Council on Aging
HICAP Orange County

2006 Orange County Medicare Advantage Comparison Chart

(714) 560-0424
or 1-800-Medicare
or www.medicare.gov

Company	Aetna	Blue Cross	Blue Cross	Blue Cross
Plan Name	Golden Medicare Plan	Senior Secure Plan 1	Senior Secure Plan 2 (MA Plan Only)	Freedom Blue Plan 1
Telephone Numbers Website	New enrollment: 1-800-832-2640 Current members: 1-800-282-5366 www.aetna.com	New enrollment: 1-800-765-2585 Current members: 1-800-765-2585 www.bluecrossca.com	New enrollment: 1-800-765-2585 Current members: 1-800-765-2585 www.bluecrossca.com	New enrollment: 1-800-765-2585 Current members: 1-800-765-2585 www.bluecrossca.com
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA ONLY (HMO)** Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**PPO-PD** Preferred Provider Plan with Prescription Drug Benefit. May choose any provider. Plan Network providers at less cost.
Monthly Premium	$0 Monthly Premium	$0 Monthly Premium ($1,500 annual out-of-pocket maximum on a combination of certain plan services)	$60 Monthly Premium	$7 Monthly Premium In network: $1000 yearly deductible and $3000 max out of-pocket. Out-of-Network: $1250 deductible/$5000 max out-of pocket.
Doctor Visit	$5 each visit	$5 each visit	$25 each visit	Network:$10 Out: 20%
Specialist Visit	$10 each visit	$10 each visit	$25 each visit	Network:$10 Out: 20%
Physician Network	251-500 physicians and providers in plan network	501-1000 physicians and providers in plan network	501-1000 physicians and providers in plan network	3501-4000 physicians and providers in plan network
In-patient Hospitalization	$75 per day, days 1-5. $0 per day, days 6-90. Unlimited days each benefit period.	$75/day per day, days 1-21. $0/per day, days 22-90. (Cost sharing may vary by hospital at which services are received.)	No copay.	In Network: 10% of cost. Out of Network: 20% of cost.
Skilled Nursing Facility	$0/day days 1-20. $20/day days 21-100. No prior hospital stay required. Max. 100 days covered per benefit period.	$0/day days 1-20. $20/day days 21-100. No prior hospital stay required. Max. 100 days covered per benefit period.	$2000 deductible. No prior hospital stay is required. 100 days each benefit period.	In Network: 10% of cost. Out of Network: 20% of cost. 100 days each benefit period.
In-patient Mental Health	$75 per day, days. $0 per day, days 1-5. 190-day psychiatric hospital lifetime limit.	$0 per day, days 1-21. $100 per day, days 22-90. 190-day psychiatric hospital lifetime limit.	No copay. 190 day psychiatric hospital lifetime limit.	In Network: 10% of cost. Out of Network: 20% of cost. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	$25 per session	$10 per session	$25 per visit	Network:10% Out: 20%
