

Company	Aetna	Arta Medicare	Anthem Blue Cross	Blue Shield
Plan Name	Medicare Select Plan	Health Plan	Senior Secure Plan I	65 Plus Plan
Telephone Numbers Website	New enrollment: 1-800-455-1560 Current members: 1-800-282-5366 aetnamedicare.com	New enrollment: 1-866-844-2170 Current members: 1-866-376-8294 artamedicare.com	New enrollment: 1-800-797-6438 Current members: 1-888-230-7338 anthem.com/ca	New enrollment: 1-800-488-8000 Current Members: 1-800-776-4466 blueshieldca.com
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium (\$3,350 annual out-of-pocket maximum on certain plan services)	\$0 Monthly Premium
Doctor Visit	\$5 each visit	\$0 each visit	\$5 to \$30 each visit	\$0 each visit
Specialist Visit	\$10 each visit	\$10 each visit	\$30 each visit	\$10 each visit
Physician Network	1501-2000 physicians and providers in plan network	1001-1500 physicians and providers in plan network	18001-19000 physicians and providers in plan network	8501-9000 physicians and providers in plan network
In-patient Hospitalization	\$50 copay per stay. Unlimited days each benefit period.	\$0 copay per stay. Unlimited days each benefit period.	\$150/day, days 1-5. \$0/day, days 6-90. \$1,500 annual out-of-pocket limit. Unlimited days each benefit period.	\$50/day, days 1-10. \$0/day days 11-90. \$0/day additional days. \$500 out-of-pocket limit. Unlimited days each benefit period.
Skilled Nursing Facility	\$0/day, days 1-20. \$20/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0 copay. No prior hospital stay required. 100 days covered each benefit period.	\$0/day days 1-20. \$130/day days 21-100. No prior hospital stay required. 100 days each benefit period.	\$0/day, days 1-20. \$85/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	\$50 copay per stay. 190-day psychiatric hospital lifetime limit.	\$250/day. 190-day psychiatric hospital lifetime limit.	\$1,068 copay for each Medicare-covered stay. 190-day psychiatric hospital lifetime limit.	\$900 copay per Medicare-covered. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	\$10 per session	\$0 per session	\$40 per session	\$30 per session
Outpatient Services/Surgery	\$25 each visit	\$0 each visit.	\$30 or \$125 each visit depending on facility	\$0 each visit
Ambulance	\$75 each service	\$50 each service. \$0 if admitted to the hospital	\$100 each service	\$100 each service
Emergency Room Visit	\$50 each visit, waived if admitted	\$50/ visit, waived if admitted. \$25,000 limit for emergency outside U.S.	\$50 each visit, waived if admitted within 72 hrs.	\$50/ visit, waived if admitted within 24 hrs. \$10,000 outside of U.S. limit.
Outpatient Rehabilitation Services	\$10 each visit	\$0 each visit	\$30 to \$50 each visit	\$10 each visit
Durable Medical Equipment	20% of the cost of each Medicare-covered item.	0% to 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.
Diagnostic Tests	\$0 for diagnostic procedures/tests, \$100 diagnostic radiology service	\$0 for diagnostic procedures/tests, \$25 diagnostic radiology service	\$30 to \$150 for diagnostic procedures/tests and radiology service	\$0 for diagnostic procedures/tests. 20% diagnostic radiology service
X-Rays	\$0 each X-ray	\$0 each X-ray	\$30 to \$150 each X-ray	\$0 each X-ray
Lab Services	\$0 each lab service, \$10 therapeutic radiology services. \$5 office visit copay may apply	\$0 each lab service, \$25 therapeutic radiology services.	\$0 each lab service, 20% for therapeutic radiology. \$5 to \$30 visit copay may apply	\$0 of the cost of each lab service. 20% of therapeutic radiology.
Part B Chemotherapy Drugs	\$45 copay for Part B chemotherapy drugs	0% to 20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	Preventative dental benefits not covered. May be covered for an extra cost - \$10. Plus \$5 per visit (limit 2/year)	Preventative benefits. \$15 copay for exams (2/year), \$20 copay for cleaning (2/year) and \$5 copay for x-rays (every 2 years)	Preventative benefits. \$0 copay for 1 exam and cleaning every year.	Preventative benefits. \$5 to \$15 exam. \$20 cleaning (2/year). \$5 to \$15 fluoride treatment (2/year). \$0 to \$10 X-ray (every 2 years).
Hearing Services	No copay for Hearing aids. \$10 for diagnostic exams. \$0 for routine hearing tests, \$1,200 limit for hearing aids every 3 years.	\$0-\$10 copay for diagnostic hearing exams. Routine exams and hearing aids not covered.	You pay 100% for hearing aids. \$30 for hearing exam (1/year). \$30 1 routine hearing test per year.	You pay 100% of hearing aids. \$0 copay for hearing exams.
Vision Services	\$0 copay for 1 pair of eyeglasses or contacts after cataract surgery. \$10 copay for diagnostic exams and treatment of conditions. \$0 for 1 routine exam per yr. \$225 limit for eyewear every 2 years. \$5 office visit.	\$0 for 1 annual routine eye exam. \$0 copay for diagnostic exam. \$0 for 1 pair of glasses or contacts every 2 years. \$160 limit for eyewear every two years.	\$0 for eye wear after cataract surgery up to 1 pair. \$20 for diagnostic exams. \$20 for routine exam up to 1 per year.	\$0 for eye wear after cataract surgery (1). \$10 copay for eye exam. \$20 for lenses 1/year. \$20 for 1 frame of eyeglasses up to \$75 every two years.
