# PPO
# MEDICARE ADVANTAGE PLANS

## ALLEN COUNTY 2026

| INCL. DRUG COVERAGE | AARP MEDICARE | | | ANTHEM | | | AETNA MEDICARE | | |
|---|---|---|---|---|---|---|---|---|---|
| **Plan Name** | **UHC IN-0001 P** | **UHC IN-0006** | **UHC IN-0001** | **Medicare Adv.** | **Medicare Advan. 3** | **Regional Medicare** | **Signature** | **Signature Extra** | **Value Care** |
| **Plan Type** | PPO | PPO | PPO | PPO | PPO | PPO | PPO | PPO | PPO |
| **Plan #** | 2406-036 | 2406-066 | 2406-035 | 7093-002 | 1607-012 | 5941-016 | 5521-099 | 5521-406 | 5521-496 |
| **Rating (5 is max)** | | | | | | | | | |
| **Prem.- mo. $** | $0 | $0 | $ 39 | $ 9 | $ 55 | $ 97 | $ - | $ - | $ 36 |
| **Deductible-medical exp.** | $0 | $0 | $0 | $ - | $ 500 | $ 500 | $ - | $ - | $ - |
| **CO-PAYS:** | | | | | | | | | |
| **Maximum-annual** | | | | | | | | | |
| In Network | $ 4,200 | $ 4,900 | $ 3,700 | $ 6,750 | $ 6,750 | $ 9,250 | $ 5,000 | $ 6,350 | $ 6,750 |
| Out of network | $ 6,300 | $ 10,100 | $ 6,300 | $ 10,000 | $ 10,100 | $ 13,900 | $ 10,100 | $ 10,100 | $ 10,100 |
| **Hospital -daily CoPay** | $ 375 | $ 425 | $ 375 | $ 345 | $ 350 | $ 345 | $ 325 | $ 320 | $ 365 |
| **- # of days** | 6 | 7 | 6 | 5 | 7 | 7 | 7 | 7 | 8 |
| **Off. Visit-Primary** | $ - | $ - | $ - | $ - | $ 10 | $ - | $ - | $ - | $ - |
| **" " -Specialist** | $ 45 | $ 50 | $ 45 | $ 30 | $ 45 | $ 40 | $ 45 | $ 45 | $ 30 |
| **Out- patient surgery:** | | | | | | | | | |
| Surgical Ctr. | $ 275 | $ 325 | $ 275 | $ 245 | $ 300 | $ 295 | $ 275 | $ 270 | $ 315 |
| Hospital | $ 375 | $ 425 | $ 375 | $ 345 | $ 350 | $ 345 | $ 325 | $ 320 | $ 365 |
| **MRI & CT scans** | $ 260 | $ 240 | $ 210 | Dr $100 Hosp 345 | Dr $140 Hosp 350 | Dr $105 Hosp 345 | $ 250 | $ 350 | $ 275 |
| **EXTRA BENEFITS:** | | | | | | | | | |
| **Hearing Aids** | 199-1,249 co-pay | 199-1,249 co-pay | 199-1,249 co-pay | 300-1500 allow. | 300-2000 allow. | 300-2000 allow. | $500/ear allow. | $500/ear allow. | $750/ear allow. |
| **Dental - Coverage limit** | $ 1,250 | $ - | $ 2,500 | $ 2,750 | $ 1,800 | $ - | $ 750 | $ 2,000 | $ 1,250 |
| **- Comprehensive coverage** | 50% copay | Routine Only | 50% copay | 25% copay | 25% copay | Routine Only | 20 - 50% copay | 20 - 50% copay | 20 - 50% copay |
| **Eyewear Allowance** | $300/2yrs. | $300/2yrs. | $300/2yrs. | $ 300 | None | No | $150 allow. | $100 | $150 |
| **OTC Drug Allow. per qtr.** | $ - | $ - | $ - | $ - | $ 60 | $ 35 | $ - | $ 50 | $ 30 |
| **Part B rebate** | $ 6 | $ - | $ - | $ - | $ - | $ - | | $ - | |
| **Transportation** | None | None | None | None | None | None | None | None | None |
| **Grocery, transport. & utility allow.** | | | | | | | | | $30/qtr. (A) |