Outpatient Services/Surgery	$100 each visit	$100 per visit	No copay	Network:10% Out: 20%
Ambulance	$100 each service	$100 each service	No copay	Network:10% Out: 20%
Emergency Room Visit	$50 each visit, waived if admitted	$50 each visit	$50 each visit	$50 each visit, regardless of location.
Outpatient Rehabilitation Services	$10 each visit	$10 each visit	$25 each visit	Network:10% Out: 20%
Durable Medical Equipment	20% of the cost of each Medicare-covered item	20% of the cost for each Medicare-covered item.	No copay	Network:10% Out: 20%
Diagnostic Tests, X-Rays, and Lab Services	$0 each lab service, $10 radiation therapy, $0-$100 each X-ray.	0-20% of the cost of each lab service	0-20% of the cost of each lab service	Network:10% Out: 20%
Chiropractic Services	$10 copay for each *Medicare covered* visit.	$20 copay for each *Medicare covered* visit.	$25 copay each visit	Network:10% Out: 20%
Dental Services	Preventative Plan: $5 monthly premium Advantage Dental Plan: $10 monthly premium	$0 copay for 2 cleaning visits and 1check-up including x-rays per year	$0 for 1 oral exam each year. $30-40 cleaning fee for up to 2 visits year year.	You pay 20% of the cost for out of netowrk comprehensive dental services
Hearing Services	No copay for Hearing aids. $0 for routine $10 hearing test. $10 for diagnostic exam. Covered up to $500 for hearing aids every 3 years.	You pay 100% for hearing aids. $10 for each hearing exam. 1 routine hearing test allowed per year.	You pay 100% for hearing aids. $25 for each diagnostic/routine exam.	No copayment for Hearing aids. $0 for routine hearing test. $10 for diagnostic exam. Covered up to $100 for hearing aids every 2 years.
Vision Services	$0 for 1 annual routine eye exam. $10 copay for diagnostic exam. $0 for 1 pair eyeglasses after cataract surgery	$10-$20 for eye exam. $0 for lenses and up to $75 for frames for 1 pair of eyglasses every two years. 20% of cost if after cataract surgery.	No copay for one pair of eyewear after cataract surgery. $20-$25 for exams. Up to $75 toward eyewear every two years.	No copay for one pair of eyeglasses after cataract surgery. $20 for exam. 20% out of netowrk. $75 toward eye wear every two years.
Miscellaneous	Health Club Membership			
Prescription Drugs	See separate Information Chart detailing Prescription Drug benefits for this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.	No Prescription Drug benefit with this plan.

