2017
Medicare Advantage Plans
in Maricopa County

There are a variety of different types of Medicare Health Plans to choose from. The attached comparison sheets should be used as a guideline in selecting the type of health plan that meets your individual needs. Things to consider in choosing a plan include cost, choice of doctor, benefits, prescription coverage, flexibility and convenience. The following types of health plans are available to most individuals enrolled in Medicare living in Maricopa County:

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.

Health Maintenance Organizations (HMO)

A group of doctors, hospitals, and other health care providers who agree to give health care to Medicare beneficiaries for a set amount of money from Medicare each month. In an HMO, you generally must get all your care and services from doctors or hospitals in the plan's network (except emergency or urgent care). You generally must see a primary care doctor to get a referral before you see any other health care provider. If you get health care outside the plan's network, you may have to pay the full cost.

Plans with Prescription Drug Coverage:

Plans WITHOUT Prescription Drug Coverage:

AARP MedicareComplete Plan 1 (HMO)
Plan Number H0609-026

United Healthcare
1-800-555-5757
aarpmedicareplans.com

STAR RATING = 4.5 STARS

Out-of-Network Services		No coverage
Additional Monthly Premium for this plan		$0.00
Maximum out-of-pocket limit		$5,500.00
Inpatient Hospital	***Optum Medical, Banner Health, Phoenix Direct Networks Only***	
	Co-pay per day for days 1 –4	$395.00
	Co-pay per day for days 5 – beyond	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20	$0.00
	Co-pay per day for days 21 – 55	$160.00
	Co-pay per day for days 56 – 100	$0.00
Outpatient Mental Health		
	Co-pay per visit	$30.00 to $40.00
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit	$75.00
	Co-pay per visit for urgent care	$30.00 to $40.00
	Foreign Travel Emergency Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$250.00
Physician Services		
	Co-pay for Primary Care Physician	$10.00
	Co-pay for Specialist	$45.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$40.00
Routine Podiatry Service		
	Co-pay per visit (Medicare covered and up to 6 supplemental visits)	$45.00
Chiropractic Care		
	Co-pay per visit	$20
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	$9 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	$0.00
	Co-pay per piece of equipment	20%
	Co-pay per prosthetic device	20%
Vision Services		
	Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$0.00 to $20.00
	Co-pay per annual vision exam	$20.00
	Frames/lenses/contacts benefit (every 2 years)	$70.00/NO COST/$105.00
Hearing Services		
	Co-pay for Medicare covered hearing exam	$10.00
	Co-pay for annual hearing exam	$10.00
	Hearing aid appliance	$330.00 to $380.00
Transportation		Not covered
Dental		Optional plan available

PRESCRIPTION DRUG COVERAGE

AARP Medicare Complete Plan 1 (HMO)

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: $205.00 (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	☐	☐

AARP MedicareComplete Plan 2 (HMO)
Plan Number H0609-027

United Healthcare
1-800-555-5757
aarpmedicareplans.com

STAR RATING = 4.5 STARS

Out-of-Network Services		No coverage
Additional Monthly Premium for this plan		$0.00
Maximum out-of-pocket limit		$3,500.00
Inpatient Hospital	***Optum Medical Network Only***	
	Co-pay per day for days 1 –7	$155.00
	Co-pay per day for days 8 – beyond	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20	$0.00
	Co-pay per day for days 21 – 42	$160.00
	Co-pay per day for days 43 – 100	$0.00
Outpatient Mental Health		
	Co-pay per visit	$30.00 to $40.00
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit	$75.00
	Co-pay per visit for urgent care	$25.00 to $40.00
	Foreign Travel Emergency Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$150.00
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	$25.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$25.00
Routine Podiatry Service		
	Co-pay per visit (Medicare covered and up to 6 supplemental visits)	$25.00
Chiropractic Care		
	Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	$8 to 20%
Outpatient Services		
	Facility co-pay at ambulatory surgical center	$155.00
	Facility co-pay per outpatient hospital facility visit	$155.00
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 & eyewear post-cataract surgery	$0.00 to $20.00
	Co-pay per annual vision exam	$20.00
	Frames/lenses/contacts benefit (every 2 years)	$70.00/NO COST/$105.00
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance	$330.00 to $380.00
Transportation		Not covered
Dental		Optional plan available

