DEKALB COUNTY MEDICARE ADVANTAGE PLANS - 2023

	AARP MEDICARE ADVANTAGE			ANTHEM MEDI BLUE					
Plan	**Choice-plan 1**	**Choice-plan 2**	**Profile**	**Access Plus**	**Access Preferred**	**Access**	**Access Basic**	**Extra**	**Plus**
Plan Type	PPO	PPO	HMO-POS *	PPO	PPO	PPO	PPO	HMO	HMO
Plan #	2228-019	2228-080	2802-007	1607-012	1607-015	7093-002	4487-001	3447-024	3447-042
Rating (5 is max)	4.0	4.0	4.5	4.0	4.0	new	4.0	4.0	4.0
Prem.- mo. $	$ 18	$ -	$ -	$ 54	$ 19	$ -	$ 81	$ 21.10	$ -
Drug Ded. (Hlth.)	$ -	$ -	$ -	$ 60	$ -	$ -	$ -	$ 505	$ -
Part B rebate	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CO-PAYS:									
Maximum-annual									
In Network	$ 3,700	$ 4,800	$ 3,900	$ 6,400	$ 3,900	$ 4,900	$ 6,400	$ 6,700	$ 3,900
Out of network	$ 8,950	$ 8,950	Won't pay	$ 10,000	$ 8,950	$ 8,950	$ 10,000	Won't pay	Won't pay
Hospital	$325/day Days 1-5	$295/day Days 1-6	$325/day Days 1-5	$310/day Days 1-7	$370/day Days 1-5	$370/day Days 1-5	$290/day Days 1-7	$290/day Days 1-7	$295/day Days 1-7
Off. Visit-Primary	$ -	$ -	$ -	$ 10	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 35	$ 40	$ 30	$ 40	$ 35	$ 40	$ 40	$ 30	$ 35
Out- patient surgery:									
Surgical Ctr.	$ 195	$ 195	$ 195	$ 225	$ 255	$ 295	$ 265	$ 200	$ 225
Hospital	$ 295	$ 295	$ 295	20%	$ 300	$ 350	20%	$ 245	$ 275
MRI & CT scans	$ 140	$ 170	$ 170	$140 Dr Off. 215 Facility	$150 Dr Off. 200 Facility	$150 Dr Off. 200 Facility	$105 Dr Off. 175 Facility	$90 Dr Off. 150 Facility	$95 Dr Off. 195 Facility
EXTRA BENEFITS:									
Hearing Aids	$175-1,225 co-pay	$175-1,225 co-pay	$175-1,225 co-pay	$3,000 allowance	$3,000 allowance	$3,000 allowance	$2,000 allowance	$3,000 allowance	$3,000 allowance
Dental:									
Coverage limit	$ 1,250	$ 1,000	$ 1,500	$ -	$ 2,000	$ 1,250	$ -	$250 allow./qtr.	$ 1,200
Comprehensive coverage	Yes	Yes	Yes	No	Yes	50-70% co-pay	No	Yes	Yes
Eyewear Allow.	$ 300	$ 250	$ 300	No	$ 275	$ 150	No	$ 200	$ 150
Fitness program	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
OTC Drug allowance/quarter	$ 50	$ 40	$ 80	$ 38	$ 50	$ 48	$ 35	$ 170	$ 67
Transportation	None	None	Yes	Yes -option	Yes -option	Yes -option	None	Yes	Yes -option
Others				$500 (A)	$500 (A)	$500 (A)		$500 (A)	

