

2024 EDITION

Health Care Choices

FOR MINNESOTANS ON MEDICARE



m MINNESOTA
SENIOR LINKAGE LINE

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Finding the Information You Need

The 2024 edition of Health Care Choices for Minnesotans on Medicare includes information to help you understand and explore your options, so that you can make informed decisions.

Additional resources

- You can compare and select health and drug coverage at [Medicare.gov](https://www.Medicare.gov) .
 - To get a more personalized experience, create a secure account and log in before doing your research.
- For more information about Medicare eligibility, enrollment, and benefits you can visit our website at mn.gov/senior-linkage-line .

Learn about Medicare

Medicare is a federal health insurance program for people who are 65 and older and certain people with a disability under 65. To learn about the four parts of Medicare, go to each section below.

| | | | |
|--------------------|-------------------|--------------------------|----------------------------------|
| PART A | PART B | PART C | PART D |
| Hospital insurance | Medical insurance | Medicare Advantage Plans | Medicare Prescription Drug plans |
| page 9 | page 10 | page 17 | page 22 |

MEDICARE OPEN ENROLLMENT: OCTOBER 15 - DECEMBER 7


The Senior LinkAge Line receives calls every year from people who failed to review their plan's changes for the coming year. Since Medicare plans can change significantly, it is a good idea to review your current coverage and plan options for the coming year. You should also read every piece of mail you get from Medicare, Social Security and your current plan. Annual plan changes could include:

Medicare Part D

- Monthly premium
- Medications covered by your plan (formulary)
- Cost sharing
- Medication restrictions, such as adding prior authorization, tiering and quantity limits
- Pharmacy network

Medicare Advantage and Cost Plans

- List above also applies to plans that include Part D
- Coverage area
- Monthly premium
- Out-of-pocket maximum cost
- Cost sharing
- Provider network
- Covered-benefits and restrictions

Use the Medicare Plan Finder tool at [Medicare.gov](https://www.Medicare.gov)  to compare your plan options.

If you need help with Medicare, contact 800-MEDICARE. You can also contact the Senior LinkAge Line, a free statewide service of the Minnesota Board on Aging in partnership with Minnesota's area agencies on aging by calling 800-333-2433, Monday through Friday from 8:00 a.m. to 4:30 p.m.

2024 Medicare Updates

Medicare is complex and frequently changing. Below are some recent changes that will affect your Medicare costs and benefits in 2024 and beyond.

Medicare enrollment changes

In 2023, changes were made that allowed coverage to begin the first of the following month after an enrollment application is received. Medicare did not include changes to when a person could enroll in a Medicare Advantage or Part D plan.

- In 2024, special enrollment periods have been added to allow someone to enroll in a Medicare Advantage and/or Part D plan during the first two months after enrolling in Medicare. This includes people who enrolled during one of the following:
 - The last three months of their Initial Enrollment Period
 - The annual General Enrollment Period
 - A special enrollment period

Colorectal cancer screening

Medicare is reducing the amount people pay when a polyp or tissue is removed during a screening for colorectal cancer. This reduction started in 2023 and will continue until cost sharing is eliminated in 2030.

Medicare Cost Plans

Cost Plans will continue to be available in the same 21 counties as in 2023. See page 19 for more information and the list of counties where people can enroll in a Medicare Cost Plan.

New coverage for power seat elevation equipment

Medicare now covers power seat elevation equipment for certain people on Medicare. The person must undergo an evaluation that confirms their ability to safely operate the equipment in their home. For Medicare to cover the equipment, at least one of the following must apply to the person:

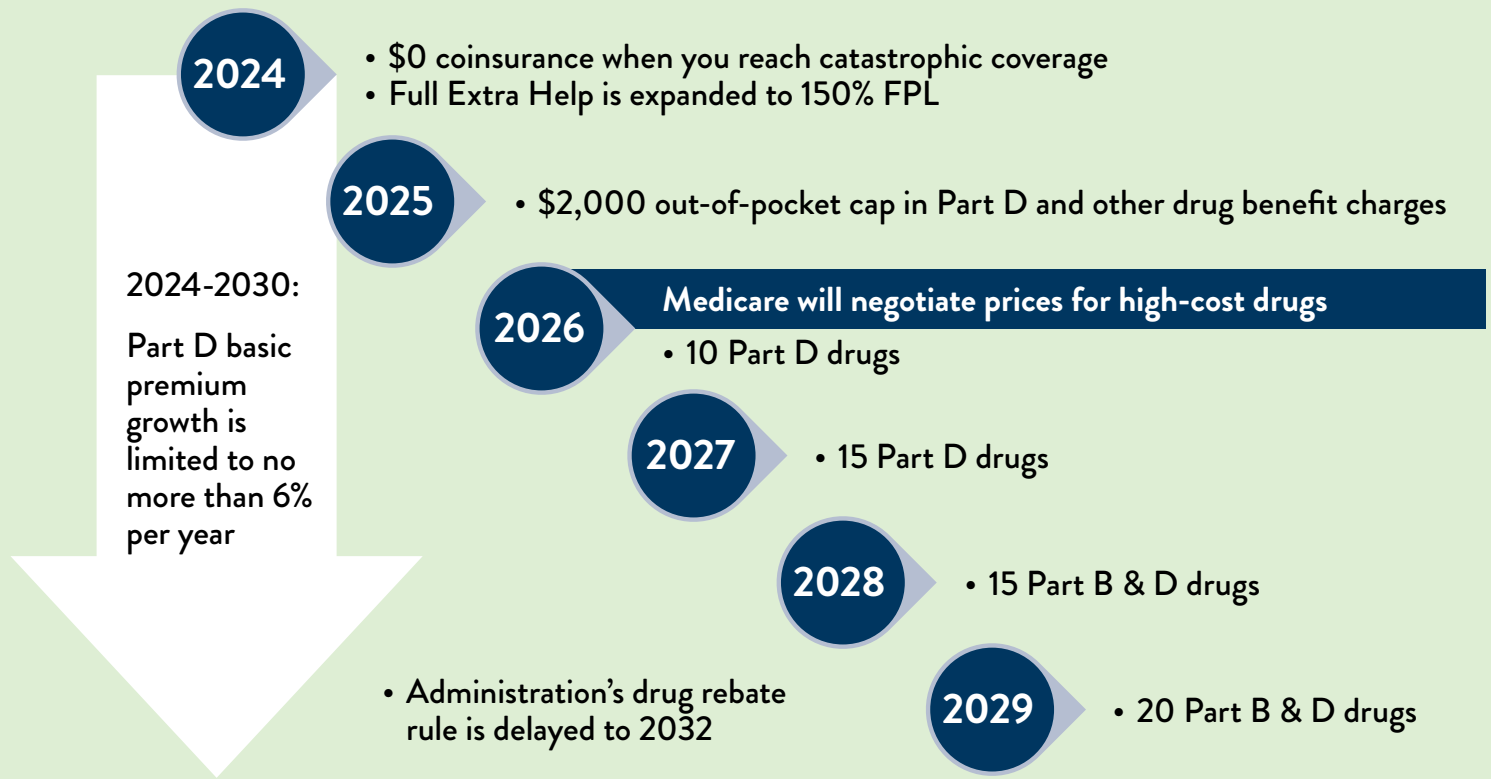
- They perform weight bearing transfers to/from a power wheelchair while in their home, using either their upper extremities during a non-level sitting transfer and/or their lower extremities during a sit to stand transfer.
- They require a non-weight bearing transfer to/from the power wheelchair while in their home. Transfers may be accomplished with or without a floor or mounted lift.
- They perform reaching from the power wheelchair to complete one or more mobility-related activities of daily living such as toileting, feeding, dressing, grooming and bathing in the home.

Inflation Reduction Act of 2022

This piece of legislation outlined changes intended to lower the costs of medications under Medicare Part D. One of the first major changes happened in 2023 with a reduction in the cost of insulin to \$35 for a month's supply. The following changes will occur in 2024:

- After people reach the Part D catastrophic coverage phase, they will pay nothing for medications under their plan's formulary.
- Medicare Part D basic premiums cannot grow faster than 6% per year from 2024-2029.
- Full Extra Help will be expanded to include people with incomes up to 150% of the federal poverty level.
 - The Extra Help Program helps lower the cost of the Medicare Part D premium and cost sharing for people with low to modest incomes. People have been eligible for either a full or partial subsidy.
 - Partial Extra Help will be eliminated and people with a partial subsidy will become eligible for a full subsidy.
 - Drug copayments will still vary, depending on a person's annual income.

Inflation Reduction Act Timeline



Postal Reform Act

Currently, about 20% of postal retirees do not enroll in Medicare. Starting in 2025, future retired postal workers and eligible family members will be required to enroll in Medicare Part A and Part B to be eligible for the Postal Services Health Benefits Program.

- A new postal version of the Federal Employee Health Benefit will be available and function as secondary coverage to Medicare.
- Current retirees who are not enrolled in Medicare will be allowed to enroll in Medicare Part B without a late enrollment penalty.
 - Enrolling in Medicare will typically eliminate cost sharing.
 - Current retirees can choose not to enroll in Medicare Part B and keep their current coverage. However, they will be subject to a penalty, if they enroll later.

Medicare Advantage and Part D plan marketing changes

Medicare continues to see an increase in complaints about the marketing of Medicare Advantage and Medicare Part D plans. The following changes will be made in 2024 to address these concerns:


- Companies must limit their advertisement to locations where the plans/benefits are available.
- Advertisements must list the organization's name, the Part D sponsor, or the marketing names registered with the federal government.
- Plans must provide an annual written notice letting people know they can opt out of future calls regarding plan business.
- Plans must explain what effect enrolling will have on the person's current coverage.

2024 Medicare Updates

- Marketing will be prohibited from taking place in the same location within 12 hours of an educational event.
- Unscheduled in-person meetings must be initiated by the customer.

End of the Public Health Emergency

May 11, 2023, marked the end of the federal COVID-19 Public Health Emergency (PHE) and as a result, states were required to begin unwinding any changes that had been made.

- During the federal COVID-19 PHE, people who were enrolled in a subsidized health care program through the state were not required to participate in the normal annual renewal process including Medical Assistance and MinnesotaCare.
 - Minnesota restarted their renewal process this spring. People are required to complete their renewal in the same month as the last completed renewal or new application (whichever applies).
 - People can check their renewal date by going to <https://www.mnrenewallookup.com> .
 - A pre-renewal notice was mailed, so people who have moved should update their address by calling their local county human services office.
 - People who are in a subsidized health care program and did not enroll in Medicare when they were first eligible because of the PHE, will be allowed a special enrollment period (SEP) to enroll in Medicare without penalty.
 - People can call the Senior LinkAge Line at 800-333-2433 to get more information or to get help in requesting a SEP.
- Changes made to tests, vaccines, and treatment coverage as it relates to COVID-19:
 - Medicare no longer covers over-the-counter tests.
 - Medicare does cover lab tests under Medicare Part B.
 - Medicare is continuing to cover vaccines at 100%.
 - Antiviral drugs used for treatment are still covered by Medicare, if you test positive, you have a mild to moderate case, and you are at a high risk for developing a severe case.

Original Medicare

Original Medicare benefits

Original Medicare is traditional fee-for-service health insurance coverage offered through the federal government for people who are 65 and older and certain people with a disability under 65. Medicare has out-of-pocket costs such as premiums, deductibles, copays and coinsurance. If you don't enroll in Medicare at the right time, it may result in premium penalties when you do enroll.

To learn more about how Original Medicare works, visit www.medicare.gov/basics/get-started-with-medicare/medicare-basics. 

