part A	Covered under Part A		
Skilled nursing facility	First 20 days-all approved amounts; 21st through 100th day-all but $164.50 per day; No coverage after 100 days per benefit period		Covered in full (100 days per benefit period)	Covered in full (100 days per benefit period)
DURABLE MEDICAL EQUIPMENT				
Medical & diabetic supplies, appliances and prosthetics	All Medicare-approved expenses for inpatient care	Generally, 80% of the Medicare-approved amount for durable medical equipment	No charge except Part B drugs covered under prescription drug benefit	20% Coinsurance for Medicare-Approved equipment
Hearing aids	Not covered; discounts available	Not covered; discount available	$1,500 per ear every 3 yrs	Not covered; discount available

	ORIGINAL MEDICARE : PART A (2016)***	ORIGINAL MEDICARE: PART B (2016)***	Kaiser Senior Advantage	Providence Medicare Align
EMERGENCY/URGENT & AMBULANCE SERVICES				
Emergency services (waived if admitted)	Covered under Part A if the patient is admitted for emergency treatment	Generally, 80% of Medicare-approved charges	$50	$50
Urgent care services	Covered under Part B		$10	$25
Ambulance services	Covered under Part B	Covers 80% of the cost for medically-necessary transportation to nearest treating facility	$50	$50
OTHER COVERED SERVICES				
X-ray & lab services	All approved expenses for inpatient care if billed by hospital	Most diagnostic tests covered at 100%; X-rays covered at 80%	Covered in full	10%
Outpatient rehabilitative services	Covered under Part B	Generally, 80% paid for Medicare-approved expenses (limits on self-injectibles other than insulin)	$10 co pay	$20 co pay
Outpatient surgery (Applies to all procedures performed in ambulatory surgery centers)		Generally, 80% paid for Medicare-approved expenses for use of facilities and services		$75 co pay per surgery
Chemotherapy & radiation	All approved expenses for inpatient care	Drugs and biologicals administered by professionals to outpatients covered at 80% of Medicare-approved charge		20% CoInsurance for chemotherapy drugs or other Part B Drugs
Home health care (Medicare-covered)	As long as under care of doctor who certifies medical need and updates progress, covered in full, limited to part-time or intermittent nursing care; 20% of the Medicare-approved amount for durable medical equipment	Covered under Part A	Covered in full for Medicare-approved charges (Up to 100 days per benefit period)	Covered in full for Medicare-approved charges (Up to 100 days per benefit period)
Hospice (Medicare-certified hospice)	As long as doctor certifies medical need, all expenses covered but a small charge per prescription for outpatient drugs and 5% for inpatient respite care	Covered under Part A	Covered in full for Medicare-approved charges	Covered in full for Medicare-approved charges
VISION				
Eye examinations	Not covered	80% of customary charges for medically necessary exams	$10 co pay	$15 co pay - administered by VSP
Lenses & frames		One pair with standard frames after cataract surgery	$200 eyewear allowance every 2 calendar years; No charge for standard eyewear post cataract surgery	Covered only after cataract surgery; otherwise basic lenses covered with $100 frame/contact allowance every two calendar years
ALTERNATIVE CARE				
Office visits	Limited coverage under Part B	Limited chiropractic services for spinal manipulation. Routine care not covered.	$10/visit for chiropractic, acupuncture, naturopath, $25 massage (12 visit limit), $1500 combined annual max	$20 co pay for each Medicare-covered chiropractic visit. Otherwise, discounts available
PRESCRIPTION DRUGS				
Generic co pay (up to 30-day supply)	Generally, covered in full when ordered by doctor for inpatient in hospital or skilled nursing facility	Not covered except in a few cases such as certain oral cancer drugs and drugs that must be administered by a professional.	$10	$10
Preferred Brand co pay (up to 30-day supply)			$20	50%
Non-Preferred Brand co pay (up to 30-day supply)			$20	50%
Mail Order Maintenance Drugs (90-day supply)			2 co pays Avail. only in Or. & Wash.	3 co pays
Annual Out-of-Pocket Maximum for Prescription Drugs	None	None	N/A (Costs decrease after $4950 in co pays)	$1000 per person; $3000 per family
*** Plans subject to change when final Medicare summaries published				