

**San Joaquin County  
Retirees  
2024-2025 Anthem COB and MAPD Comparison**

	<b>Current COB<sup>(1)</sup></b>	<b>Proposed MAPD Plan<sup>(2)</sup></b>
Provider Access	If Anthem is primary, the provider needs to be in-network. If Anthem is secondary, any provider that accepts Medicare.	Passive – Any Provider that accept Medicare is eligible, but some non-Anthem Providers may decline to work with Anthem.
Medicare Assignment	No assignment necessary. Anthem coordinates with Medicare for benefits as active or secondary carrier.	Medicare Parts A & B required to enroll.
Prior Authorization and/or Medical Management Requirements	None Required	Required for some services. Provider works with Anthem to get prior approval.
<b>Benefits</b>		
Deductible	Part B	None
Home Health	Not Covered	Covered
Office Visit	Covered after Deductible	Covered
Lab/Xray OP	Covered after Deductible	Covered
PT, ST, OT	No Deductible, Covered up to \$100/year	Covered
Chiropractic	Not Covered	Manual Manipulation Covered
Eye Exam	Not Covered	Routine exam and eyewear allowance covered using Blue View vision provider
Hearing Test	Not Covered	Routine hearing test, hearing aid fitting, and hearing aid allowance covered using Hearing Care Solutions provider
Appliances	Covered after Deductible	Covered
Mental Nervous OP	Covered after Deductible	Covered

<sup>(1)</sup> The current Assurance Plus One Medicare Supplement COB was discontinued after the 2023/2024 renewal, replaced by Anthem's proposed MAPD plan with current Part D benefits. Retirees must be enrolled in Medicare Parts A & B to enroll in the MAPD plan.

<sup>(2)</sup> The copay is \$0 for most covered medical benefits.

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	<b>Assurance Plus One Medicare Supplement COB</b>		<b>MAPD PPO 0PH</b>	
<b>Covered medical benefits</b>	<b>In-network, members pay:</b>	<b>Out-of-network, members pay:</b>	<b>In-network, members pay:</b>	<b>Out-of-network, members pay:</b>
<b>Annual medical deductible:</b>	None	None	\$0 Combined in-network and out-of-network	
<b>Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)</b>	None	None	\$0 Combined in-network and out-of-network	
<b>Inpatient hospital care*</b>	0%	0%	For Medicare-covered hospital stays: \$0 copay per admission	For Medicare-covered hospital stays: \$0 copay per admission
<b>Outpatient hospital facility or ambulatory surgical center visit for surgery*</b>	Medicare Part B deductible	Medicare Part B deductible, the excess of Medicare's allowable charges	\$0 copay per visit	\$0 copay per visit
<b>Outpatient hospital services observation room</b>			\$0 copay per visit	\$0 copay per visit
<b>Primary care office visit</b>			\$0 copay per visit	\$0 copay per visit
<b>Specialty care office visit</b>			\$0 copay per visit	\$0 copay per visit
<b>Preventive care, screenings, and tests</b>			\$0 copay per visit	\$0 copay per visit
<b>Emergency care</b>			\$0 copay for each Medicare-covered emergency room visit	
<b>Urgently needed services</b>			\$0 copay for each Medicare-covered urgently needed care visit	
<b>X-ray visit and/or simple diagnostic test*</b>			\$0 copay per visit	\$0 copay per visit
<b>Complex diagnostic test and/or radiology visit*</b>			\$0 copay per visit	\$0 copay per visit
<b>Radiation therapy treatment*</b>			\$0 copay per visit	\$0 copay per visit
<b>Clinical/diagnostic lab test*</b>	\$0 copay per visit	\$0 copay per visit		
<b>Medicare-covered basic hearing and balance exams performed by your specialist*</b>	\$0 copay per visit	\$0 copay per visit	\$0 copay per visit	\$0 copay per visit
<b>Routine hearing services</b>	not covered unless specified by Medicare	not covered unless specified by Medicare	Must use a Hearing Care Solutions participating provider. \$0 copay for routine hearing exams, one exam every calendar year combined in- network and out-of-network. \$0 copay for hearing aid fitting evaluations, one evaluation per covered hearing aid combined in-network and out-of-network. Routine hearing exams and fitting evaluations are limited to a \$70 maximum benefit every calendar year combined in- network and out-of-network. \$0 copay for hearing aids Hearing aids are limited to a \$500 benefit per ear with a maximum benefit of \$1,000 every three calendar years.	Out-of-network providers must order hearing aids through Hearing Care Solutions. \$0 copay for routine hearing exams, one exam every calendar year combined in- network and out-of-network. \$0 copay for hearing aid fitting evaluations, one evaluation per covered hearing aid combined in-network and out-of-network. Routine hearing exams and fitting evaluations are limited to a \$70 maximum benefit every calendar year combined in- network and out-of-network. \$0 copay for hearing aids through Hearing Care Solutions Hearing aids are limited to a \$500 benefit per ear with a maximum benefit of \$1,000 every three calendar years through Hearing Care Solutions.
<b>Medicare-covered dental is non- routine care performed by your specialist*</b>	Medicare Part B deductible	Medicare Part B deductible, the excess of Medicare's allowable charges	\$0 copay per visit	\$0 copay per visit
<b>Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions</b>			\$0 copay per visit	\$0 copay per visit
<b>Medicare-covered glaucoma screening</b>			\$0 copay per visit	\$0 copay per visit