(A) Allowance for additional dental, vision & hearing-optional

DEKALB COUNTY MEDICARE ADVANTAGE PLANS - 2023

HUMANA

Plan	Choice Regional	Choice	Choice	Choice	USAA Honor w/RX	Choice	Value Plus	Gold Plus
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	PPO	HMO-POS *
Plan #	0865-003	5216-112	5216-192	5216-055	5216-307	5216-309	5216-193	5619-051
Rating (5 is max)	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.0
Prem.- mo. $	$ 33	$ -	$ -	$ 39	$ -	$ -	$ 28.10	$ -
Drug Ded. (Hlth.)	$ 195	$ -	$250 ($650)	$ -	$350 ($400)	350 ($625)	$260 ($226)	$ -
Part B rebate	$ -	$ -	$ -	$ -	$ 75	$ 102	$ -	
CO-PAYS:								
Maximum-annual								
In Network	$ 7,550	$ 4,900	$ 6,700	$ 5,200	$ 6,550	$ 6,500	$ 7,550	$ 3,900
Out of network	$ 10,000	$ 8,950	$ 6,700	$ 8,950	$ 7,990	$ 7,990	$ 10,000	Won't pay
Hospital	$390/day Days 1-5	$370/day Days 1-5	$490/day Days 1-4	$360/day Days 1-5	$400/day Days 1-4	$400/day Days 1-4	$1,600/ admission	$275/day Days 1-7
Off. Visit-Primary	$ 5	$ -	$ -	$ 10	$ 15	$ -	$ -	$ -
" " -Specialist	$ 40	$ 40	$ 50	$ 45	$ 45	$ 45	20%	$ 30
Out- patient surgery:								
Surgical Ctr.	$ 340	$ 295	$ 415	$ 285	$ 325	$ 325	19%	$ 200
Hospital	$ 390	$ 345	$ 465	$ 335	$ 375	$ 375	19%	$ 250
MRI & CT scans	$ 300	$ 385	$ 475	$ 350	$ 495	$ 395	$ -	$ 450
EXTRA BENEFITS:								
Hearing Aids	$499-799 copay	$399-999 copay	$399-999 copay	$399-999 copay	$399-999 copay	$399-999 copay	$0 copay	$399-999 copay
Dental:								
Coverage limit	$ 1,000	$ 1,500	$ 1,500	$ 1,000	$ 1,500	$ 1,000	$ 1,000	$ 2,500
Comprehensive coverage	50% copay	0% copay	Fillings only	50% copay	50% copay	0% copay	0% copay	0% copay
Eyewear Allow.	None	$ 200	$ 200	$ 200	$ 100	$200	$400	$ 200
Fitness program	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
OTC Drug allowance/quarter	$15/mo	$ 45	$ 30	$ 30	$ 50	$ 50	$ 100	$ 50
Transportation	None	None	None	None	None	None	Yes	Yes
Addt'l dental,hearing & vision								$ 1,000

* Out of network coverage on dental o

DEKALB COUNTY MEDICARE ADVANTAGE PLANS - 2023

	AETNA MEDICARE			WELLCARE					PROMEDICA
Plan	**Value**	**Premiere**	**Prime**	**No Premium Open**	**Low Prem. Open**	**No Premium**	**Give Back**	**Assist**	**Medicare Plan Essential**
Plan Type	PPO	PPO	HMO-POS *	PPO	PPO	HMO	HMO	HMO	HMO
Plan #	5521-099	5521-190	3192-004	6348-002	6348-007	3499-002	3499-007	3499-008	5373-001
Rating (5 is max)	3.5	3.5	3.5	N/a	N/A	3.0	3.0	3.0	N/A
Prem.- mo. $	$ -	$ 29	$ -	$ -	$ 15	$ -	$ -	$ 12	$ -
Drug Ded. (Hlth.)	$ -	$ -	$ -	$ -	$ -	$ -	$ 200	$ 505	$ -
Part B rebate	$ -	$ -	$ -	$ -	$ -	$ -	$ 29	$ -	$ -
CO-PAYS:									
Maximum-annual									
In Network	$ 4,250	$ 3,675	$ 3,900	$ 4,300	$ 4,300	$ 3,900	$ 8,300	$ 5,500	$ 3,500
Out of network	$ 8,500	$ 7,500	Won't pay	$ 8,950	$ 8,950	Won't pay	Won't pay	Won't pay	Won't pay
Hospital	$275/day Days 1-7	$250/day Days 1-6	$300/day Days 1-7	$400/day Days 1-5	$375/day Days 1-5	$295/day Days 1-6	$400/day Days 1-5	$275/day Days 1-6	$250/day Days 1-5
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ -	$ -	$ 10	$ -	$ -
" " -Specialist	$ 35	$ 30	$ 35	$ 45	$ 40	$ 35	$ 40	$ 35	$ 30
Out- patient surgery:									
Surgical Ctr.	$ 325	$ 260	$ 265	$ 275	$ 225	$ 250	$ 275	$ 225	$ 200
Hospital	$ 325	$ 260	$ 265	$ 325	$ 250	$ 275	$ 350	$ 250	$ 200
MRI & CT scans	$ 250	$ 195	$ 200	$325	$250	$275	$350	$250	$150
EXTRA BENEFITS:									
Hearing Aids	500/ear allow.	500/ear allow.	$750/ear allow.	$750/ear allowance	$1,000 allowance	$1000/ear allowance	$350/ear allowance	$1,000 allowance	$675/ear
Dental:									
Coverage limit	$ 1,250	$ 1,500	$ 2,500	$ 1,500	$ 1,500	$ 1,500	N/A	$ 2,000	$ 1,000
Comprehensive coverage	In/out of network	In/out of network	20% copay out of network	40% copay	0% copay	40% copay	None	$0 copay	30% co-pay
Eyewear Allow.	$165	$225	$300	$ 200	$ -	$ 200	None	$ 300	$100/2 yrs.
Fitness program	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
OTC Drug allowance/quarter	$ 60	$ 90	$ 90	$ 74	$ 80	$ 78	$ 53	$ 150	$ 100
Transportation	None	None	None	No	No	Yes	No	Yes	Yes
Addt'l dental,hearing & vision						$ 500			

