UNION COUNTY MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION COVERAGE 2021

PLAN	*NEW FOR 2021* AARP Medicare Advantage Choice PPO *from United Healthcare* H8768-022-000 800-547-5514 aarpmedicareplans.com	AARP Medicare Advantage Plan 1 HMO *from United Healthcare* H0755-040-001 800-547-5514 aarpmedicareplans.com	AARP Medicare Advantage Plan 3 HMO *from United Healthcare* H0755-041-001 800-547-5514 aarpmedicareplans.com	AARP Medicare Advantage Plan 4 HMO *from United Healthcare* H0755-042-001 800-547-5514 aarpmedicareplans.com
Monthly Premium	$0	$0	$39 ($6.30 with PAAD)	$81 ($43.70 with PAAD)
Medical Deductible	$0	$0	$0	$0
Drug Deductible	$0 Tier 1&2/ $240 others	$0 Tier 1 &2/ $240 others	$0 Tier 1&2/ $200 others	$0 Tier 1&2/ $150 others
Primary doctor copay	$0 in or OON	$5	$0	$0
Specialist copay	$40 in or OON	$45	$25	$20
Referrals Required?	No	No	No	No
Hospital copays	$390/ day for days 1 thru 5 in or OON	$335/ day for days 1 thru 6	$295/ day for days 1 thru 5	$225/ day for days 1 thru 5
ER copay/ Urgency Care	$90/$30-40	$90/ $30-40	$90/$20-40	$90/$20-40
Ambulance	$250	$250	$225	$250
Outpatient surgery	$345 in network; 40% OON $0 diagnostic colonoscopy in network	$295 $0 diagnostic colonscopy	$250 $0 diagnostic colonoscopy	$225 $0 diagnostic colonoscopy
Lab services	$0 in or OON	$0	$0	$0
X-Rays	$30 in or OON	$30	$30	$30
Diagnostic tests (ex MRI)	$30-155 in network $0 diagnostic mammogram; 40% OON	$30 -$155 $0 diagnostic mammogram	$30 -$155 $0 diagnostic mammogram	$30 -$155 $0 diagnostic mammogram
Member's Max. Out of Pocke	$6,700 in network $10,000 OON	$6,700	$6,700	$6,700
Mental Health visits	$25 individual/$15 group -IN/ 40 individual/$30 group - OON	$25 individual/ $15 Group	$25 individual/ $15 group	$25 individual/ $15 group
In-patient rehab (SNF)	$0 Day 1-20, $184/day for days 21-57, $0 day 60-100 IN; $225 days 1-45 OON	$0 Day 1-20; $184/day for days 21-57; $0 day 58-100	$0 Day 1-20; $184/day for days 21-57, $0 day 58-100	$0 Day 1-20; $184/day for days 21-57, $0 day 58-100
Outpatient Physical Therapy	$40 in or OON	$40	$25	$20
Dental benefits	$0 copay preventive and comprehensive $500 max*	$0 copay preventive*	$0 copay preventive and comprehensive $500 max*	$0 copay preventive and comprehensive $500 max*
Eye Glasses benefits	$100 select products only	$200 max every 2 years	$200 max every 2 years	$200 max every 2 years
Hearing Aid Benefits	$375- $2075	$375- $2075	$375- $2075	$375- $2075
Medical Equipment Part B drugs Dialysis	DME: 20% in network, 50% OON;Part B drugs : 20% in network, 40% OON; Dialysis : 20% in or OON	20%	20%	20%
Over the Counter Spending Card for health- related items	none	none	none	none
Supplemental Benefits	*Additional comprehensive dental benefits for addil $38 -$40/mth premum; gym membership; worldwide emergency coverage; Travel Benefit; telehealth	*Additional comprehensive dental benefits for addil $38 -$40/mth premum; gym membership; worldwide emergency coverage; Travel Benefit; telehealth	*Additional comprehensive dental benefits for addil $38 -$40/mth premum; gym membership; worldwide emergency coverage; Travel Benefit; telehealth	*Additional comprehensive dental benefits for addil $38 -$40/mth premum; gym membership; worldwide emergency coverage; Travel Benefit; telehealth