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2006 Orange County Medicare Advantage Comparison Chart

Company	Blue Cross	Blue Shield	Blue Shield	Calif Health Plan
Plan Name	Freedom Blue Plan 2	65 Plus Plan	65 Plus Value Plan	Calif Medicare Advantage CareMore Value Plus
Telephone Numbers Website	New enrollment: 1-800-765-2585 Current members: 1-800-765-2585 www.bluecrossca.com	New enrollment: 1-800-400-6500 Current Members: 1-800-776-4466 www.mylifepath.com	New enrollment: 1-800-400-6500 Current Members: 1-800-776-4466 www.mylifepath.com	New enrollment: 1-800-822-6991 Current Members: 1-800-822-6991 www.californiamedicare.com
Plan Type	**PPO-PD** Preferred Provider Plan with Prescription Drug Benefit. May choose any provider. Plan Network providers at less cost.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.
Monthly Premium	$32 Monthly Premium In network: $500 yearly deductible and $3000 max out of-pocket. Out-of-Network: $750 deductible/$5000 max out-of pocket.	$0 Monthly Premium	$0 Monthly Premium Plan available in certain zip codes of Orange County only. Check with Blue Shield for more information	$0 Monthly Premium Plan available in certain zip codes of Orange County only. Check with Calif Health Plan for more information
Doctor Visit	Network:$10 Out: 20%	$5 each visit	$0 copay	$0 copay
Specialist Visit	Network:$10 Out: 20%	$10 each visit	$0 copay	$0 copay
Physician Network	3501-4000 physicians and providers in plan network	3501-4000 physicians and providers in plan network	501-1000 physicians and providers in plan network	501-1000 physicians and providers in plan network
In-patient Hospitalization	In Network: 10% of cost. Out of Network: 20% of cost.	$200/day, days 1-10. $0/day, days 11-90 Unlimited days each benefit period. $2000 maximum out-of-pocket per year.	$0 copay Unlimited days each benefit period.	$0 copay. Unlimited days each benefit period.
Skilled Nursing Facility	In Network: 10% of cost. Out of Network: 20% of cost. 100 days each benefit period.	$0/day days 1-20. $50/day days 21-100. No prior hospital stay required. Max. 100 days per benefit period.	$0 copay No prior hospital stay required. Max. 100 days covered per benefit period.	$0 copay No prior hospital stay required. Max. 100 days per benefit period.
In-patient Mental Health	In Network: 10% of cost. Out of Network: 20% of cost. 190-day psychiatric hospital lifetime limit.	$200/day, days 1-10. $0/day, days 11-90. 190-day psychiatric hospital lifetime limit.	$0 copay 190-day psychiatric hospital lifetime limit.	$150 deductible 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	Network:10% Out: 20%	$30 per session	$30 per session	$30 per session
Outpatient Services/Surgery	Network:10% Out: 20%	$125 each visit	$0 copay	$0 copay
Ambulance	Network:10% Out: 20%	$125 each service	$50 each service	$50 each service
Emergency Room Visit	$50 each visit, regardless of location.	$50 each visit, waived if admitted	$50 each visit, waived if admitted	$50 each visit, waived if admitted
Outpatient Rehabilitation Services	Network:10% Out: 20%	$10 each visit	$0 copay	$0 copay
Durable Medical Equipment	Network:10% Out: 20%	20% of the cost of each Medicare-covered item	0% to 20% of the cost of each Medicare-covered item	0% to 20% of the cost of each Medicare-covered item
Diagnostic Tests, X-Rays, and Lab Services	Network:10% Out: 20%	No copay	No copay	$0 copay
Chiropractic Services	Network:10% Out: 20%	$10 copay for each *Medicare covered* visit.	No copay for each *Medicare covered* visit.	No copay for each *Medicare covered* visit.
Dental Services	You pay 20% of the cost for out of netowrk comprehensive dental services	no coverage	$5-$20 copay depending on service. Number of visits limited.	$5-$20 copay for exams. Number of visits limited. Additional benefits available
Hearing Services	No copayment for Hearing aids. $0 for routine hearing test. $10 for diagnostic exam. Covered up to $100 for hearing aids every 2 years.	You pay 100% of hearing aids. $0 copay for hearing exams.	You pay 100% of hearing aids. $0 copay for hearing exams.	No copayment for Hearing aids. $0 one hearing exam each year. Covered up to $250 for hearing aids every 2 years.
Vision Services	No copay for one pair of eyeglasses after cataract surgery. $20 for exam. 20% out of netowrk. $75 toward eye wear every two years.	$10 for eye exam. $20 for lenses and up to $20 for frames for 1 pair of eyglasses every two years. No cost if after cataract surgery.	$0 for one exam per year. Covered up to $90 for eyeware every two years.	$0 for one exam per year. Covered up to $90 for eyeware every two years.
Miscellaneous			$0 roundtrip transportation to plan approved locations.	
Prescription Drugs	See separate Information Chart detailing Prescription Drug benefits for this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.