MEDICARE PART A

Hospital insurance

Part A is federal hospital insurance. People can go to any hospital or provider that accepts Medicare.

See page 9.

MEDICARE PART B

Medical insurance

Part B is federal medical insurance. People can go to any doctor or provider that accepts Medicare.

See page 10.



Filling the gaps in Original Medicare

You can buy a Medigap policy, also referred to as Medicare Supplement Insurance, to help pay the costs not covered by Original Medicare. You can also purchase a Medicare Part D plan to help pay for prescription medications. Part D plans may have out-of-pocket costs, such as premiums, deductibles, copays and coinsurance. If you don't enroll in Part D at the right time, it may result in premium penalties.

MEDIGAP POLICY

Pays out-of-pocket costs

Medigap is an optional private insurance policy licensed by the state of Minnesota that helps pay Medicare coinsurance, copayments and deductibles.

See pages 11-15.

MEDICARE PART D

Prescription drug coverage

Part D is a Medicare-approved private insurance plan that covers outpatient prescription drug costs.

See pages 21-24. To view available plans, see pages 156 -157.

The Basics of Medicare Part A

Medicare Part A is federal hospital insurance that helps pay for inpatient hospital care, home health care, limited skilled nursing facility care, blood transfusions and hospice care.

To find out more about what Medicare Part A covers and your out-of-pocket costs, visit www.medicare.gov/what-medicare-covers/what-part-a-covers .

Eligibility

- 65 and older and a U.S. citizen
- Permanent resident alien, 65 and older, who lived in the U.S. for five years before applying
- U.S. citizen or legal permanent resident under 65 who:
 - Receives Social Security or Railroad Retirement Board disability benefits for 24 months
 - Has End-Stage Renal Disease (ESRD) and meets certain requirements
 - Has ALS (Lou Gehrig's disease) and receives Social Security disability benefits

Enrollment

- People can enroll in Medicare Part A during:
 - Their Initial Enrollment Period
 - Special Enrollment Period
 - The annual General Enrollment Period.
- To learn more about Medicare enrollment periods see pages 25-26.

Costs

Monthly premium:

- No, if you are 65 and older and you or your spouse:
 - Receive, or are eligible to receive, Social Security or Railroad Retirement Board benefits; or
 - Worked long enough in a government job through which you paid Medicare taxes
- No, if you are under 65 and have:
 - Received Social Security or Railroad Retirement benefits for 24 months or
 - Been diagnosed with ESRD and meet certain requirements or
 - Been diagnosed with ALS and are receiving Social Security disability benefits
- Yes, if you or your spouse do not have the 40 Social Security work credits you will pay a monthly premium:
 - The premium you pay will depend on how many work credits you have. People with 29 or fewer credits pay more.

Additional out-of-pocket costs


- People who have Original Medicare pay deductibles, coinsurance and copayments. You can buy a Medigap policy to help cover these costs. See pages 11-15 for more information.

Benefit period

- You must pay the Part A deductible for each benefit period.
- The benefit period begins on the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any skilled inpatient hospital care or skilled care in a skilled nursing facility for 60 consecutive days.
- There are no limits to the number of benefit periods you can have per year.

The Basics of Medicare Part B

Medicare Part B is federal medical insurance that helps pay for outpatient medical services, physician services, home health care, supplies, limited medications and more.

To find out more about what Medicare Part B covers and your out-of-pocket costs, visit www.medicare.gov/what-medicare-covers/what-part-b-covers. 

Eligibility

If you are eligible for Part A, you are also eligible for Part B.


- If you are not eligible to enroll in premium-free Part A, you can still enroll in Part B. You must be 65 or older and a U.S. citizen or permanent resident alien for the past five years.

Enrollment

- People can enroll in Medicare Part B during:
 - Their Initial Enrollment Period
 - A special enrollment period
 - The annual General Enrollment Period.
- To learn more about Medicare enrollment periods see page 25-26.

Cost

Monthly premium in 2024

- About 95% of people pay the standard Part B premium. People with higher incomes pay an additional premium amount called an Income-Related Monthly Adjustment Amount (IRMAA). To see the IRMAA sliding scale go to <https://secure.ssa.gov/poms.nsf/lnx/O601101020> .
- The Part B premium for 2024 is \$174.70, this was an increase of \$9.50 from 2023.
- The Social Security Cost of Living Adjustment (COLA) increase for 2024 is 3.2%.
- The Social Security Act contains a hold harmless provision that protects some people from paying a larger increase in the Part B premium than they receive in their COLA.

Premium penalty

It is important to enroll in Part B when you are first eligible, or you may have to pay a monthly late enrollment penalty when you enroll later.

- The late enrollment penalty increases your monthly Part B premium by 10% for each full 12-month period you delayed Part B enrollment (unless you have health insurance from your own or your spouse's current active employment).
- In most cases, the penalty is permanent and is added to the monthly Part B premium amount.

Additional out-of-pocket costs

People with Original Medicare must also pay cost sharing under Part B. This includes an annual deductible and coinsurance (usually 20% of the Medicare-approved amount).

- Medigap insurance policies are sold by private insurance companies to supplement Original Medicare and help pay the 20% coinsurance.
- To learn more about programs that can help to pay your Medicare costs, go to pages 23-24.

Medigap Insurance

Medigap is health insurance that:

- Is sold by private insurance companies to supplement Original Medicare
- Helps pay coinsurance, copayments and some deductibles for Medicare-covered services
- May cover certain costs not covered by Original

Medicare, such as medical care needed while traveling outside of the U.S.

- Covers the coinsurance for drugs covered under Part B, but not the drugs covered under Part D

Policy basics

- You must have Medicare Part A and Part B to buy a Medigap policy.
- Policies are sold by insurance companies, brokers and licensed insurance agents.
 - Policies are guaranteed renewable, even if you have health problems in the future, as long as you pay your premiums.
- Policies and insurance agents who sell them are regulated by the Minnesota Department of Commerce.
- If you move out of state, your coverage can continue; however, your premium amount may increase..

Enrollment timing

- It is best to enroll during your initial six-month Medigap Open Enrollment Period.
 - This period begins on the first day of the month you are enrolled in Part B and ends six months later.
 - If you enroll during this period, you have guaranteed issue rights, meaning the insurance company is required by law to sell you a policy and you cannot be health screened.
- If you apply for a policy outside six-month open enrollment period, you will likely be asked to complete a health questionnaire by the insurance company and your application may be denied.
- You will get another six-month open enrollment period, if you return to work, drop your Part B, and then re-enroll in Medicare.

Policies for people under 65 and disabled

- Minnesota state law requires insurance companies to sell you a policy, even if you are under 65.
- Medigap policies are available with no health screening during the six-month period after enrolling in Part B.
 - A second six-month open enrollment period is also available when you turn 65.

Purchasing a policy

- To buy a policy, you must contact the insurance company, broker, or agent selling the policy.
- The insurance company must provide you with an outline of coverage.
- You can return the policy within 30 days of receipt and receive a full refund.

Minnesota Medigap insurance policies

- Basic
- Basic with riders
- Extended Basic
- Medicare SELECT
- Medigap policies with limited coverage (see page 13)



Policy Coverage page 13
Monthly Premium Guide..... pages 14-15

! Basic Supplement Riders

Additional coverage that can be added to a Basic policy include:

- Part A deductible
 - Pays inpatient hospital deductible for each benefit period
- Part B annual deductible
 - Pays the annual Part B deductible
 - This rider is not available for people who turn 65 or became Medicare eligible on or after January 1, 2020.

- **Part B Excess Charges**
 - Providers who don't agree to accept Medicare's allowable rates (Medicare assignment), can charge you up to 15% more than the Medicare-approved amount. This is called an excess charge.
 - Excess charges are limited for Minnesota residents when receiving health care in Minnesota.
- **Additional Preventive Care**
 - Pays up to \$120 annually for certain preventive medical care services not covered by Medicare.

Policy benefits

- Policy types are standardized and all policies of the same type include the same benefits.
- Monthly premium and level of customer service can vary between companies.
- Minnesota law requires Medigap policies to cover certain additional mandated benefits, such as cancer screenings, reconstructive surgery, vaccinations and diabetic supplies.
- Policies may cover some services not covered by Original Medicare, such as an annual physical and medical care outside the U.S.

Provider networks

- You can go to any provider that accepts Medicare payment.
 - If you enroll in a Medicare SELECT policy, you may be required to use the plan's network providers to get full benefits.

Monthly premium

- You will pay a monthly premium, in addition to the Part B premium.
- Premium amounts can change and vary by the type of policy, the amount of coverage and the insurance company selling the policy.
- Policies in Minnesota are community-rated. This means, that everyone enrolled in the same policy pays the same premium, regardless of age, gender, or when the policy was purchased.
 - Premiums can vary depending on where you live (urban or rural) and if you use tobacco products.

Additional costs

- Out-of-pocket costs vary depending on the policy you buy. These can include:
 - Deductibles - a specified amount you must pay before the insurance company will pay on a claim
 - Coinsurance - a shared cost between you and the policy on a percentage basis
 - Copayment - a set amount you must pay at the time a service is received
 - Part B excess - the difference between what Medicare pays and the amount charged

⚠ Services not covered

- Outpatient prescription drug coverage
 - You should consider enrolling in a separate Part D plan, unless you have other creditable drug coverage.
- Routine dental care, unless the dental service is covered by Medicare
- Routine eye exams for glasses or contact lenses
- Hearing aids

Becoming eligible for Medical Assistance

- If you have a Medigap policy and become eligible for Medical Assistance (Minnesota's Medicaid program), you are allowed to suspend your Medigap policy for up to 24 months.
 - If eligibility ends during this time-period, you can return to the suspended policy without underwriting.
 - You do not have to pay premiums while the Medigap policy is suspended.

2024 Medigap Policy Coverage in Minnesota

| | Basic | Extended Basic | \$20 & \$50 Copay for Part B | High Deductible* | 50% Part A Deductible | 50% | 75% |
|--|-------------------------------------|------------------|------------------------------------|-----------------------|-----------------------------|----------------------|----------------------|
| | | | Similar to plan N | Similar to plan F* | Similar to plan M | Similar to plan K | Similar to plan L |
| Annual out-of-pocket limit 2024 | None | \$1,000 | None | \$2,800* | None | \$7,060 | \$3,530 |
| Part A deductible | 100% if rider purchased | 100% | 100% | 100%* | 50% | 50% | 75% |
| Part A coinsurance | 100% | 100% | 100% | 100%* | 100% | 100% | 100% |
| Skilled nursing facility coinsurance For days 21 - 100 | 100% | 100%** | 100% | 100%* | 100% | 50% | 75% |
| Part B coinsurance | 100% | 100% | \$20 & \$50 copays | 100%* | 100% | 50% | 75% |
| Part B Excess | 100% if rider purchased | 100% | - | - | - | - | - |
| Medicare preventive care | 100% | 100% | 100% | 100%* | 100% | 100% | 100% |
| Preventive services not covered by Medicare | 100% up to \$120 if rider purchased | 100% up to \$120 | - | - | - | - | - |
| Foreign travel - Emergency | 80% | 80% | 80% | 100%* | 80% | - | - |
| Foreign travel - Hospital and medical expenses and supplies | - | 80% | - | - | - | - | - |

* You must pay for the Medicare-covered costs up to \$2,800 before the policy pays.

** Extended Basic plan provides up to 120 days of skilled nursing facility care.

Additional Medigap options

Retiree supplement coverage

Some people on Medicare may be eligible for employer retiree coverage that supplements Medicare. How the coverage works varies, depending on the policy. Benefits can change and coverage can be canceled. In most cases, if you do not enroll in retiree coverage when you are first eligible, you will not be able to enroll later. It is also possible you could be subject to a Part D premium penalty if your coverage is not creditable. See page 23 for more information.

