Golden Health Insurance Plan

(H0000-000)

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- For-profit HMO serving Nameless A and Nameless B Counties
- Provides health coverage only
- Plan network includes approximately 251–500 physicians and providers (see full list at www.goldenhealth.com/providerlist)

Important Notes

None at this time

Learn More

- View quality and satisfaction graphs for this plan
- Find out why people have left this plan
- Calculate the average monthly out-of-pocket costs for this plan
- Learn more about your Medicare health plan choices
- Learn how to select a Medicare health plan

Plan Contact Info:

151 Main Street
Anytown, CT 00000

For Prospective Members:
1-800-555-5555
1-800-555-5555 (toll-free)
1-800-555-5555 (TTY/TDD)
1-800-555-5555 (toll-free TTY/TDD)
CustomerService@goldenhealth.com

For Current Members:
1-800-555-5555
1-800-555-5555 (toll-free)
1-800-555-5555 (TTY/TDD)
1-800-555-5555 (toll-free TTY/TDD)
CustomerService@goldenhealth.com

Part D Contact Info:

151 Main Street
Anytown, CT 00000

For Prospective Members:
1-800-555-5555
1-800-555-5555 (toll-free)
1-800-555-5555 (TTY/TDD)
1-800-555-5555 (toll-free TTY/TDD)
CustomerService@goldenhealth.com

For Current Members:
1-800-555-5555
1-800-555-5555 (toll-free)
1-800-555-5555 (TTY/TDD)
1-800-555-5555 (toll-free TTY/TDD)
CustomerService@goldenhealth.com

Important Information	
1 **Premium and Other Important Information**	**$0** monthly plan premium in addition to your **$88.50** monthly Medicare Part B premium
2 **Doctor and Hospital Choice**	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits). You may have to pay separate copay for certain doctor office visits. Plan covers you when you travel inside or outside the U.S.
Inpatient Care	
3 **Inpatient Hospital Care**	**In-Network** **$50** copay per day for days 1–8 in a Medicare-covered hospital **$0** copay for additional hospital days **$400** out-of-pocket limit every stay No limit to the number of days covered by the plan each benefit period
4 **Inpatient Mental Health Care**	**In-Network** **$50** copay per day for days 1–8 in a Medicare-covered hospital **$0** copay per day for days 9–90 in a Medicare-covered hospital You get up to 190 days in a psychiatric hospital in a lifetime
5 **Skilled Nursing Facility**	**In-Network** **$0** copay per day for days 1–8 in a Medicare-covered SNF **$75** copay per day for days 9–15 in a Medicare-covered SNF **$125** copay per day for days 16–100 in a Medicare-covered SNF No prior hospital stay is required; 100 days covered for each benefit period
6 **Home Health Care**	**In-Network** **$0** copay for each Medicare-covered home health visit
7 **Hospice**	**In-Network** You must get care from a Medicare-certified hospice
Outpatient Care	
8 **Doctor Office Visits**	**In-Network** **$10** to **$15** copay for each primary care doctor visit for Medicare-covered benefits **$20** copay for each specialist visit for Medicare-covered benefits
9 **Chiropractic Services**	**In-Network** **$20** copay for each Medicare-covered visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part
10 **Podiatry Services**	**In-Network** **$0** copay for Medicare-covered podiatry benefits Medicare-covered podiatry benefits are for medically necessary foot care
13 **Outpatient Services/ Surgery**	**In-Network** **$100** copay for each Medicare-covered ambulatory surgical center visit **$100** copay for each Medicare-covered outpatient hospital facility visit
14 **Ambulance Services**	**In-Network** **$25** copay for each Medicare-covered ambulance benefits
15 **Emergency Care**	**In-Network** **$50** copay for Medicare-covered emergency room visits **$0** for the emergency room visit if you are immediately admitted to the hospital Worldwide coverage
17 **Outpatient Rehabilitation Services**	**In-Network** **$20** copay for Medicare-covered Occupational Therapy visits **$20** copay for Medicare-covered Physical and/or Speech/Language Therapy visits

