PPO MEDICARE ADVANTAGE PLANS
ALLEN COUNTY 2025

INCLUDES DRUG COVERAGE

	AARP MEDICARE			ANTHEM				AETNA MEDICARE				
Plan Name	**UHC IN-0001 P**	**UHC IN-0006**	**UHC IN-0001**	**Medicare Adv.**	**Medicare Advan. 2**	**Medicare Advan. 3**	**Regional Medicare**	**Value**	**Smart Fit**	**Value Plus**	**Gold**	**Enhanced Select**
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan #	2406-036	2406-066	2406-035	7093-002	1607-015	1607-012	4487-001	5521-099	5521-406	5521-496	5521-593	5521-386
Rating (5 is max)	4.0	4.0	4.0	3.5	3.5	3.5	3.5	4.5	4.5	4.5	4.5	4.5
Prem.- mo. $	$0	$0	$ 39	$ -	$ 31	$ 62	$ 74	$ -	$ -	$ 28	$ 57	$ 166
Deductible-medical exp.	$0	$0	$0	$ -	$ -	$ 500	$ 500	$ -	$ -	$ -	$ -	$ -
CO-PAYS:												
Maximum-annual												
In Network	$ 4,100	$ 4,500	$ 3,700	$ 6,750	$ 4,150	$ 6,750	$ 6,750	$ 4,250	$ 5,900	$ 6,350	$ 5,500	$ 1,500
Out of network	$ 6,200	$ 10,100	$ 6,200	$ 10,000	$ 6,200	$ 10,000	$ 10,000	$ 10,100	$ 10,100	$ 10,100	$ 10,000	$ 1,500
Hospital -daily CoPay	$ 325	$ 295	$ 325	$ 390	$ 370	$ 350	$ 345	$ 275	$ 350	$ 365	$ 325	$ 200
- # of days	5	6	5	5	5	5	7	7	7	7	7	7
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ -	$ 10	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 30	$ 40	$ 35	$ 35	$ 40	$ 40	$ 40	$ 35	$ 45	$ 20	$ 30	$ -
Out- patient surgery:												
Surgical Ctr.	$ 225	$ 195	$ 225	$ 340	$ 320	$ 300	$ 295	$ 275	$ 300	$ 315	$ 275	$ -
Hospital	$ 325	$ 295	$ 325	$ 390	$ 370	$ 350	$ 345	$ 325	$ 350	$ 365	$ 325	$ 200
MRI & CT scans	$ 225	$ 155	$ 155	Dr $150 Hosp 390	Dr $150 Hosp 370	Dr $140 Hosp 350	Dr $105 Hosp 345	$ 250	$ 350	$ 275	$ 220	$ -
EXTRA BENEFITS:												
Hearing Aids	99-1,249 co-pay	99-1,249 co-pay	$99-1,249 co-pay	300-1500 allow.	300-3000 allow.	300-3000 allow.	300-2000 allow.	$500/ear allow.	$500/ear allow.	$750/ear allow.	1,000/ear allow.	500/ear allow.
Dental - Coverage limit	$ 1,250	$ -	$ 2,000	$ 1,200	$ 1,000	$ -	$ -	$ 1,450	$ 2,000	$ 1,500	$ 2,500	$ 1,500
- Comprehensive coverage	0% copay (A)	Prevent. Only	0% copay (A)	0% copay	0% copay	Prevent. Only	Prevent. Only	Yes-limited	20 - 50% copay	20 - 50% copay	0% copay	0% copay
Eyewear Allowance	$ 300	$ 300	$ 300	$ 300	$ 200	None	No	$150	$125	$245	$250	$175
OTC Drug Allow. per qtr.	$ 85	$ 50	$ 50	$ 85	$ -	$ 60	$ 35	$ 75	$ 50	$ 45	$ 60	$ 30
Part B rebate	$ -	$ -	$ -	$ -	$ -	$ -	$ -					
Transportation	None	None	None	Yes (B)	Yes (B)	None	None	None	None	None	None	None
Addt'l dental, vision & hearing-optional				$500 (B)	$500 (B)							
Grocery or utility allow.	$ -	$ -	$ -	$ -	$ -	$ -	$ -			$30/qtr.(C)		