Medicare SELECT Policies

You can also choose to buy a Medicare SELECT policy with various coverage options. See page 15 for the Medicare SELECT policy available in Minnesota.

Medicare SELECT policies are a type of Medigap insurance product that:

- May require you to use specific clinics, hospitals and doctors for full benefits (except in an emergency)
- Differ from traditional supplemental policies, because they are managed care plans with networks of providers
- Do not include prescription drug coverage (Part D); it must be purchased separately

2024 Minnesota Medigap Annual Premium Guide

Additional plan options may be added and rates may vary due to rounding, discounts or fees, and they may increase or decrease at various times throughout the year (see page 13 for coverage details). Plan information and rates are provided by the Minnesota Department of Commerce and were current at the time of publication.

Always contact the insurance company to confirm current policy rates.

| Company | Basic Plan | Part A Deductible | 100% Part B Excess | Prevention | Extended Basic | \$20 and \$50 Copay Part B | High Ded. | 50% Part A Ded. | 50% | 75% |
|--|------------|-------------------|--------------------|------------|----------------|----------------------------|-------------------|-------------------|-------------------|-------------------|
| | | | | | | Similar to plan N | Similar to plan F | Similar to plan M | Similar to plan K | Similar to plan L |
| ACE Property and Casualty Insurance Company ☞ 800-601-3372 | | | | | | | | | | |
| Rural Tobacco | \$2,146 | \$351 | \$29 | \$70 | \$2,993 | \$2,029 | \$960 | | | |
| Rural N/T | \$1,866 | \$305 | \$25 | \$61 | \$2,603 | \$1,764 | \$834 | | | |
| Urban Tobacco | \$2,372 | \$387 | \$32 | \$78 | \$3,309 | \$2,243 | \$1,061 | | | |
| Urban N/T | \$2,062 | \$337 | \$27 | \$67 | \$2,877 | \$1,950 | \$922 | | | |
| BlueCross BlueShield of Minnesota ☞ 800-382-2000 | | | | | | | | | | |
| Smoker | \$3,169 | \$432 | \$12 | \$48 | \$4,252 | \$2,564 | \$903 | | \$1,849 | \$2,647 |
| N/S | \$2,722 | \$432 | \$12 | \$48 | \$3,503 | \$2,137 | \$712 | | \$1,588 | \$2,258 |
| Catholic United Financial* ☞ 800-568-6670 | | | | | | | | | | |
| Rural Tobacco | \$2,452 | \$392 | \$44 | \$97 | \$4,780 | \$2,413 | | | | |
| Rural N/S | \$2,132 | \$341 | \$39 | \$84 | \$4,129 | \$2,098 | | | | |
| Urban 1 Tobacco | \$2,721 | \$435 | \$49 | \$107 | \$5,331 | \$2,678 | | | | |
| Urban 1 N/S | \$2,366 | \$379 | \$43 | \$93 | \$4,608 | \$2,329 | | | | |
| Urban 2 Tobacco | \$2,893 | \$463 | \$52 | \$114 | \$5,682 | \$2,847 | | | | |
| Urban 2 N/S | \$2,516 | \$402 | \$45 | \$99 | \$4,914 | \$2,476 | | | | |
| Cigna Health & Life Insurance Company ☞ 855-891-9368 | | | | | | | | | | |
| Rural Tobacco | \$2,695 | \$324 | \$26 | \$65 | \$3,314 | \$2,062 | \$816 | | | |
| Rural N/S | \$2,450 | \$295 | \$24 | \$59 | \$2,996 | \$1,875 | \$741 | | | |
| Urban Tobacco | \$2,790 | \$335 | \$27 | \$67 | \$3,431 | \$2,135 | \$844 | | | |
| Urban N/S | \$2,536 | \$305 | \$24 | \$61 | \$3,101 | \$1,941 | \$768 | | | |
| Continental Life Insurance Company of Brentwood Tennessee (Aetna) ☞ 800-358-8749 | | | | | | | | | | |
| Smoker | \$3,210 | \$765 | \$142 | \$107 | \$3,160 | \$2,517 | \$1,119 | | | |
| N/S | \$2,839 | \$676 | \$129 | \$95 | \$2,770 | \$2,230 | \$989 | | | |
| HealthPartners ☞ 800-247-7015 | | | | | | | | | | |
| Smoker | \$3,108 | \$648 | \$14 | \$58 | \$4,686 | \$3,017 | | | | |
| N/S | \$2,706 | \$567 | \$12 | \$50 | \$4,075 | \$2,623 | | | | |
| Humana Insurance Company ☞ 800-457-4708 | | | | | | | | | | |
| Rural 1 Smoker | \$4,791 | \$981 | \$99 | \$108 | \$7,013 | \$4,601 | \$1,522 | | \$2,103 | \$3,632 |
| Rural 1 N/S | \$4,078 | \$821 | \$82 | \$108 | \$6,000 | \$4,057 | \$1,304 | | \$1,803 | \$3,116 |
| Rural 2 Smoker | \$4,449 | \$911 | \$92 | \$108 | \$6,511 | \$4,272 | \$1,414 | | \$1,954 | \$3,373 |
| Rural 2 N/S | \$3,787 | \$762 | \$76 | \$108 | \$5,571 | \$3,768 | \$1,212 | | \$1,675 | \$2,894 |
| Urban Smoker | \$5,082 | \$1,041 | \$105 | \$108 | \$7,440 | \$4,880 | \$1,613 | | \$2,230 | \$3,852 |
| Urban N/S | \$4,325 | \$871 | \$87 | \$108 | \$6,365 | \$4,304 | \$1,382 | | \$1,911 | \$3,305 |
| Loyal American Life Insurance Company (Cigna) ☞ 855-891-9368 | | | | | | | | | | |
| Rural Smoker | \$2,880 | \$647 | \$77 | \$96 | \$4,059 | \$3,258 | | | | |
| Rural N/S | \$2,303 | \$517 | \$62 | \$77 | \$3,206 | \$2,606 | | | | |
| Urban Smoker | \$3,200 | \$718 | \$86 | \$106 | \$4,510 | \$3,620 | | | | |
| Urban N/S | \$2,559 | \$575 | \$69 | \$86 | \$3,563 | \$2,895 | | | | |
| Lumico Life Insurance Company ☞ 855-774-4491 | | | | | | | | | | |
| Rural Tobacco | \$2,130 | \$370 | \$30 | \$73 | \$3,025 | \$2,092 | \$989 | | | |
| Rural N/S | \$1,901 | \$330 | \$27 | \$66 | \$2,677 | \$1,868 | \$883 | | | |
| Urban Tobacco | \$2,354 | \$408 | \$33 | \$81 | \$3,343 | \$2,312 | \$1,093 | | | |
| Urban N/S | \$2,102 | \$364 | \$30 | \$73 | \$2,959 | \$2,065 | \$976 | | | |

| Company | Basic Plan | Part A Deductible | 100% Part B Excess | Prevention | Extended Basic | \$20 and \$50 Copay Part B | High Ded. | 50% Part A Ded. | 50% | 75% |
|---|------------|-------------------|--------------------|------------|----------------|----------------------------|-------------------|-------------------|-------------------|-------------------|
| | | | | | | Similar to plan N | Similar to plan F | Similar to plan M | Similar to plan K | Similar to plan L |
| Medica Health Plans | | | | | | | | | | 877-704-7864 |
| Smoker | \$3,064 | \$719 | \$17 | \$40 | \$3,716 | \$2,834 | \$1,471 | | | |
| N/S | \$2,632 | \$625 | \$16 | \$36 | \$3,203 | \$2,466 | \$1,279 | | | |
| National Health Insurance Company | | | | | | | | | | 888-376-3300 |
| Rural Tobacco | \$2,463 | \$426 | \$35 | \$85 | \$3,528 | \$2,419 | \$1,144 | | | |
| Rural N/S | \$2,090 | \$362 | \$30 | \$72 | \$2,967 | \$2,053 | \$971 | | | |
| Urban Tobacco | \$2,712 | \$469 | \$39 | \$94 | \$3,884 | \$2,664 | \$1,259 | | | |
| Urban N/S | \$2,301 | \$398 | \$33 | \$79 | \$3,175 | \$2,260 | \$1,069 | | | |
| Omaha Insurance Company | | | | | | | | | | 855-879-4784 |
| Smoker | \$3,473 | \$525 | \$0 | \$80 | \$3,480 | | | | | |
| N/S | \$3,022 | \$456 | \$0 | \$70 | \$3,028 | | | | | |
| State Farm Mutual Automobile Insurance Company | | | | | | | | | | 800-782-8332 |
| Rural Tobacco | \$3,056 | \$825 | \$39 | \$82 | \$8,195 | \$2,115 | | | | |
| Rural N/S | \$2,778 | \$750 | \$35 | \$74 | \$7,450 | \$1,922 | | | | |
| Urban Tobacco | \$3,181 | \$856 | \$40 | \$82 | \$8,535 | \$2,199 | | | | |
| Urban N/S | \$2,891 | \$778 | \$36 | \$74 | \$7,759 | \$1,999 | | | | |
| UCare | | | | | | | | | | 833-276-1188 |
| Tobacco | \$2,628 | \$360 | \$24 | \$84 | \$3,276 | \$2,760 | | | | |
| N/S | \$2,280 | \$312 | \$24 | \$72 | \$2,844 | \$2,400 | | | | |
| United Healthcare AARP®* | | | | | | | | | | 800-272-2146 |
| Tobacco | \$2,822 | \$462 | \$83 | \$70 | \$3,508 | | | | | |
| N/S | \$2,565 | \$420 | \$75 | \$63 | \$3,189 | | | | | |
| Washington National Insurance Company | | | | | | | | | | 800-525-7662 |
| Tobacco | \$2,346 | \$1,033 | \$105 | \$75 | \$3,559 | \$2,004 | \$1,033 | \$2,575 | \$1,105 | \$1,898 |
| N/S | \$2,018 | \$889 | \$90 | \$64 | \$3,061 | \$1,723 | \$889 | \$2,215 | \$950 | \$1,633 |

*Group Plan policy with requirements.

Medicare SELECT Policy for 2024



Senior Gold (Medicare SELECT)

Enrollment: 877-662-2583 • Service: 800-531-6686 • TTY: 711

bluecrossmn.com/medicare

Blue Cross® and Blue Shield® of Minnesota and Blue Plan® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

| | Basic Plan | Part A Deductible Rider | Part B Excess Rider | Additional Preventive Care Rider | Extended Basic Select |
|--------------------------|---|-------------------------|---------------------|----------------------------------|-----------------------|
| Non-Tobacco | \$253.10 | \$36 | \$1 | \$4 | \$282.05 |
| Tobacco | \$303.65 | \$36 | \$1 | \$4 | \$342.40 |
| Out-of-Pocket Max | Not applicable, limited to no cost sharing for eligible services and supplies | | | | |


SELECT policy rates are per month.

Medicare Health Plans

Medicare Health Plans

You can choose to get your Medicare Part A and Part B benefits through a Medicare health plan. This is an alternative to Original Medicare, which is administered through the federal government. Medicare health plans are available through private insurance companies approved by Medicare.

Plans must cover the same benefits and offer the same rights and protections available through Original Medicare. Plans, however, can differ from Original Medicare on how you get your benefits and what you will be charged for services. Rules, costs, and the list of providers you can see may change so it's important that you reevaluate your coverage annually during Medicare Open Enrollment, October 15 – December 7.

