2019 AETNA HMO & PPO COVENTRY HEALTH CARE (An Aetna Company)

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 HEALTH PRIME RX (HMO)	AETNA SILVER RX (PPO)	AETNA GOLD RX (PPO)
Monthly Premium	**$47.00**	**$73.00**	**$167.00**	**$0**	**$0**	**$0**	**$147.00**
PCP REFERRALS REQUIRED	YES	YES	YES	YES	YES	N/A	N/A
Out of Pocket Cost	**$6,700**	**$5,900**	**$6,700**	**$6,700**	**$6,200**	**$6,700**	**$4,500 In Network $7,500 for in and out of Network combined**
Annual Deductible for Medical Services	**$0**	**$0**	**$0**	***$975* In-network for Ambulatory Surgical Centers, Therapeutic Radiology, Radiology, Dialysis, Inpatient Hospital, Inpatient Psychiatric Services, Outpatient Hospital, and Skilled Nursing Facility Services**	**$0**	**$400 for In and out of Network combined**	***$500.00* In-network for Ambulatory Surgical Centers, Therapeutic Radiology, Radiology, Dialysis, Inpatient Hospital, Inpatient Psychiatric Services, Outpatient Hospital, and Skilled Nursing Facility Services**
Primary Care Physician	$5	$10.00	$5	$30	$10.00	$10/ In Network $40 Out Network	$5/20% Out of Network
Specialist Visit	$35	$40.00	$30.00	$45.00	$45.00	$40 In and Out of Network	$25.00/20% Out of Network
Inpatient Hospital	195 (1-9 Days) **($1755)**	$185 (1-7 Days) **($1295)**	$375 Per Stay	$550 Per Stay	$215 (1-9 Days) **($1935)**	$185 (1-7 Days) **($1295)**	$300.00 Per Stay 20% - Out of Network
Skilled	$0 Day 1-20	$0 Day 1-20	$0 Day 1-20	$0 Day 1-20	$0 Day 1-20	$0 Day 1-20	$0 Day 1-20

Nursing Care Facility	**$170.50 per day Days 21- 100**	**$170.50 per day Days 21- 100**	**$170.50 per day Days 21- 100**	**$170.50 per day Days 21- 100**	**$170.50 per day Days 21- 100**	**$170.50 per day Days 21- 100**	**$170.50 per day Days 21- 100**
Outpatient Hospital/ Surgery	$220	$300	$275	$200 + $975* Deduct. **In-network for Ambulatory Surgical Centers, Therapeutic Radiology, Radiology, Dialysis, Inpatient Hospital, Inpatient Psychiatric Services, Outpatient Hospital, and Skilled Nursing Facility Services**	$285	$350 In Network/40% Out of Network	$195 + $500* Deduct./ 20% Out of Network **In-network for Ambulatory Surgical Centers, Therapeutic Radiology, Radiology, Dialysis, Inpatient Hospital, Inpatient Psychiatric Services, Outpatient Hospital, and Skilled Nursing Facility Services**
Outpatient Ambulatory	$220	$300	$275	$200	$285	$350 In Network/40% Out of Network	$195 + $500* Deduct/20% Out of Network
Lab Services/ X-Ray	$5.00/$25.00	$5.00/$25.00	$5.00/$25.00	$5.00/$40.00	$0/$25.00	$5/$25.00 In Network	$5/$40.00 In Network
Urgent Care	$50.00	$60.00	$50.00	$50.00	$50.00	$50.00	$50.00
Emergency Room	$90.00	$90.00	$90.00	$90.00	$90.00	$90.00	$90.00
World Wide Coverage	**$90** for Emergent and Urgent Care outside of US	**$90** for Emergent and Urgent Care outside of US	**$90** for Emergent and Urgent Care outside of US	**$90** for Emergent and Urgent Care outside of US	**$90** for Emergent and Urgent Care outside of US	**$90** for Emergent and Urgent Care outside of US	**$90** for Emergent and Urgent Care outside of US
Ambulance	$250.00 each one-way trip	$245.00 each one-way trip	$230.00 each one-way trip	$265.00 each one-way trip	$225.00 each one-way trip	$220.00 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**	**$0** One Routine Exam every year **Contacts and Eye Glasses Not Covered**	**$0** One Routine Exam every year **$0 Copay - Contacts and Eye Glasses $200.00 Allowance* every year**	**$0** One Routine Exam every year **$0 Copay - Contacts and Eye Glasses $125.00 Allowance* every year** *	**$0** One Routine Exam every year **$0 Copay - Contacts and Eye Glasses $200.00 Allowance* every year**	**Not Covered**	**$0** In Network One Routine Exam every year **Contacts and Eye Glasses $200.00 Allowance* every year**

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 Comprehensive	**Not Covered**	**$1000** Allowance* every year for Preventive and Comprehensive Dental combined Comprehensive Dental	**$150** Allowance* every year for Preventive and Comprehensive dental combined	**$250** Allowance* every year for Preventive and Comprehensive dental combined
Hearing Services/ Aids	**$0 Copay** for Routine Exam **once** a year. Plan offers a Hearing Aid Reimbursement of up to **$300.00** (both ears Combined) for Hearing Aids **once** a year	**$0** One Routine Exam every year **Hearing Aids Not Covered**	**$0** One Routine Exam every year **$0 Copay - $300** (Both ears combined) Allowance* every year	**Not Covered**	**$0** One Routine Exam every year **$0 Copay - $300** (Both ears combined) Allowance* every year	**$0 Copay - $500** (Both ears combined) Allowance* every year	**$0** One Routine Exam every year **$0 Copay - $1000** (Both ears combined
Discharge Meals	**14** Post Discharge Meals	**14** Post Discharge Meals	**14** Post Discharge Meals	**14** Post Discharge Meals	**14** Post Discharge Meals	**Not Covered**	**14** Post Discharge Meals
Over the Counter Benefits	**$15.00** Monthly	**$15.00** Monthly	**$25.00** Monthly	**$15.00** Monthly	**$30.00** Monthly	**$20.00** Monthly	**$20.00** Monthly
Fitness Benefit	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**							
RX Deductible	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	$0
	Tier 1 Preferred/ Standard **30** - $2/$15 **90**- $0/$45	**Tier 1 Preferred/ Standard** **30** - $0/$15 **90**- $0/$45	**Tier 1 Preferred/ Standard** **30** - $0/$15 **90**- $0/$45	**Tier 1 Preferred/ Standard** **30** - $2/$15 **90**- $0/$45	**Tier 1 Preferred/ Standard** **30** - $2/$15 **90**- $6/$30	**Tier 1 Preferred/ Standard** **30** - $2/$15 **90**- $0/$45	**Tier 1 Preferred/ Standard** **30** - $0/$15 **90**- $0/$45

	Tier 2 **30** - $5/$20 **90**- $15/$60	**Tier 2** **30** - $0/$20 **90**- $0/$60	**Tier 2** **30** - $0/$20 **90**- $15/$60	**Tier 2** **30** - $5/$20 **90**- $15/$60	**Tier 2** **30** - $5/$20 **90**- $15/$45	**Tier 2** **30** - $5/$20 **90**- $15/$60	**Tier 2** **30** - $0/$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**- $141/$141	**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 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 4** **30** - $100/$100 **90**- $300/$300
	Tier 5 **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 33%/33% **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

2019 ADVANTRA HMO & PPO COVENTRY HEALTH CARE (An Aetna Company) Edison Carrera – 267 510-1804 www.coventry-medicare.com				
PLAN NAME	**ADVANTRA SILVER RX (HMO)**	**ADVANTRA SOUTHEAST PRIME RX (HMO)**	**ADVANTRA GOLD RX (PPO)**	**ADVANTRAONE RX (PPO)**
Monthly Premium	**$0**	**$0**	**$67.00**	**$0**
PCP REFERRALS REQUIRED	NO	NO	N/A	N/A
Credit monthly to your Part B Premium	N/A	N/A	N/A	**$60.00**
Out of Pocket Cost In Network	**$6,700**	**$6,700**	**$6,700**	**$6,700**
Out of Pocket Cost – In Network/Out Network combined	**N/A**	**N/A**	**$6,600/$10,000**	**$10,000**
Annual Deductible for Medical Services	**$0**	**$0**	**$50 deductible** for some hospital and medical services	**$1,500 deductible** for some hospital and medical services
Primary Care Physician	**$5.00**	**$0**	$0 In Network 10% Out Network	$35.00 In Network 40% Out Network
Specialist Visit	$50.00	$45	$45 In Network 20% Out Network	$50.00 In Network 20% Out Network
Inpatient Hospital	$200 (1-9 Days) **($1800)**	$350 Per Stay	$350 Per Stay In Network $385 Per Stay Out Network	$360 (1-5 Days) **($1,800)**
Skilled Nursing Care Facility	$0 Day 1-20 **$170.50 per day** **Days 21- 100**	$0 Day 1-20 **$170.50 per day** **Days 21- 100**	$0 Day 1-20 **$170.50 per day** **Days 21- 100**	$0 Day 1-20 **$170.50 per day** **Days 21- 100**
Outpatient Hospital	$300	275	$395	20%
Outpatient Ambulatory	$295	$250	$245 In Network 10% Out Network	20% In Network 40% Out Network
Lab Services/ X-Ray	$5/$35 In Network	$0/$35.00 In Network	$5/$15 In Network	$30/$60 In Network
Urgent Care	$60.00	$50.00	$50.00	$60.00