UNION COUNTY MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION COVERAGE 2021

PLAN	Aetna Medicare Explorer Elite HMO H3152-084 1-800-832-2640 aetnamedicare.com	*new* Aetna Medicare Explorer Elite 2 HMO H3152-092 1-800-832-2640 aetnamedicare.com	Aetna Medicare Explorer Premier Plus PPO H5521-278 1-800-832-2640 aetnamedicare.com	Aetna Medicare Explorer Premier Plus HMO H3152-048 1-800-832-2640 aetnamedicare.com	Aetna Medicare Explorer Premier PPO H5521-037 1-800-832-2640 aetnamedicare.com
Monthly Premium	$0	$0	$36 ($13.50 with PAAD)	$99 ($62.50 with PAAD)	$104 ($66.70 with PAAD)
Medical Deductible	**$1,500 for some services**	**$1,000 for some services**	$0 IN/ $1,000 OON	$0	$0 IN/ $1,000 OON
Drug Deductible	$0 Tiers 1 & 2/ $100 Tiers 3-5	$0 Tiers 1 & 2/ $250 Tiers 3-5	$0 Tiers 1 & 2/ $200 Tier 3-5	$0 Tiers 1 & 2/ $100 Tier 3-5	$0 Tiers 1 & 2/ $100 Tier 3-5
Primary doctor copay	$10	$5	$5 IN, 30% OON	$5	$10 IN, 20% OON
Specialist copay	$50	$45	$40 IN, 30% OON	$40	$45 IN, 20% OON
Referrals Required?	No	No	No	No	No
Hospital copays	After deductible $790 Per Stay	After deductible $750 Per Stay	$335/ day for days 1 thru 6 IN/30% OON	$390/ day for days 1-5	$395/ day for days 1 thru 5 IN/20% OON
ER copay/ Urgency Care	$90/ $65	$90/ $65	$90/$65	$90/ $65	$90/ $65
Ambulance	$300	$290	$280	$250	$295
Outpatient surgery	After deductible $395	After deductible $375	$395 IN/ 30% out network	$250	$350 IN/ 20% out network
Lab services	$0	$0	$0 IN/ 30% OON	$0	$0 IN/ 20% OON
X-Rays	$50	$50	$50 IN/ 30% OON	$50	$50 IN/ 20% OON
Diagnostic tests (ex MRI)	$300	$295	$40-$295 IN/ 30% OON	$195	$50-$250 IN/ 20% OON
Member's Max. Out of Pocke	$7,550	$7,550	$7,550 IN/ $11,300 in & OON	$7,750	$7,550 IN/ $11,300 in & OON
Mental Health visits	$40	$40	$40 IN/ 30% out network	$40	$40 IN/ 20% out network
In-patient rehab (SNF)	After Deductible $0 days 1-20 ; $184 /day for days 21 -100	After Deductible $0 days 1-20 ; $184 /day for days 21 -100	$0 Day 1-20 $184/day for days 21-100 30% per stay out network	$0 Day 1-20, $184/day for days 21-100	After Deductible $0 days 1-20; $184 /day for days 21 -100; 20% OON
Outpatient Physical Therapy	`	$40	$40 IN 30% out network	$40	$40 IN 20% out network
Dental benefits	Routine*	$250 max	Routine*	$1,000 max	$350 max
Eye Glasses benefits	$100 max	$100 max	$250max	$250 max	$200 max
Hearing Aid Benefits	$1,250 max	$1,250 max	$1,250 max	$1,250 max	$1,250 max
Medical Equipment Part B drugs Dialysis	After deductible 20%	After deductible 20%	20%	20%	20%
Over the Counter Spending Card for health- related items	None	None	None	**$45/ quarter**	**$30/ quarter**