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2006 Orange County Medicare Advantage Comparison Chart

Company	Calif Health Plan	Health Net	Health Net	Kaiser
Plan Name	California Medicare Advantage PPO	Seniority Plus	Seniority Plus (MA Plan only)	Senior Advantage
Telephone Numbers Website	New enrollment: 1-800-822-8720 Current Members: 1-800-822-8720 www.californiamedicare.com	New enrollment: 1-800-935-6565 Current Members: 1-800-275-4737 www.healthnet.com	New enrollment: 1-800-935-6565 Current Members: 1-800-275-4737 www.healthnet.com	New enrollment: 1-800-777-1238 Current Members: 1-800-443-0815 www.kaiserpermanente.com
Plan Type	**PPO-PD** Preferred Provider Plan with Prescription Drug Benefit. May choose any provider. Plan network providers at less cost.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA ONLY (HMO)** Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.
Monthly Premium	$56 Monthly Premium Plan available in certain zip codes of Orange County only. Check with Calif Health Plan for more information	$0 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium (There is a $3000 maximum out-of-pocket limit every year for plan services.)
Doctor Visit	$0 copay	$10 each visit	$10 each visit	$10 each visit
Specialist Visit	$0 copay	$10 each visit	$10 each visit	$10 each visit
Physician Network	501-1000 physicians and providers in plan network	13,001-14,000 physicians and providers in plan network	13,001-14,000 physicians and providers in plan network	3501-4000 physicians and providers in plan network
In-patient Hospitalization	$912 deductible for netowrk hospital. In addition, out of network copays of $0 per day, days 1-60, $228 per day, days 61-90. $456 per day, days 91-150.	$100/day, days 1-4. $0/day, days 5-90. Unlimited days each benefit period.	$100/day, days 1-4. $0/day, days 5-90. Unlimited days each benefit period.	$300/day up to $3000 max. out of pocket annually. Unlimited days each benefit period.
Skilled Nursing Facility	$0 each day for days 1-20. $114 days 21-100. Maximum 100 days per period. 3 day hospital day required.	$0/day days 1-20. $75/day days 21-100. No prior hospital stay required. Max. 100 days per benefit period.	$0/day days 1-20. $75/day days 21-100. No prior hospital stay required. Max. 100 days per benefit period.	$0/day days 1-20. $75/day days 21-100 $3000 max. out of pocket annually. No prior hospital stay required. Max. 100 days per period.
In-patient Mental Health	$150 deductible 190-day psychiatric hospital lifetime limit.	$900 each stay. 190-day psychiatric hospital lifetime limit.	$900 each stay. 190-day psychiatric hospital lifetime limit.	$300/day up to $3000 max. out of pocket annually. Contact plan about benefits beyond 190 days.
Outpatient Mental Health	50% Individual 20% group	$25 per session	$25 per session	$10 per session
Outpatient Services/Surgery	$0 copay	$100 each visit	$100 each visit	$0 - $150 each visit
Ambulance	20% of cost	$125 each service	$125 each service	$100 each service
Emergency Room Visit	$50 each visit, waived if admitted	$50 each visit, waived if admitted	$50 each visit, waived if admitted	$50 each visit, waived if admitted
Outpatient Rehabilitation Services	$0 copay	$0 copay	$0 copay	$10 each visit
Durable Medical Equipment	0% to 20% of the cost of each Medicare-covered item	up to 20% of the cost of each Medicare-covered item	up to 20% of the cost of each Medicare-covered item	20% of the cost of each Medicare-covered item
Diagnostic Tests, X-Rays, and Lab Services	$0 copay	$0-275 for each lab service or radiation therapy.	$0-275 for each lab service or radiation therapy.	$20 each lab service. $20-$50 each X-ray.
Chiropractic Services	No copay for each *Medicare covered* visit.	$10 copay for each *Medicare covered* visit.	$10 copay for each *Medicare covered* visit.	$10 copay for each *Medicare covered* visit.
Dental Services	$14.95 monthly premium for optional dental benefits.	See Miscellaneous Section	$0-$40 for cleaning/exams/x-rays. Additional dental benefits available.	No coverage
Hearing Services	You pay 100% for hearing aids. 20% cost of diagnostic exam.	You pay 100% for hearing aids. $10 for diagnostic exam. $10 for routine exam up to 1 test per year.	You pay 100% for hearing aids. $10 for diagnostic exam. $10 for routine exam up to 1 test per year.	$10 for diagnostic exam. No other coverage
Vision Services	You pay 100% for eyewear. 20% cost of diagnostic exam.	No copay for one pair of eyeglasses after cataract surgery. $10 for diagnostic exam. $10 for routine exam up to 1 test per year.	No copay for one pair of eyeglasses after cataract surgery. $10 for exams. Up to $250 for eyewear every two years.	No copay for one pair of eyeglasses after cataract surgery. $10 for diagnostic/routine exam. Up to $150 for eyewear every two years.
Miscellaneous		$15 monthly premium for dental, vision, chiropractic, and accupuncture benefits		
Prescription Drugs	See separate Information Chart detailing Prescription Drug benefits for this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.	No Prescription Drug benefit with this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.

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2006 Orange County Medicare Advantage Comparison Chart