Emergency Room	$90.00	$90.00	$90.00	$90.00
Worldwide Coverage	**$90** for emergency and urgent care outside of the United States	**$90** for emergency and urgent care outside of the United States	**$90** for emergency and urgent care outside of the United States	**$90** for emergency and urgent care outside of the United States
Ambulance	**$260** for each one-way trip	$250 for each one-way trip	**$265** for each one-way trip	**$275** for each one-way trip
Vision Services – Routine Eye Exam **Network: EyeMed** **Vision Services – Routine Eye Exam**	**$0** One Routine Exam every year Contacts and Eye Glasses – **NOT COVERED**	$100 Every Year for Vision Benefits	**Network: EyeMed** **$0 One** Routine Exam every year **$0 Copay** - Contacts and Eye Glasses – **$150 Allowance*** every year	**NOT COVERED**
Preventive and Comprehensive Dental Benefits **Network: Denta Max**	**NOT COVERED**	**$1,000 allowance*** every year for Preventive and Comprehensive Dental Services.	**$1,000 allowance*** every year for Preventive and Comprehensive Dental Services.	**NOT COVERED**
Hearing Services – Routine Hearing Exam	$500 per ear every year for Hearing Aids	$500 per ear every year for Hearing Aids	$500 per ear every year for Hearing Aids	$500 per ear every year for Hearing Aids
Discharge Meals	**14** Post Discharge Meals	**14** Post Discharge Meals	**14** Post Discharge Meals	**14** Post Discharge Meals
Over the Counter Benefits	**$35** Monthly	**$25** Monthly	**$25** Monthly	**$15** Monthly
Transportation	**$0** Copay for 18 one-way trips every year	**$0** Copay for 30 one-way trips every year	**$0** Copay for 30 one-way trips every year	**NOT COVERED**
Fitness Benefit	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**

PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**				
RX Deductible	$0	$0	$0	$0 Deductible for Tiers 1,2&3 **$395 Deductible**
	Tier 1 **Preferred/Standard** **30** - $0/$15 **90**- $0/$45	**Tier 1** **Preferred/Standard** **30** - $0/$15 **90**- $0/$45	**Tier 1** **Preferred/Standard** **30** - $0/$15 **90**- $0/$45	**Tier 1** **Preferred/Standard** **30** - $0/$15 **90**- $6/$45
	Tier 2 **30** - $10/$20 **90**- $30/$60	**Tier 2** **30** - $10/$20 **90**- $30/$60	**Tier 2** **30** - $0/$20 **90**- $15/$60	**Tier 2** **30** - $10/$20 **90**- $30/$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**- $141/$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 5 **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 25%/25% **90- N/A**

ADVANTRA HMO and PPO Health Plans

2019 ALLWELL MEDICARE HMO – Alana Wright – 267-901-2093	
Allwell.pahealthwellness.com	
PLAN NAME	**ALLWELL MEDICARE HMO**
Monthly Premium	$0
PCP REFERRALS REQUIRED	YES
Out of Pocket Cost	$6,700
Annual Deductible for Medical Services	$0
Primary Care Physician	$0 Copay
Specialist Visit	$40
Inpatient Hospital	$295 (1-6 Days) **($1770)**
Skilled Nursing Care Facility	$0 Day 1-20 **$170.00 per day** Days 21- 100
Podiatry	$40
Outpatient Hospital	$350
Observation Services	$350
Outpatient Ambulatory	$275
Labs	$0-$20
X-Rays	$40
Chiropractor/Podiatry	$20/$40
Urgent Care	$40
World Wide Coverage	$90 for Emergent and Urgent Care outside of US
Emergency Room	$90
Ground and Air Ambulance	$295 **(Per One way trip)**
Vision Services	**$40.00 Copay** Vision Exam (Medicare Covered) **per visit** $0 Copay Routine Eye Exam $0 Routine Eyewear: Up to **$200** allowance per calendar
Preventive Dental	**$40.00 Copay** Dental Services (Medicare Covered) **per visit** $0 Copay - Preventive Dental Services: Oral Exam, Cleaning, & X-Rays Additional Comprehensive Dental Services are Available - 267-901-2093
Hearing Services/Aids	**$40 Copay** –Hearing Exam (Medicare Covered) **per visit** $0 Copay- Routine Hearing Exam (**1** every calendar year)

	$0 - $1, 508 Copay Hearing Aids (**2** Hearing Aids every year)
Over the Counter	$50.00 Quarterly **(CVS Caremark)**
Discharge Meals	NOT COVERED
Transportation	NOT COVERED
Fitness Benefit	Yes $0 Copay
	PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**
RX Deductible	**$0 Deductible**
	(90 Day is Mail Order Only)
30/90 Days	**Tier 1** **Preferred Generic** $0/$0
30/90 Days	**Tier 2** **Generic** $10/$30
30/90 Days	**Tier 3** **Preferred Brand** $47$141
30/90 Days	**Tier 4** **Non Preferred** $100/$300
30Days	**Tier 5** **Specialty** 33% **90** Day Not available
30/90 Days	**Tier 6** **Select Care Drugs** $0/$0

ALLWELL MEDICARE HMO

2019 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 ALLIANCE RX HMO**
Monthly Premium	**$15.00**	**$125.00**	**$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	$0	$0	$0
Specialist Visit	$40	$40.00	$35.00
Inpatient Hospital	$275 (**Tier** 1) (1-6 Days) **($1,650)** $295 (**Tier** 2) (1-6 Days) **($1,770)**	$225 (1-7 Days) **($1575)**	$275 (**Tier** 1) (1-6 Days) **($1,650)** $295 (**Tier** 2) (1-6 Days) **($1,770)**
Skilled Nursing Care Facility	$0 Day 1-20 **$17.50 per day Days 21- 100**	$0 Day 1-20 **$170.50 per day Days 21- 100**	$0 Day 1-20 **$170.50 per day Days 21- 100**
Outpatient Hospital/ Surgery	$400	$270	$400
Outpatient Ambulatory	$195	$0	$195
Lab Services/ X-Ray	$0/20%	$0/$10.00	$0/20%

Urgent Care	$55.00	$55.00	$55.00
Emergency Room	$80.00	$90.00	$90.00
World Wide Coverage	**$90** for Emergent and Urgent Care outside of US	**$90** for Emergent and Urgent Care outside of US	**$90** 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
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 **$300.00 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 **$500.00 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 **$500.00 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** **Comprehensive Dental Services** Restorative Services Periodontics Extractions Prosthodontics/Oral Surgery **$0 Copay** up to a Maximum Coverage amount of **$1,000** per year	**$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 **$3,000** per year	**$35.00 Copay** Dental Services **(Medicare Covered)** **$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 **$3,000** per year

