

# COMPARISON OF MEDICAL PLANS

For those enrolled in Medicare Parts A and B

Effective July 1, 2021

## Medicare Supplement Plan

- Anthem Blue Cross III

## Medicare Advantage Prescription Drug (MA-PD) HMOs

- Kaiser Permanente Senior Advantage
- UnitedHealthcare Medicare Advantage HMO
- SCAN Health Plan

This chart represents a summary of benefits only. Additional benefit information is provided by each insurance carrier. This chart does not replace or modify the official documents that legally govern each plan's operation. The benefits offered by all LACERA-administered health plans change when an enrolled member permanently moves outside the provider network area. Moving to a location outside the coverage area can impact your plan's rates and coverage levels.

## Comparison of Medical Plans

(For Medicare-Eligible Members Enrolled in Medicare Parts A and B)

Medicare Supplement		Medicare Advantage Prescription Drug (MA-PD) HMOs		
Anthem Blue Cross III		Kaiser Permanente Senior Advantage <sup>1</sup>	SCAN <sup>2</sup>	UnitedHealthcare Medicare Advantage HMO
<b>Outpatient Benefits</b>				
<b>Doctor's Office Visit</b>	20% of Medicare-approved charges	\$5 copay	\$5 copay	\$5 copay
<b>Preadmission X-ray and Lab Tests</b>	20% of Medicare-approved charges	No charge	No charge	No charge with an office visit copay
<b>Routine Checkups</b>	Not covered	No charge	\$5 copay	No charge
<b>Immunizations</b>	Not covered	No charge	No charge	No charge with an office visit copay
<b>Outpatient Surgical Services</b>	20% of Medicare-approved charges	\$5 copay per procedure	No charge	No charge
<b>Physical Therapy</b>	20% of Medicare-approved charges	\$5 copay	\$5 copay	No charge with an office visit copay
<b>Speech Therapy</b>	20% of Medicare-approved charges	\$5 copay	\$5 copay	No charge with an office visit copay
<b>Maternity</b>	Covered the same as an illness for services covered by Medicare	\$5 copay	Covered in accordance with Medicare guidelines	Covered in accordance with Medicare guidelines
<b>Chiropractic Care</b>	20% of Medicare-approved charges	\$5 copay for Medicare-covered services <sup>3</sup>	\$5 copay for Medicare-covered services <sup>3</sup>	\$5 copay for Medicare-covered services <sup>3</sup>
<b>Transportation</b>	Not covered	Not covered	No charge for unlimited number of rides to medical or dental appointments	Not covered
<b>Prescription Drug Benefits</b>				
<b>Prescription Drugs</b>	Retail: 80% in-network, 60% out-of-network Mail order: \$10 generic/\$30 brand/\$50 non-preferred brand/\$150 specialty copay for mail order for 90-day supply <sup>4</sup>	\$7 copay for up to 100-day supply; covers dental prescriptions	Retail: \$7 generic/\$15 brand for 30-day supply Mail order: \$7 generic/\$15 brand for 100-day supply Generic drug discounts at Preferred Network Pharmacies (CVS, Rite-Aid, Costco, Vons, Ralps): \$2 Retail/\$4 Mail-Order	\$7 copay for 30-day supply (or for 90-day mail order supply for maintenance medications only)
<b>Mental Health and Substance Abuse Benefits</b>				
<b>Inpatient</b>	Plan pays all Medicare inpatient deductibles for approved Medicare days; 190-day lifetime maximum	No charge; for unlimited number of days	No charge; 90 days per benefit period. 190-day lifetime maximum in Medicare facility. <sup>5</sup>	No charge; 190-day lifetime maximum if admitted to Medicare-approved psychiatric hospital
<b>Outpatient</b>	20% of Medicare-approved charges; up to 50 professional visits per year	\$5 copay for each visit per calendar year for an unlimited number of visits	\$5 copay for each visit per calendar year. No charge for severe mental illness	\$5 copay; unlimited visits
<b>Substance Abuse</b>	20% of Medicare-approved charges	Inpatient: No charge as per plan limitations; Outpatient: \$5 per individual visit; \$2 per group visit	\$5 copay; unlimited visits	Same as Mental Health Inpatient and Outpatient
<b>Vision Benefits</b>				
<b>Eye Exams</b>	Not covered	\$5 copay	\$5 copay for Medicare-covered, medically-necessary eye exam	\$5 copay
<b>Lenses</b>	Not covered unless 1st lens after eye surgery	Eyewear (frames/lenses/contacts) purchased from plan optical sales every 24 months; \$150 allowance	Not covered	Not covered
<b>Frames</b>	Not covered unless after eye surgery		Not covered	Not covered
<b>Hearing Care Benefits</b>				
<b>Hearing Exams</b>	One per calendar year; 80%	\$5 copay	\$5 copay	\$5 copay
<b>Hearing Aids</b>	50% up to \$300 lifetime maximum	Not covered	\$600 allowance, every 24 months	Not covered