To complete personalized research on your plan options, visit www.medicare.gov/plan-compare. 

MEDICARE ADVANTAGE PLANS

These are health plans offered by private insurance companies that contract with Medicare to provide your Medicare benefits.

- Plans can be sold to people in designated areas identified by the company.
- The plan is the only payer and Original Medicare cannot pay (except for hospice services).
- You may be responsible for the cost of services outside the plan's network.
- You are only allowed to enroll and disenroll at specific times.

Learn morepages 17-18

Medicare Advantage Plan Premium and Coverage Guide.....pages 47-130

MEDICARE COST PLANS

These are health plans offered by private companies that contract with Medicare to provide benefits within the plan's network.


- Medicare Cost Plans are not Medicare Advantage Plans.
- Plans are sold only to people living in certain Minnesota counties.
- Medicare-covered services received outside of the plan's network are paid by Original Medicare.
- You can enroll and disenroll at any time as long as the plan is accepting new members.

Learn more pages 19-20

Medicare Cost Plans Premium and Coverage Guidepages 39-45

The Basics of Medicare Advantage Plans

Medicare Advantage Plans are a type of health plan offered through private insurance companies. Plans have a one-year contract with Medicare to cover your Part A and Part B benefits. Most plans also include Part D benefits.

To do personalized research of your plan options, visit www.medicare.gov/plan-compare. 


Details

- Plans have different rules on how you can get services.
 - You may be required to use certain providers and get a referral to see a specialist.
 - Generally, seeing providers without a referral or outside the plan's network will increase your out-of-pocket costs.
- Additional benefits not covered by Medicare may be offered, such as vision, hearing, dental coverage or other supplemental benefits for chronically ill people.
- Part D benefits are generally offered through the plan.
 - Enrolling in a stand-alone Part D plan could cause you to be disenrolled from your Advantage Plan.
- You will be notified prior to the Medicare Open Enrollment Period if your plan will no longer be available.
 - You can choose a new plan or return to Original Medicare and use your guaranteed issue rights to buy certain Medigap policies.
- Medicare Advantage Special Needs Plans are available to provide targeted care to people with certain diseases, Medical Assistance eligibility or other characteristics (see page 18).

Eligibility

- You must have Part A and Part B to join a Medicare Advantage Plan.
- You must live in the plan's service area.

Enrollment

- You can enroll in a plan when you first become eligible for Medicare
 - During annual open enrollment (October 15 - December 7), or
 - If you qualify for a Special Enrollment Period
- You can disenroll or change plans:
 - During open enrollment
 - If you qualify for a Special Enrollment Period
 - During the Medicare Advantage Open Enrollment Period (see pages 25-26 for more details)
- To enroll in a plan, contact the company that sells the plan, go to [Medicare.gov](https://www.Medicare.gov)  or call 800-Medicare.
- To learn more about Medicare Advantage enrollment periods, see pages 25-26.

Costs

- Most plans charge a monthly premium, in addition to your Part B premium.
- Plans have additional cost sharing, such as deductibles, copayments and coinsurance.
- Plans place a limit on out-of-pocket costs for Medicare-covered services each year, not including Part D costs.

Types of Medicare Advantage Plans Available

| | |
|--|--|
| <p>Health Maintenance Organization Plans (HMO) *See below</p> | <ul style="list-style-type: none"> You may need to choose a primary care doctor. You may be required to get a referral for a specialist. You must use the plan's network of providers (except in an emergency). <ul style="list-style-type: none"> You may pay the entire cost if you use out-of-network providers. Plans may include a Point-of-Service (POS) option, which allows some flexibility to go to out-of-network providers. |
| <p>Preferred Provider Organization Plans (PPO) *See below</p> | <ul style="list-style-type: none"> Plans have provider networks, but you can see any doctor or provider that accepts Medicare (usually at a higher cost). You do not need a referral to see a specialist, but you will pay more if you go outside the plan's network. |
| <p>Private Fee-for-Service Plans (PFFS)</p> | <ul style="list-style-type: none"> Plans may have provider networks, but you may also be able to see any provider that agrees to accept the plan's reimbursement and will bill the plan for the services you receive. Providers can decide at each appointment if they will accept the plan's terms. Part D coverage may or may not be provided by the plan. <ul style="list-style-type: none"> You can enroll in a Part D stand-alone prescription drug plan, if coverage is not provided by the plan. |
| <p>Medicare Advantage Special Needs Plans (MA-SNP) *See below</p> | <ul style="list-style-type: none"> Plans are specifically designed to provide targeted care to people with Medical Assistance (MA) eligibility, certain diseases or if they live in an institution. Types of SNPs available in Minnesota: <ul style="list-style-type: none"> Minnesota Senior Health Options (MSHO): for people 65 and older with Medicare and Medical Assistance (MA) that combines health programs and support systems Special Needs Basic Care (SNBC): for people with disabilities ages 18 through 64 who have MA (some SNBC plans also coordinate with Medicare) Institutional Special Needs Plans (I-SNPs): for people who have had or are expected to need the level of services provided in certain types of facilities. |

*Medicare Part D Coverage and HMO, PPO or Special Needs Plans

- You cannot have a Medicare Advantage HMO, PPO or most MA-SNP and have a Medicare Part D stand-alone plan at the same time.
 - If you enroll in a stand-alone Part D plan, you will be disenrolled from your Medicare Advantage HMO, PPO and most MA-SNP plans.
- Enrolling in a plan without Part D may work well for someone who has other creditable drug coverage.
- If you have a PFFS plan that does not include Part D, you can enroll in a Part D stand-alone plan.

The Basics of Medicare Cost Plans

Medicare Cost Plans are a type of Medicare health plan offered through private insurance companies. Cost Plans are only available to people living in certain Minnesota counties (see below).

To do personalized research on your plan options visit www.medicare.gov/plan-compare. 

Minnesota counties where Cost Plans are available in 2024:

- Aitkin
- Carlton
- Cook
- Goodhue
- Itasca
- Kanabec
- Koochiching
- Lake
- Le Sueur
- McLeod
- Meeker
- Mille Lacs
- Pine
- Pipestone
- Rice
- Rock
- Sibley
- St. Louis
- Stevens
- Traverse
- Yellow Medicine

Coverage

- You can get Medicare Part D coverage, if offered through the plan or a Part D stand-alone plan.
- Plans may offer additional benefits, such as an annual physical, hearing, vision and dental benefits.
- Original Medicare is billed for Medicare-approved services outside the plan's network.

Eligibility

- You must be enrolled in Medicare Part A and Part B or in Medicare Part B alone.
- People with ESRD are not eligible, with limited exceptions. Contact plans for eligibility rules.
- You must live in a county where Medicare Cost Plans are sold.

Enrollment

You can enroll in a plan:

- When you first become eligible for Medicare.
- During the annual Medicare Open Enrollment Period (October 15 – December 7).
- At any time if you are enrolled in Original Medicare and the plan is taking new members.

To learn more about Medicare Cost Plan enrollment periods see pages 25-26.

Out-of-pocket costs

- Plans charge a monthly premium in addition to your Part B premium.
- Plans have additional cost sharing, such as deductibles, copayments and coinsurance.
- You will have an annual out-of-pocket limit for Medicare-covered services (does not include Part D drugs).
- You are responsible to pay the cost sharing for Original Medicare services (outside the plan network).


A Comparison of Medicare Cost Sharing Options

| | Medigap Supplemental Insurance | Medicare Cost Plans | Medicare Advantage Plans |
|-------------------------------------|--|---|---|
| Type of plan | Insurance that supplements Original Medicare Policies are sold based on the state you live in. | Cost Plans contract with Medicare to cover all Part A and Part B services within a provider's network. Plans can only be sold to people living in certain counties. Medicare-covered services outside of the plan's network are paid for by Original Medicare. Original Medicare copays and deductibles may apply. | Advantage Plans contract with Medicare to cover all Part A and Part B services. Plans can only be sold to people living in designated areas identified by the company. The plan is the only payer of services. You may be responsible for the cost of services outside the plan's network unless the plan has a point-of-service option. |
| Premium | Yes, monthly premium | Yes, monthly premium | Most have a monthly premium |
| Out-of-pocket (cost sharing) | Pays some Original Medicare deductibles, copayments and coinsurance | You will pay some out-of-pocket costs, such as deductibles, copayments and coinsurance. | |
| Prescription drug coverage | No, Part D drug coverage is not included. | May include Part D drug coverage or you can buy a stand-alone Part D plan | In most cases, you must get your Part D drug coverage from the plan. |
| Additional services | May cover additional benefits such as foreign travel or wellness benefits | May cover additional benefits, such as foreign travel, wellness benefits, dental, vision and annual physical | May cover additional benefits, such as foreign travel, wellness benefits, dental vision, hearing and other supplemental benefits |
| Provider network | You are allowed to go to any Medicare provider. SELECT policies require you to use network providers for the highest level of payment. | Covers all Medicare services within the plan's network Original Medicare will pay outside of the plan's network. You will need to pay the Medicare out-of-pocket costs. | Typically, you must get your care and services from network providers, except for care in an emergency. When you are allowed to use non-network providers, costs will often be higher. |
| Portability | You can keep the policy if you move to another state. You may need to change your policy, if you are in a Medicare SELECT policy. | If you move outside your plan's service area, you must change to a new plan or return to Original Medicare. | |
| Health screening | Policies can require health screening, if not purchased within the first six months of Part B enrollment. | Plans can deny coverage to people with ESRD. | No health screening is permitted. |

Medicare Part D Prescription Drugs

Medicare Part D Plan Types

Part D is an optional Medicare benefit. If you do not enroll when you are first eligible, you may have to pay a premium penalty if you enroll later. Coverage is offered by private insurance companies with a Medicare contract. Plans offer coverage for both brand-name and generic medications.

To do personalized research on your plan options, visit www.medicare.gov/plan-compare. 

MEDICARE PART D STAND-ALONE DRUG PLAN

- You can choose this option if you have Original Medicare (with or without a Medigap policy) or a Medicare Cost Plan without Part D.
- Plans cover prescription drugs and some vaccines, such as the shingles and RSV vaccine.

Medicare Part D Stand-Alone Premium and Coverage Guide..... pages 156 - 157

MEDICARE HEALTH PLAN WITH MEDICARE PART D

- Most Medicare Advantage Plans and some Cost Plans include Part D coverage.
 - Most Medicare Advantage Plans require you to get Part D coverage from the plan.
 - You are not required to get your Part D coverage from a Medicare Cost Plan.

Medicare Health Plans Premium and Coverage Guide pages 39 - 157

Ways to Lower Your Prescription Drug Costs

If you cannot afford your medications, there are ways to help lower your costs.


Patient assistance programs

Many of the major pharmaceutical companies offer programs to help pay for the medications they manufacture. There are also foundations and disease-specific programs that can help with these costs. You can research your options by going to:

- NeedyMeds: needymeds.org 
- RxAssist: rxassist.org 
- Medicine Assistance Tool: medicineassistancetool.org 


Extra Help Program (Low Income Subsidy or LIS) pages 24

Extra Help, also called the Low Income Subsidy, is a government program administered through Social Security. This program helps people with low to modest incomes and resources pay for their Medicare Part D premiums and medication cost sharing.

To find out if you may be eligible to get help paying for your Medicare Part D costs and/or to apply for Extra Help, visit <https://secure.ssa.gov/i1020/start>. 

The Basics of Medicare Part D

Medicare Part D is outpatient prescription drug coverage for people on Medicare. Coverage is provided by private insurance companies with a Medicare contract. You can get coverage through a stand-alone plan or as a part of a Medicare health plan.

