2017
Medicare Advantage
Special Needs Plans (SNP)
Full Dual Medicare & Medicaid
Maricopa County

Special Needs Plans for Dual Eligible beneficiaries are an HMO plan that limits their membership to people who are eligible for both Medicare and Medicaid (AHCCCS).

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 1/18/17

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.

Full Dual Special Needs Plans (SNP)

In order to be eligible for these plans, individuals need to be eligible for Medicare and FULL Medicaid (AHCCCS). In other words, they have to be eligible for QMB. SLMB and QI-1 is not considered "full Medicaid".

Bridgeway Health Solutions Advantage SNP (HMO)

Plan Number H5590-002

STAR RATING = 4 STARS

Bridgeway Health
1-877-935-8020
advantage.bridgewayhs.com

Must be eligible for Medicare and be enrolled in an ALTCS health plan		
Premiums, co-pays and coinsurance will be paid by AHCCCS		
Providers must have contract with Bridgeway ALTCS plan		
Additional Monthly Premium for this plan		$0.00
Inpatient Hospital		
	Deductible day for days 1 – 90	
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20 (3 day prior hospital stay required)	
	Co-pay per day for days 21 – 100 (100 days per benefit period)	
Outpatient Mental Health		
	Co-pay per visit	
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	
	Co-pay per visit for urgent care	
Ambulance Services		
	Co-pay per trip	
Physician Services		
	Co-pay for Primary Care Physician	
	Co-pay for Specialist	
Physical, Occupational, Speech Therapy		
	Co-pay per visit	
Routine Podiatry Service		
	Co-pay per visit	
Chiropractic Care		
	Co-pay per visit	
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	
Outpatient Services		
	Facility co-pay at ambulatory surgical center	
	Facility co-pay per outpatient hospital facility visit	
Prescription Drugs		$1.20 or $3.70
Home Health Care		
	Co-pay per visit	
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	
	Co-pay per piece of equipment	
	Co-pay per prosthetic device	
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00
	Co-pay per annual vision exam	$0.00
	Frames/lenses/contacts	$250 annual limit
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance (only one)	$1,200 annual limit
Transportation		Not Covered
Dental		
	Annual benefit	$1,500

Bridgeway Health Solutions Advantage SNP (HMO)

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 _____ ☐ ☐

Check with plan for over-the-counter benefits.

Care 1st + SNP (HMO)
Plan Number H5430-001
STAR RATING = 3.5 STARS

Care 1st Health Plan of AZ
1-877-778-1855
care1st.com/az/medicare

Must be eligible for Medicare and AHCCCS health plan		
Premiums, co-pays and coinsurance will be paid by AHCCCS		
Providers must have contract with Care 1st AHCCCS plan		
Additional Monthly Premium for this plan		$0.00
Inpatient Hospital		
	Co-pay per day for days 1 – 60	
	Co-pay per day for days 61 – 90 (90 days per benefit period)	
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20 (3 day hospital stay required)	
	Co-pay per day for days 21 – 100 (100 days per benefit period)	
Outpatient Mental Health		
	Co-pay per visit	
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	
	Co-pay per visit for urgent care (waived if admitted)	
Ambulance Services		
	Co-pay per trip	
Physician Services		
	Co-pay for Primary Care Physician	
	Co-pay for Specialist	
Physical, Occupational, Speech Therapy		
	Co-pay per visit	
Routine Podiatry Service		
	Co-pay per visit	
Chiropractic Care		
	Co-pay per visit	
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	
Outpatient Services		
	Facility co-pay at ambulatory surgical center	
	Facility co-pay per outpatient hospital facility visit	
Prescription Drugs		$1.20 or $3.70
Home Health Care		
	Co-pay per visit	
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	
	Co-pay per piece of equipment	
	Co-pay per prosthetic device	
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00
	Co-pay per annual vision exam	$0.00
	Frames/lenses/contacts	$350 annual limit
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance benefit (every three years)	Covers up to $1,200
Transportation *(10 one way trips to medical apt.)*		$0.00
Dental		
	Annual benefit (+ $825 for dentures , once every five years)	$1,250

Care 1st + SNP (HMO)

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 _____ ☐ ☐

Check with plan for over-the-counter benefits.