PRESCRIPTION DRUG COVERAGE

AARP Medicare Complete Plan 2 (HMO)

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	☐	☐

Aetna Medicare Prime Plan (HMO)
Plan Number H3931-092

Aetna Medicare
1-855-338-7027
aetnamedicare.com

STAR RATING = 4 STARS

Out-of-Network Services	No coverage
Additional Monthly Premium for this plan	$0.00
Maximum out-of-pocket limit	$3,000.00
Inpatient Hospital *Banner Hospitals and select other hospitals*	
Co-pay per day for days 1 – 7	$195.00
Co-pay per day for days 8 – beyond	$0.00
Skilled Nursing Facility	
Co-pay per day for days 1 – 20	$20.00
Co-pay per day for days 21 – 100	$160.00
Outpatient Mental Health	
Co-pay per visit	$30.00
Emergency/Urgent Care	
Co-pay per hospital emergency room visit	$75.00
Co-pay per visit for urgent care	$60.00
Foreign Travel Emergency Coverage	Check with plan
Ambulance Services	
Co-pay per trip	$315.00
Physician Services	
Co-pay for Primary Care Physician	$0.00
Co-pay for Specialist	$25.00
Physical, Occupational, Speech Therapy	
Co-pay per visit	$30.00
Routine Podiatry Service	
Co-pay per Medicare-covered visit	$30.00
Chiropractic Care	
Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0.00 to 250.00
Outpatient Services	
Facility co-pay at ambulatory surgical center	$195.00
Facility co-pay per outpatient hospital facility visit	$195.00
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 to 20%
Co-pay per piece of equipment	20%
Co-pay per prosthetic device	20%
Vision Services	
Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$0.00 to $30.00
Co-pay per annual vision exam	$0.00
Eyeglasses or contacts annual benefit	Optional plan available
Hearing Services	
Co-pay for Medicare covered diagnostic hearing exam	$25.00
Co-pay for routine annual hearing exam	$0.00
Hearing aid appliance	Optional plan available
Transportation	Not covered
Dental	Optional plan available

PRESCRIPTION DRUG COVERAGE

Aetna Medicare Prime Plan (HMO)

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

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	☐	☐

Blue Medicare Advantage Classic (HMO)
Plan Number H0302-006

Blue Cross Blue Shield
1-888-274-0367
azbluemedicare.com

STAR RATING = 3.5 STARS

Out-of-Network Services		No coverage
Additional Monthly Premium for this plan		$0.00
Maximum out-of-pocket limit		$3,200.00
Inpatient Hospital	***Banner Health Network and Other Providers***	
	Co-pay per day for days 1 – 7	$190.00
	Co-pay per day for days 8 – beyond	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 10	$0.00
	Co-pay per day for days 11 – 20	$20.00
	Co-pay per day for days 21 – 100	$120.00
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	$25.00
	Foreign Travel Emergency Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$200.00
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	$30.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$15.00 to $30.00
Routine Podiatry Service		
	Co-pay per visit	$30.00
Chiropractic Care		
	Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	$5.00 to $300.00 (or 20%)
Outpatient Services		
	Facility co-pay at ambulatory surgical center	$10.00 to $260.00 (or 20%)
	Facility co-pay per outpatient hospital facility visit	$10.00 to $260.00 (or 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 to 20%
	Co-pay per piece of equipment	20%
	Co-pay per prosthetic device	20%
Vision Services		
	Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$30.00 to 20%
	Co-pay per annual vision exam	No coverage
	Frames/lenses/contacts	No coverage
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	No coverage
	Hearing aid appliance (every 2 years)	No coverage
Transportation		No coverage
Dental		No coverage

PRESCRIPTION DRUG COVERAGE

Blue Medicare Advantage Classic (HMO)

