2018 Aetna HMO and PPO – Irwin Cherry – 267 789-7233

www.aetnamedicare.com

PLAN NAME	AETNA MEDICARE SILVER RX HMO	AETNA MEDICARE STANDARD RX HMO	AETNA PREMIER RX HMO	AETNA CHOICE RX HMO	AETNA MAIN LINE HEATH PRIME RX HMO	AETNA GOLD RX PPO
Monthly Premium	**$56.00**	**$102.00**	**$211.00**	**$0**	**$0**	**$156.00**
PCP REFERRALS REQUIRED	YES	YES	YES	YES	YES	N/A
Out of Pocket Cost	**$6,700**	**$6,700**	**$6,700**	**$6,700**	**$6,700**	**$4,500 In Network $7,500 for in and out o Network combined**
Annual Deductible for Medical Services	**$0**	**$0**	**$0**	***$1,050* for some Hospital and Medical Services**	**$0**	***$500.00* for some Hospital and Medical Services**
Primary Care Physician	$5	$30.00	$5	$20	$15.00 **Limited Hospital Network**	$5
Specialist Visit	$35	$40.00	$30.00	$45.00	$45.00	$25.00
Inpatient Hospital	195 (1-9 Days) **($1755)**	$195 (1-9 Days) **($1755)**	$220 (1-6 Days) **($1320)**	$550 Per Stay	$215 (1-9 Days) **($1935)**	$300.00 Per Stay 20% - Out of Network
Skilled Nursing Care Facility	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**
Outpatient Hospital/ Surgery	$220	$325	$300	$200 + 1050* Deduct.	$285	$195 + $500* Deduct.
Outpatient Ambulatory	$220	$325	$300	$200	$285	$195 + $500* Deduct

Lab Services/ X-ray	$10.00/$25.00	$50.00/$45.00	$25.00/$30.00	$35.00/$40.00	$0/$25.00	$0/$15.00
Urgent Care	$50.00	$60.00	$50.00	$50.00	$50.00	$50.00
Emergency Room	$80.00	$80.00	$80.00	$80.00	$80.00	$8000
World Wide Coverage	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US
Ambulance	$295.00 each one-way trip	$325.00 each one-way trip	$300.00 each one-way trip	$300.00 each one-way trip	$325.00 each one-way trip	$195.00 each one-way trip
Vision Services	**$0** One Routine Exam every year **$0 Copay - Contacts and Eye Glasses** **$125.00 Allowance* every year** ***ALLOWANCE MEANS AETNA PAYS YOU BACK**	**$0** One Routine Exam every year **Contacts and Eye Glasses** **Not Covered**	**$0** One Routine Exam every year **$0 Copay - Contacts and Eye Glasses $125.00 Allowance* every year** ***ALLOWANCE MEANS AETNA PAYS YOU BACK**	**$0** One Routine Exam every year **$0 Copay - Contacts and Eye Glasses** **$250.00 Allowance* every year** ***ALLOWANCE MEANS AETNA PAYS YOU BACK**	**$0** One Routine Exam every year **$0 Copay - Contacts and Eye Glasses** **$200.00 Allowance* every year**	**$0** In Network One Routine Exam every year **Contacts and Eye Glasses $150.00 Allowance* every year** ***ALLOWANCE MEANS AETNA PAYS YOU BACK**
Preventive Dental	**$0 Copay** for Oral Exam and **two** visits every year. Plan Pays up to **$500.00** for Preventive Dental Services every year	Preventive and Comprehensive **Dental Not Covered**	**$1,000** Allowance* every year for Preventive and Comprehensive Dental combined ***ALLOWANCE MEANS AETNA PAYS YOU BACK** Comprehensive Dental **Deductible $25.00**	**Not Covered**	**$750** Allowance* every year for Preventive and Comprehensive Dental combined ***ALLOWANCE MEANS AETNA PAYS YOU BACK** Comprehensive Dental **Deductible $25.00**	**$150** Allowance* every year ***ALLOWANCE MEANS AETNA PAYS YOU BACK**
Hearing Services/ Aids	**$0 Copay** for Routine Exam **once** a year. Plan offers a Hearing Aid Reimbursement of up to **$300.00** (both	**$0** One Routine Exam every year **Hearing Aids Not Covered**	**$0** One Routine Exam every year **$0 Copay - $300** (Both ears combined)	**$0** One Routine Exam every year **$0 Copay - $300** (Both ears combined) Allowance* every year ***ALLOWANCE MEANS**	**$0** One Routine Exam every year **$0 Copay - $300** (Both ears combined) Allowance* every	**$0** One Routine Exam every year **$0 Copay - $500** (Both ears combined) Allowance* every year ***ALLOWANCE MEANS**

	ears Combined) for Hearing Aids **once** a year		Allowance* every year ***ALLOWANCE MEANS AETNA PAYS YOU BACK**	**AETNA PAYS YOU BACK**	year ***ALLOWANCE MEANS AETNA PAYS YOU BACK**	**AETNA PAYS YOU BACK**
Fitness Benefit	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**
PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**						
RX Deductible	**NO Deductible**	**$75 Deductible for Tiers 3, 4, & 5 only**	**$0**	**$150 Deductible for Tiers 3, 4, & 5 only**	**$0**	**NO Deductible**
	Tier 1 Preferred/Standard **30** - $0/$10 **90**- $0/$30	**Tier 1 Preferred/Standard** **30** - $2/$10 **90**- $6/$30	**Tier 1 Preferred/Standard** **30** - $0/$10 **90**- $0/$30	**Tier 1 Preferred/Standard** **30** - $2/$10 **90**- $6/$30	**Tier 1 Preferred/Standard** **30** - $2/$10 **90**- $0/$30	**Tier 1 Preferred/Standard** **30** - $2/$10 **90**- $6/$30
	Tier 2 **30** - $5/$15 **90**- $15/$45	**Tier 2** **30** - $5/$15 **90**- $15/$45	**Tier 2** **30** - $5/$15 **90**- $15/$45	**Tier 2** **30** - $5/$15 **90**- $15/$45	**Tier 2** **30** - $5/$20 **90**- $15/$45	**Tier 2** **30** - $5/$15 **90**- $15/$45
	Tier 3 **30** - $42/$47 **90**- $126/$141	**Tier 3** **30** - $42/$47 **90**- $126/$141	**Tier 3** **30** - $42/$47 **90**- $126/$141	**Tier 3** **30** - $42/$47 **90**- $126/$141	**Tier 3** **30** - $42/$47 **90**- $126/$141	**Tier 3** **30** - $42/$47 **90**- $126/$141
	Tier 4 **30** - $100/$100 **90** - $300/$300	**Tier 4** **30** - $100/$100 **90**- $300/$300	**Tier 4** **30** - $100/$100 **90**- $300/$300	**Tier 4** **30** - $100/$100 **90**- $300/$300	**Tier 4** **30** - $100/$100 **90**- $300/$300	**Tier 4** **30** - $100/$100 **90**- $300/$300
	Tier 5 **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 31%/31% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 30%/30% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**

AETNA HMO AND PPO HEALTH PLANS

2018 ADVANTRA HMO & PPO COVENTRY HEALTH CARE (An Aetna Company) Irwin Cherry – 267 789-7233 www.coventry-medicare.com			
PLAN NAME	**ADVANTRA SILVER RX HMO**	**ADVANTRA GOLD RX PPO**	**ADVANTRAONE PPO**
Monthly Premium	**$45.00**	**$136.00**	**$19.00**
PCP REFERRALS REQUIRED	NO	NO	NO
Credit monthly to your Part B Premium	$0	$0	**$63.00**
Out of Pocket Cost – In Network	**$6,700**	**$6,700**	**$6,700**
Out of Pocket Cost – Out Network For in and out of network combined	**N/A**	**$10,000**	**$10,000**
Annual Deductible for Medical Services	**$0**	**$50 deductible** for some hospital and medical services	**$1,600 deductible** for some hospital and medical services
Primary Care Physician	**$25.00**	**$15.00**	**$35.00**
Specialist Visit	$50.00	$45.00	$50.00
Inpatient Hospital	$200 (1-9 Days) **($1800)**	$150 (1-5 Days) **($750)**	$360 (1-5 Days) **($1,800)**
Skilled Nursing Care Facility	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**
Outpatient Hospital	$390	$345	20%
Outpatient Ambulatory	$340	$295	20%
Lab Services/ X-Ray	$30/$30	$15/$15	$50/$60
Urgent Care	$60.00	$50.00	$60.00
Emergency Room	$80.00	$80.00	$80.00
Worldwide Coverage	**$80** for emergency and urgent care outside of the United States	**$80** for emergency and urgent care outside of the United States	**$80** for emergency and urgent care outside of the United States
Ambulance	**$285** for each one-way trip	**$225** for each one-way trip	**$325** for each one-way trip
Vision Services – Routine Eye Exam	**$0** One Routine Exam every year	**Network: EyeMed**	**$0 One** Routine Exam every year

Network: EyeMed **Vision Services – Routine Eye Exam**	Contacts and Eye Glasses – **NOT COVERED**	**$0 One** Routine Exam every year **$0 Copay** - Contacts and Eye Glasses – **$125 Allowance*** every year ***ALLOWANCE MEANS ADVANTRA PAY YOU BACK**	Contacts and Eye Glasses – **NOT COVERED**
Preventive Dental **Network: DenteMax**	Plan Offers Dental Reimbursement of up to **$150** for Preventive Dental Services every year	**Network: DenteMax** **$0 Copay – Oral Exam & Cleaning two visits every year.** ***Preventive Dental Deductible (Out of Network $100.00)**	**NOT COVERED**
Comprehensive Dental Services	**NOT COVERED**	**$1,000 allowance*** every year for Preventive and Comprehensive Dental Services. ***Comprehensive Dental Deductible (In Network $25.00)** ***Comprehensive Dental Deductible (Out Network $100.00)**	**NOT COVERED**
Hearing Services – Routine Hearing Exam	**$0** One Routine Exam every year. **Hearing Aids Not Covered**	**$0** One Routine Exam every year **Hearing Aids Not Covered**	**$0** One Routine Exam every year **Hearing Aids Not Covered**
Fitness Benefit	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**

PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**			
RX Deductible	**$150 Deductible for Tiers 4,5,&6**	**$0**	**$195 Deductible for Tiers 4,5,&6**
	Tier 1 **Preferred/Standard** **30** - $2/$10 **90**- $6/$30	**Tier 1** **Preferred/Standard** **30** - $0/$10 **90**- $0/$30	**Tier 1** **Preferred/Standard** **30** - $2/$10 **90**- $6/$30
	Tier 2 **30** - $5/$15 **90**- $15/$45	**Tier 2** **30** - $5/$15 **90**- $15/$45	**Tier 2** **30** - $5/$15 **90**- $15/$45
	Tier 3 **30** - $42/$47 **90**- $126/$141	**Tier 3** **30** - $42/$47 **90**- $126/$141	**Tier 3** **30** - $42/$47 **90**- $126/$141
	Tier 4 **30** - $100/$100 **90**- $300/$300	**Tier 4** **30** - $100/$100 **90**- $300/$300	**Tier 4** **30** - $100/$100 **90**- $300/$300
	Tier 5 **30** - 30%/30% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 29%/29% **90- N/A**

ADVANTRA HMO and PPO Health Plans

2018 Cigna Health Springs HMO - Michael Collins - 267 238-6038				
www.CignaHealthSpring.com				
PLAN NAME	**CIGNA HEALTHSPRING PREFERRED RX HMO**	**CIGNA HEALTHSPRING PREFERRED PLUS RX HMO**	**CIGNA HEALTHSPRING ADVANTAGE RX HMO MEDICAL ONLY**	**CIGNA HEALTHSPRING PREVENTIVE CARE RX HMO**
Monthly Premium	**$23.00**	**$139.00**	**$0**	**$0**
PCP REFERRALS REQUIRED	YES	YES	YES	YES
Out of Pocket Cost	**$6,700**	**$6,700**	**$6,700**	**$6,700**
Annual Deductible for Medical Services	**$147.00 Medical Services**	**$0**	**$0**	**$166 Medical Services**
Primary Care Physician	$0	$0	$5	$10
Specialist Visit	$40	$40.00	$40.00	$50.00
Inpatient Hospital	275 (1-6 Days) **($1,650)**	$225 (1-7 Days) **($1575)**	$295 (1-6 Days) **($1770)**	$1400 Per Stay
Skilled Nursing Care Facility	$0 Day 1-20 **$167.00 per day Days 21- 100**	$0 Day 1-20 **$167.00 per day Days 21- 100**	$0 Day 1-20 **$167.00 per day Days 21- 100**	$0 Day 1-20 **$167.00 per day Days 21- 100**
Outpatient Hospital/ Surgery	$400	$270	$400	30%
Outpatient Ambulatory	$195	$100	$150	$195
Lab Services/ X-Ray	$0/20%	$0/$10.00	$0/$20.00	$0/20%
Urgent Care	$55.00	$55.00	$55.00	$55.00
Emergency Room	$80.00	$80.00	$80.00	$80.00
World Wide Coverage	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US
Ambulance	$195.00 each one-way trip	$195.00 each one-way trip	$195.00 each one-way trip	$195.00 each one-way trip
Vision Services	**$0** One **Routine Exam** every year	**$0** One **Routine Exam** every year	**$0** One **Routine Exam** every year	**$0** One **Routine Exam** every year

	$0 Copay – Routine Eyewear (Eye Glasses – Lenses and Frames), Eye Glass Lenses, Eye Glass Frames, Contact Lenses, & Upgrades **Once every year** **$0 Copay** – Plan pays up to **$250.00 every year**	**$0 Copay – Routine Eyewear (Eye Glasses** – Lenses and Frames), Eye Glass Lenses, Eye Glass Frames, Contact Lenses, & Upgrades **Once every year** **$0 Copay** – Plan pays up to **$250.00 every year**	**$0 Copay – Routine Eyewear (Eye Glasses** – Lenses and Frames), Eye Glass Lenses, Eye Glass Frames, Contact Lenses, & Upgrades Once every **TWO** years **$0 Copay** – Plan pays up to **$100.00 every TWO years**	**$0 Copay – Routine Eyewear (Eye Glasses** – Lenses and Frames), Eye Glass Lenses, Eye Glass Frames, Contact Lenses, & Upgrades **Once every year** **$0 Copay** – Plan pays up to **$100.00 every year**
Preventive Dental	**$0 Copay** - **Oral Exam One** every **six months** **Cleaning – One** every **six months** **Bitewing X-ray One** every **six months** **Full Mouth & Panoramic X-ray One** every **36 months**	**$0 Copay** - **Oral Exam One** every **six months** **Cleaning – One** every **six months** **Bitewing X-ray One** every **six months** **Full Mouth & Panoramic X-ray One** every **36 months** **Comprehensive Dental Services** Restorative Services Periodontics Extractions Prosthodontics/Oral Surgery **$0 Copay** up to a Maximum Coverage amount of **$2,000** per year	**$40.00 Copay** Dental Services **(Medicare Covered)** ***Contact Cigna HealthSprings concerning Enhanced Dental – Preventative and Comprehensive Package - $12.60 per month**	**$50.00 Copay** Dental Services **(Medicare Covered)** ***Contact Cigna HealthSprings concerning Enhanced Dental – Preventative and Comprehensive Package - $12.60 per month**
Hearing Services/Aids	**$0 Copay-** Routine Exam **once** a year. **$20.00** Copay in **Specialist Office (Medicare Covered)** Hearing Aid Evaluation/Fitting **One every three years.** Hearing Aids **– One every three years.**	**$0 Copay-** Routine Exam **once** a year. **$20.00** Copay in **Specialist Office (Medicare Covered)** Hearing Aid Evaluation/Fitting **One every three years.** Hearing Aids **– One every three years.**	**$0 Copay-** Routine Exam **once** a year. **$20.00** Copay in **Specialist Office (Medicare Covered)** Hearing Aid Evaluation/Fitting **One every three years.** Hearing Aids **– One every three years.**	**$0 Copay-** Routine Exam **once** a year. **$20.00** Copay in **Specialist Office (Medicare Covered)** Hearing Aid Evaluation/Fitting **One every three years.** Hearing Aids **– One every**

	Plan pays up to **$700** per Ear per device **every three years**	Plan pays up to **$700** per Ear per device **every three years**	Plan pays up to **$700** per Ear per device **every three years**	**three years.** Plan pays up to **$700** per Ear per device **every three years**
Fitness Benefit	Contact any Cigna HealthSprings participating Fitness Center location	Contact any Cigna Health Springs participating Fitness Center location	Contact any Cigna HealthSprings participating Fitness Center location	Contact any Cigna HealthSprings participating Fitness Center location
PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**				
RX Deductible	**$280** Deductible **for Tiers 3, 4, 5 only**	**$280** Deductible **for Tiers 3, 4, & 5 only**	**NO PRESCRIPTION PLAN**	**$310** Deductible **for Tiers 3, 4, & 5 only**
30/60/90 Days	**Tier 1** **Preferred** $1/$2/$2 **Standard** $6/$12/$12	**Tier 1** **Preferred** $1/$2/$2 **Standard** $6/$12/$12		**Tier 1** **Preferred** $1/$2/$2 **Standard** $6/$12/$12
30/60/90 Days	**Tier 2** **Preferred** $10/$20/$20 **Standard** $15/$30/$30	**Tier 2** **Preferred** $8/$16/$16 **Standard** $13/$26/$26		**Tier 2** **Preferred** $10/$20/$20 **Standard** $15/$30/$30
30/60/90 Days	**Tier 3** **Preferred** $42/$84/$126 **Standard** $47/$94/$141	**Tier 3** **Preferred** $42/$84/$126 **Standard** $47/$94/$141		**Tier 3** **Preferred** $42/$84/$126 **Standard** $47/$94/$141
30/60/90 Days	**Tier 4** **Preferred** $90/$180/$270 **Standard** $95/$190/$285	**Tier 4** **Preferred** $90/$180/$270 **Standard** $95/$190/$285		**Tier 4** **Preferred** $90/$180/$270 **Standard** $95/$190/$285
30Days	**Tier 5** **Preferred/ Standard** **30 – 27%/27%** **90- N/A**	**Tier 5** **Preferred/ Standard** **30 – 27%/27%** **90- N/A**		**Tier 5** **Preferred/ Standard** **30 – 26%/26%** **90- N/A**

