# 2017 Medicare Advantage Plan Comparison Chart for Monroe County (Prepared by Lifespan (585) 244-8400 x113

| BENEFIT | EXCELLUS BLUE CHOICE PLANS<br>Phone: 800-659-1986 (Excellus Plans Accepted at all Local Hospitals) | | | | |
|---|---|---|---|---|---|
| | Select (HMO-POS) | Value (HMO) | Value Plus (HMO) | Optimum (HMO-POS) | Platinum (HMO-POS) |
| Medicare Star Rating (5 Stars Max.) | 4 (in 2016) | 4 (in 2016) | 4 (in 2016) | 4 (in 2016) | 4 (in 2016) |
| Monthly Premium | $0 | $60 | $128 | $230 | $190 (No Drug Coverage) |
| Hospitalization - Inpatient | *$360/day days 1-5 Days 6+ @ $0 ($315 days 1-5 Mentl Health)* | *$360/day days 1-5 Days 6+ @ $0 ($315 days 1-5 Mentl Health)* | $310/day days 1-5 Days 6+ @ $0 | $285/day days 1-5 Days 6+ @ $0 | $260/day days 1-5 Days 6+ @ $0 |
| Hospital - Observation | *20%* | *$390* | $380 | $250 | $250 |
| Skilled Nursing Facility for Rehab | Days 1-20 @ $0 Days 21-100 $160/day | Days 1-20 @ $0 Days 21-100 $160/day | Days 1-20 @ $0 Days 21-100 $140/day | Days 1-20 @ $0 Days 21-100 $125/day | Days 1-20 @ $0 Days 21-100 $120/day |
| Primary Care Physician / Specialist | $15 / $50 | $10 / $50 | $10 / $45 | $10 / $40 | $15 / $40 |
| Chiropractic (Spinal Manipulation) | $20 (w/ referral) | $10 (w/ referral) | $10 (w/ referral) | $10 (w/ referral) | $15 (w/ referral) |
| Outpatient - Hospital / Surgical Facil. | 20% / 20% | $390 / $390 | $380 / $380 | $250 / $250 | $250 / $250 |
| Outpatient - Mental Health | 20% | 20% | 20% | 20% | 20% |
| Ambulance (May need Authorization) | $240 | $240 | $175 | $150 | $150 |
| Emergency-*Worldwide / Urgent-in US* | $75 / $65 | $75 / $40 | $75 / $40 | $75 / $40 | $75 / $50 |
| Durable Med Equip. & Prosthetics | 20% | 20% | 20% | 20% | 20% |
| Diagnostic: Lab / Other Procedures | $25 | $15 | $15 | $0 | $10 |
| X - Rays (Standard) | $60 | $50 | $50 | $40 | $40 |
| Diag. Radiology (MRI, CT, PET, etc.) | 20% | 20% | $175 | $150 | $150 |
| Radiation Therapy (co-pay may apply) | 20% | 20% | 20% | 20% | 20% |
| Renal Dialysis -Office co-pay may apply | 20% | 20% | 20% | 20% | 20% |
| Part B Drugs & Chemotherapy | 20% | 20% | 20% | 20% | 20% |
| Part D Prescription Drug Retail Co-Pays (30 day supply - Discounts for mailorder) | $0/$15/$47/$100/25% ($360 Deduct. Tiers 3-5) | $0/$15/$47/$100/28% ($225 Deduct. Tiers 3-5) | $0/$15/$47/$100/33% | $0/$12/$47/$100/33% | No Drug Coverage |
| Diabetic Monitoring Supplies | 20% @ Preferred Suppliers | 20% @ Preferred Suppliers | 20% @ Preferred Suppliers | 20% @ Preferred Suppliers | 20% @ Preferred Suppliers |
| Preventive Dental: (Oral Exams/Cleanings/X-rays) | No Coverage | No Coverage | 2 Visit Allowance at any Dentist | 2 Visit Allowance at any Dentist | No Coverage |
| Hearing Exam / Hearing Aid Allow. | $50 / No Allowance | $50 / No Allowance | $45 / No Allowance | $40 / No Allowance | $40 / No Allowance |
| Routine Vision Exam / Glasses Allow. | $50 Exam / No Allow. | $50 Exam / No Allow. | $45 / $75 Allow. | $40 / $120 Allow. | $40 / $120 Allow. |
| Health Clubs / Wellness Programs | $25/yr Silver & Fit $150 Allow. For Non-Partic. | $25/yr Silver & Fit $150 Allow. For Non-Partic. | $25/yr Silver & Fit $150 Allow. For Non-Partic. | $25/yr Silver & Fit $150 Allow. For Non-Partic. | $25/yr Silver & Fit $150 Allow. For Non-Partic. |
| Travel Benefits - Out of Network | 30% co-pay (OoN) ($3000 Max Benefit) | Emergency Only | Emergency Only | 30% co-pay (OoN) ($3000 Max Benefit) | 30% co-pay (OoN) ($3000 Max Benefit) |
| Maximum Out of Pocket Expense (After which Plan pays 100%) Excludes premiums, drugs and uncovered costs | $6,700 In Network | $6,700 | $6,700 | $6,700 In Network | $5,500 In Network |

**Note:** The information provided is current as of Oct. 1, 2016. Please refer to documents provided by each plan for the most detailed and up-to-date information

Prepared by: R Brandwein-Monroe Cnty HIICAP Coord.
