2017
Medicare Advantage
Chronic Condition & Institutional Special Needs Plans (SNP)
in Maricopa County

Special Needs Plans are either HMO or PPO plans that limit their membership to people with one of the following special needs:

- Who have one or more chronic or disabling conditions
- Who reside in a long-term care facility

The Special Needs Plan must be designed to provide Medicare health care and services to people who can benefit the most from things like special expertise of the plan's providers, and focused care management. In some cases, you may have to choose a primary care doctor or have a care coordinator help you develop personal care plans and coordinate your care. You generally must get your care and services from doctors or hospitals in the plan's network (except emergency or urgent care).

Most current revision: 1/18/2017

BENEFITS ASSISTANCE PROGRAM
A State Health Insurance Assistance Program (SHIP)
A program of the Area Agency on Aging, Region One
1366 East Thomas, Suite 108, Phoenix, AZ 85014
602-264-2255

AREA AGENCY ON AGING
REGION ONE, INCORPORATED

SMP
Empowering Seniors To Prevent Healthcare Fraud

ship state health insurance assistance programs
NATIONAL NETWORK

This project was supported in part by grant number 15AAAZMSHI, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

Special Needs Plans (SNP)

Refer to the plan's sheet for specific information about the "Special Need".

Chronic Condition Plans: Income not an issue

Reside in Long-term Care Facility:

Must have diabetes to enroll into this plan	
Additional Monthly Premium for this plan	$0.00
Maximum out-of-pocket limit	$5,000.00
Inpatient Hospital	
Co-pay per day for days 1 – 7	$225.00
Co-pay per day for days 8-90	$0.00
Skilled Nursing Facility	
Co-pay per day for days 1 – 20 (No prior hospital stay required)	$0.00
Co-pay per day for days 21 – 100 (100 days per benefit period)	$164.00
Outpatient Mental Health	
Co-pay per visit	$40.00
Emergency/Urgent Care	
Co-pay per hospital emergency room visit	$75.00
Co-pay per visit for urgent care	$25.00
Ambulance Services	
Co-pay per trip	$300
Physician Services	
Co-pay for Primary Care Physician	$0.00
Co-pay for Specialist	$30.00
Physical, Occupational, Speech Therapy	
Co-pay per visit	$30.00
Routine Podiatry Service	
Co-pay per visit	$00.00
Chiropractic Care	
Co-pay per visit (up to 12 visits per year)	$20.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0.00 to $200.00 (or 20%)
Outpatient Services	
Facility co-pay at ambulatory surgical center	$0.00 to $75.00
Facility co-pay per outpatient hospital facility visit	$0.00 to $325.00
Prescription Drugs	See *Your Plan Comparison* or Contact plan
Home Health Care	
Co-pay per visit	$0.00
Durable Medical Equipment (DME)	
Co-pay per item for Diabetic supplies	$0.00
Co-pay per piece of equipment	20%
Co-pay per prosthetic device	20%
Vision Services	
Co-pay per Medicare covered eye exam	$0.00 to $30.00
Co-pay per vision exam (every two years)	$30.00
One pair of eyeglasses or contact lenses after cataract surgery	$0.00
Hearing Services	
Co-pay for Medicare covered hearing exam	$30.00
Co-pay for annual hearing exam	$30.00
Hearing aid appliance	No coverage
Transportation *(check with plan for details)*	$0.00
Dental (limited services) *(optional plan available)*	$30.00

Prescription drugs may be covered under Part B or Part D depending on use or place of administration. Typically, drugs administered as part of a physician service or used with a piece of durable medical equipment are billed as Part B and all others are covered under Part D.

Drugs Covered under Medicare Part B (amount you will pay):
20% of the cost for Part B-covered chemotherapy drugs and other Part B drugs.