Hearing Services/Aids	**$0 Copay-** Routine Exam **once** a year. **$35.00** Copay in **Specialist Office (Medicare Covered)** **$0 Copay** - Hearing Aid Evaluation/Fitting **One every three years.** Hearing Aids – **$0 Copay** - **One every three years.** Plan pays up to **$700** per Ear per device **every three years**	**$0 Copay-** Routine Exam **once** a year. **$35.00** Copay in **Specialist Office (Medicare Covered)** **$0 Copay** Hearing Aid Evaluation/Fitting **One every three years.** Hearing Aids – **$0 Copay -One every three years.** Plan pays up to **$700** per Ear per device **every three years**	**$0 Copay-** Routine Exam **once** a year. **$35.00** Copay in **Specialist Office (Medicare Covered)** Hearing Aid Evaluation/Fitting **One every three years.** Hearing Aids – **$0 Copay -One every three years.** Plan pays up to **$700** per Ear per device **every three years**
Over the Counter	**$10.00** Every Three Months	**$45.00** Every Three Months	**$55.00** Every Three Months
Discharge Meals	**14** Post Discharge Meals	**14** Post Discharge Meals	**14** Post Discharge Meals
Transportation	**$0** for unlimited trips to plan approved location per year	**NOT COVERED**	**$0** for unlimited trips to plan approved location per year
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
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**			
RX Deductible	**$280** Deductible **for Tiers 3, 4, 5 only**	**$0**	**$0**
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** $2/$4/$4 **Standard** $7/$14/$14	**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** $95/$190/$285 **Standard** $100/$200/$300	**Tier 4** **Preferred** $95/$190/$280 **Standard** $100/$200/$300	**Tier 4** **Preferred** $95/$190/$285 **Standard** $100/$200/$300
30Days	**Tier 5** **Preferred/ Standard** **30 – 27%/27%** **90- N/A**	**Tier 5** **Preferred/ Standard** **30 – 33%/33%** **90- N/A**	**Tier 5** **Preferred/ Standard** **30 – 33%/33%** **90- N/A**

Cigna Health Springs HMO Plans

2019 HealthPartners HMO – Lee Van Williams – 267 713-0897			
www.hpplans.com			
PLAN NAME		**HEALTHPARTNERS MEDICARE PRIME RX HMO**	
Monthly Premium		**$71.00**	
PCP REFERRALS REQUIRED		YES	
Out of Pocket Cost		**$6,700**	
Annual Deductible for Medical Services		**$0**	
Primary Care Physician		$0	
Specialist Visit		$50 **(No Referrals Needed)**	
Inpatient Hospital		$300 (1-6 Days) **($1800)**	
Skilled Nursing Care Facility		$0 Day 1-20 **$170.50 per day Days 21- 100**	
Outpatient Hospital		$300	
Outpatient Ambulatory		$200	
Lab Services/ X-Ray		$0/$30.00	
Diabetic Monitoring Supplies Test Strips, Monitors & Self - Management Training /Other Services		$0/0-20%	
Urgent Care		$65.00	
Emergency Room		$90.00	
Ambulance		$210	
Vision Services		**$0 One** Routine Exam a year **1 Pair Eye Glasses /Contacts every 2 years ($260 Limit)**	

Preventive Dental		**$0 One** X-Ray, **One** Fluoride Treatment, and **2** Routine Exams/Cleanings a year. **Other Services** (**$500** Limit **after $50.00** Deductible)	
Hearing Services/ Aids		**$0** One Routine Exam a year No Hearing Aid Benefits	
Fitness Benefit		**$0 In Network**	
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**			
RX Deductible		**$350 Deductible**	
		Tier 1 **Preferred/Standard** **30** – None/$7 **90 –** None/$14	
		Tier 2 **30** – None/$20 **90 –** None/$40	
		Tier 3 **30** – None/$47 **90 –** None/$94	
		Tier 4 **30** – None/25% **90 –** None/$25%	
		Tier 5 **30** - 26% **90 –** N/A	

HEALTHPARTNERS HMO HEALTH PLAN

2019 Humana Health Plans HMO & PPO – Gus Grant – 610 565-7214				
www.humana.com/medicare				
PLAN NAME	**HUMANA GOLD PLUS RX HMO (H6622-037)**	**HUMANA RX GREATER PHILADELPHIA HMO (H6622-039)**	**HUMANA CHOICE RX GREATER PHILADELPHIA IN NETWORK PPO (H5525-005)**	**HUMANA CHOICE RX GREATER PHILADELPHIA OUTWORK PPO (H5525-005)**
Monthly Premium	**$0**	**$0**	**$45**	**$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	**$0**	**$20**	**$10**	**$10**
Specialist Visit	$35	$45	$45	$45
Inpatient Hospital	**$225** (1-7 Days) **($1575)**	**$600** (1-3 Days) **($1800)**	$350 (1-5 Days) **($1750)**	$350 (1-5 Days) **($1750)**
Skilled Nursing Care Facility	$0 Day 1-20 **$170.50 per day Days 21- 100**	$0 Day 1-20 **$172.50 per day Days 21- 100**	$0 Day 1-20 **$172.00 per day Days 21- 100**	$0 Day 1-20 **$172.00 per day Days 21- 100**
Outpatient Hospital	$225	$600 per visit	$350	$10 - $350
Outpatient Ambulatory	$175	$350	$300	$300
Lab In Network/Out Network	$0 In Network $35.00 Out Network	$0-$40	Labs ($0-$40)	Labs ($0-$40)
X-Rays In Network/Out Network	$0 In Network $95.00 Out Network	$2-$100	X-Rays ($10- $100)	X-Rays ($10- $100)
Urgent Care	$35	$20-$45	$35	$35
Emergency Room	$90	$90	$90	$90
Ambulance	$265	$265	$265 per date of service	$265 per date of service

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	**Routine Eye Exams and other Routine Services - Not Covered** *Humana concerning MyOption Vision Benefits Package – Eye Exam and Eye Wear - **$15.35 per month**	**$75** 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.	**$75** 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 Packages - $21.20** MyOption Enhanced Dental (DEN839) **& $25.20** MyOption Total Dental per month (DEN983) (Call plan for detail information on each package)	**Preventive Dental Services - Not Covered** **Dental Supplemental Benefit Package** Comprehensive Dental, Comprehensive Dental Services, Preventive Dental, Preventive Dental Services - **$23.00**	**$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. **$1000** combined maximum benefit coverage amount per year for amalgam or composite filling, bitewing x-rays, necessary anesthesia with covered services, periodic oral exam or comprehensive oral	**$45** 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. **$1000** combined maximum benefit coverage amount per year for amalgam or composite filling, bitewing x-rays, necessary anesthesia with covered services, periodic oral exam or comprehensive oral
Hearing Services/ Aids	**$0 Copay** for Routine Hearing Exams **up to 1 per year.**	**Hearing Exam Services - $45.00** **Hearing Aids – Not Covered**	**$0** copayment for Routine Hearing Exam up to **1 per year.** **$0** copayment for	**$0** copayment for Routine Hearing Exam up to **1 per year.** **$0** copayment for

	$0 Copay 1 Fitting/Evaluation up to **3 per every year** **$499.00 Copay** for advance level hearing aid up to **1 per 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**		fitting/evaluation up to **3 per year.** **$499** Copay for premium hearing aid up to **1 per Ear per year.** **$799** copayment for premium hearing aid purchase up to **1 per Ear per year.** **Note:** Includes **48 batteries per aid and 3 year warranty.**	fitting/evaluation up to **3 per year.** **$499** Copay for premium hearing aid up to **1 per Ear per year.** **$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**
Over The Counter (Mail Order)	**$45.00** Quarterly Mail Order	**$45.00** Quarterly Mail Order	**$45.00** Quarterly Mail Order	**$45.00** Quarterly Mail Order
Discharge Meals	**Well Dine Meal Program**	**Well Dine Meal Program**	**Well Dine Meal Program**	**Well Dine Meal Program**
Transportation	**NOT COVERED**	**NOT COVERED**	**NOT COVERED**	**NOT COVERED**
Fitness Benefit	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**				
RX Deductible	**$0 Deductible** **No Deductible on Tier 3 Drugs**	**$350 Deductible** **No Deductible on Tier 3 Drugs**	**$0 Deductible** **No Deductible on Tier 3 Drugs**	**$0 Deductible** **No Deductible on Tier 3 Drugs**
	Tier 1 **Preferred/Standard** **30** - $3/$10 **90**- $9/$30	**Tier 1** **Preferred/Standard** **30** - $9/$10 **90**- $27/$30	**Tier 1** **Preferred/Standard** **30** - $5/$10 **90**- $15/$30	**Tier 1** **Preferred/Standard** **30** - $5/$10 **90**- $0/$30
	Tier 2 **30** - $15/$20 **90**- $45/$60	**Tier 2** **30** - $19/$20 **90**- $57/$60	**Tier 2** **30** - $15/$20 **90**- $45/$60	**Tier 2** **30** - $15/$20 **90**- 45/$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**- $141/$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 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