Prescription Drugs	See separate Chart	See separate Chart	See separate Chart	See separate Chart

Company	Blue Shield	CareMore Health Plan	CareMore Health Plan	Care1st
Plan Name	65 Plus Choice Plan (Some Zip Codes)	CareMore Value Plus	StartSmart Plan	Care1st Medicare Advantage Plan
Telephone Numbers Website	New enrollment: 1-800-488-8000 Current Members: 1-800-776-4466 blueshieldca.com	New enrollment: 1-866-622-2820 Current Members: 1-800-822-6991 caremorehealthplan.com	New enrollment: 1-866-622-2820 Current Members: 1-800-822-8720	New enrollment: 1-800-847-1222 Current Members: 1-800-544-0088 care1st.com
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium Plan will reduce the \$96.40 Part B Premium by \$75 per month.	\$0 Monthly Premium .
Doctor Visit	\$0 each visit	\$0 each visit	\$5-\$20 each visit	\$0 each visit
Specialist Visit	\$0 each visit	\$0 each visit	\$20 each visit	\$5 each visit
Physician Network	501-1000 physicians and providers in plan network	1001-1500 physicians and providers in plan network	1001-1500 physicians and providers in plan network	2001-2500 physicians and providers in plan network
In-patient Hospitalization	\$0 copay. Unlimited days each benefit period.	\$0 copay. Unlimited days each benefit period.	\$100/day, days 1-4. \$0/day, days 5-90. \$0 copay for additional days. Unlimited days each benefit period.	\$50/day, days 1-3. \$0/day, days 4-90. \$0 copay for additional days. Unlimited days each benefit period.
Skilled Nursing Facility	\$0/day, days 1-20. \$60/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-31. \$25/day, days 32-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-20. \$50/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-20. \$50/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	\$900 copay per Medicare-covered. 190-day psychiatric hospital lifetime limit.	\$0 copay. Contact plan for coverage beyond 190 days.	\$100/day, days 1-4. \$0/day, days 5-90. \$0 copay for additional days. Contact plan for coverage beyond 190 days.	\$400 out of pocket limit per benefit period. \$50/day, days 1-8. \$0/day, days 9-90. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	\$30 per session	\$0 per session	\$20 per session	\$10 per session
Outpatient Services/Surgery	\$0 each visit	\$0 each visit	\$75 each visit	\$20 or \$50 each visit
Ambulance	\$60 each service. \$0 if admitted to the hospital.	\$0 to \$50 each service. Waived if admitted to hospital.	\$0-\$50/service, waived if admitted.	\$50 each service, waived if admitted.
Emergency Room Visit	\$50/ visit, waived if admitted within 24 hrs. \$10,000 outside of U.S. limit.	\$50 each visit, waived if admitted within 24 hrs. \$10,000 out of US limit	\$50/visit, waived if admitted within 24hrs. \$10,000 out of US limit.	\$50/visit, waived if admitted within 1 day. \$25,000 out of U.S. limit.
Outpatient Rehabilitation Services	\$0 each visit	\$0 each visit	\$20 each visit	\$10 each visit
Durable Medical Equipment	0% to 20% of the cost of each Medicare-covered item.	\$0 to \$250 copay for Medicare-covered item.	\$0-\$250 copay for Medicare-covered item.	0% to 20% of the cost of each Medicare-covered item.
Diagnostic Tests	\$0 for diagnostic procedures/tests. 20% diagnostic radiology service	\$0 for diagnostic procedures/tests and diagnostic radiology service	\$0 for procedure/test. \$10 for radiology service	\$0 for diagnostic procedures/tests/radiology
X-Rays	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray
Lab Services	\$0 of the cost of each lab service. 20% of therapeutic radiology.	\$0 copay	\$0 for lab services. \$10 for therapeutic radiology. \$5-\$20 office visit cost may apply.	\$0 for lab services. 10% therapeutic radiology services.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	\$0 to \$550 copay [or 0% to 20% of the cost] for Part B chemotherapy drugs	\$0 to \$550 copay [or 0%-20% of the cost] for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	\$5-\$15 copays for exams. \$0-\$10 copay for x-ray. \$20 copay for 2 cleaning per year. \$5 to \$15 copay for up to 2 fluoride treatments per yr.	\$5-\$15 for oral exam. \$35-\$40 copay for 2 cleanings per yr. \$5-\$10 copay for 2 fluoride treatments per yr. \$5-\$15 for 1 X-ray every 3 yrs	\$0-\$20 for Medicare covered benefits. \$5-\$20 for oral exams. \$35-\$40 for up to 2 cleanings/yr. \$5-\$10 for up to 2 fluoride treatments/yr. \$5-\$15 for 1 X-ray every 3 yrs. \$5-\$20 visit cost may apply.	No preventative services. \$0-\$475 for Medicare covered benefits.
Hearing Services	You pay 100% of hearing aids. \$0 copay for hearing exams.	No copayment for Hearing aids. \$250 for hearing aids every year \$0 for 1 hearing test per year.	Hearing aids not covered. \$0 copy for Medicare covered diagnostic exams. Up to 1 routine hearing test and fitting-evaluation every year.	\$0 for up to 2 hearing aids every 2 years \$1000 limit per year. \$10 copay for each diagnostic exam. \$10 copay up to 1 routine test per year.
