

HUNTINGTON COUNTY MEDICARE ADVANTAGE PLANS - 2025

**INCLUDES DRUG COVERAGE**

Plan	AARP MEDICARE ADVANTAGE						ANTHEM					
	UHC IN-0001	UHC IN-0001 P	UHC IN-0006	UHC IN-0010 Essentials	UHC IN-0016 Extras	UHC IN-0020 GiveBack	Medicare Advan. 2	Medicare Advan. 3	Medicare Adv.	Regional Medicare Adv.	Extra Help	Medicare Adv.
Plan Type	PPO	PPO	PPO	HMO-POS *	HMO-POS *	HMO-POS *	PPO	PPO	PPO	PPO	HMO-POS *	HMO-POS *
Plan #	2406-035	2406-036	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	4.0	3.5	3.5	3.5	3.5	3.5	3.5
Prem.- mo. \$	\$ 39	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 31	\$ 62	\$ -	\$ 74	\$ 11.20	\$ -
Drug Ded. (tiers 3-5)	\$420	\$420	\$420	\$340	\$420	\$495	\$ 295	\$ 60	\$ 95	\$ -	\$ 590	\$ -
Medical deduct.	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ -	\$ 500	\$ -	\$ 500	\$ -	\$ -

**CO-PAYS:**

\* Out of network coverage on dental only

**Maximum-annual**

In Network	\$ 3,700	\$ 4,100	\$ 4,500	\$ 3,800	\$ 6,700	\$ 6,700	\$ 4,150	\$ 6,750	\$ 6,750	\$ 6,750	\$ 4,900	\$ 4,150
Out of network	\$ 6,200	\$ 6,200	\$ 10,100	Won't pay	Won't pay	Won't pay	\$ 6,200	\$ 10,000	\$ 10,000	\$ 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	\$395/day Days 1-5	\$495/day Days 1-5	\$370/day Days 1-5	\$350/day Days 1-5	\$390/day Days 1-5	\$345/day Days 1-7	\$290/day Days 1-7	\$350/day Days 1-7
Off. Visit-Primary	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 10	\$ -	\$ -	\$ -	\$ -
" " -Specialist	\$ 35	\$ 30	\$ 40	\$ 30	\$ 45	\$ 45	\$ 40	\$ 40	\$ 35	\$ 40	\$ 30	\$ 25

**Out-patient surgery:**

Surgical Ctr.	\$ 225	\$ 225	\$ 195	\$ 225	\$ 295	\$ 445	\$ 320	\$ 300	\$ 340	\$ 295	\$ 240	\$ 300
Hospital	\$ 325	\$ 325	\$ 295	\$ 325	\$ 395	\$ 495	\$ 370	\$ 350	\$ 390	\$ 345	\$ 290	\$ 350
MRI & CT scans	\$ 155	\$ 225	\$ 155	\$ 165	\$ 175	\$ 225	Dr \$150 Hosp 370	Dr \$140 Hosp 350	Dr \$150 Hosp 390	Dr \$105 Hosp 345	Dr \$50 Hosp 290	Dr \$95 Hosp 350

**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	\$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	\$ 2,000	\$ 1,250	\$ -	\$ 2,250	\$ 3,500	\$ -	\$ 1,000	\$ -	\$ 1,200		\$ 1,500	\$ 1,200
Comprehensive coverage	0% copay (A)	0% copay (A)	Prevent. Only	0% copay (A)	0% copay (A)	Prevent. Only	0% copay	Prevent. Only	0% copay	Prevent. Only	0% copay	0% copay
Eyewear Allow.	\$ 300	\$ 300	\$ 300	\$ 200	\$ 300	\$ 200	\$ 200	None	\$ 300	No	\$ 200	\$ 300
# of meals after hospitalization	28	28	28	28	28	28	0	0	0	0	20	20
OTC Drug allowance/quarter	\$ 50	\$ 85	\$ 50	\$ 45	\$ 80	\$ -	\$ -	\$ 60	\$ 85	\$ 35	\$ 170	\$ 105
Part B rebate	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 57	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Transportation	None	None	None	None	None	None	Yes (B)	None	Yes (B)	None	Yes (B)	Yes (B)
Add'l dental, vision & hearing-optional							\$500 (B)		\$500 (B)		\$500 (B)	500 (B)
Grocery or utility allow.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$50 -150 (B)	\$50 -150 (B)