2019 Humana Health Plans PPO – Gus Grant – 610 565-7214		
www.humana.com/medicare		
PLAN NAME	**HUMANA CHOICE RX GREATER PHILADELPHIA IN NETWORK PPO (H5216-122)**	**HUMANA CHOICE RX GREATER PHILADELPHIA OUTWORK PPO (H5216-122)**
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** per admit	$350 per admit
Skilled Nursing Care Facility	$0 Day 1-20 **$172.00 per day** **Days 21- 100**	$0 Day 1-20 **$172.00 per day** **Days 21- 100**
Outpatient Hospital	$250	$250
Outpatient Ambulatory	$150	$150
Lab In Network/Out Network	$0-$40.00	$0-$40.00
X-Ray In Network/ Out Network	$5-$90	$5-$90
Urgent Care	$5-$35	$5-$35
Emergency Room	$90	$90
Ambulance	$265 per date of service	$265 per date of service
Transportation	**NOT COVERED**	**NOT COVERED**

Well Dine Meals Program	**Well Dine Meals Program Covered**	**Well Dine Meals Program Covered**
Over the Counter	**$45.00** Quarterly (Mail Order)	$45.00 Quarterly (Mail Order)
Vision Services	**$30** Medicare Covered Vision Services **$0** Copay for Diabetic Eye Exam **$0** Copay for Glaucoma Screening **$0** Copay Eyewear Post -Cataract **$75** 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 $100 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 **$75** 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 2019 DRUG MEDICARE RX ALLOWANCE $3,820**		
RX **Deductible**	**$0 Deductible** **No Deductible on Tier 3 Drugs**	**$0 Deductible** **No Deductible on Tier 3 Drugs**
	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
	Tier 5 **30** – 33% **90**- N/A	**Tier 5** **30** – 33% **90**- N/A

HUMANA HMO HEALTH PPO PLANS

2019 Humana Health Plans PPO – Gus Grant – 610 565-7214		
www.humana.com/medicare		
PLAN NAME	**HUMANA CHOICE RX REGIONAL IN NETWORK PPO (R923-002)**	**HUMANA CHOICE RX REGIONAL OUTWORK PPO (R923-002)**
Monthly Premium	**$75.00**	**$0**
PCP REFERRALS REQUIRED	NO	NO
Out of Pocket Cost	**$6,700**	**10,000 Combined**
Annual Deductible for Medical Services	**$500**	**$500**
Primary Care Physician	**$15**	**$20%**
Specialist Visit	$45	20%
Inpatient Hospital	**$350** per 1 to 5 Days ($1,750)	20% per stay
Skilled Nursing Care Facility	$0 Day 1-20 **$172.00 per day Days 21- 100**	20% per stay
Outpatient Hospital	$350 per visit	20% per stay
Outpatient Ambulatory	$300	20%
Lab In Network/Out Network	$0-$40.00	20%
X-Ray In Network/ Out Network	$15-$100	20%
Urgent Care	$15-$45 or 20%	$15-$45 or 20%
Emergency Room	$90	$90
Ambulance	$265 per date of service	$265 per date of service
Transportation	**NOT COVERED**	**NOT COVERED**
Well Dine Meals	**Well Dine Meals Program Covered**	**Well Dine Meals Program Covered**

Program		
Over the Counter	$45.00 Quarterly (Mail Order)	$45.00 Quarterly (Mail Order)
Vision Services	**$30** Medicare Covered Vision Services **$0** Copay for Diabetic Eye Exam **$0** Copay for Glaucoma Screening **$0** Copay Eyewear Post -Cataract **$75** 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 $100 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 **$75** 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 2019 DRUG MEDICARE RX ALLOWANCE $3,820**		
RX **Deductible**	**$0 Deductible** **No Deductible on Tier 3 Drugs**	**$0 Deductible** **No Deductible on Tier 3 Drugs**
	Tier 1 **Preferred/Standard** **30** - $6/$10 **90**- $18/$30	**Tier 1** **Preferred/Standard** **30** - $6/$10 **90**- $18/$30
	Tier 2 **30** - $20/$20 **90**- $60/$60	**Tier 2** **30** - $20/$20 **90**- $60/$60
	Tier 3 **30** - $47/$47 **90**- $141/$141	**Tier 3** **30** - $47/$47 **90**- $131/$141
	Tier 4 **30** – $99/$100 **90**- $297/$300	**Tier 4** **30** – $99/$100 **90**- $297/$300
	Tier 5 **30** – 33% **90**- N/A	**Tier 5** **30** – 33% **90**- N/A

HUMANA HMO HEALTH PPO PLANS

2019 Keystone 65 HMO – Mary Blount – 267 593-0210

www.ibxmedicare.com

PLAN NAME	KEYSTONE 65 BASIC RX HMO	KEYSTONE 65 SELECT 65 RX HMO	KEYSTONE 65 PREFERRED 65 RX HMO
Monthly Premium	**$0** Choice Program: **$7.00** **Choice Plus** Program: **$20.00**	**$98.00** Choice Program: **$105.00** **Choice Plus** Program: **$118.00**	**$289.00** Choice Program: **$296.00** Plus: **$309.00**
PCP REFERRALS REQUIRED	NO	NO	NO
Out of Pocket Cost	**$6,700**	**$5,500**	**$4,000**
Annual Deductible for Medical Services	**$0**	**$0**	**$0**
Primary Care Physician	**$0 Preferred PCP** **$15-Standard PCP**	**$0 Preferred PCP** **$15-Standard PCP**	**$0 Preferred PCP** **$5-Standard PCP**
Specialist Visit	$45	$40	$40
Inpatient Hospital	$300 (1-6 Days) **($1800)**	$290 (1-6 Days) **($1,740)**	$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 **$170.50 per day** **Days 21- 100**	$0 Day 1-20 **$150.00 per day** **Days 21- 100**
Outpatient Hospital	$350	$400	$400
Outpatient Ambulatory	$200	$200	$125
Labs/X-Rays	$0/$45	$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 **$5** for Retail Clinic
Emergency Room	$90	$90	$90
Ambulance	$300 One Way Trip	$250 One Way Trip	$150 One Way Trip
World Wide Coverage	**$90** for Emergent and Urgent Care outside of US	**$90** for Emergent and Urgent Care outside of US	**$90** for Emergent and Urgent Care outside of US
Vision Services	NOT COVERED **Available with Optional Supplemental**	NOT COVERED **Available with Optional Supplemental**	**Included with Preferred: $10** copay for a Routine Eye Exam and up to **$200**

	Choice and Choice Plus Benefits Programs **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services **when purchased from Vision Works**	**Choice and Choice Plus Benefits Programs** **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services **when purchased from Vision Works**	allowance for eyewear every **2 years when purchased from Vision Works**
Preventive Dental	NOT COVERED **Available with Optional Supplemental Choice and Choice Plus Benefits Programs** **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services **(Dental Services through United Concordia)**	NOT COVERED **Available with Optional Supplemental Choice and Choice Plus Benefits Programs** **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services **(Dental Services through United Concordia)**	**Included with Preferred:** **$10** copay for Dental Exam and Cleaning **once every 6 months.** One X-Ray per year
Hearing Services/ Aids	NOT COVERED **Available with Optional Supplemental Choice and Choice Plus Benefits Programs** **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services	NOT COVERED **Available with Optional Supplemental Choice and Choice Plus Benefits Programs** **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services	**Included with Preferred:** **$10** Copay for a Routine Hearing Exam **every year.** Hearing Aid benefit of **$499.00 or $799.00** per **Hearing Aid (One per ear/per year)** Provided through **TruHearing**