To do personalized research on your plan options, visit www.medicare.gov/plan-compare .

Eligibility

- You must be enrolled in Part A and/or Part B to enroll.
- To enroll, contact the plan directly, go to [Medicare.gov](https://www.medicare.gov) or call 800-Medicare.

Enrollment period

You can enroll in Part D:

- When you first become eligible for Medicare
- During the annual open enrollment (October 15 - December 7)
- If you qualify for a Special Enrollment Period

For more information about Medicare Part D enrollment periods, see pages 25-26.


Covered drugs

- Outpatient FDA-approved generic and brand-name prescription drugs
- Insulin and certain supplies necessary for the injection of insulin (i.e., needles, syringes, alcohol swabs)
- Some vaccines, including the shingles and RSV vaccine

Non-covered drugs

- Drugs already covered under Part A or Part B
- Medication prescribed for:
 - Fertility and erectile dysfunction
 - Anorexia, weight loss or weight gain (except in certain situations)
 - Over-the-counter drugs
 - Vitamins (except prenatal vitamins and fluoride preparations)
 - Relief of cough and colds
 - Cosmetic purposes or hair growth

Monthly premium


- Most plans charge a monthly premium, which varies from plan to plan.
- Premiums may be higher if you have a late enrollment penalty.
 - The penalty is 1% of the current national base premium (\$34.70 in 2024) for each full, uncovered month that you were eligible to enroll in a Part D plan, but did not.
- People with higher incomes pay an additional premium amount called an Income-Related Monthly Adjustment Amount. To see the IRMAA sliding scale go to <https://secure.ssa.gov/poms.nsf/lnx/0601101020> .

Additional costs

You must pay additional out-of-pocket costs, such as deductibles, coinsurance and copayments. The amount you pay for your medications depends on your plan, pharmacy, medication and the coverage phase you're in.

The four Part D coverage phases in 2024

Annual deductible

- A plan's deductible cannot exceed \$545.
- You may pay up to 100% of the cost of your medications during this phase.
- If you are enrolled in a plan with enhanced benefits, costs can vary during the deductible phase.
- To find the actual costs of your medication, use the Medicare Plan Finder tool at [Medicare.gov](https://www.medicare.gov) .

Initial coverage period

- Once you have paid your annual deductible, you are in the initial coverage period.
- If you are enrolled in a plan with enhanced benefits, costs can vary during the initial coverage period.
- To find the actual costs of your medication, use the Medicare Plan Finder tool at [Medicare.gov](https://www.medicare.gov).
- During this phase, you will pay no more than 25% for all drugs on your plan's formulary.

Coverage gap

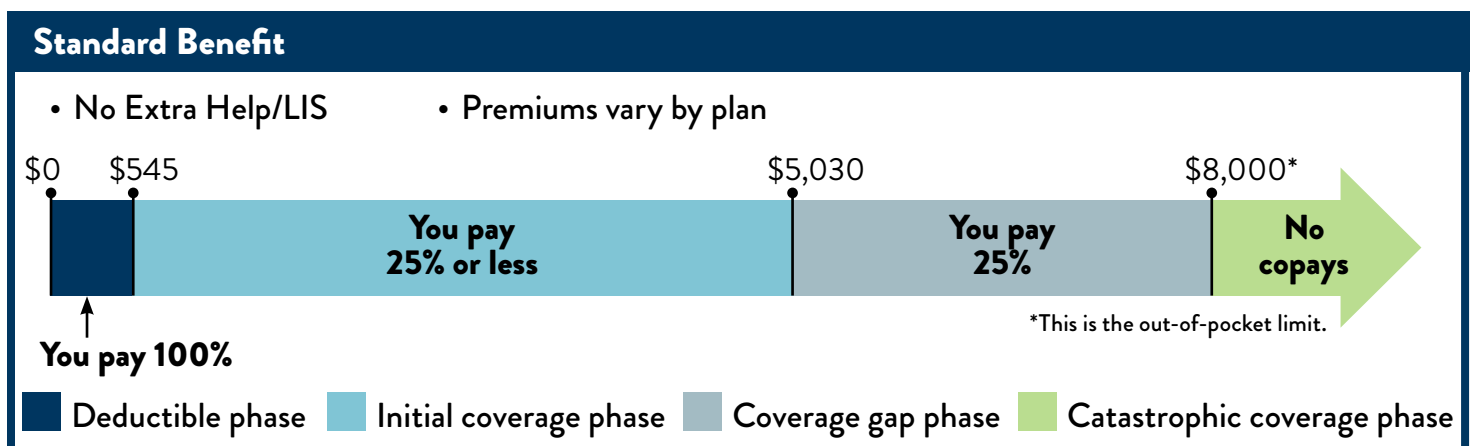
- When the total costs for your drugs exceed \$5,030, you have reached the coverage gap (donut hole).
- During this phase, you will pay no more than 25% for all drugs on your plan's formulary.

Catastrophic coverage

- Once your drug costs reach the out-of-pocket limit of \$8,000, you are eligible for catastrophic coverage.
- Not all Part D costs count toward this limit. Costs that help you reach this limit include:
 - The costs you paid during the deductible, and the initial coverage phase
 - Most of the discount you received on brand-name drugs during the coverage gap phase
 - Money paid by others on your behalf (family and charities)
- Once you reach this phase, you will pay nothing for medications on your plan's formulary.

Medicare Part D Cost Sharing for 2024

Medicare Part D has four coverage phases. Which phase you are in will be determined by your plan and your total medication costs. Not all plans have a deductible. Plans that have a deductible may choose to offer certain medications at a lower price during the deductible phase.





Creditable coverage

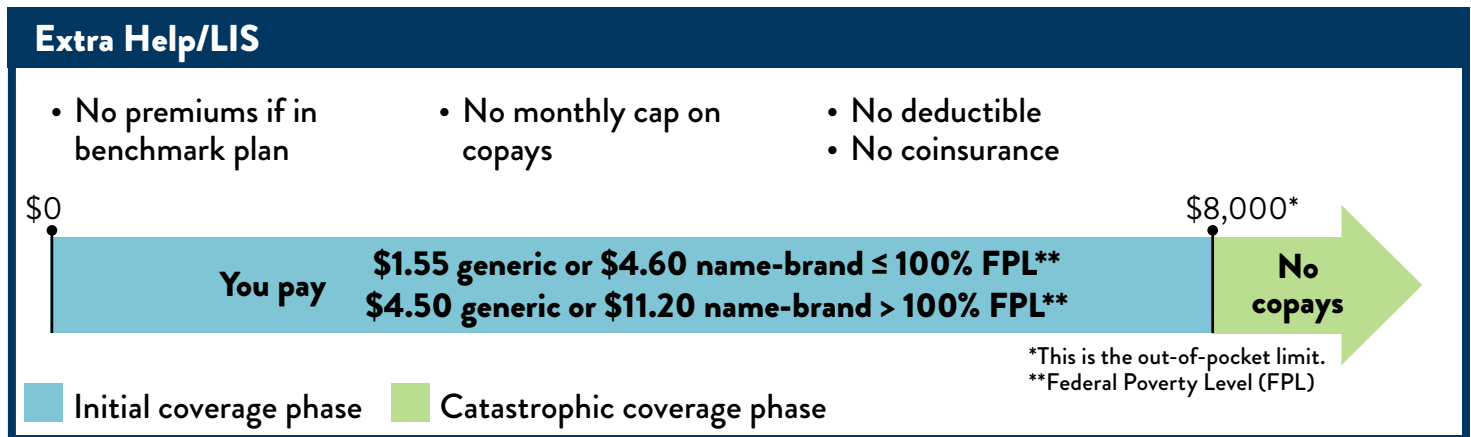
Creditable coverage is prescription drug coverage that is determined to be as good as, or better than standard Part D coverage.

- Each year before open enrollment, employer or union group health plans must notify their members whether their drug coverage is creditable or not.
- If your coverage is not creditable, consider enrolling in a Part D plan to avoid paying a penalty.
 - If you go 63 days in a row without creditable prescription drug coverage, you may have to pay a premium penalty if you enroll in a plan later.
 - Contact your employer or union group health plan prior to enrolling into a Part D plan to determine how the enrollment might affect your current coverage.
- Examples of creditable coverage include:
 - TRICARE
 - Veterans' (VA) benefits
 - Federal Employee Health Benefits Program
 - Indian Health Services benefits

Extra Help for out-of-pocket costs

Extra Help, also known as Low Income Subsidy (LIS), is a federal program administered by Social Security and available for people with limited income and assets.

- You pay no premium for certain plans called benchmark plans.
- You will pay no more than \$4.50 for generic medications and \$11.20 for brand name medications.
- You can apply for Extra Help by:
 - Calling Social Security at 800-772-1213
 - Going to <https://www.ssa.gov/medicare/part-d-extra-help> 
- You can view the income and asset limits at <https://www.medicarights.org/fliers/Help-With-Drug-Costs/Extra-Help-Chart.pdf> 



What is a Benchmark Plan?

Benchmark plans are standard Medicare Part D plans with premiums equal to or lower than the regional low-income premium subsidy amount of \$42.16 in 2024.

- Enhanced plans do not qualify as benchmark plans even if the premium is less.
- Benchmark plans do not have monthly premiums for people who are:
 - Qualified for the Extra Help Program
 - Enrolled in Medical Assistance (MA)
 - Enrolled in a Medicare Savings Program
 - Receive Supplemental Security Income (SSI) benefit

Benchmark Plans for 2024:

- AARP MedicareRx Basic
- Mutual of Omaha Rx Plus
- Wellcare Classic
- Clear Spring Health Value Rx
- SilverScript Choice

Medicare Enrollment Periods

| | Part A | Part B | Medigap |
|---|---|--|---|
| Initial Enrollment Period: Turning 65 | <p>A seven-month period that includes the three months before you turn 65, the month of your 65th birthday, and three months after.</p> <ul style="list-style-type: none"> If you enroll during this period, your coverage will begin the first day of your birthday month. <ul style="list-style-type: none"> People who have a birthday on the first day of the month are eligible for Medicare the first day of the previous month. People eligible for premium-free Part A can enroll at any time after they are first eligible. Coverage will be retroactive up to six months. | <ul style="list-style-type: none"> If you enroll during the first three months, your coverage will start the first day of your birthday month. <ul style="list-style-type: none"> People who have a birthday on the first day of the month are eligible for Medicare the first day of the previous month. If you enroll during your birthday month or after, your coverage will start the first of the following month. | <p>A six-month period that starts the month you enroll in Part B.</p> <ul style="list-style-type: none"> If you were enrolled in Medicare before 65 due to a disability, you will get another guaranteed issue period when you turn 65. |
| Initial Enrollment Period: Disabled Under 65 | <p>A seven-month period that starts 21 months after you get Social Security disability benefits and lasts through the 27th month.</p> | | <p>A six-month period that starts the month you enroll in Part B.</p> |
| General Enrollment Period | <p>This annual period begins January 1 and goes through March 31.</p> <ul style="list-style-type: none"> Part A coverage is retroactive for up to six months. Late enrollment premium penalty may apply for people who are not eligible for premium-free Part A coverage and do not enroll. | <p>This annual period begins January 1 and goes through March 31.</p> <ul style="list-style-type: none"> Part B coverage begins the first day of the month after you enroll. Late enrollment premium penalty may apply. | <p>Does not apply</p> <ul style="list-style-type: none"> If you have Part A and Part B, you can apply for a Medigap policy at any time. You can be denied coverage for health reasons, if you apply outside of your Medigap Open Enrollment Period. |
| Annual Open Enrollment Period | <p>Does not apply</p> | | |
| Special Enrollment Period | <p>This period lasts up to eight months after employment or employer or union group health plan coverage ends, whichever is first.</p> <ul style="list-style-type: none"> Part A coverage is retroactive for up to six months. Employer or union group health plan coverage must be based on your, or your spouse's, current employment (COBRA or retiree coverage does not qualify). <p>Additional Special Enrollment Periods are available, depending on your specific circumstances.</p> | <p>This period lasts up to eight months after employment or employer or union group health plan coverage ends, whichever is first. Part B coverage will begin the month after you enroll.</p> <ul style="list-style-type: none"> You can delay your effective date up to three months if you enroll while you still have employer-sponsored or union coverage or within one month after coverage ends. Employer or union group health insurance coverage must be based on your, or your spouse's, current employment (COBRA or retiree coverage does not qualify). <p>Additional Special Enrollment Periods are available, depending on your specific circumstances.</p> | <p>You may have guaranteed issue rights to enroll in a Medigap policy when you enroll in Medicare during a Special Enrollment Period.</p> |
| Medicare Advantage Open Enrollment Period | <p>Does not apply</p> | | |

