PPO
MEDICARE ADVANTAGE PLANS

ALLEN COUNTY 2027

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)	4.0	4.0	4.0	3.5	3.5	3.5	4.0	4.0	4.0
Prem.- mo. $	$0	$0	$ 46	$ 45	$ 68	$ 123	$ -	$ -	$ -
Deductible-medical exp.	$0	$0	$0	$ -	$ 500	$ 500	$ -	$ -	$ -
CO-PAYS:									
Maximum-annual									
In Network	$ 4,450	$ 5,900	$ 4,450	$ 6,750	$ 6,750	$ 9,250	$ 5,000	$ 6,350	$ 6,750
Out of network	$ 6,700	$ 10,750	$ 6,700	$ 10,000	$ 10,100	$ 13,900	$ 10,750	$ 10,100	$ 10,750
Hospital -daily CoPay	$ 455	$ 550	$ 455	$ 345	$ 350	$ 345	$ 325	$ 320	$ 365
- # of days	6	5	6	5	7	7	7	7	8
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ 10	$ -	$ -	$ -	$ -
" " -Specialist	$ 50	$ 65	$ 50	$ 35	$ 45	$ 40	$ 50	$ 40	$ 40
Out- patient surgery:									
Surgical Ctr.	$ 355	$ 450	$ 355	$ 245	$ 300	$ 295	$ 275	$ 270	$ 315
Hospital	$ 455	$ 550	$ 455	$ 345	$ 350	$ 345	$ 325	$ 320	$ 365
MRI & CT scans	$ 320	$ 320	$ 320	Dr $100 Hosp 345	Dr $140 Hosp 350	Dr $105 Hosp 345	$ 250	$ 350	$ 275
EXTRA BENEFITS:									
Hearing Aids	$700 allow.	$700 allow.	$700 allow.	300-1500 allow.	300-2000 allow.	300-2000 allow.	$500/ear allow.	$1000/ear allow.	$750/ear allow.
Dental - Coverage limit	$ 1,000	$ -	$ 1,500	$ 2,750	$ 1,800	$ -	$ -	$ 2,000	$ 1,000
- Comprehensive coverage	50% copay	Routine Only	50% copay	25% copay	25% copay	Routine Only	Routine only	20 - 50% copay	20 - 50% copay
Eyewear Allowance	$200/2yrs.	$200/2yrs.	$200/2yrs.	$ 300	None	None	$125	$125	$100
OTC Drug Allow. per qtr.	$ -	$ -	$ -	$ -	$ -	$ 35	$ -	$ -	$ 15
Part B rebate	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Grocery, transport. & utility allow. - if on Extra Help & have a chronic condition									$30/qtr.

PPO
MEDICARE ADVANTAGE PLANS
ALLEN COUNTY 2027

INCL. DRUG COVERAGE	DEVOTED HEALTH			
Plan Name	**Choice 001**	**Choice Giveback 002**	**Choice Premium 004**	**Choice Giveback Extra 024**
Plan Type	PPO	PPO	PPO	PPO
Plan #	7471-001	7471-002	7471-004	7471-024
Rating (5 is max)	new	new	new	new
Prem.- mo. $	$ -	$ -	$ 11.00	$ -
Deductible-medical exp.	$ -	$ 200	$ -	$ 150
CO-PAYS:				
Maximum-annual				
In Network	$ 4,850	$ 9,650	$ 4,500	$ 7,100
Out of network	$ 10,450	$ 14,800	$ 10,750	$ 10,750
Hospital -daily CoPay	$ 320	$ 425	$ 365	$ 495
- # of days	6	5	7	5
Off. Visit-Primary	$ -	$ -	$ -	$ -
" " -Specialist	$ 45	$ 50	$ 35	$ 50
Out- patient surgery:				
Surgical Ctr.	$ 320	$ 425	$ 365	$ 390
Hospital	$ 420	$ 525	$ 465	$ 490
MRI & CT scans	Dr $200 Hosp 300	Dr $200 Hosp 300	Dr $200 Hosp 300	Dr $200 Hosp 300
EXTRA BENEFITS:				
Hearing Aids	$399-699 copay	$599-899 copay	$399-699 copay	$599-899 copay
Dental - Coverage limit	$ 2,000	$ 250	$ 3,000	$ 2,250
- Comprehensive coverage	50% copay *	$0 copay *	$0 copay *	50% copay *
Eyewear Allowance	$300	$200	$400	$350
OTC Drug Allow. per qtr.	$ 62	$ -	$ 88	$ 100
Part B rebate	$ -	$ 183	$ -	$ 90

