

Supplement vs Advantage Plan Comparison Sheet

Name: _____

Medicare Supplement Plan

Carrier _____ Letter _____

Monthly premium \$ _____

Drug plan premium \$ _____

Total monthly Premium \$ _____ X 12 months \$ _____

Add Part B Deductible \$ _____ Annual Total \$ _____ Per month total: _____

Medicare Advantage Plan

Carrier _____

Premium \$ _____

Deductible \$ _____

Max out of Pocket \$ _____ (NOT a deductible)

Advantage Plan annual additional benefits:

Dental: \$ _____ Vision: \$ _____ Hearing: \$ _____ Over the Counter: \$ _____

Silver Sneakers/Gym Membership: \$ _____ Total plan Annual benefit: \$ _____

Advantage Plan Larger Co-Pays

Hospital \$ _____ # days _____ Primary Dr: \$ _____

Diagnostic \$ _____ Specialist: \$ _____

ER Visit \$ _____

Ambulance \$ _____ Physical Therapy \$ _____ Days _____

Surgery \$ _____ Short Term Care \$ _____ Days _____

Policies to cover exposures

Hospital Indemnity Carrier _____ Monthly Premium \$ _____ Daily Amount \$ _____

Cancer Plan Carrier _____ Monthly Premium \$ _____ Benefit Amount \$ _____

Heart/Stroke Carrier _____ Monthly Premium \$ _____ Benefit Amount \$ _____

Total Monthly Premium \$ _____

Signature: _____