Drugs Covered under Medicare Part D:

ANNUAL DEDUCTIBLE: $0.00 (for brand and specialty drugs)

Are my doctors in this plan's network?	Yes	No
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Is my pharmacy in the plan's network?		
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Does this plan offer any extra services?		
Dental	☐	☐
Vision	☐	☐
Hearing	☐	☐
Gym Membership	☐	☐

Must have ESRD requiring dialysis to enroll into this plan		
Amounts for for in-network; Most out-of-network service co-pays are 30%		
Renal dialysis co-pays for in/network and out-of-network are 20% and 30%		
Additional Monthly Premium for this plan		$28.10 (LIS $0.00)
Maximum out-of-pocket limit *in-network/out-of-network*		$6,700/$10,000
Inpatient Hospital		
	Hospital stays between 1 – 90 days	Original Medicare Part A
Skilled Nursing Facility		
	Skilled nursing facility stays between 1 – 100 days	Original Medicare Part A
Outpatient Mental Health		
	Co-pay per visit	20%
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	20% up to $75.00
	Co-pay per visit for urgent care	20% up to $65.00
	Foreign Travel Emergency Supplemental Coverage	Check with plan
Ambulance Services		
	Co-pay per trip (waived if admitted)	20%
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	$0.00 to 20%
Physical, Occupational, Speech Therapy		
	Co-pay per visit	20%
Routine Podiatry Service		
	Co-pay per visit (9 visits per year)	20%
Chiropractic Care		
	Co-pay per visit	20%
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	20%
Outpatient Services		
	Facility co-pay at ambulatory surgical center	20%
	Facility co-pay per outpatient hospital facility visit	20%
Prescription Drugs		See *Your Plan Comparison* or Contact plan
Home Health Care		
	Co-pay per visit	$0.00
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	$0.00
	Co-pay per piece of equipment	0% to 20%
	Co-pay per prosthetic device	0% to 20%
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00
	Co-pay per annual vision exam	$0.00
	Annual benefit for frames/lenses/contacts	$175.00
Hearing Services		
	Co-pay for Medicare covered hearing exam	20%
	Co-pay for annual hearing exam	No coverage
	Hearing aid appliance	No coverage
Transportation *(check with plan for details)*		$0.00
Dental (preventive dental services up to $1,500/year)		$0.00 to $5.00

Fresenius Total Health SNP

Prescription drugs may be covered under Part B or Part D depending on use or place of administration. Typically, drugs administered as part of a physician service or used with a piece of durable medical equipment are billed as Part B and all others are covered under Part D.

Drugs Covered under Medicare Part B (amount you will pay):
20% of the cost for Part B-covered chemotherapy drugs and other Part B drugs.

Drugs Covered under Medicare Part D:

ANNUAL DEDUCTIBLE: $400.00 (for brand and specialty drugs)

Are my doctors in this plan's network?	Yes	No
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Is my pharmacy in the plan's network?		
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Does this plan offer any extra services?		
Dental	☐	☐
Vision	☐	☐
Hearing	☐	☐
Gym Membership	☐	☐

Must have diabetes or chronic heart failure to enroll into this plan	
Additional Monthly Premium for this plan	$0.00
Maximum out-of-pocket limit	$3,400.00
Inpatient Hospital ***Abrazo Health, Banner Health, and St. Luke's Hospital Networks Only***	
Co-pay per day for days 1 – 8	$175.00
Co-pay for days 9 – 90	$0.00
Skilled Nursing Facility	
Co-pay per day for days 1 – 20 (no prior hospital stay required)	$0.00
Co-pay per day for days 21 – 100	$100.00
Outpatient Mental Health	
Co-pay per visit	$20.00
Emergency/Urgent Care	
Co-pay per hospital emergency room visit	$75.00
Co-pay per visit for urgent care	$20.00
Foreign Travel Emergency Supplemental Coverage	Check with plan
Ambulance Services	
Co-pay per trip	$350.00
Physician Services	
Co-pay for Primary Care Physician	$0.00
Co-pay for Specialist	$20.00
Physical, Occupational, Speech Therapy	
Co-pay per visit	$10.00
Routine Podiatry Service	
Co-pay per visit (up to 8 visits per year)	$20.00
Chiropractic Care	Optional Plan Available
Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0.00 to $200.00
Outpatient Services	
Facility co-pay at ambulatory surgical center	$150.00
Facility co-pay per outpatient hospital facility visit	$175.00
Prescription Drugs	See *Your Plan Comparison* or Contact plan
Home Health Care	
Co-pay per visit	$0.00
Durable Medical Equipment (DME)	
Co-pay per item for Diabetic supplies	$0.00
Co-pay per piece of equipment	0% to 20%
Co-pay per prosthetic device	0% to 20%
Vision Services	
Co-pay per Medicare covered eye exam	$0.00
Co-pay per annual vision exam	$10.00
Benefit for frames/lenses/contacts (every 2 years)	$100.00
Hearing Services	
Co-pay for Medicare covered hearing exam	$15.00
Co-pay for annual hearing exam	No coverage
Hearing aid appliance	No coverage
Transportation *(check with plan for details)*	$0.00
Dental (Limited services) *(optional plan available)*	$20.00