A) If on Extra Help & have a chronic condition

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| INCL. DRUG COVERAGE | HUMANA | | | | | | | | WELLCARE | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Plan Name** | **USAA Honor w/RX** | **USAA Honor w/RX** | **Choice Give Back** | **Choice Give Back** | **Full Access** | **Choice** | **Choice (Regional)** | **Choice** | **Simple Open** | **Give Back Open** | **Assist Open** |
| **Plan Type** | PPO (A) | PPO (A) | PPO (B) | PPO (B) | PPO | PPO | PPO | PPO | PPO | PPO | PPO |
| **Plan #** | 5216-307 | 7617-060 | 5216-309 | 7617-003 | 5216-192 | 5216-019 | R110-012 | 5216-463 | 6348-002 | 6348-008 | 6348-009 |
| | (A & B) Plans are identical. | | | | | | | | | | |
| **Rating (5 is max)** | | | | | | | | | | | |
| **Prem.- mo. $** | $ - | $ - | $ - | $ - | $ - | $ 24 | $ 20 | $ 28 | $ - | $ - | $ 38.40 |
| **Deductible-medical exp.** | $ 100 | $ 100 | $ 425 | $ 425 | $ 215 | $ - | $ - | $ - | $ - | $ 500 | $ - |
| **CO-PAYS:** | | | | | | | | | | | |
| **Maximum-annual** | | | | | | | | | | | |
| In Network | $ 7,900 | $ 7,900 | $ 9,150 | $ 9,150 | $ 6,700 | $ 6,550 | $ 9,150 | $ 6,350 | $ 4,300 | $ 8,500 | $ 5,000 |
| Out of network | $ 13,300 | $ 13,300 | $ 13,900 | $ 13,900 | $ 6,700 | $ 10,100 | $ 13,900 | $ 10,100 | $ 8,950 | $ 10,000 | $ 8,950 |
| **Hospital -daily CoPay** | $ 425 | $ 425 | $ 400 | $ 400 | $ 600 | $ 450 | $ 470 | $ 440 | $ 375 | $ 400 | $ 350 |
| **- # of days** | 5 | 5 | 5 | 5 | 4 | 5 | 5 | 6 | 5 | 5 | 6 |
| **Off. Visit-Primary** | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| **" " -Specialist** | $ 45 | $ 45 | $ 40 | $ 40 | $ 70 | $ 55 | $ 55 | $ 55 | $ 20 | $ 40 | $ 25 |
| **Out- patient surgery:** | | | | | | | | | | | |
| Surgical Ctr. | $ 325 | $ 325 | $ 300 | $ 300 | $ 570 | $ 350 | $ 370 | $ 340 | $ 250 | $ 250 | $ 250 |
| Hospital | $ 425 | $ 425 | $ 400 | $ 400 | $ 670 | $ 450 | $ 470 | $ 440 | $ 325 | 20% | $ 300 |
| **MRI & CT scans** | Dr. $200 Hosp 335 | Dr. $200 Hosp 335 | Dr. $200 Hosp 335 | Dr. $200 Hosp 335 | Dr. $200 Hosp 335 | Dr. $200 Hosp 335 | Dr. $200 Hosp 335 | Dr. $200 Hosp 335 | Dr. $250 Hosp 325 | Dr. $350 Hosp 400 | Dr. $100 Hosp 300 |
| **EXTRA BENEFITS:** | | | | | | | | | | | |
| **Hearing Aids** | $399-999 copay | $399-999 copay | $699-999 copay | $699-999 copay | $699-999 copay | $699-999 copay | $599-899 copay | $699-999 copay | $750 allow./ear | $350 allow./ear | $1,000 allow./ear |
| **Dental-Coverage limit** | $ 3,000 | $ 3,000 | $ 500 | $ 500 | $ - | $ 1,000 | $ 1,000 | $ 3,500 | $ 5,000 | $ 1,000 | no max. allowance |
| **-Comprehensive coverage** | 0% copay | 0% copay | None | None | Routine Only | 0% copay, Limited comp. | 0% copay, Limited comp. | 0% copay | 0% copay, | 20% copay | 0% copay |
| **Eyewear Allowance** | $75-150 | $75-100 | $50-100 | $50-100 | $50-100 | $75-150 | $50-100 | $250-300 | $ 300 | $ 200 | $ 400 |
| **OTC Drug Allow. per qtr.** | $ 50 | $ 50 | $ - | $ - | $ - | $ - | $15/Mo | $ 50 | $ 65/mo (C) | $ 15/mo. (C) | $ 54.mo. (C) |
| **Part B rebate** | $ 79 | $ 79 | $ 123 | $ 123 | $ 1 | $ - | $ - | $ - | $ - | $ 79 | $ 1 |
| **Transportation** | None | None | None | None | None | None | None | None | None | None | Yes |

C) May also be used for dental, vision and hearing.

