

HUNTINGTON COUNTY MEDICARE ADVANTAGE PLANS - 2023

Plan	AARP MEDICARE ADVANTAGE				AETNA MEDICARE			ANTHEM MEDI BLUE					
	Choice-plan 1	Focus	Choice-plan 2	Profile	Value	Premiere	Prime	Access Plus	Access Preferred	Access	Access Basic	Extra	Plus
Plan Type	PPO	PPO	PPO	HMO-POS *	PPO	PPO	HMO-POS *	PPO	PPO	PPO	PPO	HMO	HMO
Plan #	2228-019	2228-020	2228-080	2802-007	5521-099	5521-190	3192-004	1607-012	1607-015	7093-002	4487-001	3447-024	3447-042
Rating (5 is max)	4.0	4.0	4.0	4.5	3.5	3.5	3.5	4.0	4.0	new	4.0	4.0	4.0
Prem.- mo. \$	\$ 18	\$ -	\$ -	\$ -	\$ -	\$ 29	\$ -	\$ 54	\$ 19	\$ -	\$ 81	\$ 21.10	\$ -
Drug Ded. (Hlth.)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 60	\$ -	\$ -	\$ -	\$ 505	\$ -
Part B rebate	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

CO-PAYS:

* Out of network coverage on dental only

Maximum-annual

In Network	\$ 3,700	\$ 3,900	\$ 4,800	\$ 3,900	\$ 4,250	\$ 3,675	\$ 3,900	\$ 6,400	\$ 3,900	\$ 4,900	\$ 6,400	\$ 6,700	\$ 3,900
Out of network	\$ 8,950	\$ 8,950	\$ 8,950	Won't pay	\$ 8,500	\$ 7,500	Won't pay	\$ 10,000	\$ 8,950	\$ 8,950	\$ 10,000	Won't pay	Won't pay
Hospital	\$325/day Days 1-5	\$325/day Days 1-5	\$295/day Days 1-6	\$325/day Days 1-5	\$275/day Days 1-7	\$250/day Days 1-6	\$300/day Days 1-7	\$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	\$ 30	\$ 40	\$ 30	\$ 35	\$ 30	\$ 35	\$ 40	\$ 35	\$ 40	\$ 40	\$ 30	\$ 35

Out-patient surgery:

Surgical Ctr.	\$ 195	\$ 195	\$ 195	\$ 195	\$ 325	\$ 260	\$ 265	\$ 225	\$ 255	\$ 295	\$ 265	\$ 200	\$ 225
Hospital	\$ 295	\$ 295	\$ 295	\$ 295	\$ 325	\$ 260	\$ 265	20%	\$ 300	\$ 350	20%	\$ 245	\$ 275
MRI & CT scans	\$ 140	\$ 160	\$ 170	\$ 170	\$ 250	\$ 195	\$ 200	\$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	\$175-1,225 co-pay	500/ear allow.	500/ear allow.	\$750/ear allow.	\$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	\$ 1,000	\$ 1,500	\$ 1,250	\$ 1,500	\$ 2,500	\$ -	\$ 2,000	\$ 1,250	\$ -	\$250 allow./ctr.	\$ 1,200
Comprehensive coverage	Yes	Yes	Yes	Yes	In/out of network	In/out of network	20% copay out of network	No	Yes	50-70% co- pay	No	Yes	Yes
Eyewear Allow.	\$ 300	\$ 300	\$ 250	\$ 300	\$165	\$225	\$300	No	\$ 275	\$ 150	No	\$ 200	\$ 150
Fitness program	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
OTC Drug allowance/quarter	\$ 50	\$ 100	\$ 40	\$ 80	\$ 60	\$ 90	\$ 90	\$ 38	\$ 50	\$ 48	\$ 35	\$ 170	\$ 67
Transportation	None	None	None	Yes	None	None	None	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

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Plan	IU HEALTH		WELLCARE				
	Select Plus	Flex Network	No Premium Open	Low Prem. Open	No Premium	Give Back	Assist
Plan Type	HMO	HMO-POS	PPO	PPO	HMO	HMO	HMO
Plan #	7220-009	7220-011	6348-002	6348-007	3499-002	3499-007	3499-008
Rating (5 is max)	4.0	4.0	N/a	N/A	3.0	3.0	3.0
Prem.- mo. \$	\$ -	\$ -	\$ -	\$ 15	\$ -	\$ -	\$ 12
Drug Ded. (Hlth.)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 200	\$ 505
Part B rebate	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 29	\$ -
CO-PAYS:							
Maximum-annual							
In Network	\$ 3,350	\$ 3,900	\$ 4,300	\$ 4,300	\$ 3,900	\$ 8,300	\$ 5,500
Out of network	Won't pay	\$ 7,800	\$ 8,950	\$ 8,950	Won't pay	Won't pay	Won't pay
Hospital	\$340/day Days 1-6	\$335/day Days 1-6	\$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
Off. Visit-Primary	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 10	\$ -
" " -Specialist	\$ 40	\$ 35	\$ 45	\$ 40	\$ 35	\$ 40	\$ 35
Out- patient surgery:							
Surgical Ctr.	\$ 295	\$ 295	\$ 275	\$ 225	\$ 250	\$ 275	\$ 225
Hospital	\$ 310	\$ 325	\$ 325	\$ 250	\$ 275	\$ 350	\$ 250
MRI & CT scans	20%	40%	\$325	\$250	\$275	\$350	\$250
EXTRA BENEFITS:							
Hearing Aids	\$699-999 copay	\$699-999 copay	\$750/ear allowance	\$1,000 allowance	\$1000/ear allowance	\$350/ear allowance	\$1,000 allowance
Dental:							
Coverage limit	\$ 1,000	\$ 1,000	\$ 1,500	\$ 1,500	\$ 1,500	N/A	\$ 2,000
Comprehensive coverage	50% copay	50% copay	40% copay	0% copay	40% copay	None	\$0 copay
Eyewear Allow.	\$250/2 yrs.	\$250/2 yrs.	\$ 200	\$ -	\$ 200	None	\$ 300
Fitness program	Yes	Yes	Yes	Yes	Yes	Yes	Yes
OTC Drug allowance/quarter	\$ 120	\$ 120	\$ 74	\$ 80	\$ 78	\$ 53	\$ 150
Transportation	Yes	Yes	No	No	Yes	No	Yes
Add'l dental,hearing & vision					\$ 500		

HUNTINGTON 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.

2) \$8,000 Deductible. Deposit \$3000 BY LASSO. NO CO-PAYS after deductible is met.

Maximum-annual

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