PRESCRIPTION DRUG COVERAGE

Health Net Jade SNP

Prescription drugs may be covered under Part B or Part D depending on use or place of administration. Typically, drugs administered as part of a physician service or used with a piece of durable medical equipment are billed as Part B and all others are covered under Part D.

Drugs Covered under Medicare Part B (amount you will pay):
20% of the cost for Part B-covered chemotherapy drugs and other Part B drugs.

Drugs Covered under Medicare Part D:

ANNUAL DEDUCTIBLE: $0.00 (for brand and specialty drugs)

Are my doctors in this plan's network?	Yes	No
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Is my pharmacy in the plan's network?		
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Does this plan offer any extra services?		
Dental	☐	☐
Vision	☐	☐
Hearing	☐	☐
Gym Membership	☐	☐

Health Net Jade Cardiovascular SNP – (HMO)
Plan Number H0351-042

Health Net of Arizona
800-333-3930
healthnet.com/medicare

STAR RATING = 3 STARS

Must have cardiovascular disorders to enroll into this plan		
Additional Monthly Premium for this plan		$0.00
Maximum out-of-pocket limit		$3,400.00
Inpatient Hospital	***Abrazo Health, Banner Health, and St. Luke's Hospital Networks Only***	
	Co-pay per day for days 1 – 8	$175.00
	Co-pay for days 9 – 90	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20 (no prior hospital stay required)	$0.00
	Co-pay per day for days 21 – 100	$100.00
Outpatient Mental Health		
	Co-pay per visit	$20.00
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit	$75.00
	Co-pay per visit for urgent care	$20.00
	Foreign Travel Emergency Supplemental Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$350.00
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	$20.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$10.00
Routine Podiatry Service		
	Co-pay per visit (up to 8 visits per year)	$20.00
Chiropractic Care		Optional plan available
	Co-pay per visit (up to 24 visits per year)	$20.00
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	$0.00 to $200.00
Outpatient Services		
	Facility co-pay at ambulatory surgical center	$150.00
	Facility co-pay per outpatient hospital facility visit	$175.00
Prescription Drugs		See *Your Plan Comparison* or Contact plan
Home Health Care		
	Co-pay per visit	$0.00
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	$0.00
	Co-pay per piece of equipment	$0.00 to 20%
	Co-pay per prosthetic device	$0.00 to 20%
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00
	Co-pay per annual vision exam	$10.00
	Benefit for frames/lenses/contacts (every 2 years)	$100.00
Hearing Services		
	Co-pay for Medicare covered hearing exam	$15.00
	Co-pay for annual hearing exam	No coverage
	Hearing aid appliance	No coverage
Transportation *(check with plan for details)*		$0.00
Dental (Limited Services) *(optional plan available)*		$20.00

PRESCRIPTION DRUG COVERAGE

Health Net Jade Cardiovascular SNP

Prescription drugs may be covered under Part B or Part D depending on use or place of administration. Typically, drugs administered as part of a physician service or used with a piece of durable medical equipment are billed as Part B and all others are covered under Part D.

Drugs Covered under Medicare Part B (amount you will pay):
20% of the cost for Part B-covered chemotherapy drugs and other Part B drugs.