Company	Kaiser	SCAN	Secure Horizons	Secure Horizons
Plan Name	Senior Advantage (MA Plan Only)	Scan Health Plan	Classic Plan	Premier Plan
Telephone Numbers Website	New enrollment: 1-800-777-1238 Current Members: 1-800-443-0815 www.kaiserpermanente.com	New enrollment: 1-800-699-7689 Current Members: 1-800-559-3500 www.scanhealthplan.com	New enrollment: 1-800-385-5588 Current Members: 1-800-228-2144 www.securehorizons.com	New enrollment: 1-800-385-5588 Current Members: 1-800-228-2144 www.securehorizons.com
Plan Type	**MA ONLY (HMO)** Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.
Monthly Premium	Call Kaiser at 1-800-777-1238 for further information on this MA Plan.	$0 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium
Doctor Visit		$10 each visit	$5 each visit	$5 each visit
Specialist Visit		$10 each visit	$10 each visit	$10 each visit
Physician Network		1001-1500 physicians and providers in plan network	6501-7000 physicians and providers in plan network	251-500 physicians and providers in plan network
In-patient Hospitalization		$50/day, days 1-10. $0/day, days 11-90. Unlimited days each benefit period.	$200 for each covered stay at a network hospital. Unlimited days each benefit period.	$200 for each covered stay at a network hospital. Unlimited days each benefit period.
Skilled Nursing Facility		$0/day days 1-20. $20/day days 21-100. No prior hospital stay required. Max. 100 days per benefit period.	$0 per day, days 1-20. $100 per day, days 21-100. No prior hospital stay is required. 100 maximum days covered each benefit period.	$0 per day, days 1-20. $100 per day, days 21-100. No prior hospital stay is required. 100 maximum days covered each benefit period.
In-patient Mental Health		$50/day, days 1-10. $0/day, days 11-90. Unlimited days each benefit period.	$912 per stay. 190-day psychiatric hospital lifetime limit.	$912 per stay. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health		$10 per session	$30 per session	$30 per session
Outpatient Services/Surgery		$50 each visit	$100 each visit	$100 each visit
Ambulance		$50 each service	$75 each service	$75 each visit
Emergency Room Visit		$50 each visit, waived if admitted	$50 each visit	$50 each visit
Outpatient Rehabilitation Services		$10 each visit	$30 copay	$30 copay
Durable Medical Equipment		0-10% for each Medicare-covered item	20% of the cost of each Medicare-covered item	20% of the cost of each Medicare-covered item
Diagnostic Tests, X-Rays, and Lab Services		$0 copay for x-rays. 0-10% of each lab service. 20% radiation therapy.	$0 each lab test. 20% of cost radiation therapy. 0-20% for X ray.	$0 each lab test. 20% of cost radiation therapy. 0-20% for X ray.
Chiropractic Services		$10 copay for each *Medicare covered* visit.	$10 copay for each *Medicare covered* visit.	$10 copay for each *Medicare covered* visit.
Dental Services		no coverage	3 Dental Plans available. Additional monthly premium may apply	3 Dental Plans available. Additional monthly premium may apply
Hearing Services		No copay for hearing aids every two years. $10 routine/diagnostic exams. Limitations apply.	$10 for diagnostic exam. No other coverage	$10 for diagnostic exam. No other coverage
Vision Services		$10 copay for eyeglasses after cataract surgery. $10 for diagnostic/routine exam. Up to $100 for eyewear every 2 years.	$0 for eyeglass after each cataract surgery. $5-$10 for diagnostic exam. $25 routine eye exam. $20 for glasses. $150 limit every two years.	$0 for eyeglass after each cataract surgery. $5-$10 for diagnostic exam. $25 routine eye exam. $20 for glasses. $150 limit every two years.
Miscellaneous		12 Roundtrip rides to approved locations. In home assistance benefit. Check with SCAN		
Prescription Drugs	No Prescription Drug benefit with this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.

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2006 Orange County Medicare Advantage Comparison Chart