Supplemental Benefits	* Additional dental available for $18 mthly premium; SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; Travel Benefit; Telehealth	SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; Travel Benefit; Telehealth	* Additional dental available for $37 mthly premium; SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; Travel Benefit; Telehealth	SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; Travel Benefit; Telehealth	SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; Travel Benefit; Telehealth

UNION COUNTY MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION COVERAGE 2021

PLAN	Aetna Medicare Value 2 HMO *(formerly Credit Value HMO)* H3152-088 1-800-832-2640 aetnamedicare.com	Aetna Medicare Prime Value HMO H3152-080 1-800-832-2640 aetnamedicare.com	Aetna Medicare Prime Credit PPO *(formerly Credit Value PPO)* H5521-277 1-800-832-2640 aetnamedicare.com	Aetna Medicare Prime Premier PPO H5521-275 1-800-832-2640 aetnamedicare.com	Aetna Medicare Premier Regional PPO R6694-006 1-800-832-2640 aetnamedicare.com
Monthly Premium	$0	$0	$0 plus $50/month reduction in Part B premium	$49 ($18.60 with PAAD)	$98 ($64.50 with PAAD)
Medical Deductible	$0	$0	$0 IN/ $1,000 OON	$0 IN/ $1,000 OON	$0 IN/ $1,000 OON
Drug Deductible	$0 Tier 1 & 2/$300 Tier 3-5	$0 Tier 1, 2 & 3/ $195 Tier 3-5	$0 Tier 1 & 2/$300 Tier 3-5	$0 Tier 1 & 2/$250 Tier 3-5	$0 Tier 1 & 2/$100 Tier 3-5
Primary doctor copay	$35	$0	$20 IN/ 30% OON	$0 IN/ 30% OON	$15 IN/ 30% OON
Specialist copay	$50	$40	$50 IN/ 30% OON	$25 IN/ 30% OON	$30 IN/ 30% OON
Referrals Required?	No	No	No	No	No
Hospital copays	$395/day for days 1-5	$295/day for days 1-6	$315/day for days 1-5 IN/30% OON	$285/day for days 1-6 IN/30% OON	$335/day for days 1-6 IN/ 30% OON
ER copay/ Urgency Care	$90/$65	$90/$65	$90/$65	$90/$65	$90/$65
Ambulance	$290	$285	$285	$285	$290
Outpatient surgery	$425	$325	$375 IN/ 30% OON	$300 IN/ 30% OON	$375 IN/ 30% OON
Lab services	$0	$0	$0 IN/30% OON	$0 in network/30% OON	$0 IN/ 30% OON
X-Rays	$50	$50	$50 IN/ 30% OON	$30 IN/ 30% OON	$50 IN/ 30% OON
Diagnostic tests (ex MRI)	$50-$400	$40-$200	$50-$300 IN/ 30% OON	$25-$200 IN/ 30% OON	$50-$300 IN/ 30% OON
Member's Max. Out of Pocke	$7,550	$7,550	$7,550 IN/ $11,300 combined in and OON	$7,550 IN/ $11,300 combined in and OON	$7,550 IN/ $11,300 combined in and OON
Mental Health visits	$40	$40	$40 IN/ 30% OON	$40 IN/ 30% OON	$40 IN/ 30% OON
In-patient rehab (SNF)	$0 Day 1-20 $184/day for days 21-100	$0 Day 1-20 $184/day for days 21-100	$0 Day 1-20 $184/day for days 21-100/ 30% OON	$0 Day 1-20 $184/day for days 21-100/ 30% OON	$0 Day 1-20 $184/day for days 21-100/ 30% OON
Outpatient Physical Therapy	$40	$40	$40 IN/ 30% OON	$40 IN/ 30% OON	$40 IN/ 30% OON
Dental benefits	None*	$750 max	$250 max	$750 max	$225 max
Eye Glasses benefits	None**	$200 max	$155 max	$250 max	$150 max
Hearing Aid Benefits	$1,250 max	$1,250 max	$1,250 max	$1,250 max	$1,250 max
Medical Equipment Part B drugs Dialysis	20%	20%	20% IN/30% OON	20% IN/ 30% OON	20% IN/ 30% OON
Over the Counter Spending Card for health- related items	None	**$30/quarter**	None	**$60/quarter**	None
