

CLACKAMAS COUNTY - MEDICARE PLANS					
	ORIGINAL MEDICARE : PART A (2012)***	ORIGINAL MEDICARE: PART B (2012)***	Providence***	Providence***	Kaiser
	PART A: No additional premium for most participants.	PART B standard monthly premium: Variable depending on year retired; income. 2012 premium: \$99.90	Medicare Extra	Medicare Supplement F	Senior Advantage
	INPATIENT HOSPITAL SERVICES	DOCTOR SERVICES AND OTHER MEDICAL CARE	IN-PLAN COVERAGE ONLY	ANY MEDICARE PROVIDER	IN-PLAN COVERAGE ONLY
Deductible: Individual/Family Maximum	No annual deductible	\$162; first three pints of blood (if hospital has to purchase and it is not donated by blood bank)	\$0	\$0	\$0
Annual Out-of-Pocket Maximum: Individual/Family	None	None	\$0	\$0	\$600 per member; \$1200 max per family
Lifetime Maximum Benefit	None	None	N/A	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	One physical within 12 months of enrollment; otherwise only Medicare-approved routine preventative care	\$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		
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	\$15 co pay	\$0	\$10 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)	No charge if required to be administered by professional; see prescription formulary for self-injectibles		\$0
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 (except shots for travel)		
INPATIENT HOSPITAL SERVICES					
Inpatient care (per Medicare benefit period)	Per spell of illness for the same medical condition: All except \$1100 for a stay of 1-60 days; all except \$275 per day for days 61-90 per benefit period; all except \$550 per day for each of 59 lifetime reserve days (usable one-time only); no coverage for additional inpatient care until new benefit period; inpatient mental health care is limited to 190 days in a lifetime	Covered under Part A	\$250 co pay per stay (\$500 max per year)	Covers deductible and co-insurance for all Medicare-approved services, plus 365 days of Medicare-eligible hospitalization expenses	No charge
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				
Skilled nursing facility	First 20 days-all approved amounts; 21st through 100th day-all but \$137.50 per day; No coverage after 100 days per benefit period	Covered under Part A	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	Covered in full	Covered in full	No charge except Part B drugs covered under prescription drug benefit
Hearing aids	Not covered; discounts available	Not covered; discount available	Not covered; discount available		\$1,500 per ear every 3 yrs
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	Medicare-eligible charges covered in full	\$75
Urgent care services	Covered under Part B		\$25		\$10
Ambulance services	Covered under Part B		Covers 80% of the cost for medically-necessary transportation to nearest treating facility		\$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	Covered in full for Medicare-approved charges	Covered in full
Outpatient rehabilitative services	Covered under Part B	Generally, 80% paid for Medicare-approved expenses (limits on self-injectibles other than insulin)	\$15 co pay		\$10 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	Covered in full		
Chemotherapy & radiation	All approved expenses for inpatient care	Drugs and biologicals administered by professionals to outpatients covered at 80% of Medicare-approved charge	Covered in full for Medicare-approved charges (Up to 100 days per benefit period)		
Home health care (Medicare-covered)	After 3-day hospital stay, 100% for up to 100 approved visits per benefit period, limited to part-time or intermittent nursing care	80% of costs for medically necessary home health care services not otherwise covered under Part A	Covered in full for Medicare-approved charges		
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		
VISION					
Eye examinations	Not covered	80% of customary charges for medically necessary exams	\$0 co pay	Covered in full when medically necessary	\$10 co pay
Lenses & frames		One pair with standard frames after cataract surgery	Covered only after cataract surgery; otherwise discount available		\$200 eyewear allowance every 2 yrs; No charge for standard eyewear post cataract surgery
ALTERNATIVE CARE					
Office visits	Limited coverage under Part B	Limited chiropractic services for spinal manipulation. Routine care not covered.	\$15 co pay for each Medicare-covered chiropractic visit. Otherwise, discounts available	Covered in full for Medicare-approved charges. Otherwise, discounts available.	\$10/visit for chiropractic, acupuncture, naturopath, \$25 massage (12 hour limit), \$1500 combined annual max
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.	Part D Enrollment	Creditable under Part D	Part D Enrollment
Preferred Brand co pay (up to 30-day supply)			\$10	\$10	\$10
Non-Preferred Brand co pay (up to 30-day supply)			50%	50%	\$20
Mail Order Maintenance Drugs (90-day supply)			50%	50%	\$20
Annual Out-of-Pocket Maximum for Prescription Drugs			None	None	\$1000 per person; \$3000 per family
*** Plans subject to change when final Medicare summaries published					