and N Thayer and J Tinch - HIICAP Counselors 10/9/16

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# 2017 Medicare Advantage Plan Comparison Chart for Monroe County (Prepared by Lifespan (585) 244-8400 x113

| BENEFIT | MVP HEALTH CARE PLANS Phone: 800-324-3899 (MVP Plans are Accepted at all local hospitals) | | | UNIVERSAL AMERICAN Todays Option |
|---|---|---|---|---|
| | Gold Value HMO-POS | Preferred Gold HMO w/o Drugs | WellSelect PPO | Advantage 300 PPO |
| Medicare Star Rating (5 Stars Max.) | 4.5 (in 2016) | 4.5 (in 2016) | 4.5 (in 2016) | Rating Not Available Yet |
| Monthly Premium | $192.80 | $99.90 (No Drug Coverage) | $59.10 | $0.00 (No Drug Coverage) |
| Hospitalization - Inpatient | Days 1-4 @ $400/day<br>> 4 Days @ $0<br>Mental Hlth Hosp. Days 1-5 @ $295 | Days 1-5 @ $295/day<br>> 5 Days @ $0 | Days 1-4 @ $450 ($315 Mentl. Hlth.)<br>>4 days @ $0 (IN Network)<br>40% (Out of Network) | (IN) Days 1-6 $260 /day; Then $0<br>(Only RRH Hospitals In Network)<br>(OUT) Days 1-7 $300 /da;Then $0 |
| Hospital - Observation | $250/Stay | $225/Stay | $300 (IN) - 40% (OUT) | Copay for Treatment Provided |
| Skilled Nursing Facility for Rehab | Days 1-20 @ $0<br>Days 21-100 $160/day | Days 1-20 @ $0<br>Days 21-100 $160/day | (IN) Days 1-20 @ $0<br>Days 21-100 $160/day<br>(OUT) 40% | (IN and OUT) Days 1-20 @ $0/day<br>(IN) Days 21-100 @$100 /day<br>(OUT) Days 21- 100 @ $150/day |
| Primary Care Physician / Specialist | $15 / $40 (No Referral Needed) | $15 / $30 (No Referral Needed) | $15 / $50 (IN) $60 / $60 (OUT) | $5 / $30 (IN) - $15 / $50 (OUT |
| Chiropractic (Spinal Manipulation) | $20 | $20 | $20 (IN) or (OUT) | $20 (IN) - 25% (OUT) |
| Outpatient - Hospital / Surgical Facil. | $300 / $150 | $225 / $100 | $600/$300 (IN)- 40% OUT | $200 / $150 (IN) - 25% (OUT) |
| Outpatient - Mental Health | $40 (Need Authorization) | $30 (Need Authorization) | $40(In) - $60(Out) (Need Authoriz.) | $40 (IN) - 25% (OUT) |
| Ambulance (May need Authorization) | $150 | $75 | $200 | $300 (IN & OUT) |
| Emergency-*Worldwide / Urgent-in US* | $75 / $40 | $75 / $30 | $75 / $60 | $75 in US / $35 in US |
| Durable Med Equip. & Prosthetics | 20% | 20% | 20% (IN) - 40% (OUT) | 20% (IN) - 25% (OUT) |
| Diagnostic: Lab / Other Procedures | $10 / $10 | $10 / $10 | $20 / $20 (IN) - 40% (OUT) | $0 / $0 (IN) - 25% (OUT) |
| X - Rays (Standard) | $40 | $30 | $60 (IN) - $60 (OUT) | $15 (IN) - 25% (OUT) |
| Diag. Radiology (MRI, CT, PET, etc.) | $100 | $60 | 20% (IN) - 40% (OUT) | 20% (IN) - 25% (OUT) |
| Radiation Therapy (co-pay may apply) | 20% | 20% | 20% (IN) - 40% (OUT) | 20% (IN) - 25% (OUT) |
| Renal Dialysis -Office co-pay may apply | 20% | 20% | 20% (IN) - 20% (OUT) | 20% (IN) - 25% (OUT) |
| Part B Drugs & Chemotherapy | 20% | 20% | 20% (IN) - 40% (OUT) | 20% (IN) - 25% (OUT) |
| Part D Prescription Drug Retail Co-Pays<br>(30 day supply - Discounts for mailorder) | $0/$10/$40/50%/33%/$0<br>(No Drug Deductible) | No Part D Drug Coverage | $1/$11/$47/50%/25%/$0<br>($400 Deduct for Tiers 2-5) | No Drug Coverage |