Vision Services	\$0 for eye wear after cataract surgery. \$0 for diagnostic exam. \$10 for routine exam. \$15 for lenses. \$0 for frames for 1 pair of eyeglasses, \$90 limit every 2 yrs.	\$0 for one exam per year. \$0 for 1 eye wear after cataract surgery. \$0 1 pair of lenses/year. \$25 for 1 pair of glasses/2years. \$25 1 pair of contacts/year.\$25 1 frame/2 years.\$100 limit for eye glasses & \$125 for contacts.	\$0-\$20 for diagnosis, treatment, 1 routine exam and 1 pair of lenses per year, 1 pair of eye wear (after cataract surgery), 1 pair of eyewear and frame every 2yrs. \$100 limit for glasses/2yrs. \$125 limit for contacts/2yrs. \$100 limit for frames/2 yrs.	\$0 one pair of eye wear after cataract surgery. A pair of glasses/2 years.\$0-\$5 copay per exam. \$150 limit for eyewear every 2 years.
Prescription Drugs	See separate Chart	See separate Chart	See separate Chart	See separate Chart

Company	Citizens Choice	Easy Choice	Golden State	Health Net
Plan Name	Citizens Choice Health Plan	Best Plan	Golden HMO Limited OC Service Area	Health Net Healthy Heart I
Telephone Numbers Website	New enrollment: 1-866-646-2247 Current Members: 1-866-634-2247 citizenschoicehealth.com	New enrollment: 1-866-999-3945 Current Members: 1-866-999-3945 easychoicehealthplan.com	New enrollment: 1-877-541-4111 Current Members: 1-877-541-4111 greaterpacificmedical.com	New enrollment: 1-800-935-6565 Current Members: 1-800-275-4737 healthnet.com
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	\$0 Monthly Premium Plan will reduce the \$96.40 Part B Premium by \$20 per month.	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium
Doctor Visit	\$0 each visit	\$0 each visit	\$0 each visit	\$0 each visit
Specialist Visit	\$0 each visit	\$0 each visit	\$0 each visit	\$0 each visit
Physician Network	2001-2500 physicians and providers in plan network	6501-7000 physicians and providers in plan network	below 250 physicians and providers in plan network.	13001-14000 physicians and providers in plan network
In-patient Hospitalization	\$0 copay. Unlimited days each benefit period.	\$0 copay. Unlimited days each benefit period.	\$0 copay. Unlimited days each benefit period.	\$0 copay. Unlimited days each benefit period.
Skilled Nursing Facility	\$0/day, days 1-14. \$75/day, days 15-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-20. \$137.50/day, days 21-100. 3-day prior hospital stay is required. 100 days covered each benefit period.	\$0/day, days 1-20. \$50/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-20. \$75/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	\$200 copay. 60 lifetime reserve days. 190-day psychiatric hospital lifetime limit.	\$1,100/day, days 1-60. \$275/day, days 61-90. \$550/day, days 91-150. 190-day psychiatric Hospital lifetime limit.	\$0 copay. 190-day psychiatric hospital lifetime.	\$900 copay. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	\$30 per session	\$10 copay	\$0 per session	\$25 per session
Outpatient Services/Surgery	\$25-\$50 depending of facility.	\$0 each visit	\$0 each visit	\$0 each visit
Ambulance	\$50 each service, waived if admitted	\$50 each service; waived if admitted	\$50 each service, waived if admitted.	\$180 each service
Emergency Room Visit	\$50/visit, waived if admitted. \$7,500 out of US limit.	\$50/visit, waived if admitted within 24 hrs. \$25,000 out of US limit.	\$50 per visit, waived if admitted within 24 hrs.	\$50/ visit, waived if immediately admitted. \$50,000 out of US limit.
Outpatient Rehabilitation Services	\$0 each visit	\$10 each visit	\$0 each visit	\$0 each visit
Durable Medical Equipment	0% to 20% of each Medicare-covered item.	\$20 copay for Medicare-covered item.	0-20% of the cost of each Medicare-covered item.	20% of Medicare-covered item.
Diagnostic Tests	\$0 for diagnostic procedures/tests/radiology	\$0 for diagnostic procedures/tests/radiology	\$0 for diagnostic procedures/tests/radiology	\$0 for procedure/test. \$0-\$250 for diagnostic radiology service.
X-Rays	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray
Lab Services	\$0 copay	\$0 copay	\$0 copay	\$0 for lab services. \$0-\$250 copay for therapeutic radiology services.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of Part B covered chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	\$0-\$425 for Medicare covered benefits. \$0 for up to 2 exams/year. \$0-\$54 for 1 cleaning/year. \$0-\$20 for 1 fluoride treatment per year. \$0-\$30 1 x-ray/year.	\$0-\$50 for Medicare covered benefits. \$0-\$50 for 1 oral exam. \$0-\$65 for 1 cleaning. \$0-\$38 for 1 fluoride treatment. \$0-\$85 for X-ray. All per yr.	Preventive care not covered. \$0 for Medicare-covered services.	Preventative services not covered. \$0 copay for Medicare-covered dental benefits.
Hearing Services	\$0 copay for diagnostic exams. \$0 copay for hearing aids. \$500 limit for hearing aids/year.	\$50 copay for up to 1 hearing/yr. \$500 limit/2 years. \$0 copays for diagnostic or routine hearing tests.	\$0 for: hearing aids (\$400/2yr. Limit), diagnostic exam, 1 routine test/year, 1 fitting-evaluation/2yrs.	Hearing aids not covered. \$30 for diagnostic or routine hearing exams. Up to 1 routine hearing test per year.
Vision Services	\$0 copay per exam and for eyewear if after cataract surgery. Up to 1 pair of glasses or contacts every 2 years. \$150 limit for eye wear per 2 years.	\$25 for 1 eye wear after cataract surgery. \$10 for exams/test, 1 pair of lenses/2 yrs., 1 frame/2 yrs. \$25 for eye wear/2 years. \$100 limit every 2 years.	\$0 for: 1 pair eyewear after cataract surgery, diagnosis and treatment, glasses, contacts (\$150 eyewear limit every 2 yrs.	\$30 for 1 routine exam/year. \$0 for eyewear after cataract surgery. \$30 for diagnostic or treatment of condition.
