Medicare Eligible / Over 65 Only	Anthem Medicare Preferred (PPO) with Senior Rx Plus - Nationwide*		
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Plan Changes are in Orange	**2023 In-Network**	**2023 Out-of-Network**	**2023 Comments**
General Information			
Lifetime Maximum Benefit	None	None	
Annual Maximum Benefit	None	None	
Coinsurance Percentage	N/A	N/A	
Precertification Requirements			
Precertification Penalty	Prior authorization is required/requested for select services - refer to the Benefit Chart/EOC	Prior authorization is required/requested for select services - refer to the Benefit Chart/EOC	Each time you are admitted to a hospital without properly obtaining certification, benefits are reduced by 30%. This penalty will be deducted from covered expense after the deductible has been satisfied.
Health Savings Account (HSA)	N/A	N/A	
Health Reimbursement Account (HRA)	N/A	N/A	
R & C	N/A	N/A	
Deductibles			
Individual Annual Deductible	$0.00	$0.00	
Family Annual Deductible	N/A	N/A	
Applies to Out-of-Pocket Maximum	N/A	N/A	
Prescription benefits are covered under medical deductible	No	No	
Out-of-Pocket Mx per Plan Year	$2,500 combined INN & OON	$2,500 combined INN & OON	
Individual Out-of-Pocket Maximum Per Year	$2,500 combined INN & OON	$2,500 combined INN & OON	
Family Out-of-Pocket Maximum Per Year	N/A	N/A	
Outpatient Services			
Primary Care Physician Visits	$5 copay	$5 copay	
Specialist Visit	$20 copay	$20 copay	
Lab tests and X-ray	$20 copay for each Medicare-covered x-ray visit $0 copay for each Medicare-covered clinical/diagnostic lab test	$20 copay for each Medicare-covered x-ray visit $0 copay for each Medicare-covered clinical/diagnostic lab test	
Specialized Imaging	$50 copay for Medicare-covered complex diagnostic test/radiology visit	$50 copay for Medicare-covered complex diagnostic test/radiology visit	
Outpatient Surgery	$50 copay	$50 copay	
Allergy Testing	$0 copay	$0 copay	
Allergy Injections	$0 copay	$0 copay	
Preventive Care			
Well Child Care Office Visit	N/A	N/A	
Well Child Age limit	N/A	N/A	
Adult Routine Physical Exams	$0 copay	$0 copay	
Adult Immunizations	$0 copay	$0 copay	
Routine Mammogram	$0 copay	$0 copay	
Pap Smear	$0 copay	$0 copay	
Prostate Screening (PSA)	$0 copay	$0 copay	
Colon Cancer Screenings	$0 copay	$0 copay	
Cardiovascular screenings	$0 copay	$0 copay	
Hearing Evaluations	$0 copay for routine hearing exams limited to 1 exam and a $70 maximum benefit every 12 months combined INN & OON	$0 copay for routine hearing exams limited to 1 exam and a $70 maximum benefit every 12 months combined INN & OON	
Inpatient Hospital			
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Hospital Services	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	Pre-Authorization is required for all inpatient admissions.
Physicians and Surgeons' Services	$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	
Emergency Services			
Emergency Room Treatment	$50 copay for each Medicare-covered emergency room visit Copay is waived if admitted within 72 hours for the same condition	$50 copay for each Medicare-covered emergency room visit Copay is waived if admitted within 72 hours for the same condition	
Non-emergency or non-urgent use of ER	Emergency care coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States	Emergency care coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States	
Ambulance	$50 copay for Medicare-covered ambulance services per one-way trip	$50 copay for Medicare-covered ambulance services per one-way trip	
Urgent Care Facility Services	$10 copay for each Medicare-covered urgently needed care visit Copay is waived if admitted within 72 hours for the same condition	$10 copay for each Medicare-covered urgently needed care visit Copay is waived if admitted within 72 hours for the same condition	

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Physician Office Visit	$5 copay primary care physician $20 copay specialist	$5 copay primary care physician $20 copay specialist	
After Hours	$5 copay primary care physician $20 copay specialist	$5 copay primary care physician $20 copay specialist	
Maternity Care			
Physician Office Visit	$5 copay primary care physician $20 copay specialist	$5 copay primary care physician $20 copay specialist	
Maternity Care - Inpatient Delivery	Benefits depend upon the type of Medicare-covered services rendered	Benefits depend upon the type of Medicare-covered services rendered	
Midwife delivery services	Benefits depend upon the type of Medicare-covered services rendered	Benefits depend upon the type of Medicare-covered services rendered	
Mental Health			
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Mental Health Inpatient	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient hospital care combined INN & OON	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient hospital care combined INN & OON	Pre-Authorization is required for all inpatient admissions.