Drugs Covered under Medicare Part D:

ANNUAL DEDUCTIBLE: $0.00 (for brand and specialty drugs)

Are my doctors in this plan's network?	Yes	No
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Is my pharmacy in the plan's network?		
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Does this plan offer any extra services?		
Dental	☐	☐
Vision	☐	☐
Hearing	☐	☐
Gym Membership	☐	☐

CareMore Touch SNP – (HMO)

Plan Number H2593-019

NOTE: renal dialysis co-pay = $0.00 **STAR RATING = 4 STARS**

Care More
866-622-2820
caremore.com

Available in specific zip codes only. Please check with the plan.		
Additional Monthly Premium for this plan		$0.00
Maximum out-of-pocket limit		$3,400.00
Inpatient Hospital		
	Co-pay per day for days 1 – 5	$175.00
	Co-pay per day for days 6 – 130	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 100 (no prior hospital stay required)	$0.00
Outpatient Mental Health		
	Co-pay per visit	$0.00
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	$75.00
	Co-pay per visit for urgent care	$0.00
	Foreign Travel Emergency Supplemental Coverage	Check with plan
Ambulance Services		
	Co-pay per trip (waived if admitted)	$195.00
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	$0.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$0.00
Routine Podiatry Service		
	Co-pay per visit (4 visits per year)	$0.00
Chiropractic Care		
	Co-pay per visit	$0.00
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	$0.00 to $150.00
Outpatient Services		
	Facility co-pay at ambulatory surgical center	$100.00
	Facility co-pay per outpatient hospital facility visit	$175.00
Prescription Drugs		See *Your Plan Comparison* or Contact plan
Home Health Care		
	Co-pay per visit	$0.00
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	$0.00
	Co-pay per piece of equipment	0% to 20%
	Co-pay per prosthetic device	0% to 20%
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00 to $35.00
	Co-pay per annual vision exam	$0.00
	Frames/lenses/contacts ($100 total benefit every 2 years)	
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance benefit (every 2 years)	$1,500.00
Transportation		No coverage
Dental (limited services)		$0.00

PRESCRIPTION DRUG COVERAGE

CareMore Touch SNP

Prescription drugs may be covered under Part B or Part D depending on use or place of administration. Typically, drugs administered as part of a physician service or used with a piece of durable medical equipment are billed as Part B and all others are covered under Part D.

Drugs Covered under Medicare Part B (amount you will pay):
20% of the cost for Part B-covered chemotherapy drugs and other Part B drugs.

Drugs Covered under Medicare Part D:

ANNUAL DEDUCTIBLE: $0.00 (for brand and specialty drugs)

Are my doctors in this plan's network?	Yes	No
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Is my pharmacy in the plan's network?		
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Does this plan offer any extra services?		
Dental	☐	☐
Vision	☐	☐
Hearing	☐	☐
Gym Membership	☐	☐

Amounts are for in-network; you can go out-of-network for extra costs (generally 30%)	
Additional Monthly Premium for this plan	$26.30 (LIS $0.00)
Maximum out-of-pocket limit *in-network/out-of-network*	$3,400.00/$5,100.00
Inpatient Hospital	
Co-pay per day for days 1-6	$265.00
Co-pay per day for days 7 and beyond	$0.00
Skilled Nursing Facility	
Co-pay per day for days 1 – 100 (no prior hospital stay required)	$0.00
Outpatient Mental Health	
Co-pay per visit	$30.00 to $40.00
Emergency/Urgent Care	
Co-pay per hospital emergency room visit (No Coverage Outside U.S.)	$75.00
Co-pay per visit for urgent care	$30.00 to $40.00
Ambulance Services	
Co-pay per trip	$100.00
Physician Services	
Co-pay for Primary Care Physician	20%
Co-pay for Specialist	20%
Physical, Occupational, Speech Therapy	
Co-pay per visit	$0.00
Routine Podiatry Service	
Co-pay per visit (up to 4 visits per year)	$0.00
Co-pay per visit for diabetes-related exams and treatment	$0.00
Chiropractic Care	
Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0.00 to $100.00
Outpatient Services	
Facility co-pay at ambulatory surgical center	$250.00
Facility co-pay per outpatient hospital facility visit	$250.00
Prescription Drugs	See *Your Plan Comparison* or Contact plan
Home Health Care	
Co-pay per visit	$0.00
Durable Medical Equipment (DME)	
Co-pay per item for Diabetic supplies	$0.00
Co-pay per piece of equipment	20%
Co-pay per prosthetic device	0% to 20%
Vision Services	
Co-pay per Medicare covered eye exam	$0.00 to $20.00
Co-pay per annual vision exam	$0.00
Annual benefit for frames/lenses/contacts	$150.00
Hearing Services	
Co-pay for Medicare covered hearing exam	$0.00
Co-pay for annual hearing exam	$0.00
Benefit for hearing aid appliance (every 2 years)	$1,600.00
Transportation	
Check with plan for details	$0.00
Dental	
Preventive dental (1 cleaning, exam, x-ray per year) (up to $1800.00)	$0.00

PRESCRIPTION DRUG COVERAGE

United Healthcare Assisted Living Plan

Prescription drugs may be covered under Part B or Part D depending on use or place of administration. Typically, drugs administered as part of a physician service or used with a piece of durable medical equipment are billed as Part B and all others are covered under Part D.