Supplemental Benefits	*Additional dental benefits avaliable for $31 premium; **Additional Vision and Dental package available for $40.40 premium; Gym-SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; telehealth; Travel Benefit	Gym-SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; telehealth; Travel Benefit	Gym-SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; telehealth; Travel benefits	Gym-SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; telehealth; Travel Benefit	Gym-SilverSneakers; 14 home delivered meals after hospital stay; worldwide emergency coverage; telehealth; Travel Benefit

UNION COUNTY MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION COVERAGE 2021

PLAN	Clover Health Classic HMO H8010-002 888-657-1207 cloverhealth.com	Clover Health Value HMO H8010-003 888-657-1207 cloverhealth.com	Clover Health Choice PPO H5141-004 1-888-466-5044 cloverhealth.com	Clover Health Choice Value PPO H5141-007 1-888-466-5044 cloverhealth.com
Monthly Premium	$0	$37.30 ($0 PAAD)	$0	$37.30 ($0 with PAAD)
Medical Deductible	$0	$0	$0	$0
Drug Deductible	$0	$0 Tier 1/ $445 others	$0 Tier 1 &2/ $175 others	$0 Tier 1 / $445 others
Primary doctor copay	$0	$0	$0 in or OON	$0 in or OON
Specialist copay	$20	$5	$20 in or OON	$5 in or OON
Referrals Required?	No	No	No	No
Hospital copays	$290/ day for days 1-5	$200/ day for days 1-5	$290 per day for days 1 -5 in network; OON: Days 1-5 copay per day $345	$200 per day for days 1 -5 in network; OON: Days 1-5 copay per day $345
ER copay/ Urgency Care	$90/$25	$90/$25	$90/$25	$90/$25
Ambulance	$250	$200	$250	$200
Outpatient surgery	$325 hosp/ $225 ambulatory center	$200 hosp/ $115 ambulatory center	$325 hosp; $225 ambulatory	$200 hosp/ $115 ambulatory center
Lab services	$0	$0	$0 -$10	$10 in network, $40 OON
X-Rays	$30	$30	$30	$30
Diagnostic tests (ex MRI)	Up to $50 office setting or Imaging Centers. $175 outpatient facility	Up to $50 office setting or Imaging Centers. $175 outpatient facility	Up to $50 office setting or Imaging Centers. $175 outpatient facility; in network	Up to $50 office setting or Imaging Centers. $175 outpatient facility; in network
Member's Max. Out of Pocke	$7,550	$7,550	$7,550 combinted in and OON	$7,550 combinted in and OON
Mental Health visits	$20	$5	$20	$5 in or OON
In-patient rehab (SNF)	$0 Day 1-20, $178/day for days 21-100	$0 Day 1-20, $178/day for days 21-100	$0 Day 1-20, $178/day 21-100; OON 30% per day	$0 Day 1-20, $178/day 21-100; OON 30% per day
Outpatient Physical Therapy	$20	$5	$20/$50	$5 in network, and $50 OON
Dental benefits	$1000 max	$1000 max	routine	routine
Eye Glasses benefits	$100 max	$100 max	$100 max	$100 max
Hearing Aid Benefits	$699-$999 max	$699-$999 max	Yes $699-$999 max	$699-$999 max
Medical Equipment Part B drugs Dialysis	20%	20%	20%	20% in network, 30% OON
Over the Counter Spending Card for health- related items	**$75/quarter**	**$125/quarter**	**$75/quarter**	**$125/quarter**
Supplemental Benefits	Gym memberships, telehealth;	Gym memberships, telehealth;	Gym memberships, telehealth; worldwide emergency coverage	Gym memberships, telehealth

UNION COUNTY MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION COVERAGE 2021