Over the Counter	**$30** Quarterly	**$30** Quarterly	**$30** Quarterly
Meals	NOT COVERED	NOT COVERED	NOT COVERED
Transportation	NOT COVERED	NOT COVERED	NOT COVERED
Fitness Benefit	**Silver Sneakers**	**Silver Sneakers**	**Silver Sneakers**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**			
RX Deductible	**$0**	**$0**	**$0**
	Preferred Retail Preferred Generic$**2**/Generic$**10** Preferred Brand **$47** Non Preferred **$100** **33%** Coinsurance Specialty Drugs	**Preferred Retail** Preferred Generic$**1**/Generic$**9** Preferred Brand **$47** Non Preferred **$100** **33%** Coinsurance Specialty Drugs	**Preferred Retail** Preferred Generic$**1**/Generic$**9** Preferred Brand **$47** Non Preferred **$100** **33%** Coinsurance Specialty Drugs
	Standard Retail Preferred Generic**$9**/Generic**$20** Preferred Brand **$47** Non Preferred **$100** **33%** Coinsurance Specialty Drugs	**Standard Retail** Preferred Generic**$9**/Generic**$20** Preferred Brand **$47** Non Preferred **$100** **33%** Coinsurance Specialty Drugs	**Standard Retail** Preferred Generic**$9**/Generic**$20** Preferred Brand **$47** Non Preferred **$100** **33%** Coinsurance Specialty Drugs
Preferred Retail and Mail Order 90 Day supply for 2 months Copay	**Preferred Retail and Mail Order** Preferred Generic **$4**/Generic **$20**	**Preferred Retail and Mail Order** Preferred Generic **$2**/Generic **$18**	**Preferred Retail and Mail Order** Preferred Generic **$2**/Generic **$18**

2019 Keystone 65 Focus HMO (POS) – Mary Blount – 267 593-0210	
www.ibxmedicare.com	
PLAN NAME	**KEYSTONE 65** **FOCUS RX HMO - POS**
Keystone 65 Focus RX HMO-POS has an annual plan level POS Maximum limit of **$1,000 per year. The POS benefit will apply to Medicare Covered Medical (PARTS A and B) benefits**	
Monthly Premium	**$35.00** Choice Program**: $42.00** **Choice Plus** Program**: $55.00**
PCP REFERRALS REQUIRED	NO
Out of Pocket Cost	**$6,700**
Annual Deductible for Medical Services	**$0**
Primary Care Physician	**$0 Preferred PCP** **$10-Standard PCP**
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/$25** **(Up to 6 visits per year)**
Outpatient Hospital	$350
Outpatient Ambulatory	$200
Labs/X-Rays	$0/$40
Urgent Care	**$40** In Network **$10** for Retail Clinic
World Wide Coverage	**$90** for Emergent and Urgent Care outside of US
Emergency Room	**$90**
Ambulance	$275 One Way Trip
Vision Services	NOT COVERED **Available with Optional Supplemental Choice and Choice Plus Benefits Programs**

	Package 1 – $20.00 Monthly Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and **Services (Use Vision Works)**
Preventive Dental	NOT COVERED **Available with Optional Supplemental Choice and Choice Plus Benefits Programs** **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services **(Dental Services through United Concordia)**
Hearing Services/ Aids	NOT COVERED **Available with Optional Supplemental Choice and Choice Plus Benefits Programs** **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services (Use **TruHearing**)
Over the Counter	$30.00 Quarterly
Discharge Meals	NOT COVERED
Transportation	NOT COVERED
Fitness Benefit	**Silver Sneakers**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**	
RX Deductible	**$0 Deductible**
	Preferred Retail Preferred Generic$**2**/Generic$**10** Preferred Brand **$47** Non Preferred **$100** **33%** Coinsurance Specialty Drugs
	Standard Retail Preferred Generic**$9**/Generic**$20** Preferred Brand **$47**

	Non Preferred **$100** **33%** Coinsurance Specialty Drugs
	<u>Preferred Retail and Mail Order</u> Preferred Generic **$4**/Generic **$20**

KEYSTONE 65 FOCUS RX HMO HEALTH PLAN

2019 Keystone 65 – Mary Blount – 267 593-0210	
www.ibxmedicare.com	
PLAN NAME	**KEYSTONE 65** **PERSONAL CHOICE RX** **PPO**
Monthly Premium	**$160.00** Choice Program**: $167.00** **Choice Plus: $180.00**
PCP REFERRALS REQUIRED	NO
Out of Pocket Cost – In Network	**$5,500**
Out of Pocket Cost – Out Network	**$10,000**
Primary Care Physician	**$5.00**- up to 30% higher Out Network
Specialist Visit	**$40.00** – up to 30% higher Out Network
Inpatient Hospital	**$275** (1-6 Days) **($1,650)**
Skilled Nursing Care Facility	$0 Day 1-20 **$165.00 per day** **Days 21- 100**
Outpatient Hospital	**$300**- up to 30% higher Out Network
Outpatient Ambulatory	**$150** - up to 30% Out Network
Labs/X-Ray	$0/$40 - Out of Network 30%
Chiropractic/Podiatry	**$20/$20 In Network** Up to 30% /30% **Out Network** Up to 6 visits per year for each service
Ambulance	**$175** In Network & Out Network
Urgent Care	**$40** In Network **$5** for Retail Clinic
Emergency Room	$90.00
Vision Services	**NOT COVERED** **Available with Optional Supplemental Choice and Choice Plus Benefits Programs** **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services**(Dental Services through United Concordia)** **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services **(Use Vision Works)**

Preventive Dental	NOT COVERED **Available with Optional Supplemental Choice and Choice Plus Benefits Programs** **Package 1 – $20.00 Monthly** Comprehensive Dental and Services, Eye Exams, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental, and Services**(Dental Services through United Concordia)** **Package 2** – $ 7.**00** Eye Exam, Eyewear, Hearing Aids, Hearing Exams, Preventive Dental and Services **(Dental Services through United Concordia)**
Hearing Services/ Aids	**$40** Copay for a Routine Hearing Exam **every year.** Hearing Aid benefit of **(Choice) $699.00 or $999.00** per **Hearing Aid (One per ear/per year)** Provided through **TruHearing** Hearing Aid benefit of **(Choice Plus) $499.00 or $799.00** per **Hearing Aid (One per ear/per year)** Provided through **TruHearing**
Over The Counter	**$30.00** Quarterly
Discharge Meals	NOT COVERED
Transportation	NOT COVERED
Fitness Benefit	**Silver Sneakers**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**	
RX Deductible	**$0 Deductible**
	Preferred Retail Preferred Generic$**1**/Generic$**9** Preferred Brand **$47** Non Preferred **$100** **33%** Coinsurance Specialty Drugs
	Standard Retail Preferred Generic**$9**/Generic**$20** Preferred Brand **$47** Non Preferred **$100** **33%** Coinsurance Specialty Drugs
	Preferred Retail and Mail Order Preferred Generic **$2**/Generic **$18**

KEYSTONE 65 PERSONAL CHOICE PPO HEALTH

2019 UPMC FOR LIFE MEDICARE ADVANTAGE (HMO) PLANS
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	$35.00	$35.00
Inpatient Hospital	$250 (1-5 Days) **(After Deductible) ($1250)**	$250 (1-5 Days) **($1250)**
Skilled Nursing Care Facility	$0 Day 1-20 **$172.00 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	$10 per day per facility (Deductible does not apply)	$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	$90.00	$90.00
Travel Concierge Program	In-network coverage while traveling in **Florida, Georgia, North Carolina, South Carolina, and Tennessee**. Call the Health Care Concierge team before you see your provider so that we can help to coordinate your care.	
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	**$300** for each one-way trip
Vision Services	**$0 Copay** for **One** Routine Exam every **two** years. **$100.00 Allowance** for Contact Lenses and Eye Wear	**$0 Copay** for **One** Routine Exam every **two** years. **$175.00 Allowance** for Contact Lenses and Eye Wear

	every **two** years. (Deductible does not apply)	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.	**$0 Copay** for one **Oral Exam and Cleaning every six months.** **$0 Copay** for **One Bitewing X-Ray per** year. **$150** allowance for comprehensive dental services per year.
Hearing Services – Routine Hearing Exam	**$35 Medicare –Covered Hearing Exam** **Routine Hearing Services are NOT COVERED**	**$35 Medicare –Covered Hearing Exam** **Routine Hearing Services are NOT COVERED**
Fitness Benefit	**Silver Sneakers**	**Silver Sneakers**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**		
RX Deductible	NO	NO
	Tier 1 **Preferred/Standard** **30** - $0/$9 **90**- $9/$27	**Tier 1** **Preferred/Standard** **30** - $0/$9 **90**- $9/$27
	Tier 2 **30** - $10/$16 **90**- $20/$48	**Tier 2** **30** - $10/$16 **90**- $20/$48
	Tier 3 **30** - $42/$47 **90**- $105/$141	**Tier 3** **30** - $42/$47 **90**- $105/$141
	Tier 4 **30** - $95/$100 **90**- $285/$300	**Tier 4** **30** - $95/$100 **90**- $285/$300
	Tier 5 **30** - 33%/33% **90- N/A**	**Tier 5** **30** - 33%/33% **90- N/A**

UPMC FOR LIFE HMO HEALTH PLANS

MEDICAL ONLY MEDICARE ADVANTAGE HMO AND PPO HEALTH PLANS

MEDICAL ONLY MEDICARE ADVANTAGE HMO AND PPO HEALTH PLANS					
PLAN NAME	**Aetna Medicare Basic Plan HMO MEDICAL ONLY**	**CIGNA HEALTHSPRING ADVANTAGE RX HMO MEDICAL ONLY**	**HUMANA CHOICE REGIONAL PPO R0923-001 MEDICAL ONLY**	**KEYSTONE 65 SELECT HMO MEDICAL ONLY**	**KEYSTONE 65 PREFERRED HMO MEDICAL ONLY**
	Irwin Cherry 267 789-7233	**Michael Collins 267 238-6038**	**Gus Grant 610 565-7214**	**Mary Blount 267 593-0210**	**Mary Blount 267 593-0210**
Monthly Premium	**$0**	**$0**	**$0**	**$66.00** Choice Program: **$73.00** Choice Plus Program: **$86.00**	**$224.00**
PCP REFERRALS REQUIRED	YES	YES	NO	NO	NO
Out of Pocket Cost	$6,700	$6,700	$6,900 In and Out Network $45,000 In Network	$5,500	$4,000
Annual Deductible for Medical Services	NO	$0	$500	$0	$0
Primary Care Physician	$5.00	$0	$0 In Network 30% Out Network	$0 Preferred PCP $15-Standard PCP	$0 Preferred PCP $5-Standard PCP
Specialist Visit	$30.00	$40.00	$35 In Network 30% Out Network	$40	$40
Inpatient Hospital	$400 Per Stay	$295 (1-6 Days) ($1770)	**In Network** $ 350 per 1 to 5 days **($1,750)** **Out Network** 30% per visit	$290 (1-6 Days) ($1,740)	$250 (1-6 Days) ($1,500)
Outpatient Hospital	$35-$275 per visits	$400	**In Network** $ 350 per visi**t** **Out Network** 30% per visit	$400	$400
Outpatient Ambulatory	$275	$150	$300	$200	$125
Emergency	$90.00	$90.00	$90.00	$90.00	$90.00
Urgent Care	$90.00	$55.00	$0-$35.00 or 30% per visit	$40 In Network $15 for Retail Clinic	$40 In Network $15 for Retail Clinic

Labs/X-Rays	$5.00/$25.00	$0/$20.00	**In Network** $0-$95.00 **Out Network** 30% **(Both Test)**	$0/$40.00	$0/$40.00
Skilled Nursing Care Facility	$0 Day 1-20 **$167.00 per day** **Days 21- 100**	$0 Day 1-20 $172.00 per day Days 21- 100	$0 Day 1-20 $172.00 per day Days 21- 100	$0 Day 1-20 $170.50 per day Days 21- 100	$0 Day 1-20 $150.00 per day Days 21- 100
Podiatry	$35.00 Copay	$40.00 Copay	$35 In Network 30% Out Network	$20.00	$20.00
Ground Ambulance	$240	$195	$265 In Network & Out Network	$250	$150.00
Transportation	**NOT COVERED**	**NOT COVERED**	**NOT COVERED**	**NOT COVERED**	**NOT COVERED**
Over The Counter	**NOT COVERED**	**NOT COVERED**	$45.00 Quarterly	**$30.00 Quarterly**	**$30.00 Quarterly**
Discharge Meals	**14** Post Discharge Meals	**14 Discharge Meals**	**Well Dine Meals Program Covered**	**NOT COVERED**	**NOT COVERED**
Vision Services	**Routine Eye Exam** **$0 Copay** There are limits will on how much the plan will provide	**$0** One **Routine Exam** every year **$0 Copay – Routine Eyewear** **(Eye Glasses** – Lenses and Frames), Eye Glass Lenses, Eye Glass Frames, Contact Lenses (Unlimited), & Upgrades Once a year **$0 Copay** – Plan pays up to **$100.00 every year**	**Routine Exam, Contact Lenses, Eye Glasses and Frames - $0 Copay -** In Network & Out Network There are limits will on how much the plan will provide	**NOT COVERED** Choice Program and Choice Program Plus Supplemental Benefit package available *Call Plan Representative for More information concerning Choice Programs	**Included with Preferred: $10** copay for a Routine Eye Exam and up to **$200** allowance for eyewear every **2 years when purchased from Vision Works**
Preventive Dental	**Oral Exam, Cleanings, Fluoride Treatment, and Dental X-Rays -$0 Copay** **Comprehensive Dental -50% Copay** There are limits will on	**$40.00 Copay** Dental Services **(Medicare Covered)** **$0 Copay - Oral Exam One** every **six months** **Cleaning – One** every **six months** **Bitewing X-ray One**	**Oral Exam, Cleanings, Fluoride Treatment, and Dental X-Rays -$0 Copay** **Comprehensive Dental** **$0** In Network	**NOT COVERED** Choice Program and Choice Program Plus Supplemental Benefit package available *Call Plan Representative for More information	**Included with Preferred:** **$10** copay for Dental Exam and Cleaning **once every 6 months.** One X-Ray per year

	how much the plan will provide	every **six months** **<u>Full Mouth & Panoramic X-ray</u> One** every **36 months** **<u>Comprehensive Dental Services</u>** Restorative Services Periodontics Extractions Prosthodontics/Oral Surgery **$0 Copay** up to a Maximum Coverage amount of **$1,000** per year **Supplemental Dental Packages Available**	**55%** Out Network There are limits will on how much the plan will provide	concerning Choice Programs	
Hearing Services/ Aids	Hear Exam - $**35.00 Copay** Fitting /Evaluation - **$35.00 Copay** **Hearing Aids NOT COVERED** There are limits will on how much the plan will provide	**0 Copay-** <u>Routine Exam</u> **once** a year. **$35.00** Copay in **Specialist Office (Medicare Covered)** <u>Hearing Aid Evaluation/Fitting</u> **One every three years.** <u>Hearing Aids</u> **– $0 Copay -One every three years.** Plan pays up to **$700** per Ear per device **every three years**	**Hearing Exam $35.00** In Network **30%** Out Network **Fitting/Evaluation - $0 Copay** In and Out Network **Hearing Aids - $399 - $699** In Network **$399 – $699** Out Network There are limits will on how much the plan will provide	**NOT COVERED** Choice Program and Choice Program Plus Supplemental Benefit package available *Call Plan Representative for More information concerning Choice Programs	**<u>Included with Preferred</u>:** **$10** Copay for a Routine Hearing Exam **every year.** Hearing Aid benefit of **$499.00 or $799.00** per **Hearing Aid (One per ear/per year)** Provided through **<u>TruHearing</u>**
Fitness Benefit	**COVERED**	**COVERED**	**COVERED**	**SILVER SNEAKERS**	**SILVER SNEAKERS**

MEDICAL ONLY MEDICARE ADVANTAGE HEALTH PLANS

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

2019 ADVANTRA Special Needs Plans (SNP) COVENTRY HEALTH CARE (An Aetna Company) Edison Carrera 267 510-1804	
www.coventry-medicare.com	
PLAN NAME	**ADVANTRA CARES RX HMO SNP Must Have Medicare and Medicaid**
Monthly Premium	**$0**
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 or 289 per day 61-90 days**
Skilled Nursing Care Facility	**$0** or **$0** per days 1-20 **$0 or $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% - always covered**
Emergency Room	**$0 or 20% always covered**
Worldwide Coverage	**20%** for emergency and urgent care outside of the United States
Ambulance	**$0** or **20%** each one-way trip **(Ground)**
Vision Services – Routine Eye Exam	**NETWORK: EyeMed** **$0 Copay** One Routine Exam **every year** **$0 Copay** - Contacts and Eye Glasses –**$200** Allowance every year
Preventive Dental	**NETWORK: DentaMax** **$0 Copay** for Oral Exam, Cleaning, Fluoride Treatment, & X-Rays ***$1,000 Dental Network Allowance** every year for preventive and comprehensive dental combined **DenteMax will manage your dental benefits. To locate a network provider you may contact Customer Service or search the online directory.**

