PlatinumHealth

NAME _____

NAME _____

DATE _____

YOUR AGENT

OPTION #1
MEDICARE + PART D = SUPPLEMENT

A HOSPITAL
HOSPITAL DEDUCTIBLE: $1736 | 1-60

$434 | 61-90 Per Day $868 | 91-150 Per Day

SKILLED NURSING FACILITY:

$0 | 1-20 $217 | 21-100 Per Day

HOME HEALTH CARE: $0 HOSPICE: $0

B MEDICAL
- Doctors
- Outpatient Surgery
- Ambulance
- Labs
- Physical Therapy
- Part B Drugs
- DME
- Preventative

$ 202.90 MONTH

ANNUAL DEDUCTIBLE: $283 CO-INS: 80% / 20%

D PRESCRIPTION
RETAIL: _____ RETAIL: _____

MAIL ORDER: _____ MAIL ORDER: _____

$ _____ $ _____

S SUPPLEMENT
RIDERS:

- ◯ Part A Deductible
- ◯ Part B Excess
- ◯ Home Health Care
- ◯ Part B Copay
- ◯ Foreign Travel
- ◯ Gym Membership

$ _____ $ _____

DENTAL
DEDUCTIBLE _____ MAX BENEFITS _____

$ _____ $ _____

MONTHLY TOTALS
$ _____ $ _____

ANNUAL COST + $283
$ _____ $ _____

DOESN'T INCLUDE PART B PREMIUM

OPTION #2
ADVANTAGE PLAN PART C + D

◯ HMO ◯ PPO

C ADVANTAGE PLAN
HOSPITAL COPAY: _____

DAYS: _____

OUTPATIENT SURGERY: _____

PRIMARY CARE PHYSICIAN _____

SPECIALIST: _____

PHYSICAL THERAPY: _____

CHIROPRACTOR: _____

LAB: _____

XRAY: _____

AMBULANCE: _____

MRI: _____

URGENT CARE: _____

EMERGENCY ROOM: _____

PART B GIVEBACK: _____

ANNUAL MAX OUT-OF-POCKET: _____

$ _____ $ _____

D PRESCRIPTION
RETAIL: _____ RETAIL: _____

MAIL ORDER: _____ MAIL ORDER: _____

+ ADDITIONAL BENEFITS
_____ GYM MEMBERSHIP

_____ DENTAL

_____ VISION

_____ HEARING

_____ OVER THE COUNTER

MONTHLY TOTALS
$ _____ $ _____

ANNUAL COST
$ _____ $ _____

DOESN'T INCLUDE PART B PREMIUM

OPTION #3
ADDITIONAL COVERAGE
HOSPITAL INDEMNITY +/OR CANCER

HI HOSPITAL INDEMNITY
HOSPITAL COPAY: _____

DAYS: _____

OUTPATIENT SURGERY: _____

AMBULANCE: _____

EMERGENCY ROOM: _____

PHYSICAL THERAPY: _____

CHIROPRACTOR: _____

ADDITIONAL BENEFITS: _____

$ _____ $ _____

CP AND/OR CANCER POLICY
BENEFIT AMOUNT _____

(INTERNAL LIFE THREATENING)

$ _____ $ _____

NOTES / QUESTIONS:

MONTHLY TOTALS
$ _____ $ _____

ANNUAL COST
$ _____ $ _____

DOESN'T INCLUDE PART B PREMIUM

PlatinumHealth

NAME _____

NAME _____

YOUR AGENT

PART D: $34.50 NATIONAL AVERAGE PREMIUM 2026

STANDARD PLAN

DEDUCTIBLE	INITIAL COVERAGE	CATASTROPHIC
$615	25% COST OF GENERIC & BRAND RX	0% COST
MAX OUT OF POCKET: $2,100		

- PHARMACY NETWORK
- QUANTITY LIMITS
- DRUG FORMULARY / TIERS
- EXCEPTIONS
- STEP THERAPY
- PRIOR AUTHORIZATIONS
- PENALTY 1% / MONTH:
- ENHANCED PLANS
- MEDICARE PRESCRIPTION PAYMENT PLAN (MPPP)

ENROLLMENT PERIODS MA / PDP

INITIAL ENROLLMENT PERIOD (IEP): Birthday Month plus 3 Months prior & 3 Months after

ANNUAL ENROLLMENT PERIOD (AEP): October 15 to December 7 - Plan choice starts January 1

MA OPEN ENROLLMENT PERIOD (MA OEP): January 1 to March 31

SPECIAL ENROLLMENT PERIOD (SEP): Retire, Move, Medicaid, Extra Help, SPAP, 5-Star, and Others

OTHER ITEMS

LOCAL SOCIAL SECURITY OFFICE: 800-772-1213 STAR RATINGS • MULTI-LANGUAGE

RESOURCES: MEDICARE 800-633-4227