DEKALB COUNTY MEDICARE ADVANTAGE PLANS - 2024

INCLUDES DRUG COVERAGE

	AARP MEDICARE ADVANTAGE					ANTHEM					
Plan	**UHC IN-0001**	**UHC IN-006**	**UHC IN-0010**	**UHC IN-0016**	**UHC IN-0020**	**Medicare Advan. 2**	**Medicare Advan. 3**	**Medicare Adv.**	**Regional Medicare Adv.**	**Extra Help**	**Medicare Adv.**
Plan Type	PPO	PPO	HMO-POS *	HMO-POS *	HMO-POS *	PPO	PPO	PPO	PPO	HMO	HMO
Plan #	2406-035	2406-066	2802-007	2802-055	2802-059	1607-015	1607-012	7093-002	4487-001	3447-024	3447-042
Rating (5 is max)	4.0	4.0	4.0	4.0	4.0	3.5	3.5	3.0	3.5	3.5	3.5
Prem.- mo. $	$ 24	$0	$0	$0	$0	$ 28	$ 58	$ -	$ 73	$ 16.70	$ -
Drug Ded.	$0	$0	$0	$350	$395		$ 60	$ -	$ -	$ 545	$ -
Health care deduct.	$0	$0	$0	$0	$0		$ 500	$ -	$ 500	$ -	$ -
CO-PAYS:		* Out of network coverage on dental only									
Maximum-annual											
In Network	$ 3,700	$ 4,500	$ 3,800	$ 5,900	$ 6,500	$ 3,900	$ 6,400	$ 5,900	$ 6,400	$ 4,900	$ 4,250
Out of network	$ 5,750	$ 9,550	Won't pay	Won't pay	Won't pay	$ 8,950	$ 10,000	$ 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	$395/day Days 1-5	$455/day Days 1-5	$370/day Days 1-5	$310/day Days 1-7	$390/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	$ 45	$ 45	$ 40	$ 40	$ 45	$ 40	$ 30	$ 35
Out- patient surgery:											
Surgical Ctr.	$ 225	$ 195	$ 225	$ 345	$ 405	$ 255	$ 225	$ 295	$ 265	$ 200	$ 225
Hospital	$ 325	$ 295	$ 325	$ 395	$ 455	$ 300	20%	$ 350	20%	$ 245	$ 275
MRI & CT scans	$ 185	$ 180	$ 170	$ 180	$ 250	Dr $150 Hosp 200	Dr $140 Hosp 215	Dr $150 Hosp 200	Dr $105 Hosp 175	Dr $50 Hosp 150	Dr $95 Hosp 195
EXTRA BENEFITS:											
Hearing Aids	$99-1,249 co-pay	99-1,249 co-pay	$99-1,249 co-pay	$99-1,249 co-pay	$99-1,249 co-pay	300-3000 allow.	300-3000 allow.	300-1500 allow.	300-2000 allow.	300-3000 allow.	300-3000 allow.
Dental:											
Coverage limit	$ 1,750	$ 1,000	$ 2,500	$ 3,500	none	$ 2,000	none	$ 1,250	none	$ 1,500	$ 1,200
Comprehensive coverage	0% copay (A)	0% copay (A)	0% copay (A)	0% copay (A)	Prevent. Only	0% copay	No	50-70% co-pay	No	0% copay	0% copay
Eyewear Allow.	$ 300	$ 250	$ 300	$ 250	$ 200	$ 275	None	$ 150	No	$ 200	$ 150
# of meals after hospitalization	28	28	28	28	28	0	0	0	0	20	20
OTC Drug allowance/quarter	$ 50	$ 40	$ 80	$ 70	$ -	$ 50	$ 38	$ 35	$ 35	$ 170	$ 70
Part B rebate	$ -	$ -	$ -	$ -	$ 86	$ -	$ -	$ -	$ -	$ -	$ -
Transportation	None	None	None	None	None	Yes -option	None	Yes -option	None	Yes	Yes -option
Addt'l dental, vision & hearing-optional						$ 500		$ 500		$ 500	$ 500

