

Medicare Advantage/Medicare Supplement Comparison Guide

FEATURES	Medicare Advantage (10P)	Group Medicare Supplement Plan
Annual Deductible	\$0	\$198 (based on 2019 pending 2020 CMS release)
Out-of-Pocket Maximum	\$2,000 All copays, coinsurance and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services, foreign travel emergency and urgently needed care copay or coinsurance amounts.	\$2,198 All copays, coinsurance and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services, routine vision and foreign travel emergency copays or coinsurance amounts.
Inpatient Hospital Coverage <i>For Medicare-covered hospital stays.</i>	\$200 copay per admission. \$0 copay for Medicare-covered physician services received while an inpatient. No limit to the number of days covered. Requires prior authorization.*	\$250 copay per admission. \$0 copay for Medicare-covered physician services received while an inpatient. No limit to the number of days covered.
Outpatient Hospital Coverage	\$10 copay for a visit to a primary care physician or specialist in an outpatient hospital setting/ clinic, or outpatient observation room visit for Medicare-covered non-surgical service. \$10 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center, or outpatient observation room visit for surgery. Requires prior authorization.*	\$100 copay per visit for each Medicare-covered outpatient hospital facility or ambulatory surgical center, or outpatient observation room visit for surgery.

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Doctor Visits (Primary Care and Specialists)	\$10 copay for a visit to a primary care physician or specialist. No referral is needed.	\$10 copay
Preventive Care	There is no coinsurance, copayment or deductible for Medicare-covered visits, tests, therapy or benefits.	Preventive services will be covered at 100%.
Emergency Care <i>Services that are:</i> – <i>Furnished by a provider qualified to furnish emergency services, and</i> – <i>Needed to evaluate or stabilize an emergency medical condition.</i>	\$100 copay for each Medicare-covered emergency room visit worldwide. Limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States.	Member pays \$100 copay for emergency room visit, waived if admitted.
Urgently Needed Services	\$10 copay for each Medicare-covered urgently needed care visit worldwide.	Member pays \$100 copay for urgent care hospital visit.
Diagnostic Services/Labs/Imaging	\$10 copay for each Medicare-covered test, visit, therapy treatment, supplies or pint of blood. Some services require prior authorization.*	Member pays \$0 , plan pays 20% of the Medicare-approved amount, after deductible.
Mental Health Services <i>Includes mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</i>	Outpatient: \$10 copay for each Medicare-covered individual, group, partial hospitalization and outpatient hospital facility visit. Inpatient: \$200 copay per admission for Medicare-covered hospital stays. \$0 copay for Medicare-covered physician services received while an inpatient. No limit to the number of days covered by the plan.	Member pays \$0 , plan pays 20% of the Medicare-approved amount, after deductible.
Skilled Nursing Facility (SNF)	\$0 copay for Medicare-covered SNF stays, for days 1-100 per benefit period. No prior hospital stay required. Requires prior authorization.*	Member pays \$250 copay per visit for days 21-100 per benefit period for Medicare-covered stays. 3-day hospital stay requirement.
Physical Therapy <i>Part of outpatient rehabilitation services which includes physical, occupational and speech language therapy.</i>	\$10 copay for Medicare-covered physical therapy, occupational therapy and speech language therapy visits.	Member pays \$0 , plan pays 20% of the Medicare-approved amount, after deductible.

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<p>Ambulance</p> <p><i>Your provider must get an approval from the plan before you get ground, air or water transportation that is not an emergency. This is called getting prior authorization.</i></p>	<p>\$100 copay for Medicare-covered ambulance services.</p> <p>Cost share, if any, is applied per one-way trip for Medicare-covered ambulance services.</p>	<p>Member pays \$100 copay, after deductible.</p> <p>Cost share, if any, is applied per one-way trip for Medicare-covered ambulance services.</p>
<p>Medicare Part B Immunizations</p>	<p>There is no coinsurance, copayment or deductible for the pneumonia, influenza, Hepatitis B or other Medicare-covered vaccines when you are at risk and meet Medicare Part B rules.</p>	<p>There is no coinsurance, copayment or deductible for the pneumonia, influenza, Hepatitis B or other Medicare-covered vaccines when you are at risk and meet Medicare Part B rules.</p>
<p>Chiropractic Services</p> <p><i>For manual manipulation of the spine to correct subluxation only.</i></p>	<p>\$10 copay for each Medicare-covered visit.</p>	<p>Member pays \$0, plan pays 20% of the Medicare-approved amount, after deductible.</p>
<p>Durable Medical Equipment (DME) and Related Supplies</p>	<p>\$10 copay for Medicare-covered DME.</p> <p>Some services require prior authorization.*</p>	<p>Member pays \$0, plan pays 20% of the Medicare-approved amount, after deductible.</p>

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Learn more about Medicare

If you're unclear on what Medicare is and how it works, refer to your current **Medicare & You** handbook. If you do not have a copy, you can also view it online or download the booklet at www.medicare.gov. Or you can order a printed copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users, call **1-877-486-2048**.

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the Benefits Chart.

Out-of-network/non-contracted providers are under no obligation to treat Anthem Blue Cross and Blue Shield members, except in emergency situations. Out-of-network coverage is part of your Anthem Medicare Preferred (PPO) plan and you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the service you are receiving is covered and medically necessary. Please call our First Impressions Welcome Team for more information.

Anthem Blue Cross and Blue Shield is an LPPO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.