Company	Secure Horizons	Secure Horizons	Secure Horizons	UHP
Plan Name	**Value Plan**	**Enhanced Plan**	**Medical Plan (MA Plan Only)**	**Healthcare for Seniors**
Telephone Numbers Website	New enrollment: 1-800-385-5588 Current Members: 1-800-228-2144 www.securehorizons.com	New enrollment: 1-800-385-5588 Current Members: 1-800-228-2144 www.securehorizons.com	New enrollment: 1-800-385-5588 Current Members: 1-800-228-2144 www.securehorizons.com	New Enrollment 1-800-847-1222 Current Members: 1-800-544-0088 www.uhphealthcare.com
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA ONLY (HMO)** Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicans, providers and hospitals.
Monthly Premium	$0 Monthly Premium	$43 Monthly Premium	$0 Monthly Premium	$2.37 Monthly Premium
Doctor Visit	$0 copay	$5 each visit	$5 each visit	$10 each visit
Specialist Visit	$5 each visit	$10 each visit	$10 each visit	$10 each visit
Physician Network	There are approximately 250 physicians and providers in plan network	4501-5000 physicians and providers in plan network	4501-5000 physicians and providers in plan network	2001-2500 physicians and providers in plan network
In-patient Hospitalization	$200 for each covered stay at a network hospital. Unlimited days each benefit period.	$50 for each covered stay at a network hospital. Unlimited days each benefit period.	$50 for each covered stay at a network hospital. Unlimited days each benefit period.	$200 copay for each stay. Unlimited days each benefit period.
Skilled Nursing Facility	$0 per day, days 1-20. $100 per day, days 21-100. No prior hospital stay is required. 100 maximum days covered each benefit period.	$0 per day, days 1-20. $100 per day, days 21-100. No prior hospital stay is required. 100 maximum days covered each benefit period.	$0 per day, days 1-20. $100 per day, days 21-100. No prior hospital stay is required. 100 maximum days covered each benefit period.	$0/day, days 1-20. $50/day, days 21-100. No prior hospital stay required. Max. 100 days per benefit period.
In-patient Mental Health	$912 per stay. 190-day psychiatric hospital lifetime limit.	$912 per stay. 190-day psychiatric hospital lifetime limit.	$912 per stay. 190-day psychiatric hospital lifetime limit.	$50/day, days 1-8. $0/day, days 9-90. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	$30 per session	$30 per session	$30 per session	$10 per session
Outpatient Services/Surgery	$100 each visit	$50 each visit	$50 each visit	$10 each visit
Ambulance	$75 each visit	$75 each visit	$75 each visit	$50 each service
Emergency Room Visit	$50 each visit	$50 each visit	$50 each visit	$50 each visit, waived if admitted
Outpatient Rehabilitation Services	$30 copay	$30 copay	$30 copay	$10 each visit
Durable Medical Equipment	20% of the cost of each Medicare-covered item	20% of the cost of each Medicare-covered item	20% of the cost of each Medicare-covered item	$0 copay
Diagnostic Tests, X-Rays, and Lab Services	$0 each lab test. 20% of cost radiation therapy. 0-20% for X-ray.	$0 each lab test. 20% of cost radiation therapy. 0-20% for X-ray.	$0 each lab test. 20% of cost radiation therapy. 0-20% for X-ray.	$0 copay
Chiropractic Services	$5 copay for each *Medicare covered* visit.	$10 copay for each *Medicare covered* visit.	$10 copay for each *Medicare covered* visit.	$10 copay for each *Medicare covered* visit. $15 for up 12 visits per year for routine visits
Dental Services	3 Dental Plans available. Additional monthly premium may apply	3 Dental Plans available. Additional monthly premium may apply	3 Dental Plans available. Additional monthly premium may apply	No copay up to 2 visits per year. Additional benefits available.
Hearing Services	$5 for diagnostic exam. No other coverage	You pay 100% for hearing aids. $10 for each Medicare covered exam.	You pay 100% for hearing aids. $10 for each Medicare covered exam.	You pay 100% for hearing aids. $10 for exams.
Vision Services	$0 for eyeglass after each cataract surgery. $5-$10 for diagnostic exam. $25 routine eye exam. $20 for glasses. $150 limit every two years.	$0 for eyeglass after each cataract surgery. $5-$10 for diagnostic exam. $25 routine eye exam. $20 for glasses. $150 limit every two years.	$0 for eyeglass after each cataract surgery. $5-$10 for diagnostic exam. $25 routine eye exam. $20 for glasses. $150 limit every two years.	$0 for eyeglass after each cataract surgery. $5 for diagnostic/routine exam. $150 towards eyeware every two years.
Miscellaneous	$5 copay for up to six accupuncture treatments per year.			
Prescription Drugs	See separate Information Chart detailing Prescription Drug benefits for this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.	No Prescription Drug benefit with this plan.	See separate Information Chart detailing Prescription Drug benefits for this plan.

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