

JOHNSON COUNTY MEDICARE ADVANTAGE PLANS - 2024

**INCLUDES DRUG COVERAGE**

Plan	AARP MEDICARE ADVANTAGE					ANTHEM					
	UHC IN-0012	UHC IN-0002	UHC IN-0007	UHC IN-0017	UHC IN-0020	Medicare Advan. 2	Medicare Advan. 3	Medicare Adv.	Regional Medicare Adv.	Extra Help	Medicare Adv.
<b>Plan Type</b>	HMO-POS *	PPO	PPO	HMO-POS *	HMO-POS *	PPO	PPO	PPO	PPO	HMO	HMO
<b>Plan #</b>	2802-010	2406-037	2406-067	2802-056	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	3.5	3.5	3.0	3.5	3.5	3.5
<b>Prem.- mo. \$</b>	\$ -	\$27	\$0	\$0	\$0	\$ 28	\$ 58	\$ -	\$ 73	\$ 16.70	\$ -
<b>Drug Ded.</b>	\$0	\$0	\$0	\$0	\$395		\$ 60	\$ -	\$ -	\$ 545	\$ -
<b>Health care deduct.</b>	\$0	\$0	\$0	\$0	\$0		\$ 500	\$ -	\$ 500	\$ -	\$ -

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

<b>Maximum-annual</b>											
<b>In Network</b>	\$ 3,700	\$ 3,800	\$ 4,800	\$ 6,300	\$ 6,500	\$ 3,900	\$ 6,400	\$ 5,900	\$ 6,400	\$ 4,900	\$ 4,250
<b>Out of network</b>	Won't pay	\$ 5,750	\$ 9,550	Won't pay	Won't pay	\$ 8,950	\$ 10,000	\$ 8,950	\$ 10,000	Won't pay	Won't pay
<b>Hospital</b>	\$360/day Days 1-5	\$370/day Days 1-5	\$390/day Days 1-5	\$395/day Days 1-4	\$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	\$ 45	\$ 45	\$ 40	\$ 40	\$ 45	\$ 40	\$ 30	\$ 35
<b>Out- patient surgery:</b>											
<b>Surgical Ctr.</b>	\$ 250	\$ 320	\$ 335	\$ 345	\$ 405	\$ 255	\$ 225	\$ 295	\$ 265	\$ 200	\$ 225
<b>Hospital</b>	\$ 350	\$ 370	\$ 390	\$ 395	\$ 455	\$ 300	20%	\$ 350	20%	\$ 245	\$ 275
<b>MRI &amp; CT scans</b>	\$ 225	\$ 170	\$ 170	\$ 160	\$ 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:**

	\$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>Hearing Aids</b>											
<b>Dental:</b>											
<b>Coverage limit</b>	\$ 1,250	\$ 1,750	\$ 1,000	\$ 3,000	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)	Prevent. Only	0% copay	No	50-70% co-pay	No	0% copay	0% copay
<b>Eyewear Allow.</b>	\$ 250	\$ 250	\$ 250	\$ 250	\$ 200	\$ 275	None	\$ 150	No	\$ 200	\$ 150
<b># of meals after hospitalization</b>	28	28	28	28	28	0	0	0	0	20	20
<b>OTC Drug allowance/quarter</b>	\$ 40	\$ 50	\$ 40	\$ 60	\$ -	\$ 50	\$ 38	\$ 35	\$ 35	\$ 170	\$ 70
<b>Part B rebate</b>	\$ -	\$ -	\$ -	\$ -	\$ 86	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Transportation</b>	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