Prescription Drugs	See separate Chart	See separate Chart	See separate Chart	See separate Chart

**All information obtained from Medicare website and subject to change.
Contact the plan to verify information.**

Company	Health Net	Health Net	Health Net	Health Net
Plan Name	Health Net Healthy Heart 2	Seniority Plus Green Plan	Seniority Plus Ruby Plan 1	Seniority Plus Ruby Plan 2
Telephone Numbers Website	New enrollment: 1-800-935-6565 Current Members: 1-800-275-4737 healthnet.com	New enrollment: 1-800-935-6565 Current Members: 1-800-275-4737 healthnet.com	New enrollment: 1-800-935-6565 Current Members: 1-800-275-4737 healthnet.com	New enrollment: 1-800-935-6565 Current Members: 1-800-275-4737 healthnet.com
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA ONLY (HMO) Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	\$39 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$39 in addition to Part B premium
Doctor Visit	\$0 each visit	\$7 each visit	\$8 each visit	\$8 each visit
Specialist Visit	\$0 each visit	\$10 each visit	\$10 each visit	\$10 each visit
Physician Network	4001-4500 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	13,001-14,000 physicians and providers in plan network
In-patient Hospitalization	\$0 copay. Unlimited days each benefit period.	\$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.	\$100/day, days 1-4. \$0/day, days 5-90. Unlimited days each benefit period.
Skilled Nursing Facility	\$0/day, days 1-20. \$75/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-20. \$75/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-20. \$75/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-20. \$75/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	\$900 copay. 190-day psychiatric hospital lifetime limit.	\$900 copay. 190-day psychiatric hospital lifetime limit.	\$900 copay. 190-day psychiatric hospital lifetime limit.	\$900 copay. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	\$25 per session	\$25 per session	\$25 per session	\$25 per session
Outpatient Services/Surgery	\$0 each visit	\$100 each visit	\$100 each visit	\$100 each visit
Ambulance	\$180 each service	\$125 each service	\$180 each service	\$180 each service
Emergency Room Visit	\$50/ visit, waived if immediately admitted. \$50,000 out of US limit.	\$50/ visit, waived if admitted immediately. \$50,000 out of US limit.	\$50/visit, waived if admitted immediately. \$50,000 out of US limit.	\$50/visit, waived if admitted immediately. \$50,000 out of US limit.
Outpatient Rehabilitation Services	\$0 each visit	\$0 each visit	\$0 each visit	\$0 each visit
Durable Medical Equipment	20% of Medicare-covered item.	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.
Diagnostic Tests	\$0 for procedure/test. \$0-\$250 for diagnostic radiology service.	\$0 for procedure/test. \$0-\$250 for diagnostic radiology service.	\$0 for procedure/test. \$0-\$250 for diagnostic radiology service.	\$0 for procedure/test. \$0-\$250 for diagnostic radiology service.
X-Rays	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray
Lab Services	\$0 for lab services. \$0-\$250 copay for therapeutic radiology services.	\$0 for lab services. \$0-\$250 copay for therapeutic radiology services.	\$0 for lab services. \$0-\$250 copay for therapeutic radiology services.	\$0 for lab services. \$0-\$250 copay for therapeutic radiology services.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	Preventative services not covered. \$0 copay for Medicare-covered dental benefits.	\$0 copay for dental preventative services. \$500 annual limit for preventative dental services.	Preventive care not covered. \$0 for Medicare-covered services.	Preventive care not covered. \$0 for Medicare-covered services.
Hearing Services	Hearing aids not covered. \$30 for diagnostic or routine hearing exams. Up to 1 routine hearing test per year.	Hearing aids not covered. \$10 for diagnostic exam and for up to 1 routine exam per year.	Hearing aids not covered. \$10 for diagnostic exam and for up to 1 routine exam per year.	Hearing aids not covered. \$10 for diagnostic exam and for up to 1 routine exam per year.
Vision Services	\$30 for 1 routine exam/year. \$0 for eyewear after cataract surgery. \$30 for diagnostic or treatment of condition.	\$0 for one pair of eyewear after each cataract surgery. \$0 for 1 pair of eyewear every 2 years. \$10 for diagnostic exam. \$10 for routine exam.	\$0 for 1 pair of eye wear after cataract surgery. \$10 for diagnostic exam and up to 1 routine exam/year	\$0 for 1 pair of eye wear after cataract surgery. \$10 for diagnostic exam and up to 1 routine exam/year
Prescription Drugs	See separate Chart	None	See separate Chart	See separate Chart

Company	Health Net	Kaiser	MD Care Inc	MD Care Inc
Plan Name	Salud con Health Net Medicare Advantage	Senior Advantage	Advantage 1 MAPD Plan	Advantage Select MA Plan
Telephone Numbers Website	New enrollment: 1-800-935-6565 Current Members: 1-800-275-4737 healthnet.com	New enrollment: 1-800-777-1238 Current Members: 1-800-443-0815 kp.org	New enrollment: 1-888-327-2730 Current Members: 1-800-816-7978 mdcareinc.com	New enrollment: 1-888-327-2730 Current Members: 1-888-285-9676 mdcareadvantage.com
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA ONLY (HMO) Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit Must utilize plan physicians, providers and hospitals.