2018 Gateway Health HMO – Jhaisa Castillo 215 692-9838		
www.medicareassured.com **or** www.gatewayhealthplan.com		
PLAN NAME	**Health Medicare Assured SELECT RX HMO**	**Health Medicare Assured VALUE POS (POINT OF SERVICE) RX HMO**
Monthly Premium	**$0**	**$29.00**
PCP REFERRALS REQUIRED	**NO**	**NO**
Out of Pocket Cost	**$6,700**	**$6,700**
Annual Deductible for Medical Services	**NO**	**NO**
Primary Care Physician	$0	$0
Specialist Visit	$50.00	$40.00
Inpatient Hospital	$300 (1-6 Days) **($1800)**	$250 (1-6 Days) **($1,500)**
Skilled Nursing Care Facility	$0 Day 1-20 **$167.50 per day** **Days 21- 100**	$0 Day 1-20 **$167.50 per day** **Days 21- 100**
Chiropractor/Podiatry	$20.00/$50.00 Copay	$20.00/$40.00 Copay
Transportation	**NOT COVERED**	**NOT COVERED**
Vision Services	**NOT COVERED**	**NOT COVERED**
Preventive Dental	**$0 Copay for Cleaning and 1 Routine Exam every 6 Months.** **One Bitewing X-Ray per Side** **NO COMPREHENSIVE COVERAGE**	**$0 Copay for Cleaning and 1 Routine Exam every 6 Months.** **One Bitewing X-Ray per Side**
Hearing Services/ Aids	$**50.00 Copay** for Diagnostic Exam **ROUTINE HEARING EXAM NOT COVERED** **HEARING AIDS NOT COVERED**	**$25.00 In Network and $40.00 Out of Network Copay for** Diagnostic Hearing Exam **ROUTINE HEARING EXAM NOT COVERED** **HEARING AIDS NOT COVERED**
Fitness Benefit	**Health Club Membership and/or at Home Workout Kit Included with Plan Enrollment** **Silver Sneakers**	**Health Club Membership and/or at Home Workout Kit Included with Plan Enrollment** **Silver Sneakers**

Over the Counter Drugs	**$15.00 every 3 Months**	**$15.00 every 3 Months**
Diabetic Monitoring Supplies	**$0 copay** for Diabetes Self-Management Training, **20% Coinsurance** for Medicare Covered Diabetes Monitoring Supplies, Therapeutic Shoes or Inserts	**$0 copay** for Diabetes Self-Management Training, **20% Coinsurance** for Medicare Covered Diabetes Monitoring Supplies, Therapeutic Shoes or Inserts

PRESCRIPTION

TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750

Deductible	**$405**	**$250**
	Rx Generic/Brand/Specialty	**Rx Generic/Brand/Specialty**
	Tier 1 **Preferred** **30** - $0	**Tier 1** **Preferred** **30** - $0
	Tier 2 **30** - $15	**Tier 2** **30** - $15
	Tier 3 **30** - $47	**Tier 3** **30** - $47
	Tier 4 **30** - $100	**Tier 4** **30** - $100
	Tier 5 **30 - 25%**	**Tier 5** **30 - 28%**

GATEWAY MEDICARE ASSURED HMO HEALTH PLAN

2018 HealthPartners HMO – Burnett Jackson – 215 688-0897			
www.hpplans.com			
PLAN NAME	**HEALTHPARTNERS MEDICARE VALUE RX HMO**	**HEALTHPARTNERS MEDICARE PRIME RX HMO**	**HEALTHPARTNERS MEDICARE BASIC MEDICAL ONLY HMO**
Monthly Premium	**$0**	**$37.00**	**$0**
PCP REFERRALS REQUIRED	YES	YES	YES
Out of Pocket Cost	**$6,700**	**$6,700**	**$6,700**
Annual Deductible for Medical Services	**$0**	**$0**	**$0**
Primary Care Physician	$10.00	$0	$0
Specialist Visit	$50 **(No Referrals Needed)**	$45**(No Referrals Needed)**	$40 **(No Referrals Needed)**
Inpatient Hospital	$295 (1-6 Days) **$180 (Day 7) ($1770)**	$290 (1-6 Days) **($1740)**	$260 (1-7 Days) **($1820)**
Skilled Nursing Care Facility	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**
Outpatient Hospital	25%	$250	$250
Outpatient Ambulatory	$200	$175	$150
Lab Services/ X-Ray	$0/$35.00	$0/$30.00	$0/ $35.00
Diabetic Monitoring Supplies Test Strips, Monitors & Self - Management Training /Other Services	$0	$0/0-20%	$0
Urgent Care	$45.00	$45.00	$45.00
Emergency Room	$80.00	$80.00	$80.00
Ambulance	$200	$200	$200
Vision Services	**$0 One** Routine Exam a year **One** pair of Glasses/Contact Lenses every 2 years **($75.00 Limit)**	**$0 One** Routine Exam a year **1 Pair Eye Glasses /Contacts every 2 years ($260 Limit)**	**$0 One** Routine Exam a year

Preventive Dental	**NOT COVERED**	**$0 One** X-Ray, **One** Fluoride Treatment, and **2** Routine Exams/Cleanings a year. **Other Services** (**$800** Limit **after $50.00** Deductible)	**NOT COVERED**
Hearing Services/ Aids	**$0** One Routine Exam a year	**$0** One Routine Exam a year	**$0** One Routine Exam a year
Fitness Benefit	**$0 In Network**	**$0 In Network**	**$0 In Network**
PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**			
RX Deductible	**$350 Deductible for Tiers 3, 4, &5**	**$350 Deductible for Tier 3, 4, &5**	**NOT COVERED**
	Tier 1 **Preferred/Standard** **30** - $4	**Tier 1** **Preferred/Standard** **30** - $7	**NOT COVERED**
	Tier 2 **30** - $20	**Tier 2** **30** - $20	**NOT COVERED**
	Tier 3 **30** - $47	**Tier 3** **30** - $47	**NOT COVERED**
	Tier 4 **30 – 27%**	**Tier 4** **30 – 29%**	**NOT COVERED**
	Tier 5 **30 - 26%**	**Tier 5** **30 - 26%**	**NOT COVERED**

HEALTHPARTNERS HMO HEALTH PLAN

2018 Humana Health Plans HMO – Gus Grant – 610 246-7839				
www.humana.com/medicare				
PLAN NAME	**HUMANA GOLD PLUS RX HMO**	**HUMANA RX GREATER PHILADELPHIA HMO**	**HUMANA CHOICE RX GREATER PHILADELPHIA IN NETWORK PPO (H5525)**	**HUMANA CHOICE RX GREATER PHILADELPHIA OUTWORK PPO (H5525)**
Monthly Premium	**$0**	**$0**	**$77**	**$0**
PCP REFERRALS REQUIRED	YES	YES	NO	NO
Out of Pocket Cost	**$6,700**	**$6,700**	**$6,700**	**10,000 Combined**
Annual Deductible for Medical Services	**$0**	**$183**	**$1000 (Combined)**	**$1000 (Combined)**
Primary Care Physician	**$5.00**	**20%**	**$15**	**$5**
Specialist Visit	$45	20%	$45	$30
Inpatient Hospital	**$225** (1-7 Days) **($1575)**	**$600** (1-3 Days) **($1800)**	**$350** (1-5 Days) **($1750)**	$350 per admit
Skilled Nursing Care Facility	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**	$0 Day 1-20 **$167.50 per day Days 21- 100**
Outpatient Hospital	$225	20%	$350	$250
Outpatient Ambulatory	$175	20%	$300	30%
Lab In Network/Out Network	$0/$40.00	$0/20%	Labs ($0-$40)	30%
X-Rays In Network/Out Network	$5/$100.00	$0/20%	X-Rays ($15- $100)	30%
Urgent Care	$35	$35	$35	30%
Emergency Room	$80	$80	$80	$80
Ambulance	$265	20%	$265	$265

Vision Services	**$0** One Routine Exam every year Includes Refraction, up to **1** Year **$200** maximum benefit coverage Contacts and Eye Glasses / Lenses and Frames **(Includes Fittings)** Eye Glasses include Ultra Violet Protection and Scratch and Resistant Coating	**20%** Medicare Covered Vision Services **$0 Copay – Diabetic Eye Exam** **$0 Copay – Glaucoma Screening** **20% - Eyewear (Post-Cataract):** ***Humana concerning MyOption Vision Benefits Package - $15.35 per month**	**$40** Maximum Benefit Coverage amount per year for routine exam, refraction up to **1** per year. **$100** Maximum Benefit coverage amount per year for contact lenses or eye glasses – lenses and frames (include fitting). Eyeglasses will include ultra violet protection and scratch resistant coating.	**$40** Maximum Benefit Coverage amount per year for routine exam, refraction up to **1** per year. **$100** Maximum Benefit coverage amount per year for contact lenses or eye glasses – lenses and frames (include fitting). Eyeglasses will include ultra violet protection and scratch resistant coating.
Preventive Dental	**$0 Copay** for Bitewing X-Rays up to 1 set (s) per year. **$0 Copay** for Amalgam filling, Periodic Oral Exam or Comprehensive Oral Evaluation, Prophylaxis (Cleaning) up **to 1 per year** **$0** Copay for necessary Anesthesia with covered services up to **Unlimited per year** ***Humana concerning Optional Supplemental Dental Benefits Package - $25.20 per month**	**20%** Medicare Covered Dental Services. ***Humana concerning MyOption Platinum Dental Benefits Package - $22.10 per month**	**$45** Medicare Covered Dental **0%** Coinsurance for bitewing X-rays up to **1** set (s) per year. **$0** Coinsurance for Amalgam, Fillings, Periodic Oral Exam or Comprehensive Oral Evaluation, Prophylaxis (Cleaning) up to **1per year.** **$0** copayment for Necessary Anesthesia with covered service up to unlimited per year.	**$30** of Cost Medicare Covered Dental **50%** copayment for Amalgam, Fillings, Bitewing X-rays, Periodic Oral Exam or Comprehensive Oral Evaluation, Prophylaxis (Cleaning) up to **1per year.** **50%** copayment for Necessary Anesthesia with covered service up to unlimited per year.
Hearing Services/ Aids	**$0 Copay** for Routine Hearing Exams **up to 1 per year.** **$0 Copay 1**Fitting/Evaluation up to **3 per every year** **$499.00 Copay** for advance level hearing aid up to **1 per**	**20% Medicare Covered Hearing Exam Services.**	**$0** copayment for Routine Hearing Exam up to **1 per year.** **$0** copayment for fitting/evaluation up to **3 per year.** **$499** Copay for premium hearing aid up to **1 per Ear per year.**	**$0** copayment for Routine Hearing Exam up to **1 per year.** **$0** copayment for fitting/evaluation up to **3 per year.** **$499** Copay for premium hearing aid up to **1 per Ear per year.**