A) 50% copay for bridges & dentures

B) Choose only 1 benefit

C) Only if on Extra Help

PPO MEDICARE ADVANTAGE PLANS
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	HUMANA						PARAMOUNT	WELLCARE			
Plan Name	**USAA Honor w/RX**	**Choice Give Back**	**Full Access**	**Choice**	**Choice (Regional)**	**Choice**	**Elite Preferred**	**Simple Open**	**Give Back Open**	**Assist Open**	**Premium Enhanced Open**
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan #	5216-307	5216-309	5216-192	5216-019	R0110--012	5216-193	5232-001	6348-002	6348-008	6348-009	6348-010
Rating (5 is max)	3.5	3.5	3.5	3.5	3.5	3.5	new	3.0	3.0	3.0	3.0
Prem.- mo. $	$ -	$ -	$ 2	$ 35	$ 39.10	$ 49.60	$ -	$ -	$ -	$ 38.30	$ 57
Deductible-medical exp.	$ -	$ 425	$ 575	$ -	$ -	$ -	$ -	$ -	$ 500	$ -	$ -
CO-PAYS:											
Maximum-annual											
In Network	$ 8,850	$ 9,350	$ 6,500	$ 6,750	$ 9,350	$ 5,650	$ 4,200	$ 4,300	$ 7,550	$ 4,200	$ 4,000
Out of network	$ 13,300	$ 14,000	$ 6,500	$ 10,100	$ 14,000	$ 10,100	$ 5,700	$ 8,950	$ 10,000	$ 8,950	$ 6,200
Hospital -daily CoPay	$ 425	$ 400	$ 600	$ 450	$ 470	$ 440	$ 360	$ 375	$ 400	$ 350	$ 350
- # of days	5	5	4	5	5	6	5	5	5	5	7
Off. Visit-Primary	$ -	$ -	$ -	$ 10	$ 5	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 45	$ 40	$ 70	$ 55	$ 55	$ 45	$ 25	$ 25	$ 35	$ 25	$ 25
Out- patient surgery:											
Surgical Ctr.	$ 375	$ 350	$ 670	$ 450	$ 470	$ 440	$ 275	$ 275	$ 250	$ 250	$ 275
Hospital	$ 425	$ 400	$ 670	$ 450	$ 470	$ 440	$ 275	$ 325	20%	$ 300	$ 350
MRI & CT scans	Dr. $165 Hosp 325	Dr. $200 Hosp 325	Dr. $200 Hosp 325	Dr. $200 Hosp 325	Dr. $200 Hosp 325	Dr. $200 Hosp 325	$ 130	$ 325	$ 400	$ 300	$ 350
EXTRA BENEFITS:											
Hearing Aids	$399-999 copay	None	$699-999 copay	None	$499-799 copay	$699-999 copay	$675/ear	$1000 allow./ear	$350 allow./ear	$1,500 allow./ear	$2000 allow./ear
Dental-Coverage limit	$ 3,000	$ -	$ -	$ 1,000	$ 1,000	$ 1,500	$ 7,500	$ 5,000	$ 1,000	$ 5,000	$ 5,000
-Comprehensive coverage	0% copay	None	Prevent. Only	Limited compren.	Limited compren.	0% copay	0% copay	0% copay, limited	20% copay, limited	0% copay, limited	0% copay, limited
Eyewear Allowance	$100-150	None	$50-100	$100-150	$50-100	$250-300	$ 200	$ 400	$ 200	$ 400	$ 600
OTC Drug Allow. per qtr.	$ 50	$ -	$ -	$ -	$15/Mo	$ 50	$ 175	$ 169	$ 45	$ 130	$ 130
Part B rebate	$ 76	$ 124	$ -	$ -	$ -	$ 3	$ -	$ -	$ 72.60	$ -	$ -
Transportation	None	None	None	None	None	None	No	Yes	None	Yes	None