JOHNSON COUNTY MEDICARE ADVANTAGE PLANS - 2024

**INCLUDES DRUG  
COVERAGE**

Plan	IU HEALTH				WELLCARE				ZING	
	Select Plus	Flex Network	Kidney Care	Choice	No Premium Open	Low Prem. Open	No Premium	Assist	Select Care	Open Choice
<b>Plan Type</b>	HMO	HMO-POS	HMO	HMO-POS	PPO	PPO	HMO	HMO	HMO	PPO
<b>Plan #</b>	7220-009	7220-011	7220-012	7220-004	6348-002	6348-007	3499-002	3499-008	4624-003	6876-004
<b>Rating (5 is max)</b>	4.0	4.0	4.0	4.0	3.0	3.0	3.0	3.0	3.0	N/A
<b>Prem.- mo. \$</b>	\$ -	\$ -	\$ -	\$ 98	\$ -	\$ 15	\$ -	\$ 19.80	\$ -	\$ -
<b>Drug Ded.</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 175	\$ 505	\$ -	\$ -
<b>Health care deduct.</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>CO-PAYS:</b>										
<b>Maximum-annual</b>										
In Network	\$ 3,100	\$ 3,900	\$ 3,400	\$ 6,850	\$ 4,300	\$ 4,300	\$ 3,900	\$ 6,000	\$ 4,500	\$ 6,350
Out of network	Won't pay	\$ 8,500	Won't pay	\$ 6,850	\$ 8,950	\$ 8,950	Won't pay	Won't pay	won't pay	\$ 6,350
<b>Hospital</b>	\$300/day Days 1-6	\$335/day Days 1-6	\$340/day Days 1-6	\$335/day Days 1-6	\$400/day Days 1-5	\$375/day Days 1-5	\$350/day Days 1-6	\$350/day Days 1-6	\$ 350/day Days 1-6	\$ 395/day Days 1-6
<b>Off. Visit-Primary</b>	\$ -	\$ -	\$ -	\$ 5	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
" " -Specialist	\$ 40	\$ 35	\$ 40	\$ 40	\$ 40	\$ 40	\$ 35	\$ 35	\$ 30	\$ 35
<b>Out- patient surgery:</b>										
Surgical Ctr.	\$ 295	\$ 295	\$ 295	\$ 250	\$ 275	\$ 225	\$ 250	\$ 225	\$ 200	\$ 250
Hospital	\$ 350	\$ 350	\$ 350	\$ 350	\$ 325	\$ 250	\$ 350	\$ 250	\$ 300	\$ 350
<b>MRI &amp; CT scans</b>	20%	20%	20%	20%	\$200-325	\$100-250	\$250-350	\$150-250	\$50-150	\$ 150
<b>EXTRA BENEFITS:</b>										
<b>Hearing Aids</b>	\$499-999 copay	\$499-999 copay	\$499-999 copay	\$499-999 copay	\$750 allow./ear	\$1,000 allow./ear	\$1,000 allow./ear	\$1,000 allow./ear	\$750/ear every 3 yrs.	\$750/ear every 3 yrs.
<b>Dental:</b>										
<b>Coverage limit</b>	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,000	\$ 2,000	\$ 3,000	\$ 1,500	\$ 4,000	\$ 2,000	\$ 1,500
<b>Comprehensive coverage</b>	50% copay fillings, ext.	50% copay fillings, ext.	50% copay fillings, ext.	50% copay fillings, ext.	0% copay	0% copay	40% copay	\$0 copay	\$0 copay	\$0 copay
<b>Eyewear Allow.</b>	\$250/2 yrs.	\$250/2 yrs.	\$250/2 yrs.	\$150/2 yrs.	\$ 300	\$ 400	\$ 200	\$ 300	\$ 350	\$ 300
<b># of meals after hospitalization</b>	42	42	42	42	0	0	42	42	10	10
<b>OTC Drug allowance/quarter</b>	\$ 80	\$ 80	\$ 80	\$ 80	\$ 88	\$ 78	In Add Dent, Vis & hear	\$64/qtr.	\$ 120	\$ 197
<b>Part B rebate</b>	\$ -	\$ 100	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Transportation</b>	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes
<b>Add'l dental,hearing &amp; vision</b>							\$60/month		700/year	700/year
<b>Utility asst. for chronically ill</b>								\$50/mo.		
<b>Food/utility allow. If on Extra Help</b>								\$55/mo	\$55/mo.	



JOHNSON COUNTY MEDICARE ADVANTAGE PLANS - 2024

DO NOT INCLUDE DRUG COVERAGE	AARP	AETNA	ANTHEM	HUMANA		IU HEALTH	WELLCARE	MY TRU ADVAN.
Plan	Medicare Adv. Patriot	Medicare Eagle	Veteran	Choice Regional	USAA Honor	Select-Medical only	Patriot Give Back Open	Red, White & Tru
Plan Type	PPO	PPO	PPO	PPO	PPO	HMO	PPO	PPO
Plan #	2406-074	5521-286	7093-001	0865-001	5216-218	7220-002	6348-005	9042-003
Rating (5 is max)	4.0	4.0	3.0	4.0	4.5	4.0	3.0	N/A
Prem.- mo. \$	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Health care deduct.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

**CO-PAYS:**

**Maximum-annual**

In Network	\$ 8,850	\$ 4,390	\$ 6,700	\$ 4,350	\$ 5,900	\$ 5,000	\$ 5,500	\$ 4,000
Out of network	\$ 13,300	\$ 8,000	\$ 10,000	\$ 5,500	\$ 8,950	Won't pay	\$ 8,950	\$ 4,000

**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	\$335/day Days 1-6	\$400/day Days 1-5	\$350/day Days 1-5
Off. Visit-Primary \$ -	" " -Specialist \$ 45	\$ -	\$ -	\$ 15	\$ -	\$ 5	\$ -
\$ 45	\$ 30	\$ 45	\$ 30	\$ 45	\$ 40	\$ 40	\$ 35

**Out- patient surgery:**

Surgical Ctr.	\$ 325	\$ 350	\$ 245	\$ 195	\$ 300	\$ 300	\$ 250	\$ 325
Hospital	\$ 425	\$ 350	\$ 275	\$ 245	\$ 350	\$ 350	\$ 350	\$ 325

**MRI & CT scans**

\$ 250	\$ 250	Dr. \$180 Hosp \$275	Dr. \$180 Hosp \$275	Dr. \$200 Hosp \$300	20%	\$ 350	\$ 235
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**EXTRA BENEFITS:**

**Hearing Aids**

\$99-1,249 co-pay	\$1500/ear allow.	300-2000 allow.	\$0 - 299 co-pay	\$99-699 copay	\$499-999 copay	\$1000/ear allowance	\$699-999 copay
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**Dental:**

Coverage limit	\$ 2,500	\$ 3,500	\$ 2,000	\$ 1,000	\$ 2,000	\$ 1,000	\$ 1,500	\$ 1,500
Comprehensive coverage	0% copay (A)	0% copay	0% copay	0% copay	0% copay	50% copay fillings, ext.	40% copay	0% copay

**Eyewear Allow.**

\$ 300	\$ 325	\$ 200	\$250-500	\$150-200	\$250/2 yrs.	\$ 200	\$ 200
# of meals after hospitalization	28	14	14	14	14	42	0

**OTC Drug allowance/quarter**

\$ 60	\$ 120	\$ 75	\$ 100	\$ 150	\$ 80	W/Addt'l dental, vision,hear	\$ 75
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**Transportation**

No	No	Yes-option	Yes	No	Yes	No	\$ -
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**Part B rebate**

\$ 105	\$ 70	\$ 70		\$ 100	\$ 21	\$ 60	No
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**Add'l dental, vision & hearing-optional**

		\$ 500				\$25/month	
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A) 50% copay for bridges and dentures