Mental Health-Inpatient Plan Maximums	None	None	Pre-Authorization is required for all inpatient admissions.
Mental Health Outpatient	$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	
Mental Health - Group Therapy	$20 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	$20 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	
Mental Health-Outpatient Plan Maximums	None	None	
Severe Mental Illness	Covered based on Medicare guidelines	Covered based on Medicare guidelines	
Substance Abuse	$20 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	$20 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Detoxification	Covered based on Medicare guidelines	Covered based on Medicare guidelines	
Substance Abuse - Inpatient Treatment	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	Pre-Authorization is required for all inpatient admissions.
Substance Abuse-Inpatient Plan Maximums	None	None	Pre-Authorization is required for all inpatient admissions.
Substance Abuse-Outpatient	$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	
Substance Abuse-Outpatient Plan Maximums	None	None	
Rehabilitation Therapy			
Inpatient Rehabilitation	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	
Outpatient Physical, Occupational, and Speech Therapy	$10 copay for Medicare-covered visits	$10 copay for Medicare-covered visits	
Alternative Care			
Chiropractic Care	$20 copay for each Medicare-covered visit	$20 copay for each Medicare-covered visit	
Acupuncture	Not covered	Not covered	
Acupressure	Not covered	Not covered	
Massage Therapy	Not covered	Not covered	Massage Therapy is covered only if done by a licensed chiropractor or physical therapist as part of their office visit.
Other Services			
Private-Duty Nursing Care	Not covered	Not covered	
Durable Medical Equipment	10% coinsurance on all Medicare-covered DME	10% coinsurance on all Medicare-covered DME	
Prosthetic and Orthotic Appliances	10% coinsurance on all Medicare-covered prosthetics and orthotics	10% coinsurance on all Medicare-covered prosthetics and orthotics	
Smoking Cessation	$0 copay for each Medicare-covered counseling quit attempt	$0 copay for each Medicare-covered counseling quit attempt	
Weight control program	Not covered	Not covered	
Bariatric surgery	Covered based on Medicare guidelines	Covered based on Medicare guidelines	(Utilization review required; bariatric surgery covered only when performed at COE facility)
TMJ	Covered based on Medicare guidelines	Covered based on Medicare guidelines	

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Plan Changes are in Orange	**2023 In-Network**	**2023 Out-of-Network**	**2023 Comments**
Podiatry Services	$20 copay for each Medicare-covered visit Supplemental Benefit: $5 copay for primary care physician visits and $20 copay for specialist visits for routine foot care Routine foot care is limited to 4 visits per year combined INN & OON	$20 copay for each Medicare-covered visit Supplemental Benefit: $5 copay for primary care physician visits and $20 copay for specialist visits for routine foot care Routine foot care is limited to 4 visits per year combined INN & OON	
Home Health Care	$0 copay	$0 copay	Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)
Skilled Nursing Facility Care	$10 copay per day for 1-100 days and $0 copay for days 101-180 per benefit period.	$10 copay per day for 1-100 days and $0 copay for days 101-180 per benefit period.	Inpatient skilled nursing facility (SNF) coverage is limited to 180 days each benefit period. A “benefit period” begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.