Outpatient Medical Services and Supplies

18 Durable Medical Equipment	**In-Network** **$0** copay for Medicare-covered items Authorization rules may apply
20 Diabetes Self-Monitoring Training and Supplies	**In-Network** **$0** copay for Diabetes self-monitoring training **$0** copay for Diabetes supplies
21 Diagnostic Test, X-Rays, and Lab Services	**In-Network** **$20** copay for Medicare-covered Clinical/Diagnostic Lab benefits **$20** copay for Medicare-covered Radiation Therapy benefits **$20** to **$50** copay for Medicare-covered X-Rays

Additional Benefits (What Original Medicare Does NOT Cover)

28 Prescription Drugs	**$0** deductible You pay the following until total yearly drug costs reach $2250: **$5** for a one-month (30-day) supply of Tier 1 drugs from a preferred pharmacy **$25** for a one-month (30-day) supply of Tier 2 drugs from a preferred pharmacy **$35** copay for a one-month (30-day) supply of Tier 3 drugs from a non-preferred pharmacy **In-Network** After your yearly out-of-pocket drug costs reach $2250, you pay the greater of: • **$3** copay for generic (including brand drugs treated as generic) and **$5** copay for all other drugs, or • **8%** coinsurance This plan uses a formulary. A formulary is a list of drugs covered by the plan. If a plan takes a drug off the list; changes a drug on its list to a more expensive tier; or places a prior authorization, step therapy or quantity limit requirement on a drug, the plan will tell you at least 60 days before the change is effective. The plan will send you the formulary. You can also see the formulary at www.goldenhealth.com/formulary on the web. Different out-of-pocket costs may apply for people who: • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) Some drugs have quantity limits Your provider must get prior authorization from Golden Health for certain drugs
29 Dental Services	In general, you pay 100% for preventive dental services, such as cleaning This plan offers more preventive dental coverage as an optional benefit
31 Vision Services	**In-Network** **$0** copay for: • One pair of eyeglasses or contact lenses after each cataract surgery • Eyeglasses or contact lenses **$20** copay for exams to diagnose and treat diseases and conditions of the eye **$0** copay for routine eye exams up to one routine eye exam a year Up to **$100** for eyewear for 2 years
32 Physical Exams	**In-Network** **$0** copay for routine physical exams Limited to 1 exam a year When you get Medicare Part B, you can get a one-time physical exam within the first 6 months of your new Part B coverage. This coverage does not include lab tests.

National Health Insurance Plan

(H0000-000)

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- For-profit PPO serving Nameless A and Nameless B Counties
- Provides both health and drug coverage
- Plan network includes approximately 251–500 physicians and providers (see full list at www.nationalhealth.com/providerlist)

Plan Contact Info:

151 Main Street
Anytown, CT 00000

For Prospective Members:
1-800-555-5555
1-800-555-5555 (toll-free)
1-800-555-5555 (TTY/TDD)
1-800-555-5555 (toll-free TTY/TDD)
CustomerService@nationalhealth.com

For Current Members:
1-800-555-5555
1-800-555-5555 (toll-free)
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1-800-555-5555 (toll-free TTY/TDD)
CustomerService@nationalhealth.com

Part D Contact Info:

151 Main Street
Anytown, CT 00000

For Prospective Members:
1-800-555-5555
1-800-555-5555 (toll-free)
1-800-555-5555 (TTY/TDD)
1-800-555-5555 (toll-free TTY/TDD)
CustomerService@nationalhealth.com

For Current Members:
1-800-555-5555
1-800-555-5555 (toll-free)
1-800-555-5555 (TTY/TDD)
1-800-555-5555 (toll-free TTY/TDD)
CustomerService@nationalhealth.com

Important Notes

None at this time

Learn More

> View quality and satisfaction graphs for this plan
> Find out why people have left this plan
> Calculate the average monthly out-of-pocket costs for this plan
> Learn more about your Medicare health plan choices
> Learn how to select a Medicare health plan