	Ear per year **$799.00** Copay for premium hearing aid purchase up to **1 per Ear per year** **NOTE:** Includes **48 batteries** per Aid and **3-year warranty**		**$799** copayment for premium hearing aid purchase up to **1 per Ear per year.** **Note:** Includes **48 batteries per aid and 3 year warranty.**	**$799** copayment for premium hearing aid purchase up to **1 per Ear per year.** **Note:** Includes **48 batteries per aid and 3 year warranty.** **TruHearing Provider must be used for In and Out-of-Network benefit hearing aid benefits**
Fitness Benefit	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**
PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**				
RX Deductible	**NO Deductible**	**NO Deductible**	**NO Deductible**	**NO Deductible**
	Tier 1 **Preferred/Standard** **30** - $7/$10 **90**- $21/$30	**Tier 1** **Preferred/Standard** **30** - $9/$10 **90**- $27/$30	**Tier 1** **Preferred/Standard** **30** - $7/$10 **90**- $21/$30	**Tier 1** **Preferred/Standard** **30** - $7/$10 **90**- $0/$30
	Tier 2 **30** - $17/$20 **90**- $51/$60	**Tier 2** **30** - $19/$20 **90**- $57/$60	**Tier 2** **30** - $17/$20 **90**- $51/$60	**Tier 2** **30** - $17/$20 **90**- $0/$60
	Tier 3 **30** - $47/$47 **90**- $141/$141	**Tier 3** **30** - $47/$47 **90**- $141/$141	**Tier 3** **30** - $47/$47 **90**- $141/$141	**Tier 3** **30** - $47/$47 **90**- $131/$131
	Tier 4 **30** – $100/$100 **90**- $141/$141	**Tier 4** **30** – $100/$100 **90**- $300/$300	**Tier 4** **30** – $100/$100 **90**- $141/$141	**Tier 4** **30** – $100/$100 **90**- $290/$300
	Tier 5 **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 26%/26% **90-N/A**	**Tier 5** 33%/33% **90-N/A**	**Tier 5** 33%/33% **90-N/A**

HUMANA HMO HEALTH HMO & PPO PLANS

2018 Humana Health Plans HMO – Gus Grant – 610 246-7839		
www.humana.com/medicare		
PLAN NAME	**HUMANA CHOICE RX GREATER PHILADELPHIA IN NETWORK PPO (H5216)**	**HUMANA CHOICE RX GREATER PHILADELPHIA OUTWORK PPO (H5216)**
Monthly Premium	**$147**	**$0**
PCP REFERRALS REQUIRED	NO	NO
Out of Pocket Cost	**$6,700**	**10,000 Combined**
Annual Deductible for Medical Services	**$0**	**$0**
Primary Care Physician	**$5**	**$5**
Specialist Visit	$30	$30
Inpatient Hospital	**$350** Plan covers an unlimited number of days for an inpatient stay	$350 per admit
Skilled Nursing Care Facility	$0 Day 1-20 **$167.50 per day** **Days 21- 100**	$0 Day 1-20 **$167.50 per day** **Days 21- 100**
Outpatient Hospital	$250	$250
Outpatient Ambulatory	$245	30%
Lab In Network/Out Network	$0-$40.00	$0-$40.00
X-Ray In Network/ Out Network	$5-$95	$5-$95
Urgent Care	$35	30%
Emergency Room	$80	$80
Ambulance	$265	$265

Vision Services	**$30** Medicare Covered Vision Services **$0** Copay for Diabetic Eye Exam **$0** Copay for Glaucoma Screening **$0** Copay Eyewear Post -Cataract **$40** Maximum Benefit coverage amount per year for ROUTINE EXAM, which includes Refraction, up to **1per year. (Visit any In-Network provider and the routine charge will not exceed the $40 maximum benefit coverage amount)** **$100** maximum benefit coverage amount per year for Contact Lenses or Eye Glasses and frames			**$30** of cost Medicare Covered Vision Services **$0** Copay for Diabetic Eye Exam **$0** Copay for Glaucoma Screening **$0** Copay Eyewear Post -Cataract **$40** Maximum Benefit coverage amount per year for ROUTINE EXAM, which includes Refraction, up to **1per year. (Visit any In-Network provider and the routine charge will not exceed the $40 maximum benefit coverage amount)** **$100** maximum benefit coverage amount per year for Contact Lenses or Eye Glasses and frames
Preventive Dental	**$30** Medicare Covered Dental **$0** copayment for Amalgam, Fillings, Periodic Oral Exam or Comprehensive Oral Evaluation, Prophylaxis (Cleaning) up to **1per year.** **$0** copayment for Necessary Anesthesia with covered service up to unlimited per year			**$30** of Cost Medicare Covered Dental **50%** copayment for Amalgam, Fillings, Bitewing X-rays, Periodic Oral Exam or Comprehensive Oral Evaluation, Prophylaxis (Cleaning) up to **1per year.** **50%** copayment for Necessary Anesthesia with covered service up to unlimited per year
Hearing Services/ Aids	**$0** copayment for Routine Hearing Exam up to **1 per year.** **$0** copayment for fitting/evaluation up to **3 per year.** **$399** Copay for premium hearing aid up to **1 per Ear per year.** **$699** copayment for premium hearing aid purchase up to **1 per Ear per year.** **Note:** Includes **48 batteries per aid and 3 year warranty.**			**$0** copayment for Routine Hearing Exam up to **1 per year.** **$0** copayment for fitting/evaluation up to **3 per year.** **$399** Copay for premium hearing aid up to **1 per Ear per year.** **$699** copayment for premium hearing aid purchase up to **1 per Ear per year.** **Note:** Includes **48 batteries per aid and 3 year warranty.** **TruHearing Provider must be used for In and Out –of-Network benefit hearing aid benefits**
Fitness Benefit			**Silver Sneakers**	**Silver Sneakers**

PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**		
RX Deductible	**NO Deductible**	**NO Deductible**
	Tier 1 **Preferred/Standard** **30** - $5/$10 **90**- $15/$30	**Tier 1** **Preferred/Standard** **30** - $5/$10 **90**- $15/$30
	Tier 2 **30** - $15/$20 **90**- $45/$60	**Tier 2** **30** - $15/$20 **90**- $0/$60
	Tier 3 **30** - $47/$47 **90**- $141/$141	**Tier 3** **30** - $47/$47 **90**- $131/$141
	Tier 4 **30** – $97/$100 **90**- $291/$300	**Tier 4** **30** – $97/$100 **90**- $281/$300

HUMANA HMO HEALTH HMO & PPO PLANS

2018 Keystone 65 HMO – Marily Rivera – 215 360-9140

www.ibxmedicare.com

PLAN NAME	KEYSTONE 65 BASIC RX HMO	KEYSTONE 65 SELECT 65 RX HMO	KEYSTONE 65 SELECT 65 HMO MEDICAL ONLY	KEYSTONE 65 PREFERRED 65 RX HMO	KEYSTONE 65 PREFERRED 65 RX HMO MEDICAL ONLY
Monthly Premium	**$0** Choice Program: **$6.00**	**$101.00** Choice Program: **$107.00**	**$66.00** Choice Program: **$72.00**	**$289.00**	**$224.00**
PCP REFERRALS REQUIRED	NO	NO	NO	NO	NO
Out of Pocket Cost	**$6,700**	**$5,500**	**$5,500**	**$4,000**	**$4,000**
Annual Deductible for Medical Services	**$475**	**$0**	**$0**	**$0**	**$0**
Primary Care Physician	**$15**	**$15**	**$15**	**$5**	**$5**
Specialist Visit	$50	$50	$45	$40	$40
Inpatient Hospital	$300 (1-6 Days) **($1800)**	$300 (1-6 Days) **($1800)**	$300 (1-6 Days) **($1800)**	$250 (1-6 Days) **($1,500)**	$250 (1-6 Days) **($1,500)**
Skilled Nursing Care Facility	$0 Day 1-20 **$165.00 per day Days 21- 100**	$0 Day 1-20 **$165.00 per day Days 21- 100**	$0 Day 1-20 **$165.00 per day Days 21- 100**	$0 Day 1-20 **$150.00 per day Days 21- 100**	$0 Day 1-20 **$150.00 per day Days 21- 100**
Outpatient Hospital	$350	$400	$400	$400	$400
Outpatient Ambulatory	$200	$200	$200	$125	$125
Labs/X-Rays	$0/$75	$0/$75	$0/$75	$0/$40	$0/$40
Urgent Care	**$40** In Network Center **$15** for Retail Clinic	**$40** In Network Center **$15** for Retail Clinic	**$40** In Network **$15** for Retail Clinic	**$40** In Network **$5** for Retail Clinic	**$40** In Network **$5** for Retail Clinic
Emergency Room	$80	$80	$80	$75	$75
Ambulance	$300 One Way Trip	$250 One Way Trip	$250 One Way Trip	$150 One Way Trip	$150 One Way Trip
World Wide Coverage	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US	**$80** for Emergent and Urgent Care outside of US
Vision Services	**Available with Choice Program** **$50 Copay** for Medicare	**Available with Choice Program** **$45 Copay** for Medicare	**Available with Choice Program** **$45 Copay** for Medicare	**Included with Preferred: $40** copay for a Routine Eye Exam and up to **$100**	**Included with Preferred: $40** copay for a Routine