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium (\$3,400 out-of-pocket limit for Medicare covered services.)	\$0 Monthly Premium	\$0 Monthly Premium
Doctor Visit	\$0 each visit	\$5 each visit	\$0 each visit	\$0 each visit
Specialist Visit	\$0 each visit	\$0-\$5 each visit	\$5 each visit	\$0 each visit
Physician Network	8001-8500 physicians and providers in plan network	3501-4000 physicians and providers in plan network	5501-6000 physicians and providers in plan network	5501-6000 physicians and providers in plan network
In-patient Hospitalization	\$0 copay. Unlimited days each benefit period.	\$125/day, days 1-10. \$0/day, days 11-90. Unlimited days each benefit period.	\$0 copay. Unlimited days each benefit period	\$0 copay. Unlimited days each benefit period
Skilled Nursing Facility	\$0/day, days 1-20. \$75/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-20. \$100/day, days 21-100 No prior hospital stay required. 100 days covered each benefit period.	\$0 copay. No prior hospital stay required. 100 days covered each benefit period.	\$0 copay. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	\$900 copay. 190-day psychiatric hospital lifetime limit.	\$125/day, day 1-10. \$0/day, days 11-90. Contact plan for benefits beyond 190 days.	\$250/day Medicare-covered. 190-day psychiatric hospital lifetime limit.	\$250/day. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	\$25 per session	\$5 individual session. \$2 group session	\$0 per session	\$0 per session
Outpatient Services/Surgery	\$0 each visit	\$0 or \$50/visit depending on facility	\$0 each visit	\$0 each visit
Ambulance	\$180 each service	\$300 each service	\$50 each service, waived if admitted	\$50 each service, waived if admitted
Emergency Room Visit	\$50/visit, waived if admitted immediately. \$50,000 out of US limit.	\$50 each visit, waived if admitted within 24 hrs.	\$50/visit, waived if admitted within 24 hrs. \$25,000 out of US limit.	\$50/visit, waived if admitted within 24 hrs. \$25,000 out of US limit.
Outpatient Rehabilitation Services	\$0 each visit	\$5 each visit	\$0 each visit	\$0 each visit
Durable Medical Equipment	20% of the cost of each Medicare-covered item.	20% of the cost of each Medicare-covered item.	0-20%of the cost of each Medicare-covered item.	0-20%of the cost of each Medicare-covered item.
Diagnostic Tests	\$0 for procedure/test. \$0-\$250 for diagnostic radiology service.	\$15 for procedure/test. \$50 for radiology service	\$0 for procedure/test. \$25 for diagnostic radiology.	\$0 for procedure/test. \$25 for diagnostic radiology.
X-Rays	\$0 each X-ray	\$15 each X-ray	\$0 each X-ray	\$25 each X-ray
Lab Services	\$0 for lab services. \$0-\$250 copay for therapeutic radiology services.	\$0-\$15 for lab service.	\$0 lab service. \$25 for therapeutic radiology	\$0 lab service. \$25 for therapeutic radiology
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	\$5-\$35 copay for Part B chemotherapy drugs	0-20% for Part B chemotherapy drugs	0-20% for Part B chemotherapy drugs
Dental Services	Preventive care not covered. \$0 for Medicare-covered services.	Preventative services not covered. \$5-\$125 for Medicare-covered services.	\$0 for Medicare-covered benefits. \$15 for 1 oral exam, and \$20 for one cleaning every 6 mo. \$5 for 1 X-ray every 2 yrs.	\$0 for Medicare-covered benefits. \$15 for 1 oral exam, and \$20 for one cleaning every 6 mo. \$5 for 1 X-ray every 2 yrs.
Hearing Services	Hearing aids not covered. \$25 for diagnostic exam and for up to 1 routine exam per year.	\$5 for diagnostic exam. No other coverage	Hearing aids not covered. \$0 for Medicare-covered diagnostic exam and 1 routine test per year.	Hearing aids not covered. \$0 for Medicare-covered diagnostic exam and 1 routine test per year.
Vision Services	\$0 for 1 pair of eye wear after cataract surgery. \$25 for diagnostic exam and up to 1 routine exam/year	\$0 for one pair of eyewear after cataract surgery. \$5 for diagnostic/routine exam. \$120 limit for eyewear every 2 years.	\$0 for diagnostic exam. \$0 copay for eye wear after cataract surgery, 1 pair of eye wear every 2 yrs. \$160 limit every 2yrs.	\$0 for diagnostic exam. \$0 copay for eye wear after cataract surgery, 1 pair of eye wear every 2 yrs. \$160 limit every 2yrs. Up to 1 routine exam/year
Prescription Drugs	See separate Chart	See separate Chart	See separate Chart	None

Company	SCAN	SCAN	SCAN	Secure Horizons/AARP
Plan Name	Scan Health Plan Classic	Scan Health Plan Options	My Choice	Medicare Complete Plan 1
Telephone Numbers Website	New enrollment: 1-800-915-7226 Current Members: 1-800-559-3500 scanhealthplan.com	New enrollment: 1-800-915-7226 Current Members: 1-800-559-3500 scanhealthplan.com	New enrollment: 1-800-915-7226 Current Members: 1-800-559-3500 scanhealthplan.com	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 aarpmedicarecomplete.com
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO-POS Option) Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$40 Monthly Premium	\$0 Monthly Premium
Doctor Visit	\$5 each visit	\$0 each visit	\$10 per visit	\$10 each visit
Specialist Visit	\$10 each visit	\$0 each visit	\$20 per visit	\$10 each visit
Physician Network	2501-3000 physicians and providers in plan network	2501-3000 physicians and providers in plan network	1001-1500 physicians and providers in plan network	6501-7000 physicians and providers in plan network
In-patient Hospitalization	\$100/day, days 1-10. \$0 days 11-90. Unlimited days each benefit period	\$0 copay. Unlimited days each benefit period	\$100/day, days 1-10. \$0 days 11-90. Unlimited days each benefit period	\$175/day, days 1-10. \$0/day, days 11-90. \$0 additional days. Unlimited days each benefit period.