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

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	☐	☐

Blue Medicare Advantage Plus (HMO)
Plan Number H0302-001

STAR RATING = 3.5 STARS

Blue Cross Blue Shield
1-888-274-0367
azbluemedicare.com

Out-of-Network Services		No coverage
Additional Monthly Premium for this plan		$32.00 (LIS $0.00)
Maximum out-of-pocket limit		$3,200.00
Inpatient Hospital	***Banner Health Network and Other Providers***	
	Co-pay per day for days 1 – 7	$160.00
	Co-pay per day for days 8 – beyond	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 10	$0.00
	Co-pay per day for days 11 – 20	$20.00
	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	$25.00
	Foreign Travel Emergency Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$125.00
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	$15.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$10.00 to $15.00
Routine Podiatry Service		
	Co-pay per visit	$15.00
Chiropractic Care		
	Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	$0.00 to $275.00 (or 20%)
Outpatient Services		
	Facility co-pay at ambulatory surgical center	$10.00 to $200.00 (or 20%)
	Facility co-pay per outpatient hospital facility visit	$10.00 to $200.00 (or 20%)
Prescription Drugs		See *Your Plan Comparison* or Contact plan
Home Health Care		
	Co-pay per visit (includes respite care)	$0.00
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	$0.00 to 20%
	Co-pay per piece of equipment	20%
	Co-pay per prosthetic device	20%
Vision Services		
	Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$15.00 to 20%
	Co-pay per annual vision exam	No coverage
	Frames/lenses/contacts	No coverage
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	No coverage
	Hearing aid appliance	No coverage
Transportation		No coverage
Dental (cleaning, x-ray, oral exam annually)		Covers up to $500.00

PRESCRIPTION DRUG COVERAGE

Blue Medicare Advantage Plus (HMO)

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

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	☐	☐

Out-of-Network Services		No coverage
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	$250.00
	Co-pay per day for days 8 – beyond	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20	$0.00
	Co-pay per day for days 21 – 100	$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
	Foreign Travel Emergency Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$300.00
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 Medicare-covered visit	$30.00
	Co-pay for each supplemental routine visit	$30.00
Chiropractic Care		
	Co-pay per visit (up to 12 routine visits per year)	$20.00
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	$0.00 to 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 & eyewear post-cataract surgery	$0.00 to $30.00
	Co-pay per vision exam (every 2 years)	$30.00
	Co-pay for eyeglasses or contacts	No coverage
Hearing Services		
	Co-pay for Medicare covered diagnostic hearing exam	$30.00
	Co-pay for routine hearing exam	$30.00
	Hearing aid appliance	No coverage
Transportation		No coverage
Dental		Optional plan available

PRESCRIPTION DRUG COVERAGE

CIGNA HealthSpring Preferred (HMO)

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

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 Ruby 1 (HMO)
Plan Number H0351-043

Health Net of AZ
1-800-333-3930
healthnet.com

STAR RATING = 3 STARS

Out-of-Network Services		No coverage
Additional Monthly Premium for this plan		$59.00 (LIS $24.20)
Maximum out-of-pocket limit		$3,800.00
Inpatient Hospital	***Arizona Priority Care Network***	
	Co-pay per day for days 1 -5	$100.00
	Co-pay per day for days 6 and beyond	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20	$0
	Co-pay per day for days 21 – 100	$100.00
Outpatient Mental Health		
	Co-pay per visit	$15.00
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit	$75.00
	Co-pay per visit for urgent care	$20.00
	Foreign Travel Emergency Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$125.00
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	$15.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$10.00
Routine Podiatry Service		
	Co-pay per Medicare-covered visit	$15.00
Chiropractic Care		
	Co-pay per visit (optional plan available with additional visits covered)	$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	$50.00
	Facility co-pay per outpatient hospital facility visit	$75.00
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 $10.00
	Co-pay per annual vision exam	Optional plan available
	Frames/lenses/contacts benefit	Optional plan available
Hearing Services		
	Co-pay for Medicare covered hearing exam	$15.00
	Co-pay for annual hearing exam	$ 0
	Hearing aid appliance (every 3 years)	$ 0
Transportation		No coverage
Dental		Optional plan available

PRESCRIPTION DRUG COVERAGE

Health Net Ruby 1 (HMO)

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

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 Ruby Select (HMO)
Plan Number H0351-040