DEKALB COUNTY MEDICARE ADVANTAGE PLANS - 2023

NO DRUG COVERAGE	AARP	AETNA	ANTHEM	HUMANA		WELLCARE	LASSO	
Plan	**Medicare Adv. Patriot**	**Medicare Eagle**	**MediBlue Service**	**Choice**	**Honor**	**Patriot Give Back Open**	**Healthcare Growth**	**Healthcare Growth Plus**
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	MSA	MSA
Plan #	2228-091	5521-286	7093-001	0865-001	5216-218	6348-005	1924-001	1924-004
Rating (5 is max)	4.0	3.5	NEW	4.5	4.5	N/A	2.0	2.0
Prem.- mo. $	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Part B rebate	$ 50	$ 45	$ 50	$ -	$ 75	$ 40	$ -	$ -
CO-PAYS:	1) $5,000 Deductible. Deposit $2000 BY LASSO. NO CO-PAYS after deductible is met.							
Maximum-annual	2) $8,000 Deductible. Deposit $3000 BY LASSO. NO CO-PAYS after deductible is met.							
In Network	$ 5,500	$ 4,390	$ 6,700	$ 3,900	$ 5,900	$ 5,500	(1)	(2)
Out of network	$ 8,950	$ 8,000	$ 10,000	$ 8,950	$ 8,950	$ 8,950		
Hospital	$350/day Days 1-5	$275/day Days 1-7	$295/day Days 1-7	$325/day Days 1-6	$350/day Days 1-5	$400/day Days 1-5		
Off. Visit-Primary	$ -	$ -	$ -	$ 5	$ 15	$ 5		
" " -Specialist	$ 40	$ 35	$ 45	$ 30	$ 45	$ 40		
Out- patient surgery:								
Surgical Ctr.	$ 250	$ 350	$ 245	$ 225	$ 275	$ 250		
Hospital	$ 350	$ 350	$ 275	$ 245	$ 325	$ 350		
MRI & CT scans	$ 160	$ 250	$180 Dr Off. $275 facility	$ 295	$ 350	$ 350		

EXTRA BENEFITS:

Hearing Aids	$175-1,225 co-pay	$1500/ear allow.	$3,000 allowance	$199-499 copay	$99-699 copay	$1000/ear allowance	NONE OFFERED
Dental:							
Coverage limit	$ 1,500	$ 3,000	$ 2,000	$ 1,000	$ 2,000	$ 1,500	NONE OFFERED
Comprehensive coverage	Yes	Yes-in/out network	Yes-in/out network	Yes	Yes	40% copay comp.	
Eyewear Allow.	$ 300	$ 300	$ 200	$ 200	$ 200	$ 200	NONE OFFERED
Fitness program	Yes	Yes	Yes	Yes	Yes	Yes	NONE OFFERED
OTC Drug allowance/quarter	$ 60	$ 120	$ 150	$ 100	$ 200	$ 75	NONE OFFERED
Transportation	No	No	Yes-option	Yes	No	No	NONE OFFERED
Others			$500 (A)			$500 (A)	NONE OFFERED

A) Allowance for additional dental, vision & hearing-optional benefit