PPO
MEDICARE ADVANTAGE PLANS
DEKALB COUNTY 2026

INCL. DRUG COVERAGE	AARP MEDICARE		ANTHEM				DEVOTED HEALTH			AETNA
Plan Name	**UHC IN-0006**	**UHC IN-0001**	**Medicare Adv.**	**Medicare Advan. 3**	**Medicare Adv.**	**Regional Medicare**	**Choice 001**	**Choice Giveback**	**Choice Premium**	**Value Care**
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan #	2406-066	2406-035	7093-002	1607-012	1607-015	5941-016	7771-001	7771-002	7771-004	5521-496
Rating (5 is max)	4.0	4.0	3.5	3.5	3.5	3.5	new	new	new	4.5
Prem.- mo. $	$0	$ 39	$ 9	$ 55	$ 26	$ 97	$ -	$ -	$ 11.40	$ 36
Deductible-medical exp.	$0	$0	$ -	$ 500	$ 250	$ 500	$ -	$ -	$ -	$ -
CO-PAYS:										
Maximum-annual										
In Network	$ 4,900	$ 3,700	$ 6,750	$ 6,750	$ 6,750	$ 9,250	$ 4,500	$ 8,500	$ 4,500	$ 6,750
Out of network	$ 10,100	$ 6,300	$ 10,000	$ 10,100	$ 10,100	$ 13,900	$ 10,100	$ 13,900	$ 10,100	$ 10,100
Hospital -daily CoPay	$ 425	$ 375	$ 345	$ 350	$ 370	$ 345	$ 295	$ 425	$ 295	$ 365
- # of days	7	6	5	7	5	7	7	5	7	8
Off. Visit-Primary	$ -	$ -	$ -	$ 10	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 50	$ 45	$ 30	$ 45	$ 40	$ 40	$ 35	$ 45	$ 35	$ 30
Out- patient surgery:										
Surgical Ctr.	$ 325	$ 275	$ 245	$ 300	$ 320	$ 295	$ 295	$ 425	$ 295	$ 315
Hospital	$ 425	$ 375	$ 345	$ 350	$ 370	$ 345	$ 395	$ 525	$ 395	$ 365
MRI & CT scans	$ 240	$ 210	Dr $100 Hosp 345	Dr $140 Hosp 350	Dr $150 Hosp 370	Dr $105 Hosp 345	Dr $200 Hosp 300	Dr $200 Hosp 300	Dr $200 Hosp 300	$ 275
EXTRA BENEFITS:										
Hearing Aids	199-1,249 co-pay	199-1,249 co-pay	300-1500 allow.	300-2000 allow.	300-2000 allow.	300-2000 allow.	$399-699 allow.	$599-899 allow.	$199-499 allow.	$750/ear allow.
Dental - Coverage limit	$ -	$ 2,500	$ 2,750	$ 1,800	$ 1,500	$ -	$ 2,000	$ 250	$ 3,000	$ 1,250
- Comprehensive coverage	Routine Only	50% copay	25% copay	25% copay	25% copay	Routine Only	50% copay	No Coverage	50% copay	20 - 50% copay
Eyewear Allowance	$300/2yrs.	$300/2yrs.	$ 300	None	$ 200	No	$300	$200	$400	$150
OTC Drug Allow. per qtr.	$ -	$ -	$ -	$ 60	$ -	$ 35	$ 100	$ -	$ 125	$ 30
Part B rebate	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 183	$ -	
Transportation	None	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**	**Choice Give Back**	**Full Access**	**Choice Give Back**	**USAA Honor w/RX**	**Choice**	**Choice (Regional)**	**Choice**	**Simple Open**	**Give Back Open**	**Assist Open**
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan #	5216-307	5216-309	5216-192	7617-003	7617-060	5216-019	R0110--012	5216-463	6348-002	6348-008	6348-009
Rating (5 is max)	3.5	3.5	3.5	4.5	4.5	3.5	3.5	3.5	3.0	3.0	3.0
Prem.- mo. $	$ -	$ -	$ -	$ -	$ -	$ 24	$ 20	$ 28	$ -	$ -	$ 38.40
Deductible-medical exp.	$ 100	$ 425	$ 215	$ 425	$ 100	$ -	$ -	$ -	$ -	$ 500	$ -
CO-PAYS:											
Maximum-annual											
In Network	$ 7,900	$ 9,150	$ 6,700	$ 9,150	$ 7,900	$ 6,550	$ 9,150	$ 6,350	$ 4,300	$ 8,500	$ 5,000
Out of network	$ 13,300	$ 13,900	$ 6,700	$ 13,900	$ 13,300	$ 10,100	$ 13,900	$ 10,100	$ 8,950	$ 10,000	$ 8,950
Hospital -daily CoPay	$ 425	$ 400	$ 600	$ 400	$ 425	$ 450	$ 470	$ 440	$ 375	$ 400	$ 350
- # of days	5	5	4	5	5	5	5	6	5	5	6
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 45	$ 40	$ 70	$ 40	$ 45	$ 55	$ 55	$ 55	$ 20	$ 40	$ 25
Out- patient surgery:											
Surgical Ctr.	$ 325	$ 300	$ 570	$ 300	$ 325	$ 350	$ 370	$ 340	$ 250	$ 250	$ 250
Hospital	$ 425	$ 400	$ 670	$ 400	$ 425	$ 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	$699-999 copay	$699-999 copay	$699-999 copay	$399-999 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	$ 500	$ -	$ 500	$ 3,000	$ 1,000	$ 1,000	$ 3,500	$ 5,000	$ 1,000	no max. allow.
-Comprehensive coverage	0% copay	0% copay limited	Prevent. Only	0% copay limited	0% copay	0% copay, Limited comp.	0% copay, Limited comp.	0% copay	0% copay,	20% copay	0% copay
Eyewear Allowance	$75-150	$50-100	$50-100	$50-100	$75-100	$75-150	$50-100	$250-300	$ 300	$ 200	$ 400
OTC Drug Allow. per qtr.	$ 50	$ -	$ -	$ -	$ 50	$ -	$15/Mo	$ 50	$ 65/mo (A)	$ 15/mo. (A)	$ 54.mo. (A)
Part B rebate	$ 79	$ 123	$ 1	$ 123	$ 79	$ -	$ -	$ -	$ -	$ 79	$ 1
Transportation	None	None	None	None	None	None	None	None	None	None	Yes