| Diabetic Monitoring Supplies | 10% or 20% | 10% or 20% | 10% or 20% (IN) - 40% (OUT) | $0 - For Preferred Brands<br>20% - 25% Other Suppliers |
| Preventive Dental:<br>(Oral Exams/Cleanings/X-rays) | $240/yr. Prevention Allowance | No Coverage | No Coverage | No Coverage |
| Hearing Exam / Hearing Aid Allow. | $40 / $699 or $999 copay | $30 / $699 or $999 copay | Exam $50 (IN) - $60 (OUT) /<br>$699 or $999 copay for Aide | Exam $20 (IN) - 25% (OUT)<br>No Hearing Aide Allowance |
| Routine Vision Exam / Glasses | $40 / $75 Glasses / 2 yrs | $30 / $100 glasses / 2 yrs | $50 (IN) - $60 (OUT)/No Glasses | $0 (IN) - 25% (OUT) /No Glasses |
| Health Clubs / Wellness Programs | $0 for Silver Sneakers<br>Plus $75 Wellness Reward | $0 for Silver Sneakers<br>Plus $75 Wellness Reward | $0 for Silver Sneakers<br>Plus $75 Wellness Reward | No Health Club |
| Travel Benefits - Out of Network | 30% copay Out of Netwrk<br>($2500 Maximum Benefit) | 30% copay Out of Netwrk<br>($2500 Maximum Benefit) | $60 Office Visit<br>40% Other | The Plan's Out of Network Rates |
| Maximum Out of Pocket Expense<br>(After which Plan pays 100%)<br>Excludes premiums, drugs and uncovered costs | $6,700 | $5,500 | $6,700 (IN)<br>$10,000 (IN and OUT) | $6,700 (IN)<br>$6,700 (IN) and (OUT) |

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| | AETNA PLANS Phone:844-364-2146 (RRH Hospitals not in Network) | | UNIVERSAL AMERICAN PLANS - 866-249-8668 (RRH Hospitals Only) | |
|---|---|---|---|---|
| **BENEFIT** | **Premier PPO Plan** | **Elite PPO Plan w/ Part D Drugs** | **Todays Option** | **Today's Options** |
| | **With Part D Drugs** | *** (With $1000 Deduct. for Major Things)** | **Advantage Plus 550B PPO** | **Advantage Plus 150A PPO** |
| **Medicare Star Rating (5 Stars Max.)** | **4.5 (in 2016)** | **Rating Not Available Yet** | **Rating Not Available Yet** | **Rating Not Available Yet** |
| **Monthly Premium** | **$39.00** | **$0.00** | **$37.00** | **$130.00** |
| **Hospitalization - Inpatient** | (IN) Days 1-5 @$360/da. Then $0<br>(IN) Mental Health $1528 /Stay<br>(OUT) Days 1-5 @$360. Then $0 | (IN) Days 1-5 @$225/da. Then $0<br>* (IN) Mental Health $1528 /Stay<br>(OUT) Days 1-5 @$325. Then $0 | (IN) Days 1-5 $295 /day; Then $0<br>(Only RRH Hospitals In Network)<br>(OUT) Days 1-7 $300 /da;Then $0 | (Network-RRH Only) $450 per STAY<br>(OUT) Days 1-7 @ $250 / DAY<br>Days 8-90 @$0 |
| **Hospital - Observation** | $45 + Copays (IN) - 30% to 40% (OUT) | * $40 + Copays (IN) - 20% (OUT) | **Copay for Treatment Provided** | CoPays for Treatment Provided |
| **Skilled Nursing Facility for Rehab** | (IN) Days 1-20 @ $0<br>(IN) Days 21-100 @$164.50/day<br>(OUT) @40% | (IN) Days 1-20 @ $0/day<br>* (IN) Days 21-100 @$164.50<br>(OUT) @20% | (IN and Out) Days 1-20 @ $0/day<br>(IN) Days 21-100 @$150 /day<br>(OUT) Days 21- 100 @ $200/day | (IN and OUT) Days 1-20 @ $0<br>(IN) Days 21-100 @ $75/Day<br>(OUT) Days 21-100 @$150 / Day |