Skilled Nursing Facility	\$0/day, days 1-10. \$50/day days 11-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-10. \$75/day days 11-100. No prior hospital stay required. 100 days covered each benefit period.	\$30/day, days 1-10. \$100/day days 11-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-10. \$90/day, days 11-40. \$0 days 41-100. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	\$100/day, days 1-10. \$0/day, days 11-90. 190-day psychiatric hospital lifetime limit.	\$150/day, days 1-10. \$0/day, days 11-90. 190-day psychiatric hospital lifetime limit.	\$100/day, days 1-10. \$0 days 11-90. 190-day psychiatric hospital lifetime limit.	\$175/day, days 1-10. \$0 after. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	\$25 per session	\$35 per session	\$25 per session	\$30 per session
Outpatient Services/Surgery	\$50-\$100/visit depending on facility.	\$100-\$150/visit depending on facility.	\$50-\$100/visit depending on facility.	\$150 each visit
Ambulance	\$100 each service	\$150 each service	\$100 each service	\$150 each service
Emergency Room Visit	\$50/visit, waived if admitted immediately. Worldwide coverage.	\$50/visit, waived if admitted immediately. Worldwide coverage.	\$50/visit, waived if admitted immediately. Worldwide coverage.	\$50/visit. Worldwide coverage
Outpatient Rehabilitation Services	\$10 each visit	\$10 each visit	\$20 each visit	\$0-\$30 each visit
Durable Medical Equipment	0 - 20% of each Medicare-covered item.	20% of each Medicare-covered item.	0%-10% of each Medicare-covered item.	20% of the cost of each Medicare-covered item.
Diagnostic Tests	0%-10% of procedure/test. 10% of diagnostic radiology.	0%-20% of procedure/test. 20% of diagnostic radiology.	0%-20% of procedure/test. 10% diagnostic radiology	\$0-\$10 procedure/test. 20% diagnostic radiology
X-Rays	\$0 each X-ray	\$0 each X-ray	\$0 copay	\$0 each X-ray
Lab Services	\$0 lab service. 20% of radiation therapy.	\$0 lab service. 20% of radiation therapy.	\$0 lab service. 10% of radiation therapy.	\$10 lab test. 20% of therapeutic radiation.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	Preventative benefits not covered. \$10 copay for Medicare-covered visit.	Preventative benefits not covered. \$10 copay for Medicare-covered visit.	Preventative benefits not covered. \$25 copay for Medicare-covered visit.	Preventive care not covered. \$30 for Medicare-covered benefits.
Hearing Services	\$0 for up to 2 hearing aids every 3yrs. \$10 for diagnostic exam. \$0-\$10 for 1 routine test/year, and 1 fitting evaluation every 3yrs. \$400 limit for hearing aids every 3yrs.	Hearig care not covered. \$10 copay for Medicare-covered diagnostic exam.	\$0 for up to 2 hearing aids every 3yrs. \$25 for diagnostic exam, 1 routine test/year, and 1 fitting evaluation every 3yrs. \$400 limit for hearing aids every 3yrs.	\$0 for hearing aid \$300/2yrs. limit. \$30 for diagnostic exam. \$0 for 1 routine test/yr.
Vision Services	\$10 to diagnose & treat conditions and 1 pair eyewear after cataract surgery. \$15 for 1 routine exam/yr. \$25 for eyewear every 2yrs. \$75 limit for eye glasses and \$100 limit for contacts /2yrs	\$10 to diagnose and treath conditions and 1 pair eyewear after cataract surgery. \$15 for 1 routine exam/yr. \$25 for eyewear every 2yrs. \$75 limit for eye glasses and \$100 limit for contacts /2yrs	\$25 for eyewear after cataract surgery. \$25 to diagnose & treat conditions. \$30 for 1 routine exam/yr. \$25 for 1 pair of eyewear every 2yrs. \$75 limit for eye glasses/2yrs. \$100 limit for contacts/2yrs.	\$0 for eye wear after cataract surgery. \$0 for 1 pair of lenses/2yrs. \$10-\$30 for diagnostic exams. \$30 for 1 routine exam/2yrs. \$30 for contacts (\$105 limit) and frame (\$70 limit) every 2 years.
Prescription Drugs	See separate Chart	See separate Chart	See separate Chart	See separate Chart

Company	Secure Horizons/AARP	Secure Horizons/AARP	Secure Horizons/AARP	Secure Horizons/AARP
Plan Name	Medicare Complete Plan 2	Medicare Complete Premier Plan	Medicare Complete Value Plan	Medicare Complete Essential Plan
Telephone Numbers Website	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 aarpmedicarecomplete.com	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 aarpmedicarecomplete.com	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 aarpmedicarecomplete.com	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 aarpmedicarecomplete.com
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA ONLY (HMO) Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium
Doctor Visit	\$0 each visit	\$5 each visit	\$0 each visit	\$5 each visit
Specialist Visit	\$0 each visit	\$10 each visit	\$5 each visit	\$10 each visit
Physician Network	3001-3500 physicians and providers in plan network	3001-3500 physicians and providers in plan network	3001-3500 physicians and providers in plan network	15001-16000 physicians and providers in plan network
In-patient Hospitalization	\$100 for each Medicare-covered hospital stay. \$0 copay for additional days. Unlimited days each benefit period.	\$250/day, days 1-5. \$0/day, days 6-90. \$0 after 90. Unlimited days each benefit period.	\$400 for each Medical-covered stay. \$0 for additional days. Unlimited days each benefit period.	\$50 for each Medicare-covered stay. \$0 for any additional day. Unlimited days each benefit period.
