

# 2026 Summary of Benefits

A side-by-side comparison of your 2026  
Medicare-Supplement Type Plan options

*The benefits summarized are extracted from the  
ITDR 2026 Benefit Guide, pages 28-33.*



# 2026



*Delta Family Values – Quality and Service*

## SUPPLEMENT-TYPE MEDICAL PLANS | Summary of Benefits

|                                 | Supplement-Type<br>Standard Plan                                                                                                                                                                                                                                                                                           | Supplement-Type<br>Enhanced Plan                                           |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| CALENDAR YEAR<br>DEDUCTIBLE     | <b>\$300</b><br>Only applies to Part B services, and <b>must be satisfied before any Medicare Part B benefits are paid.</b> The Medicare Part B deductible is included in this \$300 calendar year deductible.<br><b>Note:</b> Plan pays entire Medicare Part A deductible; member pays \$0 of Medicare Part A deductible. | <b>\$0</b>                                                                 |
| MAXIMUM ANNUAL<br>OUT OF POCKET | <b>\$1,500</b><br>Only applies to Part B services. All Part B coinsurance and deductible amounts accrue towards the medical plan maximum annual out-of-pocket amount, with the exception of the foreign travel emergency and urgently needed care deductible or coinsurance amounts.                                       | <b>\$0</b>                                                                 |
| INPATIENT HOSPITAL<br>COVERAGE  | \$0 copay until 365 days, member pays 100% of all charges beyond 365 days.                                                                                                                                                                                                                                                 | \$0 copay until 365 days, member pays 100% of all charges beyond 365 days. |
| OUTPATIENT HOSPITAL<br>COVERAGE | 10% coinsurance, deductible applies.                                                                                                                                                                                                                                                                                       | Member pays \$0.                                                           |

If your Medical Plan has a deductible, it must be met before copayments or coinsurance will apply. See [page 41](#) for details regarding Prescription Drug Plan deductible, copays and coinsurance.

|                                                    | Supplement-Type<br>Standard Plan                                                                                      | Supplement-Type<br>Enhanced Plan                                                                                      |
|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| <b>DOCTOR VISITS</b><br>(PRIMARY &<br>SPECIALISTS) | 10% coinsurance, deductible applies.                                                                                  | Member pays \$0.                                                                                                      |
| <b>EMERGENCY<br/>CARE</b>                          | 10% coinsurance, deductible applies.                                                                                  | Member pays \$0.                                                                                                      |
| <b>SKILLED NURSING<br/>FACILITY</b>                | \$0 copay until 100 days, member pays 100%<br>of all charges beyond 100 days.<br>Prior hospital stay may be required. | \$0 copay until 100 days, member pays 100%<br>of all charges beyond 100 days.<br>Prior hospital stay may be required. |
| <b>URGENT<br/>CARE</b>                             | 10% coinsurance, deductible applies.                                                                                  | Member pays \$0.                                                                                                      |

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|                                                     | Supplement-Type<br>Standard Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Supplement-Type<br>Enhanced Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>PREVENTIVE CARE</b>                              | <p>\$0 for most exams and screenings, Medicare lists screenings that require deductible and coinsurance: <a href="https://medicare.gov/coverage/preventive-screening-services">https://medicare.gov/coverage/preventive-screening-services</a>.</p> <p>Coverage for expenses incurred for physical exams, preventive screening tests and services and any other tests or preventive measures determined to be appropriate by the attending physician, not otherwise covered by Medicare: Maximum plan benefit of \$120 per calendar year; member pays all expenses over \$120 calendar year maximum.</p> <p>Diabetes Self-Management Training: \$0 copay; 10% coinsurance. Plan deductible applies.</p> | <p>\$0 for most exams and screenings, Medicare lists screenings that require deductible and coinsurance: <a href="https://medicare.gov/coverage/preventive-screening-services">https://medicare.gov/coverage/preventive-screening-services</a>.</p> <p>Coverage for expenses incurred for physical exams, preventive screening tests and services and any other tests or preventive measures determined to be appropriate by the attending physician, not otherwise covered by Medicare: Maximum plan benefit of \$120 per calendar year; member pays all expenses over \$120 calendar year maximum.</p> <p>Diabetes Self-Management Training: Member pays \$0.</p> |
| <b>DIAGNOSTIC SERVICES/<br/>LABS/IMAGING</b>        | <p>10% coinsurance for each x-ray visit and/or simple diagnostic test, complex diagnostic test and/or radiology visit, deductible applies.</p> <p><u>Member pays \$0 for clinical lab services, blood tests, urinalysis.</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <p>Member pays \$0.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>TRANSPORTATION<br/>(MEDICALLY<br/>NECESSARY)</b> | <p>10% coinsurance, deductible applies.</p> <p>Non-emergency transportation must be medically necessary and supported by written order from a doctor.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <p>Member pays \$0.</p> <p>Non-emergency transportation must be medically necessary and supported by written order from a doctor.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