Important Information

1 Premium and Other Important Information

$99 monthly plan premium in addition to your **$88.50** monthly Medicare Part B premium

Out-of-Network

$500 yearly deductible applies to the following **Medicare-covered** benefits:

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Doctor's Office Visits
- Outpatient Mental Health Care
- Outpatient Services/Surgery
- Ambulance Services
- Emergency Care
- Outpatient Rehabilitation Services
- Diagnostic Tests, X-Rays, and Lab Services
- Colorectal Screening Exam
- Immunizations
- Mammograms (Annual Screenings)
- Pap Smears and Pelvic Exams
- Prostate Cancer Screening Exams
- Outpatient Prescription Drugs
- Hearing Services
- Vision Services
- Physical Exams
- Cardiac Rehabilitation Services
- Renal Dialysis

$500 yearly deductible applies to the following **non-Medicare-covered** benefits:

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Doctor's Office Visits
- Outpatient Mental Health Care
- Outpatient Services/Surgery
- Ambulance Services
- Emergency Care
- Outpatient Rehabilitation Services
- Diagnostic Tests, X-Rays, and Lab Services
- Colorectal Screening Exam
- Immunizations
- Mammograms (Annual Screenings)
- Pap Smears and Pelvic Exams
- Prostate Cancer Screening Exams
- Outpatient Prescription Drugs
- Hearing Services
- Vision Services
- Physical Exams
- Cardiac Rehabilitation Services
- Renal Dialysis

$5000 out-of-pocket limit for **Medicare-covered** benefits. This limit applies to benefits you get out of network.

$5000 out-of-pocket limit applies to the following **non-Medicare-covered** benefits:

- Inpatient Hospital Care
- Inpatient Mental Health Care
- Skilled Nursing Facility
- Home Health Care
- Doctor's Office Visits
- Outpatient Mental Health Care
- Outpatient Services/Surgery
- Ambulance Services
- Emergency Care
- Outpatient Rehabilitation Services
- Diagnostic Tests, X-Rays, and Lab Services
- Colorectal Screening Exam
- Immunizations
- Mammograms (Annual Screenings)
- Pap Smears and Pelvic Exams
- Prostate Cancer Screening Exams
- Outpatient Prescription Drugs
- Hearing Services
- Vision Services
- Physical Exams
- Cardiac Rehabilitation Services
- Renal Dialysis

Contact the plan for more details on what is covered out of network

2 Doctor and Hospital Choice

You may go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out-of-network benefits.