Hospice Care	$0 copay for the one time only hospice consultation	$0 copay for the one time only hospice consultation	(inpatient or outpatient services; family bereavement services)
Hearing Aids	$0 copay limited to a $1,500 maximum benefit every 36 months combined INN & OON	$0 copay limited to a $1,500 maximum benefit every 36 months combined INN & OON	
Family Planning			
Tubal ligation	Not covered	Not covered	
Vasectomy	Not covered	Not covered	
Contraceptive Drugs	Not covered, unless prescription is covered under the pharmacy formulary	Not covered, unless prescription is covered under the pharmacy formulary	
Contraceptive Devices	Covered under Part D	Covered under Part D	
Infertility Testing	Covered based on Medicare guidelines to determine a diagnosis of infertility	Covered based on Medicare guidelines to determine a diagnosis of infertility	
Infertility Treatments - Office Visit	Not covered	Not covered	
Infertility Treatments - Surgery	Not covered	Not covered	
In Vitro Fertilization	Not covered	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	Not covered	
Vision Care			
Eye Examination	$0 copay for routine vision exams limited to 1 visit and a $50 maximum benefit per year combined INN & OON $5 copay for primary care physician visits and $20 copay for specialist visits to diagnose and treat diseases of the eye	$0 copay for routine vision exams limited to 1 visit and a $50 maximum benefit per year combined INN & OON $5 copay for primary care physician visits and $20 copay for specialist visits to diagnose and treat diseases of the eye	
Lenses	Not covered except after cataract surgery Medicare guidelines apply	Not covered except after cataract surgery Medicare guidelines apply	
Frames	Not covered except after cataract surgery Medicare guidelines apply	Not covered except after cataract surgery Medicare guidelines apply	
Contact lenses- necessary	Not covered except after cataract surgery Medicare guidelines apply	Not covered except after cataract surgery Medicare guidelines apply	
Contact lenses-elective	Not covered	Not covered	
Lasik Eye Surgery	Not covered	Not covered	
Organ and Tissue Transplants			
Organ Transplant -Inpatient	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	$100 copay per admission $300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	(Utilization review required, transplants covered only when performed at COE facilities
Organs covered	Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multivisceral.	Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multivisceral.	(Utilization review required, transplants covered only when performed at COE facilities
Transplant Travel	Covered based on Medicare guidelines	Covered based on Medicare guidelines	Covered benefit for specialized transplants performed at a designated COE facility, benefit limitations may apply.
Transplant donor expenses	Covered based on Medicare guidelines	Covered based on Medicare guidelines	
Lifetime Maximum	None	None	
Prescription Drug Coverage			
Annual Prescription Deductible - Family	N/A	N/A	
Annual Prescription Deductible - Individual	$100.00	$100.00	
Out-of-Pocket Maximums - Individual	$5,100.00	$5,100.00	
Out-of-Pocket Maximums - Family	N/A	N/A	
Annual Maximum Benefit	None	None	

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Plan Changes are in Orange	**2023 In-Network**	**2023 Out-of-Network**	**2023 Comments**
Lifetime Maximum Benefit	None	None	
Generic Substitution	N/A	N/A	
Retail Refill Penalty	N/A	N/A	
Prescription Drug Retail			
Retail - Generic	$10 copay Deductible waived	$10 copay Deductible waived	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Retail - Brand Formulary	$30 copay	$30 copay	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Retail - Brand Non-Formulary	$60 copay	$60 copay	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Single Source Brand	Applicable copays apply	Applicable copays apply	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Multi Source Brand	Applicable copays apply	Applicable copays apply	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Injectable Medications	20% coinsurance with a maximum copay of $100 for Specialty Drugs (Generic and Brand)	20% coinsurance with a maximum copay of $100 for Specialty Drugs (Generic and Brand)	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Prescription Drug Mail Order			

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Plan Changes are in Orange	**2023 In-Network**	**2023 Out-of-Network**	**2023 Comments**
Mail-Order - Generic	$20 copay Deductible waived	$20 copay Deductible waived	
Mail-Order - Brand Formulary	$60 copay	$60 copay	
Mail-Order - Brand Non-Formulary	$120 copay	$120 copay	
Single Source Brand	Applicable copays apply	Applicable copays apply	
Multi Source Brand	Applicable copays apply	Applicable copays apply	
Injectable Medications	20% coinsurance with a maximum copay of $100 for Specialty Drugs (Generic and Brand)	20% coinsurance with a maximum copay of $100 for Specialty Drugs (Generic and Brand)	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Day Supply	90-day	90-day	
Other Services - Prescription Drugs			
Over the Counter	Not covered	Not covered	
Prenatal Vitamins	Covered	Covered	
Diabetic Supplies	Covered under Part B medical plan	Covered under Part B medical plan	
Lifestyle Drugs	Covered	Covered	
Contraceptives - Injectable	Not covered Contraceptive devices are covered	Not covered Contraceptive devices are covered	
Fertility Drugs	Not covered	Not covered	
Smoking Cessation	Covered	Covered	
Cosmetic Medications	Not covered	Not covered	
Nutritional Supplements	Not covered	Not covered	