A) 50% copay for bridges and dentures

B) Your choice of only 1 of these benefits

HUNTINGTON COUNTY MEDICARE ADVANTAGE PLANS - 2025

**INCLUDES DRUG COVERAGE**

Plan	HUMANA							IU HEALTH			DEVOTED HEALTH		
	Choice (Regional)	Full Access	Choice	USAA Honor w/RX	Choice Give Back	Choice	Gold Plus	Select Plus	Medicare \$0 Preferred	Flex Network	Choice Give Back	Choice	Choice Plus
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	HMO-POS*	HMO	HMO	HMO-POS	PPO	PPO	PPO
Plan #	R0110--012	5216-192	5216-019	5216-307	5216-309	5216-193	5619-051	7220-009	7220-010	7220-011	7471-002	7471-001	7471-004
Rating (5 is max)	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	new	new	new
Prem.- mo. \$	\$ 39.10	\$ 2	\$ 35	\$ -	\$ -	\$ 49.60	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 49.60
Drug Ded. (tiers 3-5)	\$ 245	\$ 590	\$ 200	\$ 350	\$ 510	\$ 300	\$ 250	\$ -	\$ -	\$ -	\$ 590	\$ 590	\$ 590
Medical deduct.	\$ -	\$ 575	\$ -	\$ -	\$ 425	\$ -	\$ 150	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

**CO-PAYS:**

\* Out of network coverage on dental, vision & emergency care.

**Maximum-annual**

In Network	\$ 9,350	\$ 6,500	\$ 6,750	\$ 8,850	\$ 9,350	\$ 5,650	\$ 4,150	\$ 4,400	\$ 4,155	\$ 4,155	\$ 8,500	\$ 4,500	\$ 4,500
Out of network	\$ 14,000	\$ 6,500	\$ 10,100	\$ 13,300	\$ 14,000	\$ 10,100	Won't pay	Won't pay	Won't pay	\$ 10,000	\$ 14,000	\$ 4,500	\$ 4,500

**Hospital**

\$470/day Days 1-5	\$600/day Days 1-4	\$450/day Days 1-5	\$425/day Days 1-5	\$400/day Days 1-5	\$440/day Days 1-6	\$400/day Days 1-6	\$395/day Days 1-6	\$395/day Days 1-6	\$395/day Days 1-6	\$295/day Days 1-7	\$295/day Days 1-7	\$350/day Days 1-6
\$ 5	\$ -	\$ 10	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
\$ 55	\$ 70	\$ 55	\$ 45	\$ 40	\$ 45	\$ 35	\$ 35	\$ 30	\$ 30	\$ 45	\$ 35	\$ 35

**Out- patient surgery:**

Surgical Ctr.	\$ 470	\$ 670	\$ 450	\$ 375	\$ 350	\$ 440	\$ 350	\$ 295	\$ 295	\$ 295	\$ 400	\$ 295	\$ 295
Hospital	\$ 470	\$ 670	\$ 450	\$ 425	\$ 400	\$ 440	\$ 400	\$ 350	\$ 350	\$ 350	\$ 400	\$ 395	\$ 395
MRI & CT scans	Dr. \$200 Hosp 325	Dr. \$200 Hosp 325	Dr. \$200 Hosp 325	Dr. \$165 Hosp 325	Dr. \$200 Hosp 325	Dr. \$200 Hosp 325	Dr. \$200 Hosp 325	20%	20%	20%	Dr. \$200 Hosp 300	Dr. \$200 Hosp 300	Dr. \$200 Hosp 300

**EXTRA BENEFITS:**

Hearing Aids	\$499-799 copay	\$699-999 copay	None	\$399-999 copay	None	\$699-999 copay	\$699-999 copay	\$499-999 copay	\$499-999 copay	\$499-999 copay	\$599-899 copay	\$399-699 copay	\$199-499 copay
Dental:													
Coverage limit	\$ 1,000	\$ -	\$ 1,000	\$ 3,000	\$ -	\$ 1,500	\$ 2,500	\$ 1,500	\$ 1,500	\$ 1,500	(B)	(B)	(B)
Comprehensive coverage	Limited comprehen.	Prevent. Only	Limited comprehen.	0% copay	None	0% copay	0% copay (A)	50% copay fillings, ext.	50% copay fillings, ext.	50% copay fillings, ext.	(B)	(B)	(B)
Eyewear Allow.	\$50-100	\$50-100	\$100-150	\$100-150	None	\$250-300	\$50-100	\$250/2 yrs	\$250/2 yrs	\$250/2 yrs	(B)	(B)	(B)
# of meals after hospitalization	14	14	14	14	14	Meal prog. Available	14	42	42	42	0	0	0
OTC Drug allowance/quarter	\$15/Mo	\$ -	\$ -	\$ 50	\$ -	\$ 50	\$ -	\$ 40	\$ 40	\$ 40	\$ -	\$92/mo. (C & D)	\$105/qtr. (C & D)
Part B rebate	\$ -	\$ -	\$ -	\$ 76	\$ 124	\$ 3	\$ -	\$ -	\$ 70	\$ 70	\$ -	\$ -	\$ -
Transportation	None	None	None	None	None	None	None	Yes	Yes	Yes	No	No	No
Preventative & Comprehensive Dental & Eyewear											\$ 250	\$ 1,000	\$ 1,250

A) 30-40% co-pay for bridges and crowns.