A) 50% copay for bridges and dentures

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INCLUDES DRUG COVERAGE

	HUMANA								PARAMOUN
Plan	**Choice Regional**	**Choice**	**Choice**	**Choice**	**USAA Honor w/RX**	**Choice**	**Choice**	**Gold Plus**	**Elite Indiana Essential**
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	PPO	HMO-POS *	HMO-POS *
Plan #	0865-003	5216-112	5216-192	5216-019	5216-307	5216-309	5216-193	5619-051	5373-001
Rating (5 is max)	4.0	4.5	4.5	4.5	4.5	4.5	4.5	4.0	NEW
Prem.- mo. $	$ 46	$ -	$ -	$ 41	$ -	$ -	$ 42.30	$ -	$ -
Drug Ded.	$ 245	$ -	$ 545	$ -	$ 350	$ 545	$ 150	$ -	$ -
Health care deduct.	$ -	$ -	$ 500	$ -	$ -	$ 510	$ -	$ -	$ -
CO-PAYS:				* Out of network coverage on dental, vision & emergency care.					
Maximum-annual									
In Network	$ 7,550	$ 5,050	$ 6,700	$ 5,800	$ 8,850	$ 7,550	$ 3,900	$ 3,900	$ 3,500
Out of network	$ 10,000	$ 9,550	$ 6,700	$ 9,550	$ 13,300	$ 10,000	$ 9,550	Won't pay	Won't pay
Hospital	$390/day Days 1-5	$370/day Days 1-6	$565/day Days 1-4	$390/day Days 1-5	$425/day Days 1-5	$400/day Days 1-5	$395/day Days 1-6	$325/day Days 1-7	$250/day Days 1-5
Off. Visit-Primary	$ 5	$ -	$ -	$ 10	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 40	$ 40	$ 50	$ 45	$ 45	$ 40	$ 35	$ 30	$ 30
Out- patient surgery:									
Surgical Ctr.	$ 340	$ 320	$ 515	$ 340	$ 375	$ 350	$ 345	$ 275	$ 200
Hospital	$ 390	$ 370	$ 565	$ 390	$ 425	$ 400	$ 395	$ 325	$ 200
MRI & CT scans	Dr. $200 Hosp 300	Dr. $200 Hosp 300	Dr. $200 Hosp 300	Dr. $200 Hosp 300	Dr. $200 Hosp 300	Dr. $200 Hosp 300	Dr. $200 Hosp 300	Dr. $200 Hosp 300	$ 150
EXTRA BENEFITS:									
Hearing Aids	$499-799 copay	$399-999 copay	$399-999 copay	$499-799 copay	$399-999 copay	$399-999 copay	$0 copay	$399-999 copay	$675/ear
Dental:									
Coverage limit	$ 1,000	$ 1,000	none	$ 1,000	$ 3,000	$ 1,000	$ 1,500	$ 2,500	$ 7,500
Comprehensive coverage	Limited compren. available	0% copay	Limited compren. available	Limited compren. available	50% copay	0% copay	0% copay	0% copay	0% copay
Eyewear Allow.	$50-100	$150-200	$200-250	$100-150	$100-150	$100-150	$350-400	$100-150	$ 200
# of meals after hospitalization	14	14	14	14	14	14	14	14	28
OTC Drug allowance/quarter	$15/Mo	$ 50	$ -	$ 50	$ 50	$ 50	$ 50	$ 50	$ 125
Part B rebate	$ -		$ -	$ -	$ 70	$ 102	$ -	$ -	$ -
Transportation	None	None	None	None	None	None	Yes	Yes	Yes
Addt'l dental,hearing & vision								$ 500	