# HMO
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| INCL. DRUG COVERAGE | AARP MEDICARE ADVAN. | | | ANTHEM | | | | HUMANA | WELLCARE | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Plan Name** | **UHC IN-0010 Essential** | **UHC IN-0016 Extras** | **UHC IN-0020 GiveBack** | **Medicare Adv.** | **Medicare Adv. 3** | **Medicare Adv. 4** | **Extra Help** | **Gold Plus** | **Simple** | **Assist** |
| **Plan Type** | HMO-POS * | HMO-POS * | HMO-POS * | HMO-POS * | HMO | HMO | HMO-POS * | HMO-POS * | HMO-POS * | HMO-POS * |
| **Plan #** | 2802-007 | 2802-055 | 2802-059 | 3447-042 | 7220-009 | 7220-010 | 3447-024 | 5619-051 | 3499-002 | 3499-008 |
| **Rating (5 is max)** | | | | | | | | | | |
| **Prem.- mo. $** | $0 | $0 | $0 | $ - | $0 | $0 | $ 22.80 | $ - | $ - | $ 31.10 |
| **Deductible-medical exp.** | $0 | $0 | $0 | $ - | $0 | $0 | $ - | $ 125 | $ - | $ - |
| **CO-PAYS:** | * Out of network coverage on dental only, out-of network medical not covered unless an emergency. | | | | | | | | | |
| **Maximum-annual** | | | | | | | | | | |
| In Network | $ 3,900 | $ 6,700 | $ 6,700 | $ 4,150 | $ 9,250 | $ 4,500 | $ 4,900 | $ 4,500 | $ 4,200 | $ 5,700 |
| Out of network | Won't pay | Won't pay | Won't pay | Won't pay | Won't pay | Won't pay | Won't pay | Won't pay | Won't pay | Won't pay |
| **Hospital -daily CoPay** | $ 425 | $ 495 | $ 550 | $ 440 | $ 440 | $ 395 | $ 290 | $ 450 | $ 350 | $ 350 |
| **- # of days** | 5 | 5 | 4 | 5 | 5 | 6 | 6 | 6 | 6 | 6 |
| **Off. Visit-Primary** | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| **" " -Specialist** | $ 40 | $ 55 | $ 60 | $ 35 | $ 35 | $ 30 | $ 25 | $ 35 | $ 25 | $ 25 |
| **Out- patient surgery:** | | | | | | | | | | |
| Surgical Ctr. | $ 325 | $ 395 | $ 500 | $ 340 | $ 340 | $ 295 | $ 200 | $ 350 | $ 250 | $ 225 |
| Hospital | $ 425 | $ 495 | $ 550 | $ 440 | $ 440 | $ 350 | $ 290 | $ 450 | $ 350 | $ 280 |
| **MRI & CT scans** | $ 200 | $ 260 | $ 260 | Dr $95 Hosp 440 | Dr $95 Hosp 440 | 20% | Dr $50 Hosp 290 | Dr. $200 Hosp 335 | Dr. $250 Hosp 350 | Dr. $150 Hosp 280 |
| **EXTRA BENEFITS:** | | | | | | | | | | |
| **Hearing Aids** | 199-1,249 co-pay | 199-1,249 co-pay | 199-1,249 co-pay | 300-2000 allow. | 300-2000 allow. | 300-2000 allow. | 300-2000 allow. | $699-999 copay | $1,000 allow./ear | no max. allow. |
| **Dental - Coverage limit** | $ - | $ 4,000 | $ - | $ 2,000 | $ 1,000 | $ 1,500 | $ 3,000 | $ 2,000 | $ 3,000 | $ 3,000 |
| **- Comprehensive coverage** | Routine cover. only | 50% co-pay | Routine cover. only | 25% co-pay | 25% co-pay | 25% co-pay | 25% co-pay | 0% copay (B) | 0% Co-Pay | 0% Co-Pay |
| **Eyewear Allowance** | $200/2 yrs | $300/2 yrs | $150/2 yrs. | $ 200 | $ 250 | $ 250 | $ 200 | $50-100 | $ 300 | $ 400 |
| **OTC Drug Allow. per qtr.** | $ - | $ 60 | $ - | $ 38 | $ - | $ 30 | $ - | $ - | $ 55 (A) | $ 70 (A) |
| **Part B rebate** | $ 14 | $ - | $ 47 | $ - | $ - | $ 20 | $ - | $ - | $ - | $ 1 |
| **Transportation** | None | None | None | None | Yes | Yes | None | None | Yes | Yes |

A) May also be used for dental, vision and hearing.

B) 30-40% copay for bridges & crowns