PLAN	*New for 2021* Braven Medicare Plus HMO (*affiliated with Horizon BCBS & Hackensack Meridan Health)* H4675-001 1-866-713-1313 bravenhealth.com	*New for 2021* Braven Medicare Choice PPO *(affiliated with Horizon BCBS & Hackensack Meridan Health)* H0885-001 1-866-713-1313 bravenhealth.com	*New for 2021* Braven Medicare Freedom PPO *(affiliated with Horizon BCBS & Hackensack Meridan Health)* H0885-002 1-866-713-1313 bravenhealth.com	Horizon Medicare Blue Advantage HMO H3154-030 1-800-224-1234 medicare.horizonblue.com	Horizon Medicare Blue Value w/ Rx HMO H3154-004 1-800-224-1234 medicare.horizonblue.com	Horizon Medicare Blue Select HMO-POS H3154-033 1-800-224-1234 medicare.horizonblue.com
Monthly Premium	$0	$0	$35 ($5.80 with PAAD)	$31	$46 ($8.70 with PAAD)	$30 ($0 with PAAD; $14.70 with LIS)
Medical Deductible	$0	$0	$0	$0	$0	$1,000 for OON services
Drug Deductible	$0	$0 Tier 1 & 2, $150 others	$0 Tier 1 & 2, $100 others	$0 Tier 1&2/ $250 others	$445	$0
Primary doctor copay	$0	$0 IN; $10 OON	$0 IN; 30% OON	$10	$10	$0 IN, 20% outnetwork
Specialist copay	$20	$20 IN; $30 OON	$20 IN; 30% OON	$25	$40	$15 IN, 20% outnetwork
Referrals Required?	No	No	No	No	No	No
Hospital copays	$325/day days 1-5	$320 for days 1-5; same In or OON	$300 for days 1-5 in-work; 30% OON	$320/ day for days 1-5	$225/ day for days 1-8, $113 Day 9	$320/ day for days 1 thru 5 IN/ 20% out network
ER copay/ Urgency Care	$90 Emergency $30 Urgent Care	$90 Emergency $40 Urgent Care	$90 Emergency $40 Urgent Care	$90/$20-25	$90/$25-$40	$90 ER, $10 IN urgent care, $15 OON urgent care
Ambulance	$250	$250	$225	$250	$250	$250
Outpatient surgery	Hospital: $250 Ambulatory Center : $195	Hospital: $295 IN; $395 OON Ambulatory : $250 In and Out	Hospital: $275 IN Ambulatory : $195 IN; 30% OON	$200 surgery center, 20% hospital outpatient; $275 Observation	$75 surgery center, 20% hospital outpatient; $175 Observation	$200 IN surgery center/ 20% hospital outpatient in or out of-network; $275 hospital Observation stay
Lab services	$0- $5	$0 - $30 IN; $20 OON	$0 -$30 IN; 30% OON	$0	$0	$0
X-Rays	$30	$25 IN; $40 OON	$25 IN; 30 OON	$15 free standing facility 20% hospital setting	$40 free standing facility 20% hospital setting	$15 IN, 20% hospital setting or OON
Diagnostic tests (ex MRI)	$40-$150	$40-$150 IN; $60-$175 OON	$40-$150 IN; 30% OON	$25 free standing facility; 20% hospital setting	$40 free standing facility; 20% hospital setting	$15 free standing facility; 20% hospital setting
Member's Max. Out of Pocke	$6,500	$6,700 IN $10,000 Combined In/Out	$6,500 IN $9,500 Combined In/Out	$6,700	$6,700	$6,700 IN, $10,000 OON
Mental Health visits	$40	$40 IN; $50 OON	$40 IN; 30% OON	$25	$40	$15 IN, 20% outnetwork
In-patient rehab (SNF)	$0 days 1-20, $175/day days 21-100	IN: $0 days 1-20, $178/day; days 21-100; OON: 20% /stay	IN: $0 days 1-20, $178/day; days 21-100; OON: 30%/stay	$0 Day 1-20, $165/day for days 21-100	$0 Day 1-20, $125/day for days 21-100	$0 Day 1-20, $165/day for days 21-100
Outpatient Physical Therapy	$20	$20 IN; $30 OON	$20 IN; $30 OON	$25	$40	$15 IN, 20% outnetwork