DEKALB COUNTY MEDICARE ADVANTAGE PLANS - 2024

INCLUDES DRUG COVERAGE

	AETNA MEDICARE			WELLCARE			
Plan	**Value**	**Premiere**	**Prime**	**No Premium Open**	**Low Prem. Open**	**No Premium**	**Assist**
Plan Type	PPO	PPO	HMO-POS *	PPO	PPO	HMO	HMO
Plan #	5521-099	5521-190	3192-004	6348-002	6348-007	3499-002	3499-008
Rating (5 is max)	4.0	4.0	3.5	3.0	3.0	3.0	3.0
Prem.- mo. $	$ -	$ 22	$ -	$ -	$ 15	$ -	$ 19.80
Drug Ded.	$ -	$ -	$ -	$ -	$ -	$ 175	$ 505
Health care deduct.	$ -	$ -	$ -	$ -	$ -	$ -	
CO-PAYS:	*Out of network coverage primarily for dental.						
Maximum-annual							
In Network	$ 4,250	$ 3,675	$ 3,900	$ 4,300	$ 4,300	$ 3,900	$ 6,000
Out of network	$ 8,500	$ 7,500	Won't pay	$ 8,950	$ 8,950	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	$350/day Days 1-6	$350/day Days 1-6
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 35	$ 30	$ 35	$ 40	$ 40	$ 35	$ 35
Out- patient surgery:							
Surgical Ctr.	$ 325	$ 260	$ 265	$ 275	$ 225	$ 250	$ 225
Hospital	$ 325	$ 260	$ 265	$ 325	$ 250	$ 350	$ 250
MRI & CT scans	$ 250	$ 195	$ 200	$200-325	$100-250	$250-350	$150-250
EXTRA BENEFITS:							
Hearing Aids	500/ear allow.	500/ear allow.	$750/ear allow.	$750 allow./ear	$1,000 allow./ear	$1,000 allow./ear	$1,000 allow./ear
Dental:							
Coverage limit	$ 1,450	$ 1,500	$ 2,800	$ 2,000	$ 3,000	$ 1,500	$ 4,000
Comprehensive coverage	Yes	Yes	Yes	0% copay	0% copay	40% copay	$0 copay
Eyewear Allow.	$165	$225	$255	$ 300	$ 400	$ 200	$ 300
# of meals after hospitalization	14	14	14	0	0	42	42
OTC Drug allowance/quarter	$ 90	$ 90	$ 90	$ 88	$ 78	In Add Dent, Vis & hear	$64/qtr.
Part B rebate				$ -	$ -	$ -	$ -
Transportation	None	None	None	No	No	Yes	Yes
Addt'l dental,hearing & vision						$60/month	
Utility asst. for chronically ill							$50/mo.
Food/utility allow. If on Extra Help							$55/mo

DEKALB COUNTY MEDICARE ADVANTAGE PLANS - 2024

DO NOT INCLUDE DRUG COVERAGE	AARP	AETNA	ANTHEM	HUMANA		WELLCARE
Plan	**Medicare Adv. Patriot**	**Medicare Eagle**	**Veteran**	**Choice Regional**	**USAA Honor**	**Patriot Give Back Open**
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO
Plan #	2406-074	5521-286	7093-001	0865-001	5216-218	6348-005
Rating (5 is max)	4.0	4.0	3.0	4.0	4.5	3.0
Prem.- mo. $	$ -	$ -	$ -	$ -	$ -	$ -
Health care deduct.	$ -	$ -	$ -	$ -	$ -	$ -
CO-PAYS:						
Maximum-annual						
In Network	$ 8,850	$ 4,390	$ 6,700	$ 4,350	$ 5,900	$ 5,500
Out of network	$ 13,300	$ 8,000	$ 10,000	$ 5,500	$ 8,950	$ 8,950
Hospital	$425/day Days 1-4	$260/day Days 1-6	$350/day Days 1-5	$275/day Days 1-6	$350/day Days 1-5	$400/day Days 1-5
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ 15	$ 5
" " -Specialist	$ 45	$ 30	$ 45	$ 30	$ 45	$ 40
Out- patient surgery:						
Surgical Ctr.	$ 325	$ 350	$ 245	$ 195	$ 300	$ 250
Hospital	$ 425	$ 350	$ 275	$ 245	$ 350	$ 350
MRI & CT scans	$ 250	$ 250	Dr. $180 Hosp $275	Dr. $180 Hosp $275	Dr. $200 Hosp $300	$ 350
EXTRA BENEFITS:						
Hearing Aids	$99-1,249 co-pay	$1500/ear allow.	300-2000 allow.	$0 - 299 co-pay	$99-699 copay	$1000/ear allowance
Dental:						
Coverage limit	$ 2,500	$ 3,500	$ 2,000	$ 1,000	$ 2,000	$ 1,500
Comprehensive coverage	0% copay (A)	0% copay	0% copay	0% copay	0% copay	40% copay
Eyewear Allow.	$ 300	$ 325	$ 200	$250-500	$150-200	$ 200
# of meals after hospitalization	28	14	14	14	14	42
OTC Drug allowance/quarter	$ 60	$ 120	$ 75	$ 100	$ 150	W/Addt'l dental, vision,hear
Transportation	No	No	Yes-option	Yes	No	No
Part B rebate	$ 105	$ 70	$ 70		$ 100	$ 60
Addt'l dental, vision & hearing-optional			$ 500			$25/month

A) 50% copay for bridges and dentures