B) Included with Preventative & Comprehensive Dental & Eyewear

C) Available to those with chronic health conditions.

D) Allowance includes Food, Rent & Utilities

HUNTINGTON COUNTY MEDICARE ADVANTAGE PLANS - 2025

**INCLUDES DRUG COVERAGE**

Plan	AETNA MEDICARE						WELLCARE						
	Value	Smart Fit	Value Plus	Gold	Enhanced Select	Premier	Simple Open	Premium Enhanced Open	Give Back Open	Assist Open	Simple	Assist	Complete Simple
<b>Plan Type</b>	PPO	PPO	PPO	PPO	PPO	HMO-POS *	PPO	PPO	PPO	PPO	HMO	HMO	HMO
<b>Plan #</b>	5521-099	5521-406	5521-496	5521-593	5521-386	3192-004	6348-002	6348-010	6348-008	6348-009	3499-002	3499-008	7925-002
<b>Rating (5 is max)</b>	4.5	4.5	4.5	4.5	4.5	3.5	3.0	3.0	3.0	3.0	3.5	3.5	3.5
<b>Prem.- mo. \$</b>	\$ -	\$ -	\$ 28	\$ 57	\$ 166	\$ -	\$ -	\$ 57	\$ -	\$ 38.30	\$ -	\$ 37.90	\$ -
<b>Drug Ded. (tiers 3-5)</b>	\$ 590	\$ 590	\$ 590	\$ -	\$ 590	\$ 590	\$ 420	\$ 420	\$ 395	\$ 500	\$ 420	\$ 500	\$ 420
<b>Medical deduct.</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 500	\$ -	\$ -	\$ -	\$ -

**CO-PAYS:**

\*Out of network coverage primarily for dental.

**Maximum-annual**

In Network	\$ 4,250	\$ 5,900	\$ 6,350	\$ 5,500	\$ 1,500	\$ 5,000	\$ 4,300	\$ 4,000	\$ 7,550	\$ 4,200	\$ 3,900	\$ 5,700	\$ 3,900
Out of network	\$ 10,100	\$ 10,100	\$ 10,100	\$ 10,000	\$ 1,500	Won't pay	\$ 8,950	\$ 6,200	\$ 10,000	\$ 8,950	Won't pay	Won't pay	Won't pay

**Hospital**

\$275/day Days 1-7	\$350/day Days 1-7	\$365/day Days 1-7	\$325/day Days 1-7	\$200/day Days 1-7	\$325/day Days 1-7	\$375/day Days 1-5	\$350/day Days 1-7	\$400/day Days 1-5	\$350/day Days 1-5	\$350/day Days 1-6	\$350/day Days 1-6	\$350/day Days 1-6	\$350/day Days 1-6
\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
" " -Specialist	\$ 35	\$ 45	\$ 20	\$ 30	\$ -	\$ 40	\$ 25	\$ 25	\$ 35	\$ 25	\$ 25	\$ 25	\$ 25

**Out-patient surgery:**

Surgical Ctr.	\$ 275	\$ 300	\$ 315	\$ 275	\$ -	\$ 275	\$ 275	\$ 275	\$ 250	\$ 250	\$ 250	\$ 225	\$ 220
Hospital	\$ 325	\$ 350	\$ 365	\$ 325	\$ 200	\$ 325	\$ 325	\$ 350	20%	\$ 300	\$ 350	\$ 280	20%
<b>MRI &amp; CT scans</b>	\$ 250	\$ 350	\$ 275	\$ 220	\$ -	\$ 275	\$ 325	\$ 350	\$ 400	\$ 300	\$250-350	\$150-280	20%

**EXTRA BENEFITS:**

<b>Hearing Aids</b>	500/ear allow.	500/ear allow.	\$750/ear allow.	1,000/ear allow.	500/ear allow.	\$750/ear allow.	\$1000 allow./ear	\$2000 allow./ear	\$350 allow./ear	\$1,500 allow./ear	\$1,000 allow./ear	\$1,000 allow./ear	\$750 allow./ear
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**Dental:**

