2027

Summary of Benefits

A side-by-side comparison of your 2027 Medicare Advantage Plan options

The benefits summarized are extracted from the ITDR 2027 Benefits & Resources Guide, pages 34-40.

INSURANCE TRUST for Delta Retirees

Anthem

Delta Family Values – Quality and Service

MEDICARE ADVANTAGE MEDICAL PLANS | Summary of Benefits

	Medicare Advantage Standard Plan	Medicare Advantage Enhanced Plan	Medicare Advantage Prime Plan
CALENDAR YEAR DEDUCTIBLE	**$1,000** **Deductible applies to covered services within each category following, prior to the copay or coinsurance, if any, being applied**, unless otherwise noted.	**$0**	**$0**
MAXIMUM ANNUAL OUT OF POCKET	**$4,200** All copays, coinsurance, and deductible amounts accrue towards the medical plan maximum annual out-of-pocket amount, with the exception of routine hearing services and the foreign travel emergency and urgently needed care deductible or coinsurance amounts.	**$2,000** All copays and coinsurance amounts accrue towards the medical plan maximum annual out-of-pocket amount, with the exception of routine hearing services and the foreign travel emergency and urgently needed care deductible or coinsurance amounts.	**$500** Applicable to Emergency Room visits only. Foreign travel emergency and urgently needed care deductible or coinsurance amounts do not accrue toward this medical plan maximum.
INPATIENT HOSPITAL COVERAGE	$500 copay per day for days 1-5 per admission; then covered 100% by the plan. No limit to the number of days covered by the plan. $0 copay for physician services received while an inpatient during a hospital stay.	$95 copay per day for days 1-5 per admission; then covered 100% by the plan. No limit to the number of days covered by the plan. $0 copay for physician services received while an inpatient during a hospital stay.	$0 copay per admission, covered 100% by the plan. No limit to the number of days covered by the plan. $0 copay for physician services received while an inpatient during a hospital stay.

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.

	Medicare Advantage Standard Plan	Medicare Advantage Enhanced Plan	Medicare Advantage Prime Plan
OUTPATIENT HOSPITAL COVERAGE	**Surgical:** $100 copay for each outpatient hospital facility or ambulatory surgical center visit for surgery. **Non-surgical:** $10 copay for a visit to a primary care physician in an outpatient hospital setting/clinic for non-surgical services. $45 copay for a visit to a specialist in an outpatient hospital setting/clinic for non-surgical services including radiation therapy. **For both surgical and non-surgical:** $100 copay for each outpatient observation room visit.	**Surgical:** $100 copay for each outpatient hospital facility or ambulatory surgical center visit for surgery. **Non-surgical:** $10 copay for a visit to a primary care physician in an outpatient hospital setting/clinic for non-surgical services. $25 copay for a visit to a specialist in an outpatient hospital setting/clinic for non-surgical services including radiation therapy. **For both surgical and non-surgical:** $100 copay for each outpatient observation room visit.	**Surgical:** $0 copay for each outpatient hospital facility or ambulatory surgical center visit for surgery. **Non-surgical:** $0 copay for a visit to a primary care physician in an outpatient hospital setting/clinic for non-surgical services. $0 copay for a visit to a specialist in an outpatient hospital setting/clinic for nonsurgical services including radiation therapy. **For both surgical and non-surgical:** $0 copay for each outpatient observation room visit.
DOCTOR VISITS (PRIMARY & SPECIALISTS)	$10 copay per visit to a Primary Care Physician (PCP) or retail health clinic. $45 copay per visit to a specialist. 10% coinsurance for allergy testing and allergy injections.	$10 copay per visit to a Primary Care Physician (PCP) or retail health clinic. $25 copay per visit to a specialist. 10% coinsurance for allergy testing and allergy injections.	$0 copay per visit to a Primary Care Physician (PCP), retail health clinic or specialist. $0 copay for Medicare-covered allergy testing and injections.
EMERGENCY CARE	$150 copay for each emergency room visit. Copay is waived if the member is admitted to the hospital within 72 hours for the same condition. Deductible does not apply.	$140 copay for each emergency room visit. Copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	$100 copay for each emergency room visit. Copay is waived if the member is admitted to the hospital within 72 hours for the same condition.

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.