	covered eye exam to diagnose and treat of the eye. **$0 Copay for Glaucoma Screening** **$0 Copay** for Medicare Covered eyeglasses or contact lenses after cataract surgery **Routine** (non-Medicare-covered eye exams and eyewear are available with the **CHOICE PROGRAM**	covered eye exam to diagnose and treat of the eye. **$0 Copay Diabetic Retinal Exam** **$0 Copay for Glaucoma Screening** **$0 Copay** for Medicare Covered eyeglasses or contact lenses after cataract surgery **Routine** (non-Medicare-covered eye exams and eyewear are available with the **CHOICE PROGRAM**	covered eye exam to diagnose and treat of the eye. **$0 Copay Diabetic Retinal Exam** **$0 Copay for Glaucoma Screening** **$0 Copay** for Medicare Covered eyeglasses or contact lenses after cataract surgery **Routine** (non-Medicare-covered eye exams and eyewear are available with the **CHOICE PROGRAM**	allowance for eyewear every **2 years.**	Eye Exam and up to **$100** allowance for eyewear every **2 years.**
Preventive Dental	**Available with Choice Program** **$50 Copay** for Non-Routine Medicare-Covered dental services in a specialist office. **$0 Copay** for non-routine Medicare-Covered dental services in an inpatient facility. **Routine** dental services are available with the **CHOICE PROGRAM**	**Available with Choice Program** **$45 Copay** for Non-Routine Medicare-Covered dental services in a specialist office. **$0 Copay** for non-routine Medicare-Covered dental services in an inpatient facility. **Routine** dental services are available with the **CHOICE PROGRAM**	**Available with Choice Program** **$45 Copay** for Non-Routine Medicare-Covered dental services in a specialist office. **$0 Copay** for non-routine Medicare-Covered dental services in an inpatient facility. **Routine** dental services are available with the **CHOICE PROGRAM**	**Included with Preferred:** **$20** copay for Dental Exam and Cleaning **once every 6 months**	**Included with Preferred:** **$20** copay for Dental Exam and Cleaning **once every 6 months**
Hearing Services/ Aids	**Available with Choice Program** **$50 Copay** for Medicare Covered Hearing Exams. Hearing Aids and Routine (Non-Medicare-Covered)	**Available with Choice Program** **$45 Copay** for Medicare Covered Hearing Exams. Hearing Aids and Routine (Non-Medicare-Covered)	**Available with Choice Program** **$45 Copay** for Medicare Covered Hearing Exams. Hearing Aids and	**Included with Preferred:** **$40** Copay for a Routine Hearing Exam **every year.** Hearing Aid benefit of **$699.00 or $999.00** per **Hearing Aid (One per ear/per year)** Provided	**Included with Preferred:** **$40** Copay for a Routine Hearing Exam **every year.** Hearing Aid benefit of **$699.00 or**

	hearing exams are available with the **CHOICE PROGRAM**	hearing exams are available with the **CHOICE PROGRAM**	Routine (Non-Medicare-Covered) hearing exams are available with the **CHOICE PROGRAM**	through **TruHearing**	**$999.00** per **Hearing Aid (One per ear/per year))** Provided through **TruHearing**
Fitness Benefit	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**
PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**					
RX Deductible	**$300 Deductible for Tiers 3,4, &5 only**	**NO Deductible**	**NOT COVERED**	**No Deductible**	**NOT COVERED**
30/60/90 Days	**Tier 1 Preferred** $3/$6/$9 **Standard** $9/$18/$27	**Tier 1 Preferred** $3/$6/$9 **Standard** $9/$18/$27	**NOT COVERED**	**Tier 1 Preferred/Standard** **30** - $2/$7	**NOT COVERED**
30/60/90 Days	**Tier 2 Preferred** $12/$24/$36 **Standard** $18/$36/$54	**Tier 2 Preferred** $12/$24/$36 **Standard** $18/$36/$54	**NOT COVERED**	**Tier 2** **30** - $10/$16	**NOT COVERED**
30/60/90 Days	**Tier 3 Preferred** $47/$94/$141 **Standard** $47/$94/$141	**Tier 3 Preferred** $47/$94/$141 **Standard** $47/$94/$141	**NOT COVERED**	**Tier 3** **30** - $47/$47	**NOT COVERED**
30/60/90 Days	**Tier 4 Preferred** $100/$200/$300 **Standard** $100/$200/$300	**Tier 4 Preferred** $100/$200/$300 **Standard** $100/$200/$300	**NOT COVERED**	**Tier 4** **30** - $100/$100	**NOT COVERED**
30/60/90 Days	**Tier 5 Preferred** 27%/27%/27% **Standard** 27%/27%/27%	**Tier 5 Preferred** 33%/33%/33% **Standard** 33%/33%/33%	**NOT COVERED**	**Tier 5** **30** - 33%/33%	**NOT COVERED**

2018 Keystone 65 Focus RX HMO – Marilee Rivera – 215 360-9140	
www.ibxmedicare.com	
PLAN NAME	**KEYSTONE 65** **FOCUS RX HMO**
Monthly Premium	**$35.00** Choice Program**: $41.00**
PCP REFERRALS REQUIRED	YES
Out of Pocket Cost	**$6,700**
Annual Deductible for Medical Services	**$0**
Primary Care Physician	$10
Specialist Visit	$40
Inpatient Hospital	$210 (1-6 Days) **($1260)**
Skilled Nursing Care Facility	$0 Day 1-20 **$164.00 per day** **Days 21- 100**
Chiropractic/Podiatry	**$20/$40** **(Up to 6 visits per year)**
Outpatient Hospital	$350
Outpatient Ambulatory	$200
Labs/X-Rays	$0/$45
Urgent Care	**$40** In Network **$10** for Retail Clinic
World Wide Coverage	**$80** for Emergent and Urgent Care outside of US
Emergency Room	**$80**
Ambulance	$275 One Way Trip
Vision Services	**Available with Choice Program** **$40 Copay** for Medicare covered eye exam to diagnose and treat of the eye. **$0 Copay Diabetic Retinal Exam** **$0 Copay for Glaucoma Screening** **$0 Copay** for Medicare Covered eyeglasses or contact lenses after cataract surgery **Routine** (non-Medicare-covered eye exams and eyewear are available with the **CHOICE PROGRAM**
Preventive Dental	**Available with Choice Program**

	$40 Copay for Non-Routine Medicare-Covered dental services in a specialist office. **$0 Copay** for non-routine Medicare-Covered dental services in an inpatient facility. **Routine** dental services are available with the **CHOICE PROGRAM**
Hearing Services/ Aids	**Available with Choice Program** **$40 Copay** for Medicare Covered Hearing Exams. Hearing Aids and Routine (Non-Medicare-Covered) hearing exams are available with the **CHOICE PROGRAM**
Fitness Benefit	**Silver Sneakers**
PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**	
RX Deductible	**$200 Deductible for Tiers 3, 4, & 5**
30/60/90 Days	**Tier 1** **Preferred** $2/$4/$6 **Standard** $7/$14/$21
30/60/90 Days	**Tier 2** **Preferred** $15/$30/$45 **Standard** $20/$40/$60
30/60/90 Days	**Tier 3** **Preferred** $47/$94/$141 **Standard** $47/$94/$141
30/60/90 Days	**Tier 4** **Preferred** $100/$200/$300 **Standard** $100/$200/$300
30/60/90 Days	**Tier 5** **Preferred** 29%/29%/29% **Standard** 29%/29%/29%

2018 Keystone 65 Personal Choice PPO – Marilee Rivera – 215 360-9140	
www.ibxmedicare.com	
PLAN NAME	**KEYSTONE 65** **PERSONAL CHOICE RX** **PPO**
Monthly Premium	**$160.00**
PCP REFERRALS REQUIRED	NO
Out of Pocket Cost – In Network	**$6,200**
Out of Pocket Cost – Out Network	**$10,000**
Primary Care Physician	**$15.00-** up to 30% higher Out Network
Specialist Visit	**$40.00** – up to 30% higher Out Network
Inpatient Hospital	**$300** (1-6 Days) **($1800)**
Skilled Nursing Care Facility	$0 Day 1-20 **$165.00 per day** **Days 21- 100**
Outpatient Hospital	**$400-** up to 30% higher Out Network
Outpatient Ambulatory	**$200 -** up to 30% Out Network
Labs/X-Ray	$0/$50 - Out of Network 30%
Chiropractic/Podiatry	**$20/$40 In Network** Up to 30% /30% **Out Network** Up to 6 visits per year for each service
Ambulance	**$175**
Urgent Care	**$40** In Network **$15** for Retail Clinic
Emergency Room	$80.00
Vision Services	**Not Covered**
Preventive Dental	**Not Covered**
Hearing Services/ Aids	**$40** Copay for a Routine Hearing Exam **every year.** Hearing Aid benefit of **$699.00 or $999.00** per **Hearing Aid (One per ear/per year)** Provided through **TruHearing**
Fitness Benefit	**Silver Sneakers**

PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**	
RX Deductible	**$400 Deductible for Tiers 3,4, &5 Only**
	Tier 1 **Preferred/Standard** **30** - $3/$9
	Tier 2 **30** - $12/$18
	Tier 3 **30** - $47/$47
	Tier 4 **30** – $100/$100
	Tier 5 **30** - 25%/25%