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<b>Medicare-covered eyewear following cataract surgery</b>			\$0 copay per surgery	\$0 copay per surgery
<b>Routine vision eye exam</b>	not covered unless specified by Medicare	not covered unless specified by Medicare	Must use a Blue View Vision provider. \$0 copay for routine vision exams, one exam every calendar year, \$70 maximum benefit every calendar year combined in-network and out-of-network.	\$0 copay for routine vision exams, one exam every calendar year, \$70 maximum benefit every calendar year combined in-network and out-of-network.
<b>Routine vision eyewear</b>	not covered unless specified by Medicare	not covered unless specified by Medicare	Must use a Blue View Vision provider. \$0 copay for eyewear Eyewear is limited to a \$100 maximum benefit every two calendar years combined in-network and out-of-network.	\$0 copay for eyewear Eyewear is limited to a \$100 maximum benefit every two calendar years combined in-network and out-of-network.
<b>Inpatient services in a psychiatric hospital*</b>	Medicare covered hospital stays: \$0 copay per hospital stays	Medicare covered hospital stays: \$0 copay per hospital stay	For Medicare-covered hospital stays: \$0 copay per admission	For Medicare-covered hospital stays: \$0 copay per admission
<b>Mental health professional individual therapy visit</b>	Medicare Part B deductible	Medicare Part B deductible, the excess of Medicare's allowable charges	\$0 copay per visit	\$0 copay per visit
<b>Substance abuse professional individual therapy visit</b>			\$0 copay per visit	\$0 copay per visit
<b>Skilled nursing facility (SNF) care*</b>	Medicare-covered SNF stays: \$0 copay for days 1-100 per benefit period 100-day limit per benefit period	Medicare-covered SNF stays: \$0 copay for days 1-100 per benefit period 100-day limit per benefit period	For Medicare-covered SNF stays: \$0 copay for days 1-100 per benefit period 100-day limit per benefit period	For Medicare-covered SNF stays: \$0 copay for days 1-100 per benefit period 100-day limit per benefit period
<b>Outpatient rehabilitation services*</b>	Medicare Part B deductible	Medicare Part B deductible, the excess of Medicare's allowable	\$0 copay per visit	\$0 copay per visit
<b>Ambulance services</b>			Your provider must get an approval from the plan before you get ground,	
<b>Medicare Part B prescription drugs*</b>	\$0 select generics; \$10 generics; \$20 preferred brands, non-preferred brands, non-formulary; \$10 diabetic supplies-insulin syringes & alcohol wipes up to a 90 day supply	\$0 select generics; \$10 generics; \$20 preferred brands, non-preferred brands, non-formulary; \$10 diabetic supplies-insulin syringes & alcohol wipes up to a 90 day supply	\$0 copay for Medicare-covered Part B drugs	\$0 copay for Medicare-covered Part B drugs
<b>Chiropractic services* Medicare-covered</b>	Medicare Part B deductible	Medicare Part B deductible, the excess of Medicare's allowable charges	\$0 copay per visit	\$0 copay per visit
<b>Acupuncture for chronic low back pain* Medicare-covered</b>			\$0 copay per visit	\$0 copay per visit
<b>Cardiac rehabilitation services*</b>			\$0 copay per visit	\$0 copay per visit
<b>Pulmonary rehabilitation services*</b>			\$0 copay per visit	\$0 copay per visit
<b>Blood glucose test strips, lancets, lancet devices, and glucose control solutions</b>			\$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions	\$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions
<b>Blood glucose monitors</b>			\$0 copay for Medicare-covered blood glucose monitors	\$0 copay for Medicare-covered blood glucose monitors
<b>Therapeutic shoes</b>			\$0 copay per purchase	\$0 copay per purchase
<b>Diabetes self-management training</b>			\$0 copay per visit	\$0 copay per visit
<b>Continuous glucose monitors (CGMs)*</b>	\$0 copay per purchase	\$0 copay per purchase		

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<b>Durable medical equipment (DME) and related supplies*</b>	Medicare Part B deductible	Medicare Part B deductible, the excess of Medicare's allowable charges	\$0 copay per purchase	\$0 copay per purchase
<b>Opioid treatment program services*</b>			\$0 copay per visit	\$0 copay per visit
<b>Podiatry services*</b>			\$0 copay per visit	\$0 copay per visit
<b>Routine foot care</b>	Not covered unless specified by Medicare	not covered unless specified by Medicare	\$0 copay per visit, 12 visits per year	\$0 copay per visit, 12 visits per year
<b>Home health agency care*</b>	Medicare Part B deductible	Medicare Part B deductible, the excess of Medicare's allowable charges	\$0 copay per visit	\$0 copay per visit
<b>Hospice care</b> When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.			\$0 copay for the one time only hospice consultation One visit per lifetime	\$0 copay for the one time only hospice consultation One visit per lifetime
<b>Additional covered benefits and services</b>	<b>Members pay:</b>		<b>Members pay:</b>	
<b>Video doctor visits LiveHealth Online†</b>	Medicare Part B deductible		\$0 copay for video doctor visits using LiveHealth Online	
<b>Health and wellness programs SilverSneakers® Membership†</b> Take fitness classes virtually or visit a participating location.	Medicare Part B deductible		\$0 copay for the SilverSneakers fitness benefit	
<b>24/7 NurseLine†</b>	Medicare Part B deductible		\$0 copay for 24/7 NurseLine	
<b>Foreign travel emergency (outside U.S. territories) Emergency care</b> Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	Medicare Part B deductible		\$0 copay for emergency care	
<b>Foreign Travel - Urgently Needed Services</b>	Medicare Part B deductible		\$0 copay for urgently needed services	
<b>Foreign Travel - Inpatient Care</b>	Medicare Part B deductible		\$0 copay per admission for emergency inpatient care 60 days per lifetime	
<b>Healthy Meals†*</b> Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition	Medicare Part B deductible		\$0 copay for Healthy Meals Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).	
<b>Medicare Community Resource Support</b>	Not covered		\$0 copay for Medicare Community Resource Support	

\* 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

†Must use the plan approved provider