Hearing Services – Routine Hearing Exam	**$0 Copay** One Routine Exam every year **$0 Copay** Hearing AIDS **0% – 20%** Medicare Covered Hearing Exam **$500** yearly Hearing Aid Allowance
Fitness Benefit	**Silver Sneakers**
Transportation Benefit	**$0 copay** 24 to 48 one way trips
Discharge Meals	**14** Home Delivered meals after an inpatient discharge
OTC	**$50.00** Maximum Benefit every month
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**	
Part D Premium	**$35.50 Monthly**
RX Deductible	$270.00 Deductible
For Generic Drugs (Including Brand Drugs Treated as Generic)	**EXTRA HELP COST** **Either $0 or $1.25 or $3.40 or 15% per prescription** **OR** **For all other drugs: Either $0 or $3.80 or $8.50 or 15% per prescription**
30/90 Days	**Tier 1** **Preferred Generic** $2/$0
30/90 Days	**Tier 2** **Generic** $5/$10
30/90 Days	**Tier 3** **Preferred Brand** $47$136
30/90 Days	**Tier 4** **Non -Preferred** $100/$300
30Days	**Tier 5** **Preferred** 27% **90 Day** Not Available

Advantra (Coventry) Special Needs Plan

2019 Allwell Dual Medicine (HMO SNP) Alana Wright – 267-901-2093	
www.allwell@pahealthwellness.com	
Plan Name	**Must have Medicare and Medicaid**
Monthly Premium	$0
PCP REFERRALS REQUIRED	YES
Out of Pocket Cost	$3,400
Annual Deductible for Medical Services	$0
Primary Care Physician	$0 Copay per visit
Specialist Visit	$0 Copay per visit
Inpatient Hospital	$0 Copay per stay, per benefit period
Skilled Nursing Facility	$0 Copay per days 1- 100 **Beyond day 100: Member is responsible for all costs**
Outpatient Hospital	$0 Copay per visit (includes ambulatory surgical center and observation services)
Outpatient Ambulatory	$0 Copay
Lab Services/ X-Ray	Lab Services - $0 Copay Diagnostic Tests and procedures - $0 Co-pay Outpatient X- Ray Services - $0 Copay Diagnostic Radiological Services - $0 Co-pay
Urgent Care	$0 Copay
Emergency Room	$0 Copay
Worldwide Coverage	$0 Copay
Ambulance	$0 Copay (ground and air ambulances) Per one way trip
Vision Services	Routine Eye Exam $0 Copay per visit $0 Copay routine eye exam **Routine Eye Care -up to $200 allowance every calendar year**
Preventive Dental	$0 Copay per visit $0 Copay (including oral exam, cleanings, and x-rays)

	$0 Copay – Comprehensive dental services **$1,000 maximum allowance every calendar year, applies to all comprehensive dental benefits** ***Benefit can be used towards Dentures***
Hearing Services	$0 Copay hearing exam, routine hearing exam (1 per calendar year), hearing aid (2 per calendar year)
Fitness Benefit	$0 Copay fitness program $0 Copay 24 Home Nurse Aid $0 Copay Silver & Fit
Transportation Benefit	$0 Copay for Lab one way trip Up to 24 one way trips to service plan approved locations **(up to 30 miles each one way each calendar year)**
Meals	$0 Copay 14 Discharge meals
OTC	$0 Copay - $250 allowance per quarter available via mail order
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**	
RX Deductible	$415 (for Medicaid deductible do not apply)
For Generic Drugs (Including Brand Drugs Treated as Generic)	30 Days – 25% 90 Days – 25%

ALLWELL DUAL MEDCARE (HMO SNP)

2019 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	$29.00	**$0 or $33.50**
PCP REFERRALS REQUIRED	YES	YES
Out of Pocket Cost	**$6,700**	**$6,700**
Annual Deductible for Medical Services	$0	**$0**
Primary Care Physician	$0	$0 - $20% Coinsurance or $3.80 Full Medicaid
Specialist Visit	$35.00	$0 or $40.00 Copay or $3.80 Full Medicaid
Inpatient Hospital	$275 (**Tier** 1) (1-6 Days) **($1,650)** $295 (**Tier** 2) (1-6 Days) **($1,770) Non Participating Provider**	$0 - $280 per day (1-6 Days) $0 - (7 -90 Days) **($1680)** $0 -$3.80 Full Medicaid
Skilled Nursing Care Facility	$0 Day 1-20 **$172.00 per day** **Days 21- 100**	$0 Day 1-20 **$172 per day** **Days 21- 100**
Outpatient Hospital/ Surgery	$0-$400	$0 – 20% $3.80 Full Medicaid
Outpatient Ambulatory	$0-$400	$0 **– 20% Coinsurance -** $3.80 Full Medicaid
Lab Services/ X-Ray	$0/20%	$0 – 20%
Urgent Care	$55.00	$0 – 20%
Emergency Room	$90.00	$0 or $90.00
World Wide Coverage	**$90** for Emergent and Urgent Care outside of US	$0 or $90.00
Ambulance	$195.00 each one-way trip	$0 – 20%
Transportation	$0 Copay	$0 Copay (Unlimited trips for year)

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 $500.00 Routine Eyewear **every year**	**$0** One **Routine Exam** every year **$500.00 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 year **Full Mouth & Panoramic X-ray** Once 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. $30.00 Copay in **Specialist Office (Medicare Covered)** $0 copay Hearing Aid Evaluation/Fitting **One every three years.** Hearing Aids **– One every three years.** Plan pays 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)**
Over The Counter	**$45.00** Quarterly	**$200.00** Quarterly
Discharge Meals	**14 Discharge Meals**	**14 Discharge Meals**
Fitness Benefit	$Copay	$0 Copay
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**		
RX Deductible	$0	$415.00 Deductible
30/90 Days	**Tier 1** **Preferred** $1/$2 **Standard** $6/$12	**Tier 1** **$0 - $3.80**

30/90 Days	**Tier 2** **Preferred** $5/$10 **Standard** $10/$20	**Tier 2** **$0 - $3.80**
30/90 Days	**Tier 3** **Preferred** $42/$126 **Standard** $47$141	**Tier 3** **$0 - $3.80**
30/90 Days	**Tier 4** **Preferred** $95/$285 **Standard** $100/$300	**Tier 4** **$0 - $3.80**
30Days	**Tier 5** **Specialty & Standard** **33% of 30 day supply** **90- N/A**	**Tier 5** **$0 - $3.80**
Select Diabetic Drugs	**Tier 6** **Preferred** $5/$10 **Standard** $5/$10	

Cigna Health Springs Special Needs Plan (SNP)

2019 Gateway Health HMO Special Needs Plan (SNP) – Karen Pike 724-882-8083 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/$35.00*** ***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**	**$35.00**
Inpatient Hospital	**$ 0 Copay per day for days 1-90**	$**275** Copay Per Day (1-5) **($1,375)** **$0 Copay Per Day - (Days 6-90)**
Outpatient Hospital	**$0 Copay** prior Authorization	
Skilled Nursing Care Facility	**$0** Copay	**$0** Day 1-20 **$172 per day** **Days 21- 100**
Emergency Care	**$0** Copay	**$90** –copay Waived, if admitted
Urgent Care	**$0** Copay	**$45** – copay – Not waived if admitted
Podiatry	**$0 – 20%** Routine Foot Care – **Authorization required**	**$35** copay - **Authorization required**
Transportation	**50** Trips per year	Up to **24** One-way trips per year
Vision Services	**1 Exam Yearly** **Supplemental Eyewear: limited to one pair of glasses or contact lenses each year** **Vendor frames and standard contact lenses at no cost per year when purchased from Davis Vision Collection.** **$200.00 Non-Davis Eyewear or $200.00 toward non-**	**$35 Copay – 1 Exam Yearly** **Supplemental Eyewear: limited to one pair of glasses or contact lenses each year** **Vendor frames and standard contact lenses at no cost per year when purchased from Davis Vision Collection.** **Upgrades yearly**

	vendor contact lenses per calendar year **Upgrades yearly** **Free-Davis Vision Network** Contact Plan for more information	**$175 Non-Davis with standard lenses & non-Davis contacts** **Free-Davis Vision Network** Contact Plan for more information
Preventive and Comprehensive Dental	**$0 Copay** for **one Oral Exam, and X-Ray every six months** **1 Panoramic X-ray** every **5 years** **Filling Simple Extractions, and 2 Crowns** per **year** **Dentures** every **5 years** **$3,500 Combined Allowance**	**$0 copay** for Cleaning, X-ray and Routine Exam every **6 Months** **1 Panoramic x-ray every 5 years**
Hearing Services/ Aids	**$1,500** every **2 years** both ears combined	**$0 copay** Testing, Exams, **$750 for Hearing Aids** every **2 years**
Over the Counter Drugs	**$300 Quarterly (With Rollover)**	**$40 per quarter (With Rollover)**
Post Discharged Meals	**14 days – 28 Meals**	**NOT COVERED**
Life (Medical Alert Response System) Phillips Company	**COVERED- Coordinated through Case Management – 1 per member/per lifetime**	**NOT COVERED**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**		
RX Generic/All Other Drugs	**$0- $1.25 or $3.40 or 15% of the cost*** **$0-$3.80 or-$8.50 or 15% of the cost*** ***Based on Level of Extra Help Program**	**$0- $1.25 or $3.40 or 15% of the cost*** **$0-$3.80 or-$8.50 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