Health Net of AZ
1-800-333-3930
healthnet.com

STAR RATING = 3 STARS

Out-of-Network Services		No coverage
Additional Monthly Premium for this plan		$0.00
Maximum out-of-pocket limit		$4,000.00
Inpatient Hospital	***Arizona Priority Care Network***	
	Co-pay per day for days 1 – 6	$195.00
	Co-pay per day for days 6 and beyond	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20	$0
	Co-pay per day for days 21 – 100	$150.00
Outpatient Mental Health		
	Co-pay per visit	$25.00
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit	$75.00
	Co-pay per visit for urgent care	$20.00
	Foreign Travel Emergency Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$275.00
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	$25.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$20.00
Routine Podiatry Service		
	Co-pay per Medicare-covered visit	$25.00
Chiropractic Care		
	Co-pay per visit (optional plan available with additional visits covered)	$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	$100.00
	Facility co-pay per outpatient hospital facility visit	$150.00
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 & eyewear post-cataract surgery	$0.00 to $10.00
	Co-pay per annual vision exam	Optional plan available
	Frames/lenses/contacts benefit	Optional plan available
Hearing Services		
	Co-pay for Medicare covered hearing exam	$25.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance (every 3 years)	$0.00
Transportation		No coverage
Dental		Optional plan available

PRESCRIPTION DRUG COVERAGE

Health Net Ruby Select (HMO)

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

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	☐	☐

Humana Gold Plus (HMO)
Plan Number H2649-032

Humana
1-800-833-2364
Humana-medicare.com

STAR RATING = 4 STARS

Out-of-Network Coverage		No Coverage
Additional Monthly Premium for this plan		$0.00
Maximum out-of-pocket limit		$5,500
Inpatient Hospital	***NOT ACCEPTED AT BARROW NEUROLOGICAL INSTITUTE***	
	Co-pay per day for days 1 – 7	$225.00
	Co-pay per day for days 8 – beyond	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20	$0
	Co-pay per day for days 21 – 100	$164.50
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	$35.00
	Foreign Travel Emergency Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$265.00
Physician Services		
	Co-pay for Primary Care Physician	$0.00
	Co-pay for Specialist	$35.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$35.00
Routine Podiatry Service		
	Co-pay per Medicare-covered visit	$35.00
Chiropractic Care		
	Co-pay per visit	$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	$175.00
	Facility co-pay per outpatient hospital facility visit	$200.00
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% to 20%
	Co-pay per piece of equipment	20%
	Co-pay per prosthetic device	20%
Vision Services		
	Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$35.00
	Co-pay per annual vision exam	$0.00
	Frames/lenses/contacts	Optional plan available
Hearing Services		
	Co-pay for Medicare covered hearing exam	$35.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance copay	$699.00 - $999.00
Transportation		No coverage
Dental		
	Limited Services	Optional plan available

PRESCRIPTION DRUG COVERAGE

Humana Gold Plus (HMO)

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: $225.00 (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	☐	☐

Humana Gold Plus (HMO)
Plan Number H2649-030

Humana
1-800-833-2364
Humana-medicare.com

STAR RATING = 4 STARS

Additional Monthly Premium for this plan	$85.00 (LIS $85.00)
Maximum out-of-pocket limit	$4,900
Inpatient Hospital ***NOT ACCEPTED AT BARROW NEUROLOGICAL INSTITUTE***	
Co-pay per day for days 1 – 6	$289.00
Co-pay per day for days 7 – beyond	$0.00
Skilled Nursing Facility	
Co-pay per day for days 1 – 20	$0
Co-pay per day for days 21 – 100	$164.50
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	$45.00
Foreign Travel Emergency Coverage	Check with plan
Ambulance Services	
Co-pay per trip	$265.00
Physician Services	
Co-pay for Primary Care Physician	$5.00
Co-pay for Specialist	$45.00
Physical, Occupational, Speech Therapy	
Co-pay per visit	$30.00 to $45.00
Routine Podiatry Service	
Co-pay per Medicare-covered visit	$45.00
Chiropractic Care	
Co-pay per visit	$40.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0.00 to $264.00 (or 20%)
Outpatient Services	
Facility co-pay at ambulatory surgical center	$239.00
Facility co-pay per outpatient hospital facility visit	$264.00
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% to 20%
Co-pay per piece of equipment	20%
Co-pay per prosthetic device	20%
Vision Services	
Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$0.00 to $45.00
Co-pay per annual vision exam	$0.00
Frames/lenses/contacts	$200.00 annual benefit
Hearing Services	
Co-pay for Medicare covered hearing exam	$45.00
Co-pay for annual hearing exam	$0.00
Hearing aid appliance copay	$699.00 – $999.00
Transportation *(12 one way trips, not to exceed 25miles per trip)*	$0.00
Dental (limited services)	Optional plan available