Skilled Nursing Facility	\$0/day, days 1-20. \$120/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-10. \$90/day, days 11-40. \$0 days 41-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-20. \$120/day, days 21-100. No prior hospital stay required. 100 days covered each benefit period.	\$0/day, days 1-10. \$85/day, days 11-40. \$0 days 41-100. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	\$100/day. 190-day psychiatric hospital lifetime limit.	\$150/day, days 1-5. \$0 days 6-90. 190-day psychiatric hospital lifetime limit.	\$400 per stay. 190-day psychiatric hospital lifetime limit.	\$50/day. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	\$30 per session	\$30 per session	\$30 per session	\$30 per session
Outpatient Services/Surgery	\$75 each visit	\$100 each visit	\$175 each visit	\$0 each visit
Ambulance	\$150 each service	\$200 each service	\$150 each service	\$150 each service
Emergency Room Visit	\$50/visit. Worldwide coverage	\$50/visit. Worldwide coverage	\$50/visit. Worldwide coverage	\$50/visit. Worldwide coverage
Outpatient Rehabilitation Services	\$0-\$30 each visit	\$10-\$20 each visit	\$0-\$30 each visit	\$0-\$30 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.	20% of the cost of each Medicare-covered item.
Diagnostic Tests	\$0-\$10 procedure/test. 20% diagnostic radiology	\$0-\$10 procedure/test. 20% diagnostic radiology	\$0-\$10 procedure/test. 20% diagnostic radiology	0% procedure/test. 20% Diagnostic radiology.
X-Rays	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray
Lab Services	\$10 lab test. 20% of therapeutic radiation.	\$10 lab test. 20% of therapeutic radiation.	\$10 lab test. 20% of therapeutic radiation.	\$0 lab test. 20% of cost radiation therapy.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	Preventive care not covered. \$0 for Medicare-covered benefits.	Preventive care not covered. \$10 for Medicare-covered benefits.	Preventive care not covered. \$5 for Medicare-covered benefits.	\$10 copay for Medicare-covered benefit. \$20 copay for up to 2 exams per year.
Hearing Services	\$0 for hearing aid \$300/2yr. limit. \$0 for diagnostic exam and for 1 routine test/yr.	\$0 for hearing aid \$300/2yr. limit. \$10 for diagnostic exam. \$0 for 1 routine test/yr.	\$0 for hearing aid \$300/2yr. limit. \$5 for diagnostic exam. \$0 for 1 routine test/yr.	\$0 copay for 1 hearing aid up \$800 limit every 2 years. \$10 for diagnostic exam. \$0 copay for 1 routine exam per year.
Vision Services	\$0 for eye wear after cataract surgery, diagnostic exams and 1 pair of lenses/2yrs. \$30 for 1 routine exam every 2 years. \$30 copay for contacts (\$105 limit) and 1 frame (\$70 limit) every 2 years.	\$0 for eye wear after cataract surgery, diagnostic exams and 1 pair of lenses/2yrs. \$30 for 1 routine exam every 2 years. \$30 copay for contacts (\$105 limit) and 1 frame (\$70 limit) every 2 years.	\$0 for eye wear after cataract surgery and 1 pair of lenses/2yrs. \$0-\$5 for diagnose exam. \$30 for 1 routine exam every 2 years. \$30 copay for contacts (\$105 limit) and 1 frame (\$70 limit) every 2 years.	\$0 for eyewear after cataract surgery. \$5-\$10 for diagnostic exam. \$10 for 1 routine exam/yr. \$0 for 1 pair eyewear, and frame/yr. \$130 limit for frame/yr. \$125 limit for contacts every 2 years.
Prescription Drugs	See separate Chart	See separate Chart	See separate Chart	None

**2010
Orange County Medicare Advantage (HMO, PPO)
Comparison Chart**

Company	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
Plan Name	Freedom Blue Plan 1	Freedom Blue Classic	Freedom Blue Plus
Telephone Numbers Website	New enrollment: 1-800-797-0524 Current members: 1-877-811-3107 anthem.com/ca	New enrollment: 1-800-797-0524 Current members: 1-877-811-3107 anthem.com/ca	New enrollment: 1-800-797-0524 Current members: 1-877-811-3107 anthem.com/ca
Plan Type	PPO-PD* Preferred Provider Plan with Prescription Drug Benefit. May choose any provider. Plan Network providers at lower cost.	PPO* Preferred Provider. Plan Plan does NOT have Prescription Drug Benefit. May choose any provider. Lower cost in-network.	PPO-PD* Preferred Provider Plan with Prescription Drug Benefit. May choose any provider. Plan Network providers at lower cost.