Drugs Covered under Medicare Part B (amount you will pay):
20% of the cost for Part B-covered chemotherapy drugs and other Part B drugs.

Drugs Covered under Medicare Part D:

ANNUAL DEDUCTIBLE: $220.00 (for brand and specialty drugs)

Are my doctors in this plan's network?	Yes	No
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Is my pharmacy in the plan's network?		
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Does this plan offer any extra services?		
Dental	☐	☐
Vision	☐	☐
Hearing	☐	☐
Gym Membership	☐	☐

UnitedHealthcare Nursing Home (PPO SNP)
Plan Number H0710-005

STAR RATING = 4 STARS

UnitedHealthcare
888-834-3721
unitedhealthcare.com

Amounts are for in-network; you can go out-of-network for extra costs (generally 30%)		
Additional Monthly Premium for this plan		$28.30 (LIS $0.00)
Maximum out-of-pocket limit *in-network/out-of-network*		$6,700.00/$10,000
Inpatient Hospital		
	Deductibles and co-pays	Original Medicare Part A
Skilled Nursing Facility		
	Co-pay per day for days 1 – 100 (no prior hospital stay required)	$0.00
Outpatient Mental Health		
	Co-pay per visit	0% to 20%
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (No Coverage Outside U.S.)	$65.00
	Co-pay per visit for urgent care	20% (up to $65.00)
Ambulance Services		
	Co-pay per trip	20%
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	%0 to 20%
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$0.00
Routine Podiatry Service		
	Co-pay per visit (up to 6 visits per year)	$0.00
	Co-pay per visit for diabetes-related exams and treatment	$0.00 to 20%
Chiropractic Care		
	Co-pay per visit	$0.00 to 20%
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	$0.00 to 20%
Outpatient Services		
	Facility co-pay at ambulatory surgical center	20%
	Facility co-pay per outpatient hospital facility visit	20%
Prescription Drugs		See *Your Plan Comparison* or Contact plan
Home Health Care		
	Co-pay per visit	$0.00
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	20%
	Co-pay per piece of equipment	20%
	Co-pay per prosthetic device	0% to 20%
Vision Services		
	Co-pay per Medicare covered eye exam	0% to 20%
	Co-pay per annual vision exam	$0.00
	Annual benefit for frames/lenses/contacts	$225.00
Hearing Services		
	Co-pay for Medicare covered hearing exam	0% to 20%
	Co-pay for annual hearing exam	$0.00
	Benefit for hearing aid appliance (every 2 years)	$1,400.00
Transportation		
	(check with plan for details)	$0.00
Dental	*(check with plan for additional dental services covered)*	
	Preventive (2 cleanings, 2 exams, 1 x-ray per year) (up to $1,800/year)	$0.00

PRESCRIPTION DRUG COVERAGE
United Healthcare Nursing Home

Prescription drugs may be covered under Part B or Part D depending on use or place of administration. Typically, drugs administered as part of a physician service or used with a piece of durable medical equipment are billed as Part B and all others are covered under Part D.

Drugs Covered under Medicare Part B (amount you will pay):
20% of the cost for Part B-covered chemotherapy drugs and other Part B drugs.

Drugs Covered under Medicare Part D:

ANNUAL DEDUCTIBLE: $400.00 (for brand and specialty drugs)

Are my doctors in this plan's network?	Yes	No
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Is my pharmacy in the plan's network?		
• Name _____ Phone _____	☐	☐
• Name _____ Phone _____	☐	☐
Does this plan offer any extra services?		
Dental	☐	☐
Vision	☐	☐
Hearing	☐	☐
Gym Membership	☐	☐