PRESCRIPTION DRUG COVERAGE

Humana Gold Plus (HMO)

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: $205.00 (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 Green (HMO)
Plan Number H0351-030

Health Net of AZ
1-800-333-3930
healthnet.com/medicare

STAR RATING = 3 STARS

Out-of-Network Services		No coverage
Additional Monthly Premium for this plan		$0.00
Maximum out-of-pocket limit		$6,700.00
Inpatient Hospital	***Not Accepted at any Scottsdale Health Care Facility***	
	Co-pay per day for days 1 – 8	$195.00
	Co-pay per day for days 9 – beyond	$0.00
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20	$0
	Co-pay per day for days 21 – 100	$100.00
Outpatient Mental Health		
	Co-pay per visit	$35.00
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	$75.00
	Co-pay per visit for urgent care	$20.00
	Foreign Travel Emergency Coverage	Check with plan
Ambulance Services		
	Co-pay per trip	$300.00
Physician Services		
	Co-pay for Primary Care Physician	$5.00
	Co-pay for Specialist	$35.00
Physical, Occupational, Speech Therapy		
	Co-pay per visit	$25.00
Routine Podiatry Service		
	Co-pay per visit	$35.00
Chiropractic Care		
	Co-pay per Medicare-covered visit (optional plan w/ additional visits)	$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	$125.00
	Facility co-pay per outpatient hospital facility visit	$175.00
Prescription Drugs		No coverage
	20% of Part B chemotherapy and other Part B drugs	20%
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 & eyewear post-cataract surgery	$0.00 to $10.00
	Co-pay per annual vision exam	Optional plan available
	Frames/lenses/contacts	Optional plan available
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		No coverage
Dental (limited services)		Optional plan available

Health Net Green (HMO)

THIS PLAN DOES NOT PROVIDE PRESCRIPTION DRUG COVERAGE

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	☐	☐

Preferred Provider Organizations (PPO)

A health care plan in which you use doctors, hospitals, and providers that belong to the network. You can receive services outside of the network for an additional cost. You do *not* need a referral from a primary care physician to see a specialist.

Plans with Prescription Drug Coverage:

Local PPO (Maricopa county-wide only)

Select Counties PPO (Maricopa, Pima, Pinal & Santa Cruz county-wide)

Regional PPO (provider network is state-wide)

Plans WITHOUT Prescription Drug Coverage:

Private Fee For Service PFFS

Private Fee For Service (nationwide coverage w/o a network or contracts)

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Aetna Medicare Prime Plan (PPO)
Plan Number H5521-100

Aetna Medicare
1-855-338-7027
aetnamedicare.com

STAR RATING = 4 STARS

Out-of-Network Services	Up to 40%
Additional Monthly Premium for this plan	$89.00 (LIS $75.50)
Maximum out-of-pocket limit *in-network/out-of-network*	$6,700.00/$10,000
Inpatient Hospital *Banner Hospitals and select other hospitals*	
Co-pay per day for days 1 – 6	$255.00
Co-pay per day for days 7 – beyond	$0.00
Skilled Nursing Facility	
Co-pay per day for days 1 – 20	$0.00
Co-pay per day for days 21 – 100	P$160.00
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	$60.00
Foreign Travel Emergency Coverage	$75.00
Ambulance Services	
Co-pay per trip	$325.00
Physician Services	
Co-pay for Primary Care Physician	$5.00
Co-pay for Specialist	$25.00
Physical, Occupational, Speech Therapy	
Co-pay per visit	$25.00
Routine Podiatry Service	
Co-pay per Medicare-covered visit	$25.00
Chiropractic Care	
Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0-$25.00 to 20%
Outpatient Services	
Facility co-pay at ambulatory surgical center	$195.00
Facility co-pay per outpatient hospital facility visit	$25.00 to $195.00
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% to 20%
Co-pay per piece of equipment	20%
Co-pay per prosthetic device	20%
Vision Services	
Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$0.00
Co-pay per annual vision exam	$0.00
Eyeglasses or contacts annual benefit – plan pays up to $125.00/year	Limited coverage
Hearing Services	
Co-pay for Medicare covered diagnostic hearing exam	$25.00
Co-pay for routine annual hearing exam	$0.00
Hearing aid appliance benefit	Plan pays up to $500
Transportation	Not covered
Dental (preventive & comprehensive dental services)	Plan pays up to $1000