*** You pay the costs yourself. then you submit a request for reimbursement.**

PPO
MEDICARE ADVANTAGE PLANS
ALLEN COUNTY 2027

INCL. DRUG COVERAGE	HUMANA						WELLCARE	
Plan Name	**Choice Giveback**	**Essentials Plus Giveback**	**Full Access**	**Choice**	**Choice (Regional)**	**Choice**	**Simple Open**	**Give Back Open**
Plan Type	PPO	PPO	PPO	PPO	PPO	PPO	PPO	PPO
Plan #	5216-481	7617-144	5216-192	5216-019	R110-012	5216-463	6348-002	6348-008
Rating (5 is max)	4.0	4.5	4.0	4.0	3.5	4.0	2.5	2.5
Prem.- mo. $	$ -	$ -	$ -	$ 34	$ 68	$ 43	$ -	$ -
Deductible-medical exp.	$ 432	$ 425	$ 375	$ -	$ -	$ -	$ -	$ 415
CO-PAYS:								
Maximum-annual								
In Network	$ 9,850	$ 9,850	$ 7,150	$ 6,800	$ 9,850	$ 6,350	$ 6,200	$ 9,850
Out of network	$ 14,800	$ 14,800	$ 7,150	$ 10,100	$ 14,800	$ 10,100	$ 10,000	$ 11,100
Hospital -daily CoPay	$ 400	$ 400	$ 625	$ 550	$ 485	$ 440	$ 450	$ 425
- # of days	5	5	4	5	5	6	5	5
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 50	$ 50	$ 75	$ 55	$ 55	$ 45	$ 40	$ 45
Out- patient surgery:								
Surgical Ctr.	$ 450	$ 450	$ 450	$ 450	$ 450	$ 450	$ 350	$ 400
Hospital	$ 550	$ 550	$ 550	$ 550	$ 550	$ 550	$ 500	30%
MRI & CT scans	Dr. $205 Hosp 345	Dr. $330 Hosp 345	Dr. $205 Hosp 345	Dr. $205 Hosp 345	Dr. $205 Hosp 345	Dr. $205 Hosp 345	Dr. $300 Hosp 500	Dr. $350 Hosp 500
EXTRA BENEFITS:								
Hearing Aids	$575-750 copay	$575-750 copay	$575-750 copay	$575-750 copay	$575-750 copay	$499-725 copay	$500 allow./ear	$350 allow./ear
Dental-Coverage limit	$ 500	$ 500	$ -	$ 750	$ -	$ 3,000	$ 1,000	$ 1,500
-Comprehensive coverage	0%-25% copay-min. cover.	0% copay limited	Very limited	0% copay-min. cover.	very limited	0% copay	0% copay,	20% copay
Eyewear Allowance	$50-100	$50 - 100	$50-100	$75-150	$50-100	$250-350	$ 200	$ 200
OTC Drug Allow. per qtr.	$ -	$ -	$ -	$ -	$10/Mo	$ 50	$ -	$ 15/mo.
Part B rebate	$ 123	$ 124	$ -	$ -	$ -	$ -	$ -	$ 39.50

HMO
MEDICARE ADVANTAGE PLANS
ALLEN COUNTY 2027

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**	**Medicare Adv.7**	**Medicare Adv. 6**	**Gold Plus**	**Simple**
Plan Type	HMO-POS *	HMO-POS *	HMO-POS *	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	7220-009	7220-010	3447-024	3529-002	3529-001	5619-051	3499-002
Rating (5 is max)	3.5	3.5	3.5	3.0	3.0	3.0	3.0	new	new	4.0	3.0
Prem.- mo. $	$0	$0	$0	$ -	$0	$0	$ 17.00	$ -	$ 34.00	$ -	$ -
Deductible-medical exp.	$0	$0	$0	$ -	$0	$0	$ -	$ -	$ -	$ 350	$ 75
CO-PAYS:	* Out of network coverage on dental only, out-of network medical not covered unless an emergency.										
Maximum-annual											
In Network	$ 5,400	$ 7,150	$ 7,150	$ 8,750	$ 9,850	$ 7,150	$ 4,900	$ 7,150	$ 4,450	$ 5,900	$ 5,900
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	Won't pay
Hospital -daily CoPay	$ 495	$ 550	$ 550	$ 440	$ 480	$ 395	$ 290	$ 490	$ 450	$ 450	$ 400
- # of days	5	5	4	5	5	6	6	5	6	6	7
Off. Visit-Primary	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
" " -Specialist	$ 50	$ 65	$ 65	$ 40	$ 40	$ 30	$ 25	$ 45	$ 40	$ 40	$ 35
Out- patient surgery:											
Surgical Ctr.	$ 395	$ 450	$ 500	$ 340	$ 340	$ 295	$ 200	$ 300	$ 200	$ 400	$ 350
Hospital	$ 495	$ 550	$ 550	$ 440	$ 480	$ 350	$ 290	$ 490	$ 450	$ 500	$ 500
MRI & CT scans	$ 320	$ 320	$ 320	Dr $95 Hosp 440	Dr $95 Hosp 480	20%	Dr $50 Hosp 290	Dr $95 Hosp 490	Dr $95 Hosp 450	Dr. $205 Hosp 345	Dr. $250 Hosp 475
EXTRA BENEFITS:											
Hearing Aids	$700 allow.	$1,000 allow.	$1,000 allow.	none	300-2000 allow.	none	300-2000 allow.	300-2000 allow.	300-2000 allow.	$575-750 copay	$ 500 allow./ear
Dental - Coverage limit	$ -	$ 3,000	$ -	$ 1,000	$ 1,000	$ 1,500	$ 3,000	$ 500	$ 1,500	$ 1,000	$ 2,000
- Comprehensive coverage	Routine cover. only	50% co-pay	Routine cover. only	25% co-pay	25% co-pay	25% co-pay	25% co-pay	25% co-pay	25% co-pay	0%-30 copay	0% Co-Pay
Eyewear Allowance	$200/2 yrs	$300/2 yrs	$200/2 yrs.	none	$ 125	none	$ 225	$ 200	$ 200	$50-100	$ 200
OTC Drug Allow. per qtr.	$ -	$ 40	$ -	$ -	$ -	$ -	$ -	$ -	$ 35	$ -	$ 15/mo.
Part B rebate	$ -	$ -	$ 47	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -