American SENIOR BENEFITS
Putting people back into the people business

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 $ __________

Short Term Care Carrier __________ Monthly Premium $ __________

Home Health Carrier __________ Monthly Premium $ __________

Cancer Plan Carrier __________ Monthly Premium $ __________ Benefit amount $ __________

Total Monthly Premium ***$*** ______________

Signature: ____