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<b>Calendar Year Deductibles</b>	None	None	None	None
<b>Annual Maximum Out-Of-Pocket Expenses (for most services)</b>	None	Maximum copayments of \$1,500 – individual \$3,000 – family	\$3,400	\$6,700
<b>Lifetime Maximum Benefits</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Hospital Benefits</b>				
<b>Room and Board</b>	Plan pays all Medicare inpatient deductibles for approved Medicare days	No charge	No charge	No charge
<b>Surgical Services</b>	Plan pays all Medicare inpatient deductibles for approved Medicare days	No charge	No charge	No charge
<b>Hospital Services and Supplies</b>	Plan pays all Medicare inpatient deductibles for approved Medicare days	No charge	No charge	No charge
<b>Nursing Benefits</b>				
<b>Skilled Nursing Facility Care</b>	Plan pays Medicare daily deductible for days 21–100; no coverage beyond 100 days	No charge; 100 days per benefit period in a Medicare-certified facility	No charge; 100 days per benefit period in a Medicare-certified facility	No charge; 100 days per benefit period in a Medicare-certified facility
<b>Private Duty Nurses</b>	Not covered	No charge if authorized by a Kaiser Permanente physician	No charge when medically necessary only, per Medicare guidelines	No charge when medically necessary only, per Medicare guidelines
<b>Home Healthcare</b>	Plan pays nothing except 20% of the Medicare-approved amount for durable medical equipment only	No charge for Medicare-covered Home Health and no charge for part-time intermittent care if authorized by a Kaiser Permanente physician	No charge for Medicare-covered Home Health. See (*) below for expanded coverage info	No charge when medically necessary only, per Medicare guidelines
<b>Hospice Care</b>	100% of all remaining costs not covered by Medicare	No charge if authorized by a Kaiser Permanente physician	No charge, provided care is in accordance with Medicare guidelines	No charge, provided care is in accordance with Medicare guidelines
<b>Emergency Benefits</b>				
<b>Inpatient</b>	Plan pays all Medicare inpatient deductibles for approved Medicare days	\$5 copay; waived if admitted	No charge	No charge
<b>Outpatient</b>	20% of Medicare-approved charges	\$5 copay; waived if admitted	\$25 copay; waived if admitted	\$50 copay; waived if admitted
<b>Ambulance</b>	20% of Medicare-approved charges	No charge for emergency	No charge	No charge (if medically necessary)

<sup>1</sup> Kaiser Senior Advantage - Supplemental Benefits with Meals and Transportation available effective July 1, 2021. Silver&Fit Exercise & Healthy Aging available effective July 1, 2019. Contact Kaiser at (877) 750-2746.

<sup>2</sup> SCAN includes expanded coverage for Independent Living Power™ services, which are only available in Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties. Qualifying members are eligible for up to \$650 per month of these additional services.

- No charge for personal care coordination via phone
- No copay for emergency response system
- \$15 copay per visit for alternative caregiver visit to a member's home when his or her regular caregiver is not available
- \$15 copay per visit for adult day care to provide relief for regular caregiver
- No copay for up to five days in a facility when regular caregiver is unavailable
- \$15 copay per visit for transportation escort to medical, dental, optometric or other necessary appointments
- \$15 copay per visit for personal care such as assistance with bathing, dressing, eating, getting in and out of bed, moving about/walking and grooming
- \$15 copay per visit for homemaker services such as light cleaning, grocery shopping, laundry and meal preparation
- No copay for bathroom durable medical equipment
- No copay for home-delivered meals
- No copay for inpatient custodial care up to 5 days in a facility. Medicare will not pay for a stay in a facility if the services received are primarily for those purposes.
- SilverSneakers by Tivity Health Fitness Program available at no extra cost.

<sup>3</sup> Manual manipulation of the spine to correct subluxation that can be demonstrated by X-ray, when the manipulation is prescribed by plan physician and performed by plan provider.

<sup>4</sup> Copayment for specialty drugs will be prorated if you receive less than a 90-day supply.

<sup>5</sup> Note: Visit or day limits do not apply to certain mental healthcare described in the evidence of coverage.