HMO MEDICARE ADVANTAGE PLANS
ALLEN COUNTY 2025
INCLUDES DRUG COVERAGE

	AARP MEDICARE ADVAN.			ANTHEM		AETNA	HUMANA
Plan Name	**UHC IN-0010 Essentials**	**UHC IN-0016 Extras**	**UHC IN-0020 GiveBack**	**Medicare Adv.**	**Extra Help**	**Premier**	**Gold Plus**
Plan Type	HMO-POS *	HMO-POS *	HMO-POS *	HMO-POS *	HMO-POS *	HMO_POS *	HMO-POS *
Plan #	2802-007	2802-055	2802-059	3447-042	3447-024	3192-004	5619-051
Rating (5 is max)	4.0	4.0	4.0	3.5	3.5	3.5	3.5
Prem.- mo. $	$0	$0	$0	$ -	$ 11.20	$ -	$ -
Deductible-medical exp.	$0	$0	$0	$ -	$ -	$ -	$ 150
CO-PAYS:	* Out of network coverage on dental only						
Maximum-annual							
In Network	$ 3,800	$ 6,700	$ 6,700	$ 4,150	$ 4,900	$ 5,000	$ 4,150
Out of network	Won't pay	Won't pay	Won't pay	Won't pay	Won't pay	Won't pay	Won't pay
Hospital -daily CoPay	$ 325	$ 395	$ 495	$ 350	$ 290	$ 325	$ 400
- # of days	5	5	5	7	7	7	6
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 30	$ 45	$ 45	$ 25	$ 30	$ 40	$ 35
Out- patient surgery:							
Surgical Ctr.	$ 225	$ 295	$ 445	$ 300	$ 240	$ 275	$ 350
Hospital	$ 325	$ 395	$ 495	$ 350	$ 290	$ 325	$ 400
MRI & CT scans	$ 165	$ 175	$ 225	Dr $95 Hosp 350	Dr $50 Hosp 290	$ 275	Dr. $200 Hosp 325
EXTRA BENEFITS:							
Hearing Aids	$99-1,249 co-pay	$99-1,249 co-pay	$99-1,249 co-pay	300-3000 allow.	300-3000 allow.	$750/ear allow.	$699-999 copay
Dental - Coverage limit	$ 2,250	$ 3,500	$ -	$ 1,200	$ 1,500	$ 2,000	$ 2,500
- Comprehensive coverage	0% copay (A)		Prevent. Only	0% copay	0% copay	20 - 50% copay	0% copay (C)
Eyewear Allowance	$ 200	$ 300	$ 200	$ 300	$ 200	$ 185	$50-100
OTC Drug Allow. per qtr.	$ 45	$ 80	$ -	$ 105	$ 170	$ 60	$ 50
Part B rebate	$ -	$ -	$ 57	$ -	$ -		$ -
Transportation	None	None	None	Yes (B)	Yes (B)	None	Yes
Addt'l dental, vision & hearing				500 (B)	$500 (B)		$ 500
Grocery or utility allow.	$ -	$ -	$ -	$50 -150 (B)	$50 -150 (B)		

A) 50% copay for bridges & dentures

B) Choose only 1 benefit.

C) 30-40% copay for bridges & crowns

HMO MEDICARE ADVANTAGE PLANS
ALLEN COUNTY 2025
INCLUDES DRUG COVERAGE

	IU HEALTH			PARAMOUNT	WELLCARE	
Plan Name	**Select Plus**	**Medicare $0 Preferred**	**Flex Network**	**Elite Standard**	**Simple**	**Assist**
Plan Type	HMO	HMO	HMO-POS	HMO-POS *	HMO	HMO
Plan #	7220-009	7220-010	7220-011	3653-015	3499-002	3499-008
Rating (5 is max)	3.5	3.5	3.5	4.0	3.5	3.5
Prem.- mo. $	$0	$0	$0	$ -	$ -	$ 37.90
Deductible-medical exp.	$0	$0	$0	$ -	$ -	$ -
CO-PAYS:	* Out of network coverage on dental only					
Maximum-annual						
In Network	$ 4,400	$ 4,155	$ 4,155	$ 3,500	$ 3,900	$ 5,700
Out of network	Won't pay	Won't pay	$ 10,000	Won't pay	Won't pay	Won't pay
Hospital -daily CoPay	$ 395	$ 395	$ 395	$ 325	$ 350	$ 350
- # of days	6	6	6	5	6	6
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 35	$ 30	$ 30	$ 20	$ 25	$ 25
Out- patient surgery:						
Surgical Ctr.	$ 295	$ 295	$ 295	$ 275	$ 250	$ 225
Hospital	$ 350	$ 350	$ 350	$ 275	$ 350	$ 280
MRI & CT scans	20%	20%	20%	$ 200	$250-350	$150-280
EXTRA BENEFITS:						
Hearing Aids	$499-999 co-pay	$499-999 co-pay	$499-999 co-pay	$500/ear	$1,000 allow./ear	$1,000 allow./ear
Dental - Coverage limit	$ 1,500	$ 1,500	$ 1,500	$ 6,000	$ 2,000	$ 3,000
- Comprehensive coverage	50% copay fillings, ext.	50% copay fillings, ext.	50% copay fillings, ext.	0% copay	Limited coverage	Limited coverage
Eyewear Allowance	$250/2 yrs.	$250/2 yrs.	$250/2 yrs.	$ 200	$ 200	$ 400
OTC Drug Allow. per qtr.	$ 40	$ 40	$ 40	$ 150	$ 147	$ 85
Part B rebate	$ -	$ 70	$ 70	$ -	$ -	$ -
Transportation	Yes	Yes	Yes	Yes	Yes	Yes