| | Part C (Advantage) | Cost Plans | Part D |
|--|---|---|---|
| Initial Enrollment Period <ul style="list-style-type: none"> • Turning 65 • Disabled Under 65 | This period begins three months before you are enrolled in both Parts A and B and ends either: <ul style="list-style-type: none"> • Last day of the month before you enrolled in both A and B, or • Last day of your Part B IEP, whichever is later | This period is available when you are first eligible for Medicare and live in a county where the plan is sold. <ul style="list-style-type: none"> • You must be enrolled in both Part A and Part B or just Part B alone. | This period includes the three months before you turn 65, the month of your 65th birthday and the three months after. <ul style="list-style-type: none"> • You can enroll in Part D if you have Part A, Part B, or both. |
| General Enrollment Period | This annual period begins January 1 and goes through March 31. Your Medicare coverage begins the first of the following month. If you enroll during this period: <ul style="list-style-type: none"> • You have a two-month Special Enrollment Period to enroll in a Advantage Plan, with or without Part D. • You must have both Part A and Part B to enroll in a Advantage Plan. | You can enroll any time the plan is taking new members, and you live in the plan service area. <ul style="list-style-type: none"> • Coverage will start the first day of the following month after you enroll in the plan. | This annual period begins January 1 and goes through March 31. Your Medicare coverage begins the first of the following month. If you enroll during this period: <ul style="list-style-type: none"> • You have a two-month Special Enrollment Period to join a Part D plan. |
| Annual Open Enrollment Period | October 15 - December 7, coverage begins January 1 | | |
| Special Enrollment Period | Additional Special Enrollment Periods are available depending on your circumstances. | You can enroll at any time the plan is taking new members and you live in the plan service area. <ul style="list-style-type: none"> • Coverage starts the first day of the following month. • Additional Special Enrollment Periods are available depending on your specific circumstances. | Additional Special Enrollment Periods are available depending on your specific circumstances. |
| Medicare Advantage Open Enrollment Period | This annual period begins January 1 and goes through March 31. This period is for people enrolled in a Advantage Plan. <ul style="list-style-type: none"> • Offers a one-time opportunity to switch to a different Advantage Plan or return to Original Medicare during this enrollment period. • If you switch to a different Advantage Plan: <ul style="list-style-type: none"> ○ You can join a plan with or without Part D drug coverage. • If you return to Original Medicare: <ul style="list-style-type: none"> ○ You do not have guaranteed issue rights to enroll in a Medigap policy. ○ You can enroll in a stand-alone Part D plan. If you enrolled in a Advantage Plan during your IEP, you can use this period to: <ul style="list-style-type: none"> • Change to a different Advantage Plan or return to Original Medicare one-time only during the first three months of enrolling in Part A and B. | Does not apply | If you return to Original Medicare during this period, you can: <ul style="list-style-type: none"> • Enroll in a Part D stand-alone drug plan. If you switch to another Advantage Plan during this period, you can: <ul style="list-style-type: none"> • Choose a plan with or without drug coverage. |

Medicare Savings Programs

Medicare Savings Programs (MSP) are state and federally funded programs available to help people pay Medicare expenses, such as premiums, deductibles, coinsurance and copayments. People on an MSP can save thousands of dollars a year.

Medicare Savings Programs and benefits

You will automatically qualify for lower drug costs through the Medicare Part D Extra Help (Low Income Subsidy - LIS) Program with all Medicare Savings Programs.

Qualified Medicare Beneficiary (QMB)

- Pays Medicare premiums (no retroactive coverage):
 - Medicare Part A premium (if not premium-free)
 - Medicare Part B premium
- People on QMB pay nothing for Medicare-covered services.
- Medicare providers are not allowed to charge deductibles, coinsurance or co-pays for Medicare-covered Part A and Part B services.

Specified Low-Income Medicare Beneficiary (SLMB)


- Pays the Medicare Part B premium.
- Up to three months retroactive coverage for Part B premiums

Qualified Individual (QI)

- Pays the Medicare Part B premium.
- Pays up to three months retroactive coverage for Part B premiums


Eligibility

MSPs have income and asset eligibility guidelines.

- Money you receive for working is counted differently. If you work, you may qualify, even if your income is higher than the stated guidelines.
- For more information on Medicare Savings Program eligibility and benefits see <https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/help-with-medicare-costs.jsp> 

Applying for a Medicare Savings Program

Complete a *Minnesota Health Care Programs Application for Certain Populations*.

- Contact your local county social services office and ask for DHS publication #3876.
- Go to edocs.dhs.state.mn.us/lfserver/Public/DHS-3876-ENG  to download an application.
- Call the Senior LinkAge Line at 800-333-2433 for more information.

Medicare Plans Change Annually

If you have a Medicare health plan or Medicare Part D plan, your plan will send you an Annual Notice of Change (ANOC) every fall. The ANOC outlines changes in coverage, costs or service area for the following year.

⚠️ Reviewing plan changes carefully

Read the ANOC to understand which changes might affect you. These could include:

Medicare Advantage Plan or Medicare Cost Plan changes:

- Monthly premium
- Deductibles, copayments and coinsurance
- Covered services
- Annual out-of-pocket maximum costs
- Network of providers (i.e., doctors and pharmacy)
- Travel benefits
- Extra benefits (dental, hearing, vision, health club membership, etc.)

Medicare Part D plan changes:

- Monthly premium
- Drug restrictions
- Annual deductible
- Pharmacy network
- Formulary changes
- Copayment and coinsurance amounts

What to do if your plan will be ending:

- ✓ **Read the notice carefully and keep it as proof of coverage.**
 - The ANOC will tell you if your plan is ending and if you were enrolled into a new plan.
 - It also includes information about your rights to choose a new plan for next year.
- ✓ **Review options by going to [Medicare.gov](https://www.Medicare.gov) and enroll in a new plan by December 31.**
- ✓ **If your Medicare health plan ends and you are not enrolled in another Medicare health plan, you will automatically be returned to Original Medicare on January 1.**
- ✓ **Call Medicare at 800-MEDICARE.**
- ✓ **Call the Senior LinkAge Line at 800-333-2433 to discuss your plan options.**

Things to consider if your plan is ending and it included drug coverage:

- ✓ **If you are not enrolled in a new Medicare health plan, you will return to Original Medicare.**
 - If you want Medicare prescription drug coverage and plan to stay in Original Medicare, you must enroll in a stand-alone Part D plan by December 31.
- ✓ **If you do not have Medicare Part D or other creditable drug coverage, you may have to pay a late enrollment penalty.**
 - See page 23 for more information.

Special rights when plans end

- If your plan does not renew its contract, you have a Special Enrollment Period to switch to another plan from December 8 through the last day of February of the following year.
- If you have a Medicare health plan that is ending, and you decide to return to Original Medicare:
 - You have the right to purchase certain Medigap policies and the company cannot deny you coverage. This is called Guaranteed Issue Rights.

Beneficiary & Family Centered Care Quality Improvement Organization

Beneficiary & Family Centered Care Quality Improvement Organizations (BFCC-QIO) are under contract with the Center for Medicare & Medicaid Services to improve the quality of care and health outcomes for Medicare beneficiaries.

Contacting Livanta

Livanta serves as the BFCC-QIO for Minnesota.

- Livanta manages all consumer complaints and quality of care reviews.
- You can get immediate help from Livanta to resolve a healthcare concern.
 - You can also contact Livanta to appeal a notice that you will be discharged from the hospital or that other services will be ending.

To file a quality of care complaint

- ✔ **Call the Livanta Beneficiary Helpline at 888-524-9900 if you are not satisfied with the quality of care received.**

- You or your representative can request that a quality of care concern form be mailed to you.
- Complaints must be submitted in writing and can take up to 30 days to review.
- A medical professional from Livanta will review the medical record to determine if appropriate medical care was provided.

- ✔ **Immediate advocacy**

Immediate advocacy is an informal process used by the BFCC-QIO to resolve a complaint more quickly.

- The process begins when the person on Medicare or their representative calls the Livanta Beneficiary Helpline and gives verbal consent to proceed with the complaint.
 - Livanta will contact the provider or practitioner on behalf of the person.
- This is a voluntary process for both parties.

To file a discharge appeal

- ✔ **Call the Livanta Beneficiary Helpline at 888-524-9900 if you believe that you are being discharged too soon from a:**

- Hospital
- Skilled nursing facility
- Home health agency
- Hospice


- ✔ **Your financial liability during a discharge appeal**

You will be able to stay in the hospital while Livanta reviews your case.

- During the discharge appeal, people have financial protections. You only have to pay applicable cost sharing while you are awaiting a decision.

Contacting Livanta

Call Livanta toll-free at 888-524-9900 (TTY: 888-985-8775) to file a quality of care complaint, discharge appeal or to request immediate advocacy.

- Monday - Friday from 9:00 a.m. - 5:00 p.m.
- Saturday - Sunday from 11:00 a.m. - 3:00 p.m. (discharge appeals only)
- Visit livantaqio.com  to learn more about Livanta's free services.

Medicare Appeal Rights

You have the right to file an appeal with Medicare, your Medicare health plan or Medicare Part D plan when:

- You disagree with a decision about coverage or payment.
- Payment was denied for a health care service, supply or item you received or were denied.
- The plan will no longer pay for services, supplies, items or prescriptions that you believe are needed.

There are five levels of appeal. It is important to pay attention to the instructions at each level. There are strict deadlines and a minimum dollar amount to file an appeal after the second level.

Filing an appeal - disagree with a coverage or payment decision

| Original Medicare | Medicare Health Plan | Medicare Part D Plan |
|---|--|---|
| <ul style="list-style-type: none">• Your Medicare Summary Notice (MSN) shows the services and supplies billed to Medicare during a three-month period, what Medicare paid and what you may still owe.• If you disagree with the decision, you have 120 days from the time you received the MSN to appeal.• To appeal, follow the instructions on the back of the MSN. | <ul style="list-style-type: none">• Your Explanation of Benefits (EOB) shows the services and supplies billed to the plan. It will show you what the plan paid and what you paid or still owe.• Contact your plan directly to file an appeal.• The plan phone number should be on the back of your insurance card or on the EOB. | <ul style="list-style-type: none">• If your Part D plan won't cover a drug, speak with your health care provider. There may be a similar drug your plan will cover.• To request an exception, have your physician contact your plan. Depending on the situation, you may be able to request a fast decision within 24 hours.• If you disagree with the plan's decision, you can appeal. |

Appeal documentation

If you decide to appeal, it is important to include supporting documentation with your appeal.