KEYSTONE 65 PERSONAL CHOICE PPO HEALTH

2018 UPMC FOR LIFE MEDICARE ADVANTAGE PLANS HMO & PPO
Kim Harvey – 267 315-5074

www.upmchealthplan.com/medicare

PLAN NAME	UPMC FOR LIFE DEDUCTIBLE RX HMO	UPMC FOR LIFE RX HMO
Monthly Premium	**$0**	**$81.00**
PCP REFERRALS REQUIRED	**NO**	**NO**
Out of Pocket Cost	**$5,500**	**$4,000**
Annual Deductible for Medical Services	**$750.00 (For Applicable Services)**	**$0**
Primary Care Physician	$10.00	$5.00
Specialist Visit	$45.00	$35.00
Inpatient Hospital	$250 (1-5 Days) **(After Deductible) ($1250)**	$250 (1-5 Days) **($1250)**
Skilled Nursing Care Facility	$0 Day 1-20 **$160.00 per day Days 21- 100**	$0 Day 1-20 $160.00 per day Days 21- 100
Outpatient Hospital	$125	$250
Outpatient Ambulatory	$125 **(After Deductible)**	$250 per surgery
Lab Services	$0 to $10 per day per facility	$0/$5 per day per facility
X-Ray	$10.00 per service **(After Deductible)**	$40.00 per service
Urgent Care	$50.00	$50.00
Emergency Room	$80.00	$80.00
Assist America – Emergency Travel Coverage	**$0 800 872-1414 609 986-1234 – Collect Number out of United States www.assistamerica.com**	**$0 800 872-1414 609 986-1234 – Collect Number out of United States www.assistamerica.com**
Ambulance	**$100** for each one-way trip	**$200** for each one-way trip
Vision Services	**$0 Copay** for **One** Routine Exam every **two** years. **$150.00 Allowance** for Contact Lenses and Eye Wear every **two** years	**$0 Copay** for **One** Routine Exam every **two** years. **$175.00 Allowance** for Contact Lenses and Eye Wear every **two** years

Preventive Dental	**$15 Copay** for one **Oral Exam and Cleaning every six months.** **$15 Copay** for **One Bitewing X-Ray per** year.	**$15 Copay** for one **Oral Exam and Cleaning every six months.** **$15 Copay** for **One Bitewing X-Ray per** year.
Hearing Services – Routine Hearing Exam	**$50 Medicare –Covered Hearing Exam** **Routine Hearing Services are NOT COVERED**	**$50 Medicare –Covered Hearing Exam** **Routine Hearing Services are NOT COVERED**
Fitness Benefit	**Silver & Fit**	**Silver & Fit**
RX Deductible	NO	**NO**
	Tier 1 **Preferred/Standard** **30** - $0/$0 **90**- $9/$27	**Tier 1** **Preferred/Standard** **30** - $0/$0 **90**- $9/$27
	Tier 2 **30** - $10/$30 **90**- $16/$48	**Tier 2** **30** - $10/$30 **90**- $16/$48
	Tier 3 **30** - $42/$126 **90**- $47/$141	**Tier 3** **30** - $42/$126 **90**- $47/$141
	Tier 4 **30** - $95/$285 **90**- $100/$300	**Tier 4** **30** - $95/$285 **90**- $100/$300
	Tier 5 **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**

UPMC FOR LIFE HMO HEALTH PLANS

DELAWARE COUNTY MEDICARE SPECIAL NEEDS HEALTH PLANS FOR PEOPLE WITH MEDICARE AND MEDICAID OR THE EXTRA HELP/ MEDICARE SAVINGS PROGRAMS

2018 ADVANTRA Special Needs Plans (SNP) COVENTRY HEALTH CARE (An Aetna Company) Irwin Cherry – 267 789-7233	
www.coventry-medicare.com	
PLAN NAME	**ADVANTRA CARES RX HMO SNP Must Have Medicare and Medicaid**
Monthly Premium	**$0 or $27.80**
PCP REFERRALS REQUIRED	NO
Out of Pocket Cost – In Network	**$6,700**
Annual Deductible for Medical Services	**$0 or $140** deductible for some hospital and medical services
Primary Care Physician	**$0 or 20%**
Specialist Visit	**$0 or 20%**
Inpatient Hospital	**$0 per stay** or **$820 Inpatient Deductible**
Skilled Nursing Care Facility	**$0** or **$0** per days 1-20 **$167.50 per day - Days 21- 100**
Outpatient Hospital	**$0 or 20%**
Outpatient Ambulatory	**$0 or 20%**
Lab Services/ X-Ray	**0%/$0 or 20%**
Urgent Care	**$0 or 20% ($65 Maximum per visit)**
Emergency Room	**$0 or 20% ($80 Maximum per visit)**
Worldwide Coverage	**20%** for emergency and urgent care outside of the United States
Ambulance	**$0** or **20%** each one-way trip
Vision Services – Routine Eye Exam	**$0 Copay** One Routine Exam **every year** $0 Copay - Contacts and Eye Glasses –*** $100** allowance **every year** ***ALLOWANCE MEANS ADVANTRA PAYS YOU BACK** **NETWORK: EyeMed**
Preventive Dental	**NETWORK: DenteMax** **DenteMax will manage your dental benefits. To locate a network provider you may contact Customer Service or search the online directory.** *** $1,000** allowance every year for preventive and comprehensive dental combined

	***ALLOWANCE MEANS ADVANTRA PAY S YOU BACK** $0 Copay for Oral Exam and Cleaning **yearly** 1-4 Bitewing X-Ray per **year** **Panoramic X-Rays and Not Covered** Fillings - Covered
Hearing Services – Routine Hearing Exam	**$0** One Routine Exam every **year** **Hearing AIDS Not Covered** **0% – 20% Medicare Covered Hearing Exam**
Fitness Benefit	**Silver Sneakers**
Nonemergency Transportation Benefit	**24** One-way trips every year
Meals	**14** Home Delivered meals after an inpatient discharge
OTC	**$25** Maximum Benefit every month
RX Deductible	**Deductible $0-$83**
For Generic Drugs (Including Brand Drugs Treated as Generic)	Either **$0, or $1.25, or $3.35 per prescription** **OR** **For all other drugs: Either $0, or $3.70, or $8.35 per prescription**

ADVANTRA CARES SPECIAL NEEDS (SNP) HEALTH PLAN

2018 Cigna Health Springs Special Needs Plan (SNP) HMO - Michael Collins - 267 238-6038		
www.CignaHealthSpring.com		
PLAN NAME	**CIGNA HEALTHSPRING ACHIEVE RX (SNP) HMO** **MUST BE DIAGNOSED WITH DIABETES MELLITUS**	**CIGNA HEALTHSPRING TOTALCARE (SNP) RX HMO** **MUST HAVE FULL MEDICARE AND MEDICAID**
Monthly Premium	**$58.00**	**$0-$29.00**
PCP REFERRALS REQUIRED	YES	YES
Out of Pocket Cost	**$6,700**	**$6,700**
Annual Deductible for Medical Services	**$147.00 Medical Services**	20% **$0-$3.80 With Full Medicaid**
Primary Care Physician	$0	$50 **$0-$3.80 With Full Medicaid**
Specialist Visit	$40	$40.00
Inpatient Hospital	$275 (1-6 Days) **($1,650)**	$295 (1-6 Days) **($1770)** **$3 per day or $21 per admission With Full Medicaid**
Skilled Nursing Care Facility	$0 Day 1-20 **$167.00 per day** **Days 21- 100**	$0 Day 1-20 **$167.00 per day** **Days 21- 100**
Outpatient Hospital/ Surgery	$400	$0
Outpatient Ambulatory	$195	$0 or 20% **Coinsurance** **$0-$3.80 With Full Medicaid**
Lab Services/ X-Ray	$0/20%	$0
Urgent Care	$55.00	$0
Emergency Room	$80.00	$0
World Wide Coverage	**$80** for Emergent and Urgent Care outside of US	$0
Ambulance	$195.00 each one-way trip	$0
Transportation	$0 Copay for up to 40 one-way to plan approved locations every year. **LIFTS** Transportation Services can be ordered	$0 for Unlimited Trips every year **LIFTS** Transportation Services can be ordered

Vision Services	**$0** One **Routine Exam** every year **$0 Copay – Routine Eyewear** **(Eye Glasses** – Lenses and Frames), Eye Glass Lenses, Eye Glass Frames, Contact Lenses, & Upgrades **Once every year** **$0 Copay** – Plan pays up to **$250.00 every year**	**$0** One **Routine Exam** every year **$400.00 Allowance for Routine Eyewear every year. (Same with Full Medicaid)**
Preventive Dental	**$0 Copay - Oral Exam One** every **six months** **Cleaning – One** every **six months** **Bitewing X-ray One** every **six months** **Full Mouth & Panoramic X-ray One** every **36 months**	**Preventive and Comprehensive; $2,000** Maximum for comprehensive **every year (Same with Full Medicaid)**
Hearing Services/Aids	**$0 Copay-** Routine Exam **once** a year. **$20.00** Copay in **Specialist Office (Medicare Covered)** Hearing Aid Evaluation/Fitting **One every three years.** Hearing Aids **– One every three years.** Plan pay up to **$700** per Ear per device **every three years**	**$0 Copay** for one hearing test every**; $700.00** Allowance per Ear per device **every 3 years. (Same with Full Medicaid)**
Fitness Benefit	Contact any Cigna HealthSprings participating Fitness Center location	**Contact any Cigna Health Springs participating Fitness Center location**
RX Deductible	**$280** Deductible **for Tiers 3, 4, 5 only**	**NO** Deductible
30/60/90 Days	**Tier 1** **Preferred** $1/$2/$2 **Standard** $6/$12/$12	**Tier 1** **$1.10 – $3.80**
30/60/90 Days	**Tier 2** **Preferred** $10/$20/$20 **Standard** $15/$30/$30	**Tier 2** **$1.10 – $3.80**

