

COMPARISON OF MEDICAL PLANS

For those enrolled in Medicare Parts A and B

Effective July 1, 2009



Medicare Supplement Plan

- Anthem Blue Cross III

Medicare Advantage Prescription Drug (MA-PD) HMOs

- Kaiser Senior Advantage
- PacifiCare/Secure Horizons
- 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 Senior Advantage	SCAN ¹	Secure Horizons ⁵
Outpatient Benefits				
Doctor's Office Visit	20% of Medicare-approved charges	\$5 copay	\$5 copay	\$5 copay
Preadmission X-ray and Lab Tests	20% of Medicare-approved charges	No charge	No charge	No charge with an office visit copay
Routine Checkups	Not covered except for dependent children under age 17	\$5 copay	\$5 copay	No charge
Immunizations	Not covered except for dependent children under age 17	No charge	No charge	No charge with an office visit copay
Outpatient Surgical Services	20% of Medicare-approved charges	\$5 copay per procedure	No charge	No charge
Physical Therapy	20% of Medicare-approved charges	\$5 copay	\$5 copay	No charge with an office visit copay
Speech Therapy	20% of Medicare-approved charges	\$5 copay	\$5 copay	No charge with an office visit copay
Maternity	Covered the same as an illness for services covered by Medicare	\$5 copay	Covered as any illness	\$5 copay
Chiropractic Care	20% of Medicare-approved charges	\$5 copay for Medicare-covered services ³	\$5 copay for Medicare-covered services ³	\$5 copay for Medicare-covered services ³
Transportation	Not covered	Not covered	No charge for unlimited number of rides to medical or dental appointments	Not covered
Prescription Drug Benefits				
Prescription Drugs	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 ⁴	\$7 copay for up to 100-day supply; covers dental prescriptions	Retail: \$7 generic/\$15 brand Mail order: \$7 generic/ \$15 brand for 90-day supply	\$7 copay for 31-day supply (or for 90-day mail order supply for maintenance medications only)
Mental Health Benefits				
Inpatient	Plan pays all Medicare inpatient deductibles for approved Medicare days; 190-day lifetime maximum	No charge; 190-day lifetime maximum plus additional 45 days per calendar year after the 190-day maximum is exhausted ²	No charge; 190-day lifetime maximum in Medicare facility ²	No charge; 190-day lifetime maximum if admitted to Medicare-approved psychiatric hospital
Outpatient	30% of Medicare-approved charges	\$5 copay for each visit per calendar year ²	\$5 copay for each visit per calendar year. No charge for severe mental illness	\$5 copay; unlimited visits
Substance Abuse	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
Vision Benefits				
Eye Exams	Not covered	\$5 copay	\$5 copay for Medicare-covered eye exam once every 12 months	\$5 copay
Lenses	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
Frames	Not covered unless after eye surgery		Not covered	Not covered
Hearing Care Benefits				
Hearing Exams	One per calendar year; 80%	\$5 copay	\$0 copay preferred provider \$5 copay non-preferred provider	\$5 copay
Hearing Aids	50% up to \$300 lifetime maximum	Not covered	\$300 allowance per aid, every 24 months (\$600 total)	Not covered

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	Anthem Blue Cross III	Kaiser Senior Advantage	SCAN ¹	Secure Horizons ⁵
Calendar Year Deductibles	None	None	None	None
Annual Maximum Out-Of-Pocket Expenses (for most services)	None	Maximum copayments of \$1,500 – individual \$3,000 – family	None	None
Lifetime Maximum Benefits	Unlimited	Unlimited	Unlimited	Unlimited
Hospital Benefits				
Room and Board	Plan pays all Medicare inpatient deductibles for approved Medicare days	No charge	No charge	No charge
Surgical Services	Plan pays all Medicare inpatient deductibles for approved Medicare days	No charge	No charge	No charge
Hospital Services and Supplies	Plan pays all Medicare inpatient deductibles for approved Medicare days	No charge	No charge	No charge
Nursing Benefits				
Skilled Nursing Facility Care	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
Private Duty Nurses	Not covered	No charge if authorized by a Kaiser physician	No charge when medically necessary only, per Medicare guidelines	No charge when medically necessary only, per Medicare guidelines
Home Health Care	100% of all remaining costs not covered by Medicare	No charge for Medicare-covered Home Health and no charge for part-time intermittent care if authorized by a Kaiser physician	No charge for Medicare-covered Home Health. See ⁽¹⁾ below for expanded coverage info	No charge when medically necessary only, per Medicare guidelines
Hospice Care	100% of all remaining costs not covered by Medicare	No charge if authorized by a Kaiser physician	No charge	No charge, provided care is in accordance with Medicare guidelines
Emergency Benefits				
Inpatient	Plan pays all Medicare inpatient deductibles for approved Medicare days	\$5 copay; waived if admitted	No charge	No charge
Outpatient	20% of Medicare-approved charges	\$5 copay; waived if admitted	\$25 copay; waived if admitted	\$50 copay; waived if admitted
Ambulance	20% of Medicare-approved charges	No charge for emergency	No charge	No charge (if medically necessary)

¹SCAN includes expanded coverage for Independent Living Power™ services. Qualifying members are eligible for up to \$500 per month of these additional services.

- No charge for personal care coordination via phone
- \$15 copay per month 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 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.

² Note: Visit or day limits do not apply to certain mental health care described in the evidence of coverage.

³ 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.

⁴ Copayment for speciality drugs prorated for less than a 90-day supply.

⁵ PacifiCare/Secure Horizons includes coverage for Evercare Solutions for Caregiver's services
— No charge for advice, information and referrals. See the Caregiver flyer for additional services.