| **Primary Care Physician / Specialist** | **$20 / $45 (IN) - 30% to 40% (OUT)** | **$10 / $40 (IN) - 20% / 20% (OUT)** | **$10 / $35 (IN) - $25 / $60 (OUT** | $0 / $25 (IN) - $10 / $35 (OUT) |
| **Chiropractic (Spinal Manipulation)** | **$20 (IN) - 40% (OUT)** | **$20 (IN) - 20% (OUT)** | **$20 (IN) - 25% (OUT)** | **$20 (IN) - 25% (OUT)** |
| **Outpatient - Hospital / Surgical Facil.** | **$325 (IN) - 30% (OUT)** | *** $350 (IN) - 20% (OUT)** | **$300 / $250 (IN) - 25% (OUT)** | **$150 / $75 (IN) - 25% (OUT)** |
| **Outpatient - Mental Health** | **$40 (IN) - 40% (OUT)** | **$40 (IN) - 20% (OUT)** | **$40 (IN) - 25% (OUT)** | **$30 (IN) - 25% (OUT)** |
| **Ambulance (May need Authorization)** | **$300 (IN & OUT)** | *** $300 (IN & OUT)** | **$300 (IN & OUT)** | **$300** |
| **Emergency-*Worldwide / Urgent-in US*** | **$75 / $45** | **$75 / $40** | **$75 in US / $35 in US** | **$75 / $35** |
| **Durable Med Equip. & Prosthetics** | **20% (IN) - 20% or 40% (OUT)** | **20% (IN & OUT)** | **20% (IN) - 25% (OUT)** | **20% (IN) - 25% (OUT)** |
| **Diagnostic: Lab / Other Procedures** | **$5 / $40 (IN) - 40% (OUT)** | **$0 / * $40 (IN) - 20% (OUT)** | **$0 / $0 (IN) - 25% (OUT)** | **$0 / $0 (IN) - 25% (OUT)** |
| **X - Rays (Standard)** | **$45 (IN) - 40% (OUT)** | **$50 (IN) - 20% (OUT)** | **$15 (IN) - 25% (OUT)** | **$15 (IN) - 25% (OUT)** |
| **Diag. Radiology (MRI, CT, PET, etc.)** | **20% (IN) - 30% (OUT)** | *** $200 (IN) - 20% (OUT)** | **20% (IN) - 25% (OUT)** | **20% (IN) - 25% (OUT)** |
| **Radiation Therapy** (co-pay may apply) | **20% (IN) - 40% (OUT)** | *** 20% (IN & OUT)** | **20% (IN) - 25% (OUT)** | **20% (IN) - 25% (OUT)** |
| **Renal Dialysis -**Office co-pay may apply | **20% (IN & OUT)** | *** 20% (IN & OUT)** | **20% (IN) - 25% (OUT)** | **20% (IN) - 25% (OUT)** |
| **Part B Drugs & Chemotherapy** | **20% (IN) - 40% (OUT)** | **20% (IN & OUT)** | **20% (IN) - 25% (OUT)** | **20% (IN) - 25% (OUT)** |
| **Part D Prescription Drug Retail Co-Pays (30 day supply - Discounts for mailorder)** | $2/$5/$47/$100/29%<br>At Preferred Pharmacies<br>($200 Drug Deductible Tiers 3-5 ) | $2/$5/$47/$100/29%<br>At Preferred Pharmacies<br>($200 Drug Deductible Tiers 3-5 ) | **$2/$7/$37/$90/33%<br>@ Preferred Pharmacies** | **$0/$5/$35/$75/33%<br>(At Preferred Pharmacies)** |
| **Diabetic Monitoring Supplies** | $0 - @ OneTouch & Lifescan<br>20% Other Suppliers | $0 - @ OneTouch and Lifescan<br>20% Other Suppliers | $0 - For Preferred Brands<br>20% - 25% Other Suppliers | $0 for Preferred Brands<br>20% - 25% at other suppliers |
| **Preventive Dental:<br>(2 Oral Exams/Cleanings/X-rays)** | **$350 Prevent. Allow.-any dentist<br>Pre-Authoriz. may be required** | **$150 Prevent. Allow.-any dentist<br>Pre-Authoriz. may be required** | $0 to $5 copay (IN) - 25% (OUT)<br>$500 Preventive Allowance<br>$500 Comprenensive Allowance | $0 to $5 copay (IN) - 25% (OUT)<br>$500 Preventive Allowance<br>$500 Comprenensive Allowance |
| **Hearing Exam / Hearing Aid Allow.** | **Exam $0 (IN) / 40% (OUT) -<br>No Hearing Aide Allowance** | **Exam $0 (IN) / 20% (OUT) -<br>No Hearing Aide Allowance** | **Exam $20 (IN) - 25% (OUT)<br>No Hearing Aide Allowance** | **Exam $20 (IN) - 25% (OUT)<br>No Hearing Aide Allowance** |