Dental benefits	Routine preventive dental plus 50% for comprehensive care up to $800	Routine preventive dental plus 50% for comprehensive care up to $800	Routine preventive dental plus 50% for comprehensive care up to $800	routine	routine	$250 max
Eye Glasses benefits	$200 max	$200 max	$200 max	$100 Max	$100 Max	$100 Max
Hearing Aid Benefits	$1,250 max	$1,250 max	$1,250 max	$1250 max	$1250 max	$1250 max
Medical Equipment Part B drugs Dialysis	20% coinsurance	20% coinsurance	20% coinsurance IN; 30% OON	20%	20%	20%
Over the Counter Spending Card for health- related items	**$70/quarter**	**$70/quarter**	**$90/quarter**	none	none	none
Supplemental Benefits	$200 towards Gym/Yoga membership; worldwide emergency coverage; telemedicine; Home delivered meals after hospital stay; $200 towards weight mgmt/nutrition counseling, acupucture, massage or bathroom safety devices	$200 towards Gym/Yoga membership; worldwide emergency coverage; telemedicine; Home delivered meals after hospital stay; travel benefit; $200 towards weight mgmt/nutrition counseling, acupucture, massage or bathroom safety devices	$200 towards Gym/Yoga membership; worldwide emergency coverage; telemedicine; Home delivered meals after hospital stay; travel benefit; $200 towards weight mgmt/nutrition counseling, acupucture, massage or bathroom safety devices	$200 towards Gym/Yoga membership; worldwide emergency coverage; telemedicine	$200 towards Gym/Yoga membership; worldwide emergency coverage; telemedicine;	$200 towards Gym/Yoga membership; worldwide emergency coverage; telemedicine; $200 towards weight mgmt/nutrition counseling, acupucture, massage or bathroom safety devices

UNION COUNTY MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION COVERAGE 2021

PLAN	Amerivantage Classic HMO *from Amerigroup* H3240-022 1-877-470-4131 shop.amerigroup.com/medicare	Amerivantage Balance HMO *from Amerigroup* H3240-021 844-316-0355 shop.amerigroup.com/medicare	Humana Choice PPO H5216-169 1-800-833-2364 human.com/medicare	Humana Choice PPO H5216-172 1-800-833-2364 human.com/medicare	Humana Choice PPO H5216-170 1-800-833-2364 human.com/medicare	Humana Gold Plus HMO H6622-063 1-800-833-2364 human.com/medicare
Monthly Premium	$0	$37.30 ($0 with PAAD)	$0	$0 plus $40/mth reduction in Part B Premium	$33 ($0 with PAAD/ $12.20 LIS)	$0
Medical Deductible	$0	$0	$0	**$400 Deductible combined for some in and OON services**	$0	$0
Drug Deductible	$0 Tier 1 & 2/ $200 others	$0 Tier 1 / $445 others	$0 Tier 1 & 2/ $275 others	$0 Tier 1 & 2/ $295 others	$0 Tier 1, 2 & 3/ $250 others	$0 Tier 1,2,3/ $275 others
Primary doctor copay	$5	$0	$ 0 in- Network/ $10 OON	$ 0 in- Network; $15 OON	$ 0 in- Network/ $5 OON	$0
Specialist copay	$25	$25	$30 in network/ $40 OON	$50 in network/ $60 OON	$ 20 in- Network/ $25 OON	$30
Referrals Required?			No	No	No	No
Hospital copays	$350 per day 1 to 5 days	$325 per day 1 to 5 days	$320 per day for days 1 to 6 in or OON	After deductible: $550 per stay IN; $1000 per stay OON	$275 per day for days 1 to 5 in or OON	$320 per day for days 1 to 5
