

HUNTINGTON COUNTY MEDICARE ADVANTAGE PLANS - 2024

**INCLUDES DRUG  
COVERAGE**

Plan	AARP MEDICARE ADVANTAGE						ANTHEM					
	UHC IN-0001	UHC IN-0001 P	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.
<b>Plan Type</b>	PPO	PPO	PPO	HMO-POS *	HMO-POS *	HMO-POS *	PPO	PPO	PPO	PPO	HMO	HMO
<b>Plan #</b>	2406-035	2406-036	2406-066	2802-007	2802-055	2802-059	1607-015	1607-012	7093-002	4487-001	3447-024	3447-042
<b>Rating (5 is max)</b>	4.0	4.0	4.0	4.0	4.0	4.0	3.5	3.5	3.0	3.5	3.5	3.5
<b>Prem.- mo. \$</b>	\$ 24	\$0	\$0	\$0	\$0	\$0	\$ 28	\$ 58	\$ -	\$ 73	\$ 16.70	\$ -
<b>Drug Ded.</b>	\$0	\$0	\$0	\$0	\$350	\$395		\$ 60	\$ -	\$ -	\$ 545	\$ -
<b>Health care deduct.</b>	\$0	\$0	\$0	\$0	\$0	\$0		\$ 500	\$ -	\$ 500	\$ -	\$ -

**CO-PAYS:** \* Out of network coverage on dental only

<b>Maximum-annual</b>	AARP MEDICARE ADVANTAGE						ANTHEM					
<b>In Network</b>	\$ 3,700	\$ 3,800	\$ 4,500	\$ 3,800	\$ 5,900	\$ 6,500	\$ 3,900	\$ 6,400	\$ 5,900	\$ 6,400	\$ 4,900	\$ 4,250
<b>Out of network</b>	\$ 5,750	\$ 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
<b>Hospital</b>	\$325/day Days 1-5	\$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
<b>Off. Visit-Primary</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 10	\$ -	\$ -	\$ -	\$ -
<b>" " -Specialist</b>	\$ 35	\$ 30	\$ 40	\$ 30	\$ 45	\$ 45	\$ 40	\$ 40	\$ 45	\$ 40	\$ 30	\$ 35
<b>Out- patient surgery:</b>												
<b>Surgical Ctr.</b>	\$ 225	\$ 225	\$ 195	\$ 225	\$ 345	\$ 405	\$ 255	\$ 225	\$ 295	\$ 265	\$ 200	\$ 225
<b>Hospital</b>	\$ 325	\$ 325	\$ 295	\$ 325	\$ 395	\$ 455	\$ 300	20%	\$ 350	20%	\$ 245	\$ 275
<b>MRI &amp; CT scans</b>	\$ 185	\$ 160	\$ 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:**

<b>Hearing Aids</b>	\$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	\$99-1,249 co-pay	300-3000 allow.	300-3000 allow.	300-1500 allow.	300-2000 allow.	300-3000 allow.	300-3000 allow.
<b>Dental:</b>												
<b>Coverage limit</b>	\$ 1,750	\$ 1,250	\$ 1,000	\$ 2,500	\$ 3,500	none	\$ 2,000	none	\$ 1,250	none	\$ 1,500	\$ 1,200
<b>Comprehensive coverage</b>	0% copay (A)	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
<b>Eyewear Allow.</b>	\$ 300	\$ 300	\$ 250	\$ 300	\$ 250	\$ 200	\$ 275	None	\$ 150	No	\$ 200	\$ 150
<b># of meals after hospitalization</b>	28	28	28	28	28	28	0	0	0	0	20	20
<b>OTC Drug allowance/quarter</b>	\$ 50	\$ 100	\$ 40	\$ 80	\$ 70	\$ -	\$ 50	\$ 38	\$ 35	\$ 35	\$ 170	\$ 70
<b>Part B rebate</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 86	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Transportation</b>	None	None	None	None	None	None	Yes -option	None	Yes -option	None	Yes	Yes -option
<b>Add'l dental, vision &amp; hearing-optional</b>							\$ 500		\$ 500		\$ 500	\$ 500

A) 50% copay for bridges and dentures





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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.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>CO-PAYS:</b>						
<b>Maximum-annual</b>						
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
<b>Hospital</b>	\$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
<b>Off. Visit-Primary</b>	\$ -	\$ -	\$ -	\$ -	\$ 15	\$ 5
" " -Specialist	\$ 45	\$ 30	\$ 45	\$ 30	\$ 45	\$ 40
<b>Out- patient surgery:</b>						
Surgical Ctr.	\$ 325	\$ 350	\$ 245	\$ 195	\$ 300	\$ 250
Hospital	\$ 425	\$ 350	\$ 275	\$ 245	\$ 350	\$ 350
<b>MRI &amp; CT scans</b>	\$ 250	\$ 250	Dr. \$180 Hosp \$275	Dr. \$180 Hosp \$275	Dr. \$200 Hosp \$300	\$ 350
<b>EXTRA BENEFITS:</b>						
<b>Hearing Aids</b>	\$99-1,249 co-pay	\$1500/ear allow.	300-2000 allow.	\$0 - 299 co-pay	\$99-699 copay	\$1000/ear allowance
<b>Dental:</b>						
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
<b>Eyewear Allow.</b>	\$ 300	\$ 325	\$ 200	\$250-500	\$150-200	\$ 200
<b># of meals after hospitalization</b>	28	14	14	14	14	42
<b>OTC Drug allowance/quarter</b>	\$ 60	\$ 120	\$ 75	\$ 100	\$ 150	W/Addt'l dental, vision,hear
<b>Transportation</b>	No	No	Yes-option	Yes	No	No
<b>Part B rebate</b>	\$ 105	\$ 70	\$ 70		\$ 100	\$ 60
<b>Add'l dental, vision &amp; hearing-optional</b>			\$ 500			\$25/month

A) 50% copay for bridges and dentures