| **Routine Vision Exam / Glasses** | **$0 (IN) / 40% (OUT)** - No Glasses | **$0 (IN) / 20% (OUT)**- $125Allow. / yr | **$0 (IN) - 25% (OUT) /No Glasses** | **$0 (IN) - 25% (OUT) /No Glasses** |
| **Health Clubs / Wellness Programs** | **$0 @ Participating Health Clubs** | **$0 @ Participating Health Clubs** | **No Health Club** | **No Health Club** |
| **Travel Benefits - Out of Network** | The Plan's Out of Network Rates<br>(With $1000 Deductible for OoN Costs) | The Plan's Out of Network Rates<br>(With $1000 Deductible for OoN Costs) | **The Plan's Out of Network Rates** | **The Plan's Out of Network Rates** |
| **Maximum Out of Pocket Expense**<br>(After which Plan pays 100%)<br>Excludes premiums, drugs and uncovered costs | **$6,700 (IN)<br>$10,000 (IN & OUT)** | **$6,700 (IN)<br>$10,000 (IN & OUT)** | **$6,700 (IN)<br>$6700 (IN) and (OUT)** | **$3,400 (IN)<br>$3,400 (IN) and (OUT)** |

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| | UNITED HEALTH CARE PLANS (Accepted at All Local Hospitals) Phone: 844-846-3400 | | | | | |
|---|---|---|---|---|---|---|
| **BENEFIT** | **Complete Choice PPO Plan 1** | | **Complete Choice PPO Plan 3** | | **Complete Choice PPO Plan 4** | |
| | **(In Network)** | **(Out of Network)** | **(In Network)** | **(Out of Network)** | **(In Network)** | **(Out of Network)** |
| **Medicare Star Rating (5 Stars Max.)** | **3.5 (in 2016)** | | **3.5 (in 2016)** | | **3.5 (in 2016)** | |
| **Monthly Premium** | **$0 / mo.** | | **$36 / mo.** | | **$66 / mo.** | |
| **Hospitalization - Inpatient** | **Days 1-4 @ $395 / Day > 4 days @ $0** | **Days 1-20 @ $500 /Day > 20 days @ $0** | **Days 1-4 @ $325 / Day > 4 days @ $0** | **Days 1-20 @ $500 /Day > 20 days @ $0** | **Days 1-4 @ $295 / Day > 4 days @ $0** | **Days 1-20 @ $500 /Day > 20 days @ $0** |
| **Hospital - Observation** | **20%** | **40%** | $295 /day | 40% | $250 /day | 40% |
| **Skilled Nursing Facility for Rehab** | **Days 1-20 @ $0/day Days 21 - 62 @$160/Day Days 63 - 100 @ $0/Day** | **Days 1- 40 @$250/day Days 41 - 100 @$0/Day** | **Days 1-20 @ $0/day Days 21 - 57 @$160/Day Days 58 - 100 @ $0/Day** | **Days 1- 40 @$250/day Days 41 - 100 @$0/Day** | **Days 1-20 @ $0/day Days 21 - 54 @$160/Day Days 55 - 100 @ $0/Day** | **Days 1- 40 @$250/day Days 41 - 100 @$0/Day** |
| **Primary Care Physician / Specialist** | **$10 / $45** | **$50 / $75** | $5 / $30 | $50 / $75 | $0 / $25 | $50 / $75 |
| **Chiropractic (Spinal Manipulation)** | **$20** | **$75** | $20 | $75 | $20 | $75 |
| **Outpatient - Hospital / Surgical Facil.** | **20%** | **40%** | $295 | 40% | $250 | 40% |
| **Outpatient - Mental Health** | **$30 Group - $40 Individ.** | **$35 Group - $45 Individ.** | **$30 Group - $40 Individ.** | **$35 Group - $45 Individ.** | **$30 Group - $40 Individ.** | **$35 Group - $45 Individ.** |
| **Ambulance (May need Authorization)** | **$250** | **$250** | **$250** | **$250** | **$250** | **$250** |