ER copay/ Urgency Care	$90/$65	$90/ $65	$90/$25 IN; $90/$30 OON	After deductible: $90/$25 in Network; $90/$30 OON	$90/$20 in Network; $90/$25 OON	$90/$25
Ambulance	$300	$350	$290	After deductible: $290	$290	$270
Outpatient surgery	$295 Hosp. $250 ASC.	$275 Hosp. $225 ASC.	$270 - $320 in or OON	After deductible: $450/ $500	$225/$275	$270 to $320
Lab services	$0	$0	$0-$30 in Network; $0-$40 OON	$0-$50 in network/ $0-$60 OON	$0-$20 inNetwork; $0-25 OON	$0 to $30
X-Rays	$20 to $30	$45 to $90	In-nework $0-$80; $10 - $90 OON	After deductible: $0-$100 in network/$15-$110 OON	$0-$70 in Network; $5- $75 OON	$0 to $80
Diagnostic tests (ex MRI)	20%	$45 to $90	In-net work $0-$80; OON $10-$90	In-net work $0-$100; $15-$110 OON	$0-$70 in Network; $5- $75 OON	$0 to $80
Member's Max. Out of Pocke	$6,950	$7,550	in network $7,400; OON $11,000	in network $7,550; OON $11,000	in network $6,500; OON $10,000	$7,200
Mental Health visits	$40	$40	$30 - $100 in Network; $40-$100 OON	In-net work $40-$100; OON $60-$110	$20-$100 in Network; $25-$100 OON	$30 - $100
In-patient rehab (SNF)	$0 Day 1-20 $184/day for days 21-100	$0 Day 1-20 $184/day for days 21-100	$0 Day 1-20, $184/day for days 21-100; 20% OON	$0 Day 1-20, $184/day for days 21-100; 20% OON	$0 Day 1-20, $184/day for days 21-100; 20% OON	$0 Day 1-20, $184 day for days 21-100
Outpatient Physical Therapy	$25	$25	in network $30/ OON $40	in network $40/ OON $60	in network $20/ OON $25	$30
Dental benefits	$920 max	$1000 max	Routine*	Routine*	$2,000 max	$2,000 max
Eye Glasses benefits	$100 max	$125 max	$200 max	$100 max	$200 max	$200 max
Hearing Aid Benefits	$2000 max	$2000 max	$699-$999	$699-$999	$399-$699	$699-$999
Medical Equipment Part B drugs Dialysis	20%	20%	20%	13% Part B meds; 17% DME, 20% dialysis	20%	20%
Over the Counter Spending Card for health- related items	**$56/qrt**	**$68/qrt**	**$25/quarter**	None	**$50/quarter**	**$50/quarter**
Supplemental Benefits	Gym-Silver Sneakers; Telehealth; 24/7 NurseLine Worldwide emergency coverage	Gym-Silver Sneakers; Telehealth;Worldwide emergency coverage; home-delivered meals (16 meals up to 4 times per year); in-home support up to 31 days (4 hours per day); $500 for in-home safety devices; Transportation 40 one-way trips (up to 60 miles distance); Personal Emergency Response System (PERS);	*Additional dental plans available for premium $29.50 or $41.30 per month; gym membership; travel coverage; home delivered meals after hospital stay; telehealth	*Comprehensive Dental additional premium $29.50 and $41.30; gym membership; travel coverage; home delivered meals after hospital stay; telehealth	Additional dental plans available for premium $41.30 per month; gym membership; travel coverage; home delivered meals after hospital stay;telehealth; transportation- 24 one-way trips up to 25 miles	gym membership, home delivered meals after hospital stay; telehealth

UNION COUNTY MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION COVERAGE 2021