Inpatient Care		
3	**Inpatient Hospital Care**	**In-Network** **$750** copay for each hospital stay **$0** copay for additional hospital days No limit to the number of days covered by the plan each benefit period **Out-of-Network** **30%** of the cost per hospital stay
4	**Inpatient Mental Health Care**	**In-Network** **$750** copay for each hospital stay **Out-of-Network** **30%** of the cost per hospital stay You get up to 190 days in a Psychiatric Hospital in a lifetime
5	**Skilled Nursing Facility**	**In-Network** **$0** copay per day for days 1–9 in a Medicare-covered SNF **$75** copay per day for days 10–19 in a Medicare-covered SNF **$125** copay per day for days 20–100 in a Medicare-covered SNF No prior hospital stay is required; 100 days covered for each benefit period **Out-of-Network** **30%** of the cost for SNF benefits
6	**Home Health Care**	**In-Network** **$20** copay for each Medicare-covered home health visit **Out-of-Network** **30%** of the cost for home health visit
7	**Hospice**	**In-Network** You must get care from a Medicare-certified hospice
Outpatient Care		
8	**Doctor Office Visits**	**In-Network** **$15** to **$20** copay for each primary care doctor visit for Medicare-covered benefits **$30** copay for each specialist visit for Medicare-covered benefits **Out-of-Network** **30%** for each primary care doctor visit **30%** for each specialist visit
9	**Chiropractic Services**	**In-Network** **$30** copay for each Medicare-covered visit **Out-of Network** **30%** of the cost for chiropractic benefits Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part
10	**Podiatry Services**	**In-Network** **$30** copay for each Medicare-covered visit **Out-of Network** **30%** of the cost for podiatry benefits Medicare-covered podiatry benefits are for medically-necessary foot care
13	**Outpatient Services/ Surgery**	**In-Network** **$100** copay for each Medicare-covered ambulatory surgical center visit **$100** copay for each Medicare-covered outpatient hospital facility visit **Out-of Network** **30%** of the cost for ambulatory surgical center benefits **30%** of the cost for outpatient hospital facility benefits
14	**Ambulance Services**	**In-Network** **$100** copay for each Medicare-covered ambulance benefits **Out-of Network** **$100** copay for Medicare-covered ambulance benefits
15	**Emergency Care**	**In-Network** **$50** copay for Medicare-covered emergency room visits **$0** for the emergency room visit if you are immediately admitted to the hospital Worldwide coverage
17	**Outpatient Rehabilitation Services**	**In-Network** **$30** copay for Medicare-covered Occupational Therapy visits **$30** copay for Medicare-covered Physical and/or Speech/Language Therapy visits **Out-of-Network** **30%** of the cost for Occupational Therapy visits **30%** of the cost for Physical and/or Speech/Language Therapy visits
Outpatient Medical Services and Supplies		
18	**Durable Medical Equipment**	**In-Network** **20%** for Medicare-covered items **Out of Network** **30%** of the cost for durable medical equipment Authorization rules may apply
20	**Diabetes Self-Monitoring Training and Supplies**	**In-Network** **$0** copay for Diabetes self-monitoring training **$0** copay for Diabetes supplies **Out of Network** **30%** of the cost for Diabetes self-monitoring training **30%** of the cost for Diabetes supplies

21	**Diagnostic Test, X-Rays, and Lab Services**	**In-Network** **$30** copay for Medicare-covered Clinical/Diagnostic Lab benefits **$100** copay for Medicare-covered Radiation Therapy benefits **$30** to **$100** copay for Medicare-covered X-Rays **Out-of-Network** **30%** of the cost for Clinical/Diagnostic Lab benefits **30%** of the cost for Radiation Therapy benefits **30%** of the cost for X-Rays

Additional Benefits (What Original Medicare Does NOT Cover)

28	**Prescription Drugs**	**$0** deductible You pay the following until total yearly drug costs reach $2500: **$5** for a one-month (30-day) supply of Tier 1 drugs from a preferred pharmacy **$25** for a one-month (30-day) supply of Tier 2 drugs from a preferred pharmacy **$35** copay for a one-month (30-day) supply of Tier 3 drugs from a non-preferred pharmacy **In-Network** After your yearly out-of-pocket drug costs reach $2500, you pay the greater of: • **$2** copay for generic (including brand drugs treated as generic) and **$5** copay for all other drugs, or • **5%** coinsurance This plan uses a formulary. A formulary is a list of drugs covered by the plan. If a plan takes a drug off the list; changes a drug on its list to a more expensive tier; or places a prior authorization, step therapy or quantity limit requirement on a drug, the plan will tell you at least 60 days before the change is effective. The plan will send you the formulary. You can also see the formulary at www.nationalhealth.com/formulary on the web. Different out-of-pocket costs may apply for people who: • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service)
29	**Dental Services**	In general, you pay 100% for preventive dental services, such as cleaning This plan offers more preventive dental coverage as an optional benefit
31	**Vision Services**	**In-Network** **$0** copay for: • One pair of eyeglasses or contact lenses after each cataract surgery • Eyeglasses or contact lenses **$30** copay for exams to diagnose and treat diseases and conditions of the eye **$0** copay for routine eye exams up to one routine eye exam a year Up to **$100** for eyewear for 2 years **Out-of-Network** **30%** of the cost for eye exams
32	**Physical Exams**	**In-Network** **$0** copay for routine physical exams **Out-of-Network** **30%** of the cost for routine physical exams When you get Medicare Part B, you can get a one-time physical exam within the first 6 months of your new Part B coverage. This coverage does not include lab tests.