30/60/90 Days	**Tier 3** **Preferred** $42/$84/$126 **Standard** $47/$94/$141	**Tier 3** **$1.10 – $3.80**
30/60/90 Days	**Tier 4** **Preferred** $90/$180/$270 **Standard** $95/$190/$285	**Tier 4** **$1.10 – $3.80**
30Days	**Tier 5** **Preferred/ Standard** **30 – 27%/27%** **90- N/A**	**Tier 5** **$1.10 – $3.80**

Cigna HealthSprings Achieve & Total Care RX HMO (SNP) Plans

2018 Gateway Health HMO Special Needs Plan (SNP) – Jhaisa Castillo - 215 692-9838 Must have Medicare and Medicaid or Medicare Savings Program or Extra Help Program		
www.gatewayhealthplan.com		
PLAN NAME	**HEALTH MEDICARE ASSURED DIAMOND RX HMO SNP MEDICARE AND MEDICAID**	**HEALTH MEDICARE ASSURED RUBY RX HMO SNP MEDICARE AND MEDICAID/ * EXTRA HELP PROGRAM**
Monthly Premium	**$0**	**$0-$37.20*** ***Based on Level of Extra Help Program**
PCP REFERRALS REQUIRED	**NO**	**NO**
Out of Pocket Cost	**$3,400**	**$6,700**
Annual Deductible for Medical Services	**NO**	**NO**
Primary Care Physician	$0	$0
Specialist Visit	$0	$0-$35.00
Inpatient Hospital	**$ 0** (1-90 Days)	$0 (1-5 Days) **OR** $**275** Copay Per Day **($1,375)** **$0 Copay Per Day - (Days 6-90)**
Skilled Nursing Care Facility	$0 Day 1-20 **$167.50 per day** **Days 21- 100**	$0 Day 1-20 **$167.50 per day** **Days 21- 100**
Chiropractor/Podiatry	$0/20% copay	$0-$20 /$0 or $35 copay
Transportation	Up to **36** one-way trips per year **LIFTS** Transportation Services can be ordered	Up to **24** one-way trips per year **LIFTS** Transportation Services can be ordered
Vision Services	**$ 150** towards eyewear per year **4** Exams per year	**$ 100** towards eyewear per year **4** Exams per year
Preventive Dental	**$0 Copay** for **one Routine Exam, Cleaning, and Bitewing X-Ray per side'** **$3,000** total dental benefits every **year** Inclusive of **$500** benefits towards Dentures	**$0 copay** for Cleaning and Routine Exam every **6 Months**

Hearing Services/ Aids	**$0 copay** Testing, Exams, and Fitting Hearing Aids **$1500** every **2 years**	**$0 copay** Testing, Exams, and Fitting Hearing Aids **$750** every **2 years**
Over the Counter Drugs (No Cough/Cold Medicine)	**$200 per quarter (With Rollover)**	**$40 per quarter (With Rollover)**
Post Discharged Meals	**UP to 10 Meals**	**NOT COVERED**
Life (Medical Alert Response System) Phillips Company	**COVERED**	**NOT COVERED**
PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**		
RX Generic/All Other Drugs	**$0-$3.35 or $0-$8.35 or 15% of the cost*** ***Based on Level of Extra Help Program**	**$0-$3.35 or $0-$8.35 or 15% of the cost*** ***Based on Level of Extra Help Program**
Fitness Benefit	**Silver Sneakers** **Health Club Membership and/or at Home Workout Kit Included with Plan Enrollment**	**Silver Sneakers** **Health Club Membership and/or at Home Workout Kit Included with Plan Enrollment**

GATEWAY MEDICARE DIAMOND AND RUBY HMO SPECIAL NEEDS (SNP) HEALTH PLAN

2018 HealthPartners HMO Special Needs Plan (SNP) Burnett Jackson – 215 688-0897	
www.hpplans.com	
PLAN NAME	**HEALTHPARTNERS** **SPECIAL RX** **HMO SNP** **Must Have Medicare and Medicaid**
Monthly Premium	**$0 or $37.00**
PCP REFERRALS REQUIRED	YES
Out of Pocket Cost – In Network	**$6,700**
Annual Deductible for Medical Services	**$183** (This Number may change for 2018)
Primary Care Physician	**$0 or 20%**
Specialist Visit	**$0 or 20%**
Inpatient Hospital (Unlimited Days)	**$0 copay or Original Medicare Cost Sharing**
Skilled Nursing Care Facility	**$0** days 1-20 **$167.50 per day - Days 21- 100**
Outpatient Hospital	**$0 or 20%**
Outpatient Ambulatory	**$0 or 20%**
Lab Services/X-Ray	**$0 or 20%**
Urgent Care	**$0 or 20% (Up to $65)**
Emergency Room	**$0 or 20% (Up to $80)**
Diabetes Test Strips, Monitors & Self-Monitoring Training/ Other Diabetic Supplies	**$0 or 20%**
Ambulance	**$0** or **20%**
Vision Services	**$0** for **1**Routine Exam **yearly** **1 pair** Contacts and/or Eye Glasses **every year ($200 limit)**
Preventive Dental	**$0** for **1** X-Ray, 1 Fluoride Treatment and **2** Exams/Cleanings **yearly** Other Services: (**$1000 Limit)**
Hearing Services	**$0** for Routine Exam **yearly: Hearing Aids every 3 years** **(1000 limit)**

Fitness Benefit	**$0 In Network**
	PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**
RX Deductible	**NO Deductible**
Prescription Drugs	**Generic: $0/ or $1.25/ or $3.35/ 15%** **OR** **Other Drugs: $0/ or $3.70/ or $8.35/ or 15%**

HEALTHPARTNERS SPECIAL NEEDS HEALTH PLAN (SNP)

2018 Humana HMO Special Needs Plan (SNP) Gus Grant – 610 246-7839	
www.humana.com/medicare	
PLAN NAME	**HUMANA** **GOLD PLUS RX** **HMO SNP** **MUST HAVE MEDICARE AND MEDICAID**
Monthly Premium	**$0**
PCP REFERRALS REQUIRED	YES
Out of Pocket Cost – In Network	**$6,700**
Annual Deductible for Medical Services	**$0**
Primary Care Physician	**$0**
Specialist Visit	**$0**
Inpatient Hospital	**$0**
Skilled Nursing Care Facility	**$0** **Plans covers up to 100 days in a Skilled Nursing Facility**
Outpatient Hospital	**$0**
Outpatient Ambulatory	**$0**
Lab Services/X-Ray	**$0/$0**
Urgent Care	**$0**
Emergency Room	**$0**
Diabetes Test Strips, Monitors & Self-Monitoring Training/ Other Diabetic Supplies	No Limits **$0 copay** for children under **18 years** of age **Sliding Scale Fee** from **$0.65 - $3.80** for individuals **18 years of** age and older
Ambulance	**$0**
Vision Service	**$0** Routine Exam, Refraction up to 1 year. **$0** Copay for: **Diabetic Eye exams, Glaucoma Screening, Eyewear (Post Cataract)** **$200** maximum benefit coverage Contacts and Eye Glasses / Lenses and Frames. **Medicaid: Sliding scale copay from $0.65 - $3.80 for individuals 18 years of age and up.**
Preventive Dental	**$0** copayment for Panoramic film or diagnostic x-ray up to 1 every 5 years' **$0** coinsurance for bitewing x-ray up to 1 set per year.

	$0 coinsurance for amalgam or composite filling, extraoral x-rays, intraoral x-rays up to 1 per year. **$0** coinsurance for emergency diagnostic exam, emergency treatment for pain, fluoride treatment, periodic oral exam and/or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year $0 coinsurance for extractions up to unlimited per year. **Medicaid: Sliding scale copay from $0.65 - $3.80 for individuals 18 years of age and up.**
Hearing Services	**$0** for Routine Hearing Test for fitting/evaluation for hearing aid up to **1 year.** **Medicaid: Sliding scale copay from $0.65 - $3.80 for individuals 18 years of age and up.**
Fitness Benefit	**$0 Silver Sneakers**
	PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**
RX Deductible	**Deductible $0**
Prescription Drugs	**30 Days - For Generic Drugs (Including brand drugs treated as generics: $**0/ or $1.25/ or $3.35 **OR** **Other Drugs**: $0/ or $3.70/ or $8.35 **90 Days - For Generic Drugs (Including brand drugs treated as generics:** $0/ or $1.25/ or $3.35 **OR** **Other Drugs:** $0/ or $3.70/ or $8.35 Specialty Drugs are limited to **30-day supply**

HUMANA GOLD PLUS SPECIAL NEEDS (SNP) HEALTH PLAN

2018 Keystone VIP Choice Special Needs Plan (SNP) John Kearney – 267 212-3628	
www.keystonefirstvipchoice.com	
PLAN NAME	**KEYSTONE VIP** **CHOICE RX** **HMO SNP** **MUST HAVE MEDICARE AND MEDICAID**
Monthly Premium	**$0**
PCP REFERRALS REQUIRED	NO
Out of Pocket Cost	**$3,400**
Annual Deductible for Medical Services	**$0**
Primary Care Physician	**$0**
Specialist Visit	**$0**
Inpatient Hospital	**$0**
Skilled Nursing Care Facility	**$0 - Pay 100 days in a SNF** – Prior authorization required
Outpatient Hospital	**$0**
Outpatient Ambulatory	**$0**
Lab Services/X-Ray	**$0/$0**
Urgent Care	**$0**
Emergency Room	**$0**
Chiropractic/Podiatry	**$0//$0**
Diabetes Test Strips, Monitors & Self-Monitoring Training/ Other Diabetic Supplies	No Limits **$0 copay** for children under **18 years** of age **Sliding Scale Fee** from **$0.65 - $3.80** for individuals **18 years of** age and older
Ambulance	**$0**
Transportation	**$0** for up to **30 one-way trip(s)** to plan- approved locations **every year**
Vision Services	**$0 Medicare - Covered Exam to diagnose and treat diseases and conditions of the eye (Including yearly glaucoma screening):** **$0 Routine Eye Exam** for up to **1 every year** **$200 every two years** for contact lenses or Eye Glasses (Frames and Lenses)