	Medicare Advantage Standard Plan	Medicare Advantage Enhanced Plan	Medicare Advantage Prime Plan
SKILLED NURSING FACILITY	$0 copay for days 1-20 and $50 copay per day for days 21-100 per benefit period. Deductible applies. No prior hospital stay required. Your provider must obtain approval from the plan before you get skilled nursing care. This is called getting prior authorization.	$0 copay for days 1-20 and $50 copay per day for days 21-100 per benefit period. No prior hospital stay required. Your provider must obtain approval from the plan before you get skilled nursing care. This is called getting prior authorization.	$0 copay for days 1-100 per benefit period. No prior hospital stay required. Your provider must obtain approval from the plan before you get skilled nursing care. This is called getting prior authorization.
URGENT CARE	$65 copay for each visit. Copay is waived if the member is admitted to the hospital within 72 hours for the same condition. Deductible does not apply.	$30 copay for each visit. Copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	$0 copay for each visit. Copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
PREVENTIVE CARE	$0 copay. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received.	$0 copay. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received.	$0 copay. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received.
DIAGNOSTIC SERVICES/ LABS/IMAGING	$45 copay for each x-ray visit and/or simple diagnostic test. 10% coinsurance for complex diagnostic test and/or radiology visit. Member pays $0 for clinical lab services, blood tests, urinalysis.	10% coinsurance for each x-ray visit and/or simple diagnostic test, complex diagnostic test and/or radiology visit. Member pays $0 for clinical lab services, blood tests, urinalysis.	$0 copay for each x-ray visit and/or simple diagnostic test, complex diagnostic test and/or radiology visit. Member pays $0 for clinical lab services, blood tests, urinalysis.

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.

	Medicare Advantage Standard Plan	Medicare Advantage Enhanced Plan	Medicare Advantage Prime Plan
TRANSPORTATION (MEDICALLY NECESSARY)	Non-emergency transportation is covered at 10% coinsurance per one-way trip with prior authorization from the plan.	Non-emergency transportation is covered at 10% coinsurance per one-way trip with prior authorization from the plan.	Non-emergency transportation is covered at $0 copay per one-way trip with prior authorization from the plan.
MEDICAL SUPPLIES*	10% coinsurance. $0 copay for Medicare-covered Continuous Glucose Monitors (CGMs) and related supplies. Deductible will be waived for 2027 when the CGM is purchased through the pharmacy.	10% coinsurance. $0 copay for Medicare-covered Continuous Glucose Monitors (CGMs) and related supplies.	$0 copay $0 copay for Medicare-covered Continuous Glucose Monitors (CGMs) and related supplies.

* Medical Supplies refers to Medicare Part B - covered durable medical equipment and supplies. Diabetes testing equipment and supplies (lancets, test strips, blood glucose monitor and therapeutic inserts/shoes) benefit is $0 copay for preferred brand 30-day supplies and glucometers. Two preferred brand continuous glucose monitors are covered: FreeStyle Libre and Dexcom. Other brands will not be covered unless it is medically necessary. Therapeutic shoes/inserts - deductible waived.

* Insulin cost share capped at $35 copay.

PHYSICAL THERAPY	$45 copay for physical therapy, occupational therapy, and speech language therapy visits. Deductible applies. Your provider must obtain approval before receiving services. This is called getting prior authorization.	$25 copay for physical therapy, occupational therapy, and speech language therapy visits. Your provider must obtain approval before receiving services. This is called getting prior authorization.	$0 copay Your provider must obtain approval before receiving services. This is called getting prior authorization.
AMBULANCE	10% coinsurance per one-way trip. Deductible does not apply. Your provider must obtain approval before non-emergency ground, air, or water transportation. This is called getting prior authorization.	10% coinsurance per one-way trip. Your provider must obtain approval before non-emergency ground, air, or water transportation. This is called getting prior authorization.	$0 copay per one-way trip. Your provider must obtain approval before non-emergency ground, air, or water transportation. This is called getting prior authorization.

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.

	Medicare Advantage Standard Plan	Medicare Advantage Enhanced Plan	Medicare Advantage Prime Plan
HOSPICE CARE	$45 copay for the one time only hospice consultation. **Deductible does not apply.** 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.	$25 copay for the one time only hospice consultation. 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. 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.
FOREIGN TRAVEL EMERGENCY CARE*	Member pays 20% of expenses incurred for emergency care. Lifetime maximum of $100,000. Member pays 100% thereafter. After the plan pays benefits for foreign travel emergency and urgently needed services, you are responsible for the remaining cost. Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months.	Member pays 20% of expenses incurred for emergency care. Lifetime maximum of $100,000. Member pays 100% thereafter. After the plan pays benefits for foreign travel emergency and urgently needed services, you are responsible for the remaining cost. Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months.	$0 copay Lifetime maximum of $100,000. Member pays 100% thereafter. After the plan pays benefits for foreign travel emergency and urgently needed services, you are responsible for the remaining cost. Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months.
PART B DRUGS	10% coinsurance for Medicare-covered Part B drugs. Deductible does not apply. Member pays $0 for the Covid-19, pneumonia, influenza, hepatitis B, or other Medicare-covered vaccines. The Insulin cost-share maximum is a $35 copay.	10% coinsurance for Medicare-covered Part B drugs. Member pays $0 for the Covid-19, pneumonia, influenza, hepatitis B, or other Medicare-covered vaccines. The Insulin cost-share maximum is a $35 copay.	$0 copay for Medicare-covered Part B drugs. Member pays $0 for the Covid-19, pneumonia, influenza, hepatitis B, or other Medicare-covered vaccines. The Insulin cost-share maximum is a $35 copay.