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

HMO
MEDICARE ADVANTAGE PLANS
DEKALB COUNTY 2026

INCL. DRUG COVERAGE	AARP MEDICARE ADVAN.			ANTHEM		HUMANA	WELLCARE	
Plan Name	**UHC IN-10 Essentials**	**UHC IN-0016 Extras**	**UHC IN-0020 GiveBack**	**Medicare Adv.**	**Extra Help**	**Gold Plus**	**Simple**	**Assist**
Plan Type	HMO-POS *	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	5619-051	3499-002	3499-008
Rating (5 is max)	4.0	4.0	4.0	3.5	3.5	3.0	3.0	3.0
Prem.- mo. $	$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 covered only.							
Maximum-annual								
In Network	$ 3,900	$ 6,700	$ 6,700	$ 4,150	$ 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
Hospital -daily CoPay	$ 425	$ 495	$ 550	$ 440	$ 290	$ 450	$ 350	$ 350
- # of days	5	5	4	5	6	6	6	6
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 40	$ 55	$ 60	$ 35	$ 25	$ 35	$ 25	$ 25
Out- patient surgery:								
Surgical Ctr.	$ 325	$ 395	$ 500	$ 340	$ 200	$ 350	$ 250	$ 225
Hospital	$ 425	$ 495	$ 550	$ 440	$ 290	$ 450	$ 350	$ 280
MRI & CT scans	$ 200	$ 260	$ 260	Dr $95 Hosp 440	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.	$699-999 copay	$1,000 allow./ear	$1,000 allow./ear
Dental - Coverage limit	$ -	$ 4,000	$ -	$ 2,000	$ 3,000	$ 2,000	$ 3,000	no max. allow.
- Comprehensive coverage	Routine Only	50% co-pay	Routine Only	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	$ 200	$50-100	$ 300	$ 400
OTC Drug Allow. per qtr.	$ -	$ 60	$ -	$ 38	$ -	$ -	$ 55 (A)	$ 70 (A)
Part B rebate	$ 14	$ -	$ 47	$ -	$ -	$ -	$ -	$ 1
Transportation	None	None	None	None	None	None	Yes	Yes

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

B) 30-40% copay for bridges & crowns