PRESCRIPTION DRUG COVERAGE

Aetna Medicare Prime Plan (PPO)

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

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	☐	☐

Out-of- Network Services; ***contact plan for out-of-network costs***	Up to 50%
Additional Monthly Premium for this plan	$135.00 ($99.90 LIS)
Maximum out-of-pocket limit in network/out of network	$6,700.00/$10,000
Inpatient Hospital (In-Network)	
Co-pay per day for days 1-6	$289.00
Co-pay per day for days 7 - beyond	$0.00
Skilled Nursing Facility (In Network)	
Co-pay per day for days 1 – 20	$0.00
Co-pay per day for days 21 – 100	$164.50
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	$45.00
Foreign Travel Emergency Coverage	Check with plan
Ambulance Services	
Co-pay per trip	$265.00
Physician Services	
Co-pay for Primary Care Physician	$5.00
Co-pay for Specialist	$45.00
Physical, Occupational, Speech Therapy	
Co-pay per visit	$30.00-$45.00
Routine Podiatry Service	
Co-pay per Medicare-Covered visit	$45.00
Chiropractic Care	
Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0.00 to $264.00 (or 20%)
Outpatient Services	
Facility co-pay at ambulatory surgical center	$239.00
Facility co-pay per outpatient hospital facility visit	$264.00
Prescription Drugs	See *Your Plan Comparison* or Contact Plan
Home Health Care (In Network)	
Co-pay per visit	$0.00
Durable Medical Equipment (DME)	
Co-pay per item for Diabetic supplies	$0.00 to 20%
Co-pay per piece of equipment	20%
Co-pay per prosthetic device	20%
Vision Services	
Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$0.00 - $45.00
Co-pay per annual vision exam	$40.00
Co-pay for Frames/lenses/contacts	Optional plan available
Hearing Services	
Co-pay for Medicare covered hearing exam	$45.00
Co-pay for annual hearing exam	No coverage
Hearing aid appliance	No coverage
Transportation	No coverage
Dental (limited benefits)	Optional plan available

PRESCRIPTION DRUG COVERAGE

Humana Choice PPO (MAPD)

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: $225.00 (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	☐	☐

Out-of- Network Services; *contact plan for out-of-network costs*	Up to 50%
Additional Monthly Premium for this plan	$166.00 ($133.10 LIS)
Maximum out-of-pocket limit in network/out of network	$6,700.00
Inpatient Hospital (In-Network)	
Co-pay per day for days 1-6	$254.00
Co-pay per day for days 7 – beyond	$0.00
Skilled Nursing Facility (In Network)	
Co-pay per day for days 1 – 20	$0.00
Co-pay per day for days 21 – 100	$164.50
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	$45.00
Foreign Travel Emergency Coverage	Check with plan
Ambulance Services	
Co-pay per trip	$265.00
Physician Services	
Co-pay for Primary Care Physician	$15.00
Co-pay for Specialist	$45.00
Physical, Occupational, Speech Therapy	
Co-pay per visit	$30.00 to $45.00
Routine Podiatry Service	
Co-pay per Medicare-Covered visit	$45.00
Chiropractic Care	
Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0.00 to $264.00 or 20%
Outpatient Services	
Facility co-pay at ambulatory surgical center	$239.00
Facility co-pay per outpatient hospital facility visit	$264.00
Prescription Drugs	See *Your Plan Comparison* or Contact plan
Home Health Care (In Network)	
Co-pay per visit	$0.00
Durable Medical Equipment (DME)	
Co-pay per item for Diabetic supplies	$0.00 to 20%
Co-pay per piece of equipment	20%
Co-pay per prosthetic device	20%
Vision Services	
Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$0.00 to $45.00
Annual vision exam – maximum benefit	$40.00
Co-pay for Frames/lenses/contacts	Optional plan available
Hearing Services	
Co-pay for Medicare covered hearing exam	$45.00
Co-pay for annual hearing	No coverage
Hearing aid appliance	No coverage
Transportation	No coverage
Dental	Optional plan available

PRESCRIPTION DRUG COVERAGE

Humana Choice Regional PPO (MAPD)