| **Emergency-*Worldwide / Urgent-in US*** | **$75 / $30** | **$75 / $40** | **$75 / $30** | **$75 / $40** | **$75 / $25** | **$75 / $40** |
| **Durable Med Equip. & Prosthetics** | **20%** | **40% - 50%** | **20%** | **40% - 50%** | **20%** | **40% - 50%** |
| **Diagnostic: Lab / Other Procedures** | **$10 / 20%** | **$10 / 40%** | **$10 / 20%** | **$10 / 40%** | **$10 / 20%** | **$10 / 40%** |
| **X - Rays (Standard)** | **$11** | **$16** | **$14** | **$21** | **$14** | **$21** |
| **Diag. Radiology (MRI, CT, PET, etc.)** | **20%** | **40%** | **20%** | **40%** | **20%** | **40%** |
| **Radiation Therapy** (co-pay may apply) | **20%** | **40%** | **20%** | **40%** | **20%** | **40%** |
| **Renal Dialysis -**Office co-pay may apply | **20%** | **20%** | **20%** | **20%** | **20%** | **20%** |
| **Part B Drugs & Chemotherapy** | **20%** | **40%** | **20%** | **40%** | **20%** | **40%** |
| **Part D Prescription Drug Retail Co-Pays (30 day supply - Discounts for mailorder)** | **$2/$12/$47/$100/27% ($290 Deduct. Tiers 3-5)** | **Limited Out of Network Pharmacy Coverage** | **$2/$8/$45/$95/30% ($150 Deduct. Tiers 3-5)** | **Limited Out of Network Pharmacy Coverage** | **$2/$8/$45/$95/33%** | **Limited Out of Network Pharmacy Coverage** |
| **Diabetic Monitoring Supplies** | **$0 - Specific Brands** | **40%** | **$0 - Specific Brands** | **40%** | **$0 - Specific Brands** | **40%** |
| **Preventive Dental: (2 Oral Exams/Cleanings/X-rays)** | **Additional $36 / mo. for a Dental Rider ($1000 Max Benefit with $100 Deductible)** | | **Additional $36 / mo. for a Dental Rider ($1000 Max Benefit with $100 Deductible)** | | **$0 Copay at UHC Dental Plan Dentists May have higher copays at non-network dentists (Max. Benefit $500 Preven.+$500 comprehensive)** | |
| **Hearing Exam / Hearing Aid Allow.** | **$10 Exam / $330-$380 copay on Aide** | **$75 Exam / $330-$380 copay on Aide** | **$5 Exam / $330-$380 copay on Aide** | **$75 Exam / $330-$380 copay on Aide** | **$0 Exam / $330-$380 copay on Aide** | **$75 Exam / $330-$380 copay on Aide** |
| **Routine Vision Exam / Glasses** | **$20 / No Glasses** | **$75 / No Glasses** | **$20 / No Glasses** | **$75 / No Glasses** | **$20 / No Glasses** | **$75 / No Glasses** |
| **Health Clubs / Wellness Programs** | **$18/mo. Silver Sneakers Rider Available $50 / Quarter Credit for OTC Items** | | **$0 for Silver Sneakers** | **$0 Slvr Snkrs Step Kit** | **$0 for Silver Sneakers** | **$0 Slvr Snkrs Step Kit** |
| **Travel Benefits - Out of Network** | **Passport Program or Out of Network Rates** | | **Passport Program or Out of Network Rates** | | **Passport Program or Out of Network Rates** | |
| **Maximum Out of Pocket Expense** (After which Plan pays 100%) Excludes premiums, drugs and uncovered costs | **$6,700 (IN Network)** | **$10,000 (IN & OUT of Ntwrk)** | **$5,900 (IN Network)** | **$10,000 (IN & OUT of Ntwrk)** | **$5,400 (IN Network)** | **$10,000 (IN & OUT of Ntwrk)** |

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