- Contact your health care provider or supplier and request they provide you with information you can use to defend your claim. Some examples are:
 - Letters of support showing the service or item was medically necessary
 - Health records
- Keep copies of your appeal and supporting documents.
- Send appeals by certified mail, if possible.

Fast Appeals

You have a right to a Fast Appeal when:

- Your Medicare-covered services from a hospital, home health care agency, comprehensive outpatient rehabilitation facility or hospice are ending too soon
- You need a medication and waiting for a standard decision may endanger your health

Requesting a Fast Appeal when services are ending

- If you feel Medicare-covered hospital services are ending too soon, follow the instructions provided in the notice called, *An Important Message from Medicare about Your Rights*.
 - You should receive the notice within two days of your admission and before discharge.
- If you feel services other than those in a hospital are ending too soon, you should follow the instructions that you receive in the *Notice of Medicare Non-Coverage*.
 - You will receive this notice at least two days before covered services end.
 - Both notices will give you information on how to contact Livanta, Minnesota's Beneficiary and Family

Centered Quality Improvement Organization, to file an appeal. You will be given the option to file an appeal by phone or online.

- When appealing a Part D plan decision, you can request a fast decision by calling or writing the plan to make the request.
 - You will get a fast decision (within 24 hours) if your plan determines that waiting 72 hours may endanger your health.


Quality of care complaint

If you have a concern about the quality of care you received from a Medicare provider, you have the right to file a complaint/grievance. This must be done within 60 days of the event.

- If the complaint is with the doctor, hospital or other provider you can contact:
 - Livanta, Minnesota's BFCC-QIO, at 888-524-9900
 - Your Medicare health plan
- If the complaint is with your health or drug plan, you can:
 - Follow the plan instructions provided when you enrolled
 - Contact the plan directly
 - Complete a *Medicare Complaint Form* on the [Medicare.gov](https://www.medicare.gov) website
- If the complaint is with your Medigap company or insurance agent, you can file a written complaint with the Minnesota Department of Commerce.

Minnesota Department of Commerce
Attn: Consumer Services Center
85 7th Place East, Suite 280
St. Paul, MN 55101

On-line complaints: <https://mn.gov/commerce/consumer/file-a-complaint/> 

Website: <https://mn.gov/commerce/contact/> 
651-539-1500 (local) or 800-657-3602 (greater MN only)

Need help?

- Call the Senior LinkAge Line at 800-333-2433 for help with the appeals process.

Protecting Yourself from Fraud

Fraud and financial scams happen to millions of people every year, resulting in billions of dollars lost. Medicare fraud results in higher taxes and health care costs for everyone. Scams are a type of fraud that can happen by mail, email, in-person and over the phone. Because of technology, fraud continues to be on the rise and it is becoming more sophisticated. It is important to know how to recognize fraud and financial scams and learn how to protect yourself.

Medicare fraud and abuse

Medicare fraud is when someone intentionally schemes to get money or property from the Medicare program. Abuse describes practices that may result in unnecessary costs to the Medicare program. Examples of fraud and abuse include:

- Billing for services and supplies you did not receive or need
- Offering or accepting kickbacks and bribes
- Allowing someone else to use your Medicare number
- Double billing or overcharging for services and supplies
- Misusing billing codes on a claim

How to fight Medicare fraud and abuse

- Protect your Medicare, Medical Assistance and Social Security numbers.
 - Medicare and Social Security won't call to sell you anything.
- Document doctor visits, tests and procedures.
- Save your Medicare Summary Notices and Explanation of Benefits statements and make sure you review them for errors.
- When disposing of documents, shred anything with personal information.
- Be wary of promises that Medicare will pay for certain services or devices with no cost to you.


What to do if you suspect fraud or abuse

- ✓ **If you're confused about a charge for health care services, supplies, or equipment, call the provider.**
 - This may help you better understand the charge, or they may realize they made a billing error.
- ✓ **If Medicare is billed for an item you didn't receive, or you don't know the supplier on the claim, call 800-Medicare (800-633-4227).**
- ✓ **If you believe you may have been a victim of a scam, call your local law enforcement agency.**
- ✓ **See the Minnesota Attorney General's website at for more information on scams <https://www.ag.state.mn.us/consumer/Scams>**
- ✓ **Call the Senior LinkAge Line at 800-333-2433 to report Medicare fraud, abuse and scams.**


Consumer scam examples

- Identity theft
- Fake cashier's check or money order as payment
- Phony emails, texts or corrupt websites
- Impersonations
 - Someone is in distress and needs money
 - IRS or other government agency
- Soliciting donations for fake charities
- Fraudulent investment options
- Fake prize winnings and lotteries
- COVID-19 health benefit scams
- New Medicare card with a chip is needed (real Medicare cards do not have chips).

Protect yourself from becoming a victim of a scam

- Be wary when things sound too good to be true.
- Don't allow someone to rush you into making a decision.
- Research the product, company or person.
 - Do an online search.
 - Check with the Better Business Bureau at bbb.org. 
- Before acting, get the opinion of someone you trust.
- Don't click on links in emails (even from people you know).
 - Check with the person sending the email to make sure it is really from them.
- If you receive a possible scam call, hang up.

What to do if you suspect a scam

- ✓ **File a report with local law enforcement.**
- ✓ **Call the FBI at 763-569-8000.**
- ✓ **Contact the Office of Minnesota Attorney General at 800-657-3787.**
- ✓ **Report Identity Theft**
 - Visit the Federal Trade Commission's (FTC) website: IdentityTheft.gov  or call 877-382-4357.
 - Call one of the three credit reporting agencies: Equifax 877-322-8228, Experian 888-397-3742 or TransUnion 833-395-6938.
 - Record the dates and times you make calls or send letters.
 - Keep copies of your reports and letters on file.
- ✓ **Call the Senior LinkAge Line at 800-333-2433 to report Medicare fraud, abuse and scams.**



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DON'T MISS OUT ON THE SAVINGS!

The Senior LinkAge Line helps people of all ages find help to pay for and/or reduce their prescription drug costs. You may be able to save as much as \$5,000 a year in Medicare Part D drug costs.

One Number to Call

If you or someone you know can't afford their prescription medications, call the Senior LinkAge Line at 800-333-2433 for help.

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Icon Key: Look for these icons to help you quickly identify plans with additional benefits.



Additional dental coverage included



Additional vision coverage included



Additional hearing coverage included



Part D drug coverage included



Additional health benefits included

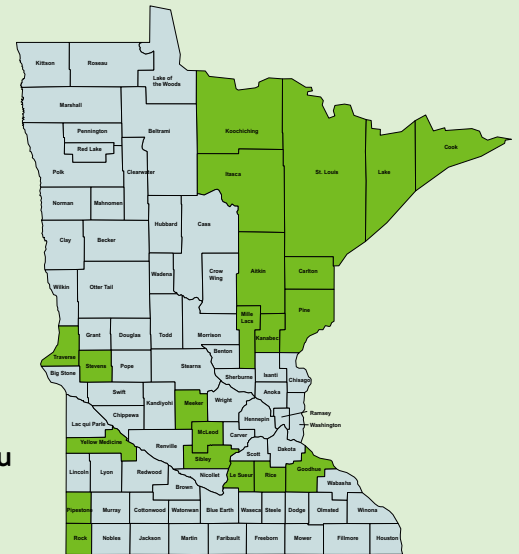
Medicare Cost Plans

What You Need to Know

Medicare Cost Plans are a type of Medicare health plan. Plans are offered by private companies that contract with Medicare to provide all your Medicare benefits within the plan's network. Medicare-covered services outside the plan's network are covered by Original Medicare. You must be enrolled in Medicare Part B or in both Part A and Part B to enroll in a Cost Plan.

- Minnesota counties where plans can be sold in 2024:

- Aitkin
- Carlton
- Cook
- Goodhue
- Itasca
- Kanabec
- Koochiching
- Lake
- Le Sueur
- McLeod
- Meeker
- Mille Lacs
- Pine
- Pipestone
- Rice
- Rock
- Sibley
- St. Louis
- Stevens
- Traverse
- Yellow Medicine



- You can enroll in a Medicare Cost Plan:

- During your Initial Enrollment Period
- Throughout the year, if the plan is accepting new members, you have Original Medicare and you live in county where the plan can be sold.

- You may be responsible to pay the cost sharing for out-of-network services that are billed under Original Medicare.
- Plans cover additional services not covered under Original Medicare.
- You must pay your Part B premium in addition to other out-of-pocket costs.
- See pages 19-20 for more information on Medicare Cost Plans.

Prescription Drug Coverage

- You can choose to get your Medicare prescription drug coverage through the plan, or through a Medicare Part D stand-alone plan.
- See the information on pages 21-24.



Call the Senior LinkAge Line at 800-333-2433 for free help with Medicare-related issues, including appeals and plan options.



Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Platinum Blue Core (H2461-005)

Cost Plan

Enrollment: 877-662-2583
 Service: 866-340-8654 • TTY: 711
bluecrossmn.com/medicare



Monthly Premium: \$34

| | |
|---------------------------------|---|
| Medicare Part D Coverage | No, you can enroll in a separate Part D stand-alone plan for Part D coverage. |
|---------------------------------|---|



Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Platinum Blue Core with Rx (H2461-008)

Cost Plan

Enrollment: 877-662-2583
 Service: 866-340-8654 • TTY: 711
bluecrossmn.com/medicare



Monthly Premium: \$58.50

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|-----------------------------------|--|
| Medicare Part D Coverage | Yes, but if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$545 |

PLAN DETAILS LISTED BELOW ARE THE SAME FOR BOTH PLANS ABOVE.

Plan Area: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St. Louis, Stevens, Traverse, and Yellow Medicine Counties

| | |
|---|---|
| Out-of-Pocket Max | \$6,000 annually |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$600 copay/each Medicare-covered hospital stay |
| Physician/Outpatient | Medicare-covered services - \$20 copay primary care doctor or 20% coinsurance/specialist, ambulatory surgical center or outpatient hospital facility visit |
| Ambulance | 20% coinsurance/Medicare-covered ambulance, includes while in a foreign country |
| Outpatient Surgery | 20% coinsurance/Medicare-covered outpatient hospital facility visits |
| Outpatient Mental Health | \$40 copay/Medicare-covered visits |
| Emergency/Urgent Care | Emergency: \$95 copay, waived if re-admitted within 24 hours for the same condition Urgent Care: \$60 copay/Medicare-covered visit |
| Travel Coverage | For providers that accept Medicare - up to 9 months U.S. travel, no referrals needed, same cost sharing as network providers in Minnesota |
| X-rays, Lab & Diagnostic Tests | \$60 copay/Medicare-covered x-rays, \$0 copay/Medicare-covered lab service, 20% coinsurance/Medicare-covered diagnostic radiology and therapeutic radiology services |
| Physical/Speech/Occupational Therapy | \$40 copay/Medicare-covered physical/occupational/speech therapy visit |
| Skilled Nursing Facility Care | Medicare-covered services - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 |
| Diabetic Supplies & Services | \$0 copay/self-management training, diabetic supplies, 20% coinsurance/Medicare-covered therapeutic shoes or inserts |
| DMEPOS | 20% coinsurance/Medicare-covered durable medical equipment item and related supplies |
| Dental | 20% coinsurance/Medicare-covered dental services |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic visit, \$20 copay/acupuncture visit |
| Vision | 20% coinsurance/1 pair of eyeglasses or contact lenses post cataract surgery, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye |
| Hearing | \$699 copay for Advanced hearing aids, \$999 copay for Premium hearing aids; must see a TruHearing provider |
| Medicare Part B Drugs | 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps. |
| Discounts & Programs | SilverSneakers program and 24-hour nurse advice line, \$25 quarterly/over-the-counter drugs and supplies |