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: $280.00 (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	☐	☐

Out-of- Network Services; *contact plan for out-of-network costs*	Up to 50%
Additional Monthly Premium for this plan	$0.00
Annual Deductible for out of network services	$599.00
Maximum out-of-pocket limit in network/out of network	$6,700.00/$10,000
Inpatient Hospital (In-Network)	
Co-pay per day for days 1-6	$289.00
Co-pay per day for days 7 - beyond	$0.00
Skilled Nursing Facility (In Network)	
Co-pay per day for days 1 – 20	$0.00
Co-pay per day for days 21 – 100	$164.50
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	$40.00
Foreign Travel Emergency Coverage	Check with the plan
Ambulance Services	
Co-pay per trip	$265.00
Physician Services	
Co-pay for Primary Care Physician	$15.00
Co-pay for Specialist	$40.00
Physical, Occupational, Speech Therapy	
Co-pay per visit	$30.00 to $40.00
Routine Podiatry Service	
Co-pay per Medicare-Covered visit	$40.00
Chiropractic Care	
Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0.00 to 264.00 or 20%)
Outpatient Services	
Facility co-pay at ambulatory surgical center	$239.00
Facility co-pay per outpatient hospital facility visit	$264.00
Prescription Drugs	No coverage
Home Health Care (In Network)	
Co-pay per visit	$0.00
Durable Medical Equipment (DME)	
Co-pay per item for Diabetic supplies	$0.00 to 20%
Co-pay per piece of equipment	15%
Co-pay per prosthetic device	15%
Vision Services	
Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$0.00 - $40.00
Co-pay per annual vision exam	$0.00
Co-pay for Frames/lenses/contacts	Optional plan available
Hearing Services	
Co-pay for Medicare covered hearing exam	$40
Co-pay for annual hearing exam	No coverage
Hearing aid appliance	No coverage
Transportation	No coverage
Dental	Optional plan available

Humana Choice Regional PPO (MA)

THIS PLAN DOES NOT PROVIDE PRESCRIPTION DRUG COVERAGE

	Yes	No
Are my doctors in this plan's network?		
• 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	☐	☐

Humana Gold Choice (PFFS)
Plan Number H8145-103

Humana Insurance
1-800-833-2364
Humana-medicare.com

STAR RATING = 3.5 STARS

Out-of-Network Services; ***contact plan for out-of-network costs***	Up to 50%
Additional Monthly Premium for this plan	$192.00 (LIS $162.30)
Maximum out-of-pocket limit	$6,700.00
Inpatient Hospital	
Co-pay per day for days 1 – 5	$275.00
Co-pay per day for days 6 – beyond	$0.00
Skilled Nursing Facility	
Co-pay per day for days 1 – 20	$0.00
Co-pay per day for days 21 – 100	$164.50
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	$45.00
Foreign Travel Emergency Coverage	Check with plan
Ambulance Services	
Co-pay per trip	$265.00
Physician Services	
Co-pay for Primary Care Physician	$20.00
Co-pay for Specialist	$45.00
Physical, Occupational, Speech Therapy	
Co-pay per visit	$30.00 - $45.00
Routine Podiatry Service	
Co-pay per Medicare-covered visit	$45.00
Chiropractic Care	
Co-pay per visit	$20.00
Diagnostic Tests, X-Rays, and Lab Services	
Clinical/diagnostic lab service	$0.00 -$250.00 or 20 - 25%
Outpatient Services	
Facility co-pay at ambulatory surgical center	$225.00
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% to 20%
Co-pay per piece of equipment	20%
Co-pay per prosthetic device	20%
Vision Services	
Co-pay per Medicare covered eye exam & eyewear post-cataract surgery	$0.00 to $45.00
Co-pay per annual vision exam	$0.00
Eyeglasses or contacts annual benefit *(optional plan available)*	$130.00
Hearing Services	
Co-pay for Medicare covered diagnostic hearing exam	$45.00
Co-pay for routine annual hearing exam	No coverage
Hearing aid appliance	Optional plan available
Transportation	No coverage
Dental *(limited services available for $45.00 co-pay)*	Optional plan available

PRESCRIPTION DRUG COVERAGE
Humana Gold Choice (PFFS)

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: $225.00 (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	☐	☐