Health Choice Generations SNP (HMO)

Plan Number H5587-002

STAR RATING = 3 STARS

Health Choice
1-800-656-8991
healthchoicegenerations.com

Must be eligible for Medicare and be enrolled in an AHCCCS health plan		
Premiums, co-pays and coinsurance will be paid by AHCCCS		
Providers must have contract with Health Choice AHCCCS plan		
Additional Monthly Premium for this plan		$0.00
Inpatient Hospital		
	Co-pay per day for days 1 – 90	
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20 (no prior hospital stay required)	
	Co-pay per day for days 21 – 100 (100 days per benefit period)	
Outpatient Mental Health		
	Co-pay per visit	
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	
	Co-pay per visit for urgent care	
Ambulance Services		
	Co-pay per trip	
Physician Services		
	Co-pay for Primary Care Physician	
	Co-pay for Specialist	
Physical, Occupational, Speech Therapy		
	Co-pay per visit	
Routine Podiatry Service		
	Co-pay per visit	
Chiropractic Care		
	Co-pay per visit	
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	
Outpatient Services		
	Facility co-pay at ambulatory surgical center	
	Facility co-pay per outpatient hospital facility visit	
Prescription Drugs		$1.20 or $3.70
Home Health Care		
	Co-pay per visit	
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	
	Co-pay per piece of equipment	
	Co-pay per prosthetic device	
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00
	Co-pay per annual vision exam	$0.00
	Frames/lenses/contacts benefit	$175 annual limit
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance (only one)	$500 annual limit
Transportation		$0.00
Dental		
	Annual benefit	$1,600

Health Choice Generations SNP (HMO)

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 _____ ☐ ☐

Check with plan for over-the-counter benefits.

Health Net Amber SNP (HMO)
Plan Number H0351-029
STAR RATING = 3 STARS

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

Must be eligible for Medicare and be enrolled in an AHCCCS health plan		
Premiums, co-pays and coinsurance will be paid by AHCCCS		
Providers must have contract with Health Net AHCCCS plan		
Additional Monthly Premium for this plan		$0.00
Inpatient Hospital	***Abrazo, Dignity, and St. Lukes Hospital Networks Only***	
	Deductible day for days 1 – 90	
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20 (3 day prior hospital stay required)	
	Co-pay per day for days 21 – 100 (100 days per benefit period)	
Outpatient Mental Health		
	Co-pay per visit	
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	
	Co-pay per visit for urgent care	
Ambulance Services		
	Co-pay per trip	
Physician Services		
	Co-pay for Primary Care Physician	
	Co-pay for Specialist	
Physical, Occupational, Speech Therapy		
	Co-pay per visit	
Routine Podiatry Service		
	Co-pay per visit	
Chiropractic Care		
	Co-pay per visit	
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	
Outpatient Services		
	Facility co-pay at ambulatory surgical center	
	Facility co-pay per outpatient hospital facility visit	
Prescription Drugs		$1.20 or $3.70
Home Health Care		
	Co-pay per visit	
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	
	Co-pay per piece of equipment	
	Co-pay per prosthetic device	
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00
	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	$0.00
	Hearing aid appliance benefit (every three years)	Covers up to $1,000
Transportation		No coverage
Dental		
	Annual benefit	$1,750

Health Net Amber SNP (HMO)

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 _____ ☐ ☐

Check with plan for over-the-counter benefits.

Mercy Care Advantage SNP (HMO)

Plan Number H5580-001

STAR RATING = 3.5 STARS

Mercy Care Advantage
866-571-5781
mercycareadvantage.com

Must be eligible for Medicare and be enrolled in an AHCCCS health plan		
Premiums, co-pays and coinsurance will be paid by AHCCCS		
Providers must have contract with Mercy Care AHCCCS plan		
Additional Monthly Premium for this plan		$0.00
Inpatient Hospital		
	Co-pay per day for days 1 – 60	
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20 (3 day hospital stay required)	
	Co-pay per day for days 21 – 100 (100 days per benefit period)	
Outpatient Mental Health		
	Co-pay per visit	
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	
	Co-pay per visit for urgent care	
Ambulance Services		
	Co-pay per trip	
Physician Services		
	Co-pay for Primary Care Physician	
	Co-pay for Specialist	
Physical, Occupational, Speech Therapy		
	Co-pay per visit	
Routine Podiatry Service		
	Co-pay per visit	
Chiropractic Care		
	Co-pay per visit	
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	
Outpatient Services		
	Facility co-pay at ambulatory surgical center	
	Facility co-pay per outpatient hospital facility visit	
Prescription Drugs		$1.20 or $3.70
Home Health Care		
	Co-pay per visit	
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	
	Co-pay per piece of equipment	
	Co-pay per prosthetic device	
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00
	Co-pay per annual vision exam	$0.00
	Benefit for frames/lenses/contacts	$250 annual limit
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance benefit (every three years)	$1,700
Transportation *(cover up to 20-one way trips or 10-round trips)*		$0.00
Dental		
	Annual benefit	$3,000

Mercy Care Advantage SNP (HMO)

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 _____ ☐ ☐

Check with plan for over-the-counter benefits.