Preventive Dental	**$0** Limited dental services (This does not include services in connection with care, treatment, filling, removal, or replacement of teeth): **Preventive Dental Services:** **$0 Cleaning** up to **1 every six months** **$0 Dental X-Ray (s)** for up to **1 every six months** **$0 Fluoride Treatment** for up to **1 every six months** **$0 Oral Exam for up to 1 every six months** Comprehensive Dental Benefit covers minor restorations (Fillings), Simple extractions, dentures and denture repairs up to **$1000 every two years.** **Periodontics, endodontics, oral/maxillofacial surgery and other prosthodontics are not covered services**
Hearing Services	**$0 copay** for up to one supplemental routine hearing exam every year. **$1000** allowance for hearing exam every year.
Fitness Benefit	**$0**
Over the Counter Items	**$70 every three months (No Roll Over)**
	PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**
RX Deductible	**Deductible $0**
Prescription Drugs	**30 Days - For Generic Drugs (Including brand drugs treated as generics: $**0/ or $1.25/ or $3.35 **OR** **Other Drugs**: $0/ or $3.70/ or $8.35 **Mail Order - For Generic Drugs (Including brand drugs treated as generics:** $0/ or $1.25/ or $3.35 **OR** **Other Drugs:** $0/ or $3.70/ or $8.35 Specialty Drugs are limited to **30-day supply**

KEYSTONE VIP CHOICE SPECIAL NEEDS (SNP) HEALTH

2018 UPMC For Life Dual (HMO-SNP) Special Needs Plan Kim Harvey – 267 315-5074	
www.upmchealthplan.com/snp.	
PLAN NAME	**UPMC FOR LIFE DUAL RX** **HMO SNP** **MUST HAVE MEDICARE AND MEDICAID**
Monthly Premium	**$0**
PCP REFERRALS REQUIRED	NO
Out of Pocket Cost	**$3,400**
Annual Deductible for Medical Services	**$0**
Primary Care Physician	**$0**
Specialist Visit	**$0**
Inpatient Hospital	**$0** Per Stay
Skilled Nursing Care Facility	**$0** **Plans covers up to 100 days is a Skilled Nursing Facility**
Outpatient Hospital	**$0**
Outpatient Ambulatory	**$0**
Lab Services/X-Ray	**$0/$0**
Urgent Care	**$0**
Emergency Room	**$0**
Assist America – Emergency Travel Coverage	**$0** **800 872-1414** **609 986-1234 – Collect Number out of United States** **www.assistamerica.com**
Diabetes Test Strips, Monitors & Self-Monitoring Training/ Other Diabetic Supplies	**$0**
Ambulance	**$0**
Meals	**$0 up to 14 meals**

Vision Service	**$0** Routine Exam ever year. **$250** yearly allowance for eyewear including contact lenses or frames (excludes eyeglasses or contact lenses after cataract surgery).
Preventive Dental	**$O Copay for one Oral Exam, Cleaning and X-Rays every six months** **$2,500 yearly allowance** for additional services i.e. Dentures, Bridges, Root Canals, Fillings, Tooth Extractions, and Crowns.
Hearing Services	**$0** for Routine Hearing Exam **each year** **$0** for **one** hearing and fitting **each year** **1,500 allowance every three years** for hearing aids**.**
Over the Counter	**$125 Quarterly Allowance for Wellness Items**
Fitness Benefit	**$0 Active and Fit Health and Wellness Program**
	PRESCRIPTION **TOTAL 2018 DRUG MEDICARE RX ALLOWANCE $3,750**
RX Deductible	**Deductible $0**
Prescription Drugs	**30 Days - For Generic Drugs (Including brand drugs treated as generics: $**0/ or $1.25/ or $3.35 **OR** **Other Drugs**: $0/ or $3.70/ or $8.35 **90 Days - For Generic Drugs (Including brand drugs treated as generics:** $0/ or $1.25/ or $3.35 **OR** **Other Drugs:** $0/ or $3.70/ or $8.35 Specialty Drugs are limited to **30-day supply**

2018 HMO AND PPO PLAN HOSPITAL AFFILIATIONS

ADVANTRA HMO AMD PPO

ADVANTRA HMO HEALTH PLAN

All Delaware County Hospitals	**Thomas Jefferson University Hospital**
All Crozer Hospitals	**University of Penn Health System**
	NO Main Line Hospital for ADVANTRA HMO PLAN **(Lankenau, Bryn Mawr, Paoli, and Riddle)**

COVENTRY ADVANTRA PPO GOLD HEALTH PLAN HOSPITAL - same as above, but of course, **one can still go to the NON- PAR hospitals** such as **Main Line**, but they must pay a **deductible and coinsurance**.

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AETNA HMO HEALTH PLANS

STANDARD AND PREMIER HEALTH PLANS - All Hospitals Participate

AETNA MAIN LINE HEALTH PLAN -All MAIN LINE HEALTH HOPSITALS PLUS

Abington Memorial Hospital	**Pottstown Memorial Medical Center**
Bryn Mawr Hospital	**Riddle Memorial Hospital**
Doylestown Hospital	**Thomas Jefferson University Hospital**

Grand View Hospital	**Valley Forge Medical Center and Hospital**
Lankenau Medical Center	**Mercy Fitzgerald Hospital**
Lansdale Hospital	**Mercy Philadelphia Hospital**
Paoli Memorial Hospital	**Methodist Hospital**

CIGNA HEALTH SPRINGS HMO HEALTH PLANS

Mercy Fitzgerald Hospital and Riddle Memorial Hospital

HEALTH PARTNERS HEALTH PLANS

Crozer – Chester Hospital	**Frankford/Aria Hospital**
Delaware Memorial Hospital	**Hahnemann/Tenet Hospital**
Mercy Fitzgerald Hospital	**Pennsylvania Hospital**
Springfield Hospital	**Presbyterian University Hospital**
Taylor Hospital	**University of Pennsylvania Hospital**
Einstein Hospital	

HUMANA HMO/PPO HEALTH PLANS

Abington Memorial Hospital	**Pottstown Memorial Medical Center**
Bryn Mawr Hospital – Delaware County	**Riddle Memorial Hospital – Delaware County**
Doylestown Hospital	**Thomas Jefferson University Hospital**
Grand View Hospital	**Methodist Hospital**
Lankenau Medical Center	**Temple Hospital**
Lansdale Hospital	**Holy Redeemer Hospital**
Paoli Memorial Hospital	**Roxborough Memorial Hospital**
Einstein Hospital	**Crozer Hospitals only in Emergencies**

GATEWAY ASSURED SELECT HEALTH PLAN

Mercy Fitzgerald Hospital
University of Pennsylvania Health Systems
Pennsylvania Hospital
Thomas Jefferson Health System

GATEWAY SPECIAL NEEDS PLANS

DIAMOND & RUBY HEALTH PLANS

Delaware County Hospitals except for Riddle and the Mainline Hospitals
All Crozer Hospitals
Hahnemann Hospital

KEYSTONE 65 HMO/PPO– Preferred and Select Health Plans

Abington Memorial Hospital	**Lankenau Hospital**	
Aria Hospital – Frankford	**Paoli Hospital**	***Focus Health Plan Hospitals***
Brandywine Hospital	**Riddle Hospital**	**Crozer Hospitals**
Chestnut Hill Hospital	**Methodist Hospital**	**Lansdale Hospital**
Doylestown Hospital	**Phoenixville Hospital**	**Bryn Mawr** - Hospital Main Line Health
Holy Redeemer Hospital	**Thomas Jefferson University Hospital**	**Lankenau Medical Center** – Main Line Health
Lansdale Hospital	**Bryn Mawr – Main Line**	**Paoli Hospital** – Main Line Health
		Riddle Hospital - Main Line Health
		Methodist Hospital– TJUH
		Thomas Jefferson University Hospital
University of Pennsylvania Health Systems		

UPMC FOR LIFE MEDICARE ADVANTAGE PLANS HOSPITALS	
Crozer Chester Medical Center	**Taylor Hospital**
Springfield Hospital	**Delaware County Memorial Hospital**
Main Line Hospital Bryn Mawr	**Riddle Memorial Hospital**
Albert Einstein Medical Center	**Aria Health-Frankford Campus**
Aria Health-Torresdale Campus	**Chestnut Hill Hospital**
Thomas Jefferson University Hospital	**Jefferson Hospital for Neuroscience**
Jeanes Hospital	**Methodist Hospital**
Temple University Hospital-Episcopal Campus - Fox Chase Cancer Center	**Temple University Hospital**
Hahnemann University Hospital	**St. Christopher's Hospital for Children**

SCS SENIOR COMMUNITY SERVICES

APPRISE State Health Insurance Assistance Program ... counseling for people with Medicare in Pennsylvania

PDA pennsylvania DEPARTMENT OF AGING

"Funded in whole or part by a grant through the Administration for Community Living"