<b>Coverage limit</b>	\$ 1,450	\$ 2,000	\$ 1,500	\$ 2,500	\$ 1,500	\$ 2,000	\$ 5,000	\$ 5,000	\$ 1,000	\$ 5,000	\$ 2,000	\$ 3,000	\$ 3,000
<b>Comprehensive coverage</b>	Yes-limited	20 - 50% copay	20 - 50% copay	0% copay	0% copay	20 - 50% copay	0% copay, limited	0% copay, limited	20% copay, limited	0% copay, limited	Limited coverage	Limited coverage	0% copay, limited

**Eyewear Allow.**

\$150	\$125	\$245	\$250	\$175	\$185	\$ 400	\$ 600	\$ 200	\$ 400	\$ 200	\$ 400	limited
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**# of meals after hospitalization**

14	0	14	14	0	14	0	42	0	42	0	42	0
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**OTC Drug allowance/quarter**

\$ 75	\$ 50	\$ 45	\$ 60	\$ 30	\$ 60	\$ 169	\$ 130	\$ 45	\$ 130	\$ 147	\$ 85	\$ 185
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**Part B rebate**

						\$ -	\$ -	\$ 72.60	\$ -	\$ -	\$ -	\$ -
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**Transportation**

None	None	None	None	None	None	Yes	None	None	Yes	Yes	Yes	Yes
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**Food/utility allow. If on Extra Help**

\$30/qtr.

HUNTINGTON COUNTY MEDICARE ADVANTAGE PLANS - 2025

DOES NOT INCLUDE DRUG COVERAGE	AARP	AETNA	ANTHEM	HUMANA			WELLCARE
Plan	Medicare Adv. Patriot	Medicare Eagle	Veteran	USAA Honor Giveback	USAA Honor Giveback	Choice Regional	Patriot Give Back Open
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan #	2406-074	5521-286	7093-001	5216-441	5216-218	R0110-011	6348-005

Rating (5 is max)	4.0	4.5	3.5	3.5	3.5	3.5	3.0
Prem.- mo. \$	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medical deduct.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

**CO-PAYS:**

**Maximum-annual**

In Network	\$ 8,850	\$ 4,900	\$ 9,350	\$ 8,100	\$ 9,350	\$ 5,600	\$ 5,500
Out of network	\$ 14,000	\$ 8,000	\$ 14,000	\$ 14,000	\$ 14,000	\$ 10,050	\$ 8,950
Hospital	\$475/day Days 1-5	\$300/day Days 1-6	\$350/day Days 1-5	\$430/day Days 1-5	\$475/day Days 1-5	\$275/day Days 1-6	\$400/day Days 1-5
Off. Visit-Primary	\$ -	\$ -	\$ -	\$ 15	\$ 15	\$ -	\$ -
" " -Specialist	\$ 55	\$ 30	\$ 45	\$ 45	\$ 45	\$ 30	\$ 40

**Out- patient surgery:**

Surgical Ctr.	\$ 325	\$ 300	\$ 300	\$ 425	\$ 425	\$ 195	\$ 250
Hospital	\$ 475	\$ 350	\$ 350	\$ 475	\$ 475	\$ 245	\$ 350
MRI & CT scans	\$ 225	\$ 250	Dr. \$180 Hosp \$350	Dr. \$195 Hosp \$325	Dr. \$200 Hosp \$325	Dr. \$180 Hosp \$275	\$ 350

**EXTRA BENEFITS:**

Hearing Aids	\$99-1,249 co-pay	\$1500/ear allow.	300-2000 allow.	\$99 - 699 co-pay	\$399-699 copay	\$0-299 copay	\$1000/ear allowance
Dental:	\$ 2,500	\$ 3,500	\$ 2,000	\$ 2,000	\$ 2,000	\$ 1,000	\$ 1,500
Coverage limit Comprehensive coverage	0% copay (A)	0% copay	0% copay	0% copay	0% copay	0% copay	0% copay - limited
Eyewear Allow.	\$ 300	\$ 300	\$ 200	\$250-500	\$150-200	\$250-300	\$ 200
# of meals after hospitalization	28	14	14	14	14	14	42
OTC Drug allowance/quarter	\$ 100	\$ 100	\$ 75	\$ -	\$ 150	\$ 100	\$ 75
Transportation	None	No	Yes (B)	No	No	Yes	No
Part B rebate	\$ 105	\$ 70	\$ 70	\$ 155	\$ 100	\$ -	\$ 80
Add'l dental, vision & hearing-optional			\$500 (B)				

A) 50% copay for bridges and dentures

B) Your choice of only 1 of these benefits