United Healthcare Dual Complete SNP (HMO)
Plan Number H0321-002
STAR RATING = 3.5 STARS

UHC Community Plan
1-888-834-3721
UHCdualcomplete.com

Must be eligible for Medicare and AHCCCS health plan		
Premiums, co-pays and coinsurance will be paid by AHCCCS		
Providers must have contract with United Healthcare/APIPA AHCCCS plan		
Monthly Premium for this plan		$0.00
Inpatient Hospital		
	Co-pay per day for days 1 - 60	
	Co-pay per day for days 61 – 90	
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20 (3 day hospital stay required)	
	Co-pay per day for days 21 - 100 (100 days per benefit period)	
Outpatient Mental Health		
	Co-pay per visit	
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	
	Co-pay per visit for urgent care (waived if admitted)	
Ambulance Services		
	Co-pay per trip	
Physician Services		
	Co-pay for Primary Care Physician	
	Co-pay for Specialist	
Physical, Occupational, Speech Therapy		
	Co-pay per visit	
Routine Podiatry Service		
	Co-pay per visit	
Chiropractic Care		
	Co-pay per visit	
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	
Outpatient Services		
	Facility co-pay at ambulatory surgical center	
	Facility co-pay per outpatient hospital facility visit	
Prescription Drugs		$1.20 or $3.70
Home Health Care		
	Co-pay per visit	
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	
	Co-pay per piece of equipment	
	Co-pay per prosthetic device	
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00
	Co-pay per annual vision exam	$0.00
	Benefit for frames/lenses/contacts (every two years)	$150
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance benefit (every two years)	$1,500
Transportation *(24-one way trips to approve locations)*		$0.00
Dental		
	Annual benefit	$2,500

United Healthcare Dual Complete SNP (HMO)

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 _____ ☐ ☐

Check with plan for over-the-counter benefits.

United Healthcare Dual Complete ONE SNP (HMO)
Plan Number H0321-004
STAR RATING = 3.5 STARS

UHC Community Plan
1-888-834-3721
UHCdualcomplete.com

CLIENT MUST BE ON ALTCS		
Premiums, co-pays and coinsurance will be paid by AHCCCS		
Providers must have contract with United Healthcare/APIPA AHCCCS plan		
Additional Monthly Premium for this plan		$0.00
Inpatient Hospital		
	Co-pay per day for days 1 – 60	
	Co-pay per day for days 61 – 90	
Skilled Nursing Facility		
	Co-pay per day for days 1 – 20 (3 day hospital stay required)	
	Co-pay per day for days 21 - 100 (100 days per benefit period)	
Outpatient Mental Health		
	Co-pay per visit	
Emergency/Urgent Care		
	Co-pay per hospital emergency room visit (waived if admitted)	
	Co-pay per visit for urgent care (waived if admitted)	
Ambulance Services		
	Co-pay per trip	
Physician Services		
	Co-pay for Primary Care Physician	
	Co-pay for Specialist	
Physical, Occupational, Speech Therapy		
	Co-pay per visit	
Routine Podiatry Service		
	Co-pay per visit	
Chiropractic Care		
	Co-pay per visit	
Diagnostic Tests, X-Rays, and Lab Services		
	Clinical/diagnostic lab service	
Outpatient Services		
	Facility co-pay at ambulatory surgical center	
	Facility co-pay per outpatient hospital facility visit	
Prescription Drugs		$1.20 or $3.70
Home Health Care		
	Co-pay per visit	
Durable Medical Equipment (DME)		
	Co-pay per item for Diabetic supplies	
	Co-pay per piece of equipment	
	Co-pay per prosthetic device	
Vision Services		
	Co-pay per Medicare covered eye exam	$0.00
	Co-pay per annual vision exam	$0.00
	Benefit for frames/lenses/contacts (every two years)	$200
Hearing Services		
	Co-pay for Medicare covered hearing exam	$0.00
	Co-pay for annual hearing exam	$0.00
	Hearing aid appliance benefit (every two years)	$1,500
Transportation *(24-one way trips to approved locations)*		$0.00
Dental		
	Annual benefit	$1,500

United Healthcare Dual Complete ONE SNP (HMO)

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 _____ ☐ ☐

Check with plan for over-the-counter benefits.