* Insulin cost share capped at $35 copay. No Cost for Part D vaccines.
* Refer to your EOC for deductible details.

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.

	Medicare Advantage Standard Plan	Medicare Advantage Enhanced Plan	Medicare Advantage Prime Plan
MENTAL HEALTH: OUTPATIENT	$45 copay for each: • professional or group therapy visit. • professional partial hospitalization visit. $0 copay for each: • outpatient hospital facility individual or group therapy visit. • partial hospitalization facility visit. Deductible applies. Your provider must obtain prior plan approval for intensive outpatient mental health services or partial hospitalization for mental health.	$25 copay for each: • professional or group therapy visit. • professional partial hospitalization visit. $0 copay for each: • outpatient hospital facility individual or group therapy visit. • partial hospitalization facility visit. Your provider must obtain prior plan approval for intensive outpatient mental health services or partial hospitalization for mental health.	$0 copay for each: • professional or group therapy visit. • professional partial hospitalization visit. • outpatient hospital facility individual or group therapy visit. • partial hospitalization facility visit. Your provider must obtain prior plan approval for intensive outpatient mental health services or partial hospitalization for mental health.
MENTAL HEALTH: INPATIENT	$500 copay per day for days 1-5 per admission; then covered by the plan 100%. Deductible applies. No limit to the number of days covered by the plan. $0 copay for physician services received while an inpatient during a hospital stay.	$95 copay per day for days 1-5 per admission; then covered by the plan 100%. No limit to the number of days covered by the plan. $0 copay for physician services received while an inpatient during a hospital stay.	$0 copay per admission No limit to the number of days covered by the plan. $0 copay for physician services received while an inpatient during a hospital stay.
HEARING SERVICES*	$10 copay per visit to a Primary Care Physician (PCP) or retail health clinic. Deductible applies. $45 copay per visit to a specialist. Deductible applies. Hearing aids are limited to a $500 benefit per ear with a maximum benefit of $1,000 every three calendar years.** Deductible does not apply.	$10 copay per visit to a Primary Care Physician (PCP) or retail health clinic. $25 copay per visit to a specialist. Hearing aids are limited to a $500 benefit per ear with a maximum benefit of $1,000 every three calendar years.**	$0 copay per visit to a Primary Care Physician (PCP) or retail health clinic. $0 copay per visit to a specialist. Hearing aids are limited to a $500 benefit per ear with a maximum benefit of $1,000 every three calendar years.**

* 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. Routine hearing exams and fitting evaluations are limited to a $70 maximum annual benefit, combined in- and out-of-network.

** You pay 80% coinsurance for hearing aids not supplied by TruHearing. Deductible does not apply.

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	Medicare Advantage Standard Plan	Medicare Advantage Enhanced Plan	Medicare Advantage Prime Plan
DENTAL SERVICES*	$10 copay per visit to a Primary Care Physician (PCP) or retail health clinic. $45 copay per visit to a specialist.	$10 copay per visit to a Primary Care Physician (PCP) or retail health clinic. $25 copay per visit to a specialist.	$0 copay per visit to a Primary Care Physician (PCP) or retail health clinic. $0 copay per visit to a specialist.

* 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.

EYE HEALTH*	$10 copay for visits to a primary care physician for exams to diagnose and treat diseases of the eye. $45 copay for visits to a specialist for exams to diagnose and treat diseases of the eye. $0 copay for glaucoma and diabetic retinopathy screenings. 10% coinsurance for glasses/ contacts following cataract surgery.	$10 copay for visits to a primary care physician for exams to diagnose and treat diseases of the eye. $25 copay for visits to a specialist for exams to diagnose and treat diseases of the eye. $0 copay for glaucoma and diabetic retinopathy screenings. 10% coinsurance for glasses/ contacts following cataract surgery.	$0 copay for visits to a primary care physician for exams to diagnose and treat diseases of the eye. $0 copay for visits to a specialist for exams to diagnose and treat diseases of the eye. $0 copay for glaucoma and diabetic retinopathy screenings. $0 copay for glasses/contacts following cataract surgery.

* 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 or by calling the ITDR Service Center at 877-325-7265.

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://medicare.gov/medicare-and-you/medicare-and-you.html.

This information is not a complete description of benefits. **ITDR Benefit Questions:** (877) 325-7265.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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