Monthly Premium	\$0 Monthly Premium, \$500 yearly deductible. (\$3,350 annual out-of-pocket limit on all Medicare covered services)	\$0 Monthly Premium, \$500 yearly deductible. (\$3,350 annual out-of-pocket limit on all Medicare covered services)	\$31 Monthly Premium, \$500 yearly deductible. (\$3,350 annual out-of-pocket limit on all Medicare covered services)
Doctor Visit	Network: \$15-\$25 Out: \$30	Network: \$15-\$30 Out: \$29	Network: \$10-\$25 Out: \$25
Specialist Visit	Network: \$25 Out: \$40	Network: \$30 Out: \$44	Network: \$25 Out: \$40
Physician Network	3501-4000 physicians and providers in plan network	3501-4000 physicians and providers in plan network	3501-4000 physicians and providers in plan network
In-patient Hospitalization	In Network: \$850 copay/ Medicare-covered. \$0 additional days. Out of Network: 15% of cost. Unlimited days each benefit period.	In Network: \$850 copay/ Medicare-covered. \$0 additional days. Out of Network: 15% of cost. Unlimited days each benefit period.	In Network: \$850 copay/ Medicare-covered. \$0 additional days. Out of Network: 15% of cost. Unlimited days each benefit period.
Skilled Nursing Facility	In Network:\$0/day, days 1-20. \$130/day, days 21-100. Out of Network:30% of cost. No prior hospital required. 100 days each benefit period	In Network:\$0/day, days 1-20. \$130/day, days 21-100. Out of Network:30% of cost. No prior hospital required. 100 days each benefit period	In Network:\$0/day, days 1-20. \$130/day, days 21-100. Out of Network:30% of cost. No prior hospital required. 100 days each benefit period
In-patient Mental Health	In Network: \$850/hospital stay. Out of Network: 15% of cost. 190-day psychiatric hospital lifetime limit.	In Network: \$850/hospital stay. Out of Network: 15% of cost. 190-day psychiatric hospital lifetime limit.	In Network: \$850/hospital stay. Out of Network: 15% of cost. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	Network: \$40 Out: 30%	Network: \$40 Out: 30%	Network: \$40 Out: 30%
Outpatient Services/Surgery	Network: \$25-\$250 depends on facility. Out: 30%	Network: \$30-\$200 depends on facility. Out: 30%	Network: \$30-\$200 depends on facility. Out: 30%
Ambulance	\$175 In or Out	\$100 In or Out	\$100 In or Out
Emergency Room Visit	\$50 each visit, waived if admitted within 72 hrs. Worldwide coverage.	\$50 each visit, waived if admitted within 72 hrs. Worldwide coverage.	\$50 each visit, waived if admitted within 72 hrs. Worldwide coverage.
Outpatient Rehabilitation Services	Network: \$20-\$50 Out: 30%	Network: \$30-\$50 Out: 30%	Network: \$25-\$50 Out: 30%
Durable Medical Equipment	Network: 20% for each Medicare-covered item. Out: 30%	Network: 20% for each Medicare-covered item. Out: 30%	Network: 20% for each Medicare-covered item. Out: 30%
Diagnostic Tests	Network: \$25-\$150 procedure/test. \$100 for diagnostic radiology. Out:30% procedure/test. \$200 diagnostic radiology	Network: \$30-\$100 procedure/test. \$100 for diagnostic radiology. Out:30% procedure/test. \$150 diagnostic radiology	Network: \$25-\$100 procedure/test. \$100 for diagnostic radiology. Out:30% procedure/test. \$150 diagnostic radiology
X-Rays	Network: \$25-\$150 Out: 30%	Network: \$30-\$100 Out: 30%	Network: \$25-\$100 Out: 30%
Lab Services	Network: \$15 for lab services. 20% therapeutic radiology. Out: 30% lab test. 30% therapeutic radiology	Network: \$10 for lab services. 20% therapeutic radiology. Out: 30% lab test. 30% therapeutic radiology	Network: \$10 for lab services. 20% therapeutic radiology. Out: 30% lab test. 30% therapeutic radiology
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs. 25% out of network.	20% of the cost for Part B chemotherapy drugs. 25% out of network.	20% of the cost for Part B chemotherapy drugs. 25% out of network.
Dental Services	Network: Preventive care not covered. \$0 for Medicare-covered benefits.. Out: \$0 for comprehensive benefits	Network: \$0 for exam (1 /yr) \$0 for cleanings (1/yr). \$0 for Medicare-covered benefits.. Out: \$0 for comprehensive benefits. 20% for preventative benefits	Network: \$0 for exam (1 /yr) \$0 for cleanings (1/yr). \$0 for Medicare-covered benefits.. Out: \$0 for comprehensive benefits. 20% for preventative benefits
Hearing Services	Network:Hearing aids not covered. \$25 for diagnostic exam. Out: 30% of cost of hearing aids.	Network:\$0 for hearing aids (\$100 limit/2yr). \$0 for 1 routine test/yr. \$30 for diagnostic exam. Out: 30% for hearing exams. \$0 for hearing aids.	Network:\$0 for hearing aids (\$100 limit/2yr). \$0 for 1 routine test/yr. \$25 for diagnostic exam. Out: 30% for hearing exams. \$0 for hearing aids.
Vision Services	Network: \$0 for one pair of eyewear after cataract surgery. \$25 for diagnose exam. \$20 for1 routine exam/year. Out: 20%-30% of exam. \$0 for eye wear.	Network: \$0 for one pair of eyewear after cataract surgery. \$30 for diagnose exam. \$20 for1 routine exam/year. (\$80-\$175eyewear limit/2yrs) Out: 20%-30% of exam. \$0 for eye wear.	Network: \$0 for one pair of eyewear after cataract surgery. \$25 for diagnostic exam. \$20 for1 routine exam/year. (\$80-\$100 eyewear limit/2yrs) Out: 20%-30% of exam. \$0 for eye wear.
Prescription Drugs	See separate Chart	None	See separate Chart

†**Health Maintenance Organization (HMO)** - A type of Medicare Health Plan that is available in most areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency.

* **Preferred Provider Organization (PPO)** - A type of Medicare Advantage Plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.