

2017 Medicare Advantage Plan Comparison Chart for Monroe County Prepared by Lifespan 585-244-8400 ext. 113

BENEFIT	EXCELLUS BLUE CHOICE PLANS				
	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	4	4	4	4
Monthly Premium	\$0	\$60	\$128	\$230	\$190 (No Drug Coverage)
Hospitalization - Inpatient	\$360/day days 1-5 Days 6+ @ \$0 (\$315 days 1-5 Mental Health)	\$360/day days 1-5 Days 6+ @ \$0 (\$315 days 1-5 Mental 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. 31, 2016. Refer to documents provided by each plan for the most detailed & up-to-date information. Check with your doctor(s).

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BENEFIT	MVP HEALTH CARE PLANS Phone: 800-324-3899			UNIVERSAL AMERICAN
	(MVP Plans are Accepted at all local hospitals)			Today's Option
	Gold Value HMO-POS	Preferred Gold HMO w/o Drugs	WellSelect PPO	Advantage 300 PPO
Medicare Star Rating (5 Stars Max.)	4.5	4.5	4.5	4.0
Monthly Premium	\$192.80	\$99.90 (No Drug Coverage)	\$59.10	\$0.00 (No Drug Coverage)
Hospitalization - Inpatient	Days 1-4 @ \$400/day > 4 Days @ \$0 Mental Hlth Hosp. Days 1-5 @ \$295	Days 1-5 @ \$295/day > 5 Days @ \$0	Days 1-4 @ \$450 (\$315 Mentl. Hlth.) >4 days @ \$0 (IN Network) 40% (Out of Network)	(IN) Days 1-6 \$260 /day; Then \$0 (Only RRH Hospitals In Network) (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 Days 21-100 \$160/day	Days 1-20 @ \$0 Days 21-100 \$160/day	(IN) Days 1-20 @ \$0 Days 21-100 \$160/day (OUT) 40%	(IN and OUT) Days 1-20 @ \$0/day (IN) Days 21-100 @ \$100 /day (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 (30 day supply - Discounts for mailorder)	\$0/\$10/\$40/50%/33%/\$0 (No Drug Deductible)	No Part D Drug Coverage	\$1/\$11/\$47/50%/25%/\$0 (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 20% - 25% Other Suppliers
Preventive Dental: (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) / \$699 or \$999 copay for Aide	Exam \$20 (IN) - 25% (OUT) 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 Plus \$75 Wellness Reward	\$0 for Silver Sneakers Plus \$75 Wellness Reward	\$0 for Silver Sneakers Plus \$75 Wellness Reward	No Health Club
Travel Benefits - Out of Network	30% copay Out of Netwrk (\$2500 Maximum Benefit)	30% copay Out of Netwrk (\$2500 Maximum Benefit)	\$60 Office Visit 40% Other	The Plan's Out of Network Rates
Maximum Out of Pocket Expense (After which Plan pays 100%) Excludes premiums, drugs and uncovered costs	\$6,700	\$5,500	\$6,700 (IN) \$10,000 (IN and OUT)	\$6,700 (IN) \$6,700 (IN) and (OUT)

Note: The information provided is current as of Oct. 31 2016. Refer to documents provided by each plan for the most detailed and up-to-date information & check with your doctor.

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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	Today's 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.)	4.0	4	4.0	4
Monthly Premium	\$39.00	\$0.00	\$37.00	\$130.00
Hospitalization - Inpatient	(IN) Days 1-5 @\$360/da. Then \$0 (IN) Mental Health \$1528 /Stay (OUT) Days 1-5 @\$360. Then \$0	*(IN) Days 1-5 @\$225/da. Then \$0 * (IN) Mental Health \$1528 /Stay (OUT) Days 1-5 @\$325. Then \$0	(IN) Days 1-5 \$295 /day; Then \$0 (Only RRH Hospitals in Network) (OUT) Days 1-7 \$300 /da;Then \$0	(Network-RRH Only) \$450 per STAY (OUT) Days 1-7 @ \$250 / DAY Days 8-90 @\$0
Hospital - Observation	\$45 + Copays (IN) - 30% (OUT)	* \$40 + Copays (IN) - 20% (OUT)	Copay for Treatment Provided	CoPays for Treatment Provided
Skilled Nursing Facility for Rehab	(IN) Days 1-20 @ \$0 (IN) Days 21-100 @\$164.50/day (OUT) @40%	(IN) Days 1-20 @ \$0/day * (IN) Days 21-100 @\$164.50 (OUT) @20%	(IN and Out) Days 1-20 @ \$0/day (IN) Days 21-100 @\$150 /day (OUT) Days 21- 100 @ \$200/day	(IN and OUT) Days 1-20 @ \$0 (IN) Days 21-100 @ \$75/Day (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% At Preferred Pharmacies (\$200 Drug Deductible Tiers 3-5)	\$2/\$5/\$47/\$100/29% At Preferred Pharmacies (\$200 Drug Deductible Tiers 3-5)	\$2/\$7/\$37/\$90/33% @ Preferred Pharmacies	\$0/\$5/\$35/\$75/33% (At Preferred Pharmacies)
Diabetic Monitoring Supplies	\$0 - @ OneTouch & Lifescan 20% Other Suppliers	\$0 - @ OneTouch and Lifescan 20% Other Suppliers	\$0 - For Preferred Brands 20% - 25% Other Suppliers	\$0 for Preferred Brands 20% - 25% at other suppliers
Preventive Dental: (2 Oral Exams/Cleanings/X-rays)	\$350 Prevent. Allow.-any dentist	\$150 Prevent. Allow.-any dentist	\$0 to \$5 copay (IN) - 25% (OUT) \$500 Preventive Allowance \$500 Comprehensive Allowance	\$0 to \$5 copay (IN) - 25% (OUT) \$500 Preventive Allowance \$500 Comprehensive Allowance
Hearing Exam/Hearing Aid Allow.	Routine exam \$0 (IN) /40% (OUT) -No Hearing Aide Allowance\$0	Routine exam \$0 (IN) / 20% (OUT) No Hearing Aide Allowance	- Exam \$20 (IN) - 25% (OUT) No Hearing Aide Allowance	Exam \$20 (IN) - 25% (OUT) No Hearing Aide Allowance
Routine Vision Exam / Glasses	(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	Silver Fit\$0@Partic. Health Clubs	Silver Fit \$0@ Partic. Health Clubs	No Health Club	No Health Club
Travel Benefits - Out of Network	The Plan's Out of Network Rates (With \$1000 Deductible for OoN Costs)	The Plan's Out of Network Rates (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 (After which Plan pays 100%) Excludes premiums, drugs and uncovered costs	\$6,700 (IN) \$10,000 (IN & OUT)	\$6,700 (IN) \$10,000 (IN & OUT)	\$6,700 (IN) \$6700 (IN) and (OUT)	\$3,400 (IN) \$3,400 (IN) and (OUT)

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	UNITED HEALTH CARE PLANS (Accepted In-Network at Strong & Highland 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		3.5		3.5	
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 \$1000)	
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%) <small>Excludes premiums, drugs and uncovered costs</small>	\$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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