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Platinum Blue Choice (H2461-006)

Cost Plan

Enrollment: 877-662-2583
 Service: 866-340-8654 • TTY: 711
bluecrossmn.com/medicare



Monthly Premium: \$119

| | |
|---------------------------------|---|
| Medicare Part D Coverage | No, you can enroll in a separate Part D stand-alone plan for Part D coverage. |
|---------------------------------|---|



Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Platinum Blue Choice with Rx (H2461-009)

Cost Plan

Enrollment: 877-662-2583
 Service: 877-340-8654 • TTY: 711
bluecrossmn.com/medicare



Monthly Premium: \$166

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|---------------------------------|--|
| Medicare Part D Coverage | Yes, but if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
|---------------------------------|--|

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| Medicare Part D Deductible | \$0/tiers 1&2, \$545/tiers 3-5 |
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PLAN DETAILS LISTED BELOW ARE THE SAME FOR BOTH PLANS ABOVE.

| | |
|---|---|
| Plan Area: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St. Louis, Stevens, Traverse, and Yellow Medicine Counties | |
| Out-of-Pocket Max | \$3,500 annually |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$200 copay/each Medicare-covered hospital stay |
| Physician/Outpatient | Medicare-covered services - \$0 copay/primary, \$15 copay/specialist, \$0 copay/nonsurgical outpatient hospital facility services |
| Ambulance | \$20 copay/Medicare-covered ambulance, \$15 copay/emergency ambulance outside the U.S. |
| Outpatient Surgery | \$50 copay/Medicare-covered outpatient hospital facility visit or ambulatory surgical center |
| Outpatient Mental Health | \$15 copayment/Medicare-covered visit |
| Emergency/Urgent Care | Emergency: \$95 copay, waived if re-admitted within 24 hours for the same condition Urgent Care: \$15 copay/Medicare-covered visit |
| Travel Coverage | For providers that accept Medicare - up to 9 months U.S. travel, no referrals needed, same cost sharing as network providers in Minnesota |
| X-rays, Lab & Diagnostic Tests | \$0 copay/Medicare-covered x-ray, diagnostic radiology, therapeutic radiology and lab services |
| Physical/Speech/Occupational Therapy | \$15 copay/Medicare-covered physical/occupational/speech therapy visit |
| Skilled Nursing Facility Care | \$0 copay/day for Medicare-covered service |
| Diabetic Supplies & Services | \$0 copay/self-management training, diabetic supplies, 20% coinsurance/Medicare-covered therapeutic shoes or inserts |
| DMEPOS | 20% coinsurance/Medicare-covered durable medical equipment item and related supplies |
| Dental | \$15 copay/Medicare-covered dental service Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments |
| Chiropractic/Acupuncture | \$15 copay/Medicare-covered chiropractic visit, \$15 copay/acupuncture visit |
| Vision | 20% coinsurance/1 pair of eyeglasses/contact lenses post cataract surgery, \$0 copay/Medicare-covered exams to diagnose and treat eye diseases and conditions, \$0 copay/1 supplemental routine eye exam/year, \$125 plan benefit allowance/non-Medicare-covered eyewear/year |
| Hearing | \$599 copay for Advanced hearing aids, \$899 copay for Premium hearing aids; must see a TruHearing provider |
| Medicare Part B Drugs | 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps. |
| Discounts & Programs | SilverSneakers program and 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies |



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Platinum Blue Complete (H2461-007)

Cost Plan

Enrollment: 877-662-2583
 Service: 866-340-8654 • TTY: 711
bluecrossmn.com/medicare



Monthly Premium: \$199

| | |
|---------------------------------|---|
| Medicare Part D Coverage | No, you can enroll in a separate Part D stand-alone plan for Part D coverage. |
|---------------------------------|---|



Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Platinum Blue Complete with Rx (H2461-010)

Cost Plan

Enrollment: 877-662-2583
 Service: 866-340-8654 • TTY: 711
bluecrossmn.com/medicare



Monthly Premium: \$265.90

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|---------------------------------|--|
| Medicare Part D Coverage | Yes, but if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
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| Medicare Part D Deductible | \$0/tiers 1&2, \$545/tiers 3-5 |
|-----------------------------------|--------------------------------|

PLAN DETAILS LISTED BELOW ARE THE SAME FOR BOTH PLANS ABOVE.

Plan Area: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St. Louis, Stevens, Traverse, and Yellow Medicine Counties

| | |
|---|---|
| Out-of-Pocket Max | \$2,700 annually |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$100 copay/Medicare-covered hospital stay |
| Physician/Outpatient | \$0 copay/Medicare-covered benefits and outpatient hospital facility visit |
| Ambulance | \$0 copay/Medicare-covered ambulance transportation, includes while in a foreign country |
| Outpatient Surgery | \$0 copay/Medicare-covered surgery in an ambulatory surgical center or outpatient hospital facility |
| Emergency/Urgent Care | Emergency: \$0 copay Urgent Care: \$0 copay/Medicare-covered visit |
| Outpatient Mental Health | \$0 copayment/Medicare-covered visit |
| Travel Coverage | For providers that accept Medicare - up to 9 months U.S. travel, no referrals needed, same cost sharing as network providers in Minnesota |
| X-rays, Lab & Diagnostic Tests | \$0 copay/Medicare-covered x-rays, diagnostic radiology services, therapeutic radiology services and lab services |
| Physical/Speech/Occupational Therapy | \$0 copay/Medicare-covered physical/occupational/speech therapy visit |
| Skilled Nursing Facility Care | \$0 copay/day for Medicare-covered service |
| Diabetic Supplies & Services | \$0/self-management training preventive benefit for eligible members; \$0 copay/Medicare-covered diabetic supplies, therapeutic shoes or inserts |
| DMEPOS | \$0 copay/Medicare-covered durable medical equipment item and related supplies |
| Dental | \$0 copay/Medicare-covered dental service Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments |
| Chiropractic/Acupuncture | \$0 copay/Medicare-covered chiropractic visit, \$0 copay/acupuncture visit |
| Vision | 20% coinsurance/1 pair of eyeglasses/contact lenses post cataract surgery, \$0 copay/Medicare-covered exams to diagnose and treat eye diseases and conditions, 1 supplemental routine eye exam/year, \$150 plan benefit allowance/non-Medicare-covered eyewear/year |
| Hearing | \$499 copay for Advanced hearing aids, \$799 copay for Premium hearing aids; must see a TruHearing provider |
| Medicare Part B Drugs | Medicare-covered medications - 20% coinsurance/Part B prescription drugs, \$35 cap for one-month supply of insulin for use in pumps, \$0 copay/Part B Drugs and biologicals injected during an office visit, oxygen and medications for use in a nebulizer and self-administered Erythropoietin (EPO) |
| Discounts & Programs | SilverSneakers program and 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies |



Medica Prime Solution Standard (H2450-044)

Cost Plan

Enrollment: 800-906-5432
 Service: 800-234-8755 • TTY/TDD: 711
medica.com/medicare



Monthly Premium: \$0

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|---------------------------------|---|
| Medicare Part D Coverage | No, you can enroll in a separate Part D stand-alone plan for Part D coverage. |
|---------------------------------|---|

Medica Prime Solution Standard w/Rx (H2450-049)

Cost Plan

Enrollment: 800-906-5432
 Service: 800-234-8755 • TTY/TDD: 711
medica.com/medicare



Monthly Premium: \$49.30

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| Medicare Part D Coverage | Yes, but if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
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| Medicare Part D Deductible | \$0/all tiers |
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PLAN DETAILS LISTED BELOW ARE THE SAME FOR BOTH PLANS ABOVE.

Plan Area: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St. Louis, Stevens, Traverse, Yellow Medicine Counties

| | |
|---|---|
| Out-of-Pocket Max | \$5,000 annually |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$325 copay/day for days 1-4 of each benefit period, no limit to the number of days covered |
| Physician/Outpatient | Medicare-covered benefits - \$15 copay/primary, \$50 copay/specialist |
| Ambulance | \$250 copay/ground ambulance, \$400 copay/air ambulance |
| Outpatient Surgery | \$150 copay/Medicare-covered visit to an ambulatory surgical center, \$325 copay/Medicare-covered visit to an outpatient hospital facility |
| Outpatient Mental Health | \$30 copay/visit with other mental health professionals, \$50 copay/visit with psychiatrist, \$40 copay/partial hospitalization program services |
| Emergency/Urgent Care | Emergency: \$120 copay/Medicare-covered visit inside and outside the U.S. Urgent Care: \$15-\$50 copay/Medicare-covered visit |
| Travel Coverage | Travel throughout the U.S. and its territories for up to 9 months and receive plan benefits at in-network cost sharing from any provider who accepts Medicare, emergency care covered worldwide |
| X-rays, Lab & Diagnostic Tests | Medicare-covered benefits: \$0 copay/lab services, \$15-\$50 copay/diagnostic procedures and tests, \$15-\$50 copay/x-rays, \$50-\$150 copay/diagnostic radiology services, \$50-\$75 copay/therapeutic radiology services |
| Physical/Speech/Occupational Therapy | \$45 copay/Medicare-covered visit for occupational therapy, \$50 copay/Medicare-covered visit for physical or speech therapy |
| Skilled Nursing Facility Care | Medicare-covered stays: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100, up to 100 days/benefit period. |
| Diabetic Supplies & Services | \$25 copay/testing supplies, 20% coinsurance/diabetic footwear or inserts, \$0 copay/self-management training |
| DMEPOS | 20% coinsurance/Medicare-covered items, up to a \$35 copay/one-month supply of insulin furnished through an external insulin pump. |
| Dental | \$15-\$50 copay/Medicare-covered dental benefits, up to \$400 reimbursement for all other dental services |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic service, \$15-\$50 copay/Medicare-covered acupuncture service |
| Vision | \$0 copay/1 routine eye exam and up to 2 refractions/year, \$0 copay/Medicare-covered glaucoma and diabetic retinopathy screenings, \$150/year prescription eyewear allowance, \$15-\$50 copay/Medicare-covered diagnostic exam, \$45 copay/ Medicare-covered eyewear |
| Hearing | \$15-\$50 copay/1 routine hearing exam/year, \$50 copay/Medicare-covered diagnostic exam |
| Medicare Part B Drugs | 20% coinsurance. Part B rebatable drugs may be subject to a lower coinsurance. |
| Discounts & Programs | In-Network: One Pass fitness & memory training program, HealthAdvocate nursesline, \$0 e-visit from Amwell, \$25 quarterly allowance/eligible OTC health and wellness products, no rollover |



Medica Prime Solution Thrift (H2450-030)

Cost Plan

Enrollment: 800-906-5432
Service: 800-234-8755 • TTY/TDD: 711
medica.com/medicare



Monthly Premium: \$43

| | |
|---------------------------------|---|
| Medicare Part D Coverage | No, you can enroll in a separate Part D stand-alone plan for Part D coverage. |
|---------------------------------|---|



Medica Prime Solution Thrift w/Rx (H2450-007)

Cost Plan

Enrollment: 800-906-5432
Service: 800-234-8755 • TTY/TDD: 711
medica.com/medicare



Monthly Premium: \$79.70

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| Medicare Part D Coverage | Yes, but if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
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| Medicare Part D Deductible | \$545 |
|-----------------------------------|-------|

PLAN DETAILS LISTED BELOW ARE THE SAME FOR BOTH PLANS ABOVE.

Plan Area: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St. Louis, Stevens, Traverse