2019 HealthPartners HMO Special Needs Plan (SNP) Lee Van Williams – 267 713-0897	
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	**$3,400**
Annual Deductible for Medical Services	**Coming Soon**
Primary Care Physician	**$0 or 20%**
Specialist Visit	**$0 or 20%**
Inpatient Hospital	**Coming Soon - $0 copay or Original Medicare Cost Sharing**
Skilled Nursing Care Facility	**$0** days 1-20 **$170.50 per day - Days 21- 100** **Prior Authorization Required**
Outpatient Hospital	**$0 or 20%**
Outpatient Ambulatory	**$0 or 20%**
Lab Services/X-Ray	**$0 or 20%**
Urgent Care	**$0 or 20%**
Emergency Room	**$0 or 20%**
Diabetes Test Strips, Monitors & Self-Monitoring Training/ Other Diabetic Supplies	**$0 or 20%**
Ambulance	**$0** or **20%** **Prior Authorization Required for Non- Emergency Services**
Vision Services	**$0** for **2** Routine Exam **$0 or 20% for Medicare Covered Exams.** **1 pair** Contacts and/or Eye Glasses **every year ($200 limit)**
Preventive Dental	**$0 or 20%** for **1** X-Ray, 1 Fluoride Treatment and **2** Exams/Cleanings **yearly** **$0 or 20% cost for Medicare Covered Dental Benefits** Other Services: (**$3,000 Limit)**

Hearing Services	**$0 or 20%** for Routine Exam **yearly: Hearing Aids every 3 years (1000 limit)** **$0 Copay for Supplemental Hearing Exams**
Fitness Benefit	**$0 In Network**
Transportation Benefit (routine)	**$0 Copay up to 60 one- way (van or medical trips) per year to approved locations**
OTC	**$50 Monthly OTC** **Unused Portions, No Carryover/ month- to- month** **Physician Approval required**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**	
RX Deductible	**$415/Deductible**
Prescription Drugs	**Generic: $0/ or $1.25/ or $3.40/ 25%** **OR** **Other Drugs: $0/ or $3.80/ or $8.50/ or 15%**

HEALTH PARTNERS SPECIAL NEEDS HEALTH PLAN (SNP)

2019 Humana HMO Special Needs Plan (SNP) Gus Grant – 610 565-7214	
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** copay for amalgam or composite filling, extra oral x-rays, and 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 • Maximum benefit $1,000 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.** **$0 copay for advance level hearing aids (1 per ear/per year) includes 48 batteries per aid and 3 year warranty.** **Medicaid: Sliding scale copay from $0.65 - $3.80 for individuals 18 years of age and up.**
Fitness Benefit	**$0 Silver Sneakers**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,750**	
RX Deductible	$0 Deductible
Transportation	**$0 – unlimited one way trips – not to exceed 25 miles – must contact transportation vendor**
Over the Counter	**$0 copay -Mail Order – up to $300 Quarterly**
Prescription Drugs	**30 Days - For Generic Drugs (Including brand drugs treated as generics: $**0/ or $1.25/ or $3.40 • **Must Use Tru Hearings** **OR** **Other Drugs**: $0/ or $3.80/ or $8.50 **90 Days - For Generic Drugs (Including brand drugs treated as generics:** $0/ or $1.25/ or $3.40 **OR** **Other Drugs:** $0/ or $3.80/ or $8.50 Specialty Drugs are limited to **30-day supply** **$0 – Copay – Chemotherapy Drugs**

HUMANA GOLD PLUS RX –SPECIAL NEEDS PLAN

2019 Keystone VIP Choice Special Needs Plan (SNP) John Kearney – 267 212-3628	
www.keystonefirstvipchoice.com	
PLAN NAME	**KEYSTONE FIRSTVIP** **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** - Prior Authorization
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 –**certain test need Prior Authorization
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 year**s 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 year** **$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 three (3) years.
Fitness Benefit	**$0 - Health Club/Fitness Club/Membership Classes**
Over the Counter Items	**$70 every three months (No Roll Over)**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**	
RX Deductible	$0 Deductible
Prescription Drugs	**30 Days - For Generic Drugs (Including brand drugs treated as generics: $**0/ or $1.25/ or $3.40 **OR** **Other Drugs**: $0/ or $3.80/ or $8.50 **Mail Order - For Generic Drugs (Including brand drugs treated as generics:** $0/ or $1.25/ or $3.40 **OR** **Other Drugs:** $0/ or $3.80/ or $8.50 Specialty Drugs are limited to **30-day supply**

KEYSTONE VIP CHOICE SPECIAL NEEDS PROGRAM (SNP)

2019 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 – single delivery**
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**

	$3,000 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 Silver Sneakers**
PRESCRIPTION **TOTAL 2019 DRUG MEDICARE RX ALLOWANCE $3,820**	
RX Deductible	$0 Deductible
Transportation	**0 – copay - 50 one way trips**
UPMC My Health	**24/7 Nurse Line – No Cost**
Prescription Drugs	**30 Days - For Generic Drugs (Including brand drugs treated as generics: $**0/ or $1.25/ or $3.50/15% **OR** **Other Drugs**: $0/ or $3.80/ or $8.50 **90 Days - For Generic Drugs (Including brand drugs treated as generics:** $0/ or $1.25/ or $3.40 **OR** **Other Drugs:** $0/ or $3.80/ or $8.50 Specialty Drugs are limited to **30-day supply**

UMPC FOR LIFE DUAL (HMO (SNP) SPECIAL NEEDS PLAN

2019 HMO AND PPO PLAN HOSPITAL AFFILIATIONS

ADVANTRA **HMO and PPO Plans** - accepts all Delaware County, Philadelphia, and Main Line Health Hospitals

All Delaware County Hospitals	**Thomas Jefferson University Hospital**
All Crozer Hospitals	**University of Penn Health System**
Lankenau Hospital	**Main Line Hospitals**
Bryn Mawr Hospital	**Paoli Hospital**
Riddle Hospital	**Not Accepted:** Lower Buck and Roxborough Hospitals

AETNA **HMO and PPO Plans** - accepts all Delaware County, Philadelphia, and Main Line Health Hospitals

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**
University of Penn Health System	**Not Accepted:** Lower Buck and Roxborough Hospitals

ALLWELL HMO HEALTH PLANS

University of Pennsylvania Network	**Main Line Health Network**
Crozer- Keystone Health Network	

CIGNA HEALTH SPRINGS HMO HEALTH PLANS

Mercy Fitzgerald Hospital and Riddle Memorial Hospital
No Crozer Hospitals

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 and 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 SPECIAL NEEDS PLANS DIAMOND & RUBY HEALTH PLANS

Mercy Fitzgerald Hospital	**Delaware County Hospitals** except for Riddle and the Mainline Hospitals
Springfield Hospital	**Taylor Hospital**
University of Pennsylvania Health Systems	**All Crozer Hospitals**
Pennsylvania Hospital	**Hahnemann Hospital**
Thomas Jefferson Health System	

KEYSTONE 65 HMO/PPO– Basic, Preferred, Personal Choice, & Select Health Plans

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

UPMC FOR LIFE MEDICARE ADVANTAGE HMO 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**
Lankenau Hospital	

SCS APPRISE Program is funded in part through the Administration for Community Living under contract with Delaware County

SCS SENIOR COMMUNITY SERVICES

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

PDA pennsylvania DEPARTMENT OF AGING

COUNTY OF DELAWARE PENNSYLVANIA