Original Medicare Plan

(H0000-000)

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- Original Medicare Plan plan serving Nameless A and Nameless B Counties
- Provides only health coverage

Plan Contact Info:

151 Main Street
Anytown, CT 00000

For Prospective Members:
1-800-MEDICARE
1-800-633-4227 (toll-free)
1-877-486-2048 (TTY/TDD)
CustomerService@medicare.gov

For Current Members:
1-800-MEDICARE
1-800-633-4227 (toll-free)
1-877-486-2048 (TTY/TDD)
CustomerService@medicare.gov

Important Notes

This plan does not let providers charge you more than the plan's stated payment amount for each service. Contact the plan for details. You may go to any doctor, specialist, or hospital that accepts the plan's payment.

Learn More

> View quality and satisfaction graphs for this plan
> Find out why people have left this plan
> Calculate the average monthly out-of-pocket costs for this plan
> Learn more about your Medicare health plan choices
> Learn how to select a Medicare health plan
> Compare Medigap policies in your area

Important Information

1 Premium and Other Important Information	**$88.50** monthly Medicare Part B premium If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more
2 Doctor and Hospital Choice	You may go to any doctor, specialist, or hospital that accepts Medicare

Inpatient Care

3 Inpatient Hospital Care	**For each benefit period:** **$952** deductible for days 1–60 **$238** copay per day for days 61–90 **$476** copay per lifetime reserve day for days 91–150 Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days Lifetime reserve days can only be used once A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
4 Inpatient Mental Health Care	Same deductible and copay as **3 Inpatient Hospital Care** 190 day limit in a psychiatric hospital
5 Skilled Nursing Facility	**For each benefit period after at least a 3-day covered hospital stay:** **$0** copay per day for days 1–20 **$119** copay per day for days 21–100 100 day limit per benefit period You must get care in a Medicare-certified SNF A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
6 Home Health Care	**$0** copay
7 Hospice	You pay part of the cost for outpatient drugs and inpatient respite care You must get care from a Medicare-certified hospice

Outpatient Care

8 Doctor Office Visits	**20%** coinsurance
9 Chiropractic Services	**20%** coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractor or othe qualified provider **100%** for routine care
10 Podiatry Services	**20%** coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs **100%** for routine care
13 Outpatient Services/ Surgery	**20%** coinsurance for the doctor **20%** of outpatient facility charges
14 Ambulance Services	**20%** coinsurance
15 Emergency Care	**20%** coinsurance for the doctor **20%** of facility charge, or a set copay per emergency room visit For more information, call 1-800-MEDICARE (1-800-633-4227) You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit Not covered outside the U.S. except under limited circumstances
17 Outpatient Rehabilitation Services	**20%** coinsurance

Outpatient Medical Services and Supplies	
18 Durable Medical Equipment	**20%** coinsurance
20 Diabetes Self-Monitoring Training and Supplies	**20%** coinsurance
21 Diagnostic Test, X-Rays, and Lab Services	**20%** coinsurance for diagnostic tests and X-rays **$0** copay for Medicare-covered lab services **Lab Services:** Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare **does not** cover most routine screening tests, like checking your cholesterol.
Additional Benefits (What Original Medicare Does NOT Cover)	
28 Prescription Drugs	Most drugs not covered
29 Dental Services	Preventive dental services, such as cleaning, not covered
31 Vision Services	**20%** coinsurance for diagnosis and treatment of diseases and conditions of the eye **100%** for routine eye exams and glasses Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery Annual glaucoma screenings covered for people at risk
32 Physical Exams	**20%** coinsurance When you get Medicare Part B, you can get a one-time physical exam within the first 6 months of your new Part B coverage. This coverage does not include lab tests.