PLAN	Wellcare Value HMO-POS H0913-002 1-866-527-0056 wellcare.com	Wellcare Compass HMO H0913-015 1-866-527-0056 wellcare.com	*New for 2021* Wellcare Absolute PPO H8711-002 1-866-527-0056 wellcare.com	*New for 2021* Wellcare Premier PPO H8711-001 1-866-527-0056 wellcare.com
Monthly Premium	$0	$28.20 ($0 with PAAD)	$0 plus $60/mth reduction in Part B premium	$0
Medical Deductible	$0	$0	$0	$0
Drug Deductible	$0	$0 tier 1, $445 others	$0 Tier 1, $200 others	$0 Tier 1, $150 others
Primary doctor copay	$5 IN/ 40% OON,	$0	$0 IN 40% coinsurance Out	$0 In and OON
Specialist copay	$30 IN/ 40% OON,	$25	$45 IN 40% coinsurance Out	$25 In and OON
Referrals Required?	YES	YES	No	No
Hospital copays	$385 per days 1-5/ 40% OON	$330 per days 1-4 not covered OON	$325/day days 1-4 IN 20% coinsurance days 1-90 Out	$400 for days 1-4 In and OON
ER copay/ Urgency Care	$90 / $25	$90 / $25	$90 Emergency $40 Urgent Care	$225
Ambulance	$255	$260	$225	$225
Outpatient surgery	Hospital: $250 In, 20%/service; 40% coinsurance Out Ambulatory : $150 In, 40% out	Hospital: $250 In, 20%/service Ambulatory : $150 In Not covered OON	Hospital: $350 In; 40% Out Ambulatory : $250 In, 40% out	Hospital: $300 In and Out Ambulatory : $250 In and Out
Lab services	$0 In Network 40% OON	$0 In Network not covered OON	$0 IN 40% coinsurance Out	$0 In and OON
X-Rays	$0 In Network 40% OON	$0 In Network not covered OON	$0 IN 40% coinsurance Out	$0 In and OON
Diagnostic tests (ex MRI)	$0 to $250 copay In Network 40% OON	$0 to $250 copay In Network not covered OON	$0-$350 copay IN 40% coinsurance Out	$0-$300 copay In and OON
Member's Max. Out of Pocke	$7,550 combined in and OON	$6,700 IN not covered OON	$7,550 IN $11,300 Combined In/Out	$7,550 IN $11,300 Combined In/Out
Mental Health visits	$40 copay In Network 40% OON	$40 copay In Network not covered OON	$40 IN 40% coinsurance Out	$40 In and OON
In-patient rehab (SNF)	$0 days 1-20, $165 /day 21-100 In 40% OON	$0 days 1-20, $172 /day days 21-100	$0 days 1-20, $184/day days 21-100 ; 20% OON	$0 days 1-20, $184/day days 21-100 in or OON
Outpatient Physical Therapy	$25 copay in network 40% OON	$25 copay In Network not covered OON	$40 IN 40% coinsurance Out	$25 In and OON
Dental benefits	Yes $500 max	Yes $1000 max	$0 copay basic preventative In 50% coinsurance Out	Yes, $1,000 max
Eye Glasses benefits	Yes $100 max	Yes $100 max	Yes, $100 max	Yes, $100 max
Hearing Aid Benefits	Yes $1,000 max	Yes $1,000 max	$700	$1,500
Medical Equipment Part B drugs Dialysis	20% In Network 40% OON	20% In Network not covered OON	20% coinsurance IN 20-40% coinsurance Out	20-30% In and OON
Over the Counter Spending Card for health- related items	**$30/ quarter**	**$100 / quarter;**	**$25/quarter**	**$44/quarter**
Supplemental Benefits	Fitness; Personal Emergency Response System (PERS); World Wide Emergency Coverage	Fitness; Personal Emergency Response System (PERS); World Wide Emergency Coverage; Transportation (24 one-way trips); In-Home Services 12 2 hour visits	Fitness; World Wide Emergency Coverage	Fitness; World Wide Emergency Coverage; $200 Flex card towards dental, vision or hearing aids