If your Medical Plan has a deductible, it must be met before copayments or coinsurance will apply. See [page 41](#) for details regarding Prescription Drug Plan deductible, copays and coinsurance.

|                                          | Supplement-Type<br>Standard Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Supplement-Type<br>Enhanced Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>MEDICAL<br/>SUPPLIES*</b>             | 10% coinsurance, deductible applies.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Member pays \$0.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PHYSICAL<br/>THERAPY</b>              | 10% coinsurance, deductible applies.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Member pays \$0.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>AMBULANCE</b>                         | 10% coinsurance, deductible applies.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Member pays \$0.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>HOSPICE<br/>CARE</b>                  | Member pays \$0.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Member pays \$0.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>FOREIGN TRAVEL<br/>EMERGENCY CARE</b> | <p>\$250 annual deductible.</p> <p>Member pays 20% of expenses incurred for emergency care during the first six months of each trip. Lifetime maximum of \$100,000. Member pays 100% thereafter.</p> <p>After the plan pays benefits for foreign travel emergency and urgently needed services, you are responsible for the remaining cost.</p> <p>Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months.</p> | <p>Member pays \$0 of expenses incurred for emergency care during the first six months of each trip. Lifetime maximum of \$100,000. Member pays 100% thereafter.</p> <p>After the plan pays benefits for foreign travel emergency and urgently needed services, you are responsible for the remaining cost.</p> <p>Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months.</p> |

If your Medical Plan has a deductible, it must be met before copayments or coinsurance will apply. See [page 41](#) for details regarding Prescription Drug Plan deductible, copays and coinsurance.

|                                      | Supplement-Type<br>Standard Plan                                                                                                                                             | Supplement-Type<br>Enhanced Plan                                                                                      |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| <b>PART B<br/>DRUGS</b>              | 10% coinsurance for Medicare-covered Part B drugs, deductible applies.<br><br>Member pays \$0 for the pneumonia, influenza, hepatitis B, or other Medicare-covered vaccines. | Member pays \$0.<br><br>Member pays \$0 for the pneumonia, influenza, hepatitis B, or other Medicare-covered vaccines |
| <b>MENTAL HEALTH:<br/>OUTPATIENT</b> | 10% coinsurance, deductible applies.                                                                                                                                         | Member pays \$0.                                                                                                      |
| <b>MENTAL HEALTH:<br/>INPATIENT</b>  | \$0 copay until 365 days, member pays 100% of all charges beyond 365 days.                                                                                                   | \$0 copay until 365 days, member pays 100% of all charges beyond 365 days.                                            |
| <b>HEARING<br/>SERVICES*</b>         | 10% coinsurance, deductible applies.                                                                                                                                         | Member pays \$0.                                                                                                      |
| <b>DENTAL<br/>SERVICES*</b>          | 10% coinsurance, deductible applies.                                                                                                                                         | Member pays \$0.                                                                                                      |

\* Hearing services refer to Medicare-covered basic diagnostic hearing and balance exams; to determine if you need medical treatment, and these services are furnished by a physician, audiologist, or other qualified provider.

\* Dental services refer to non-routine Medicare-covered services and are limited to: surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician.

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|                        | <b>Supplement-Type<br/>Standard Plan</b> | <b>Supplement-Type<br/>Enhanced Plan</b> |
|------------------------|------------------------------------------|------------------------------------------|
| <b>EYE<br/>HEALTH*</b> | 10% coinsurance, deductible applies.     | Member pays \$0.                         |

\* Eye health refers to glaucoma screenings for high risk members, diabetic retinopathy screening, macular degeneration tests and treatment, and eye prostheses (replacement covered once every five years).

For a complete list of services, refer to the Evidence of Coverage (EOC) for each plan, which is available at [anthem.com/login](https://www.anthem.com/login). An additional resource is the “Medicare & You” handbook, which Medicare will mail to you each year. You can also access it online anytime at <https://www.medicare.gov/medicare-and-you/medicare-and-you.html>.

This information is not a complete description of benefits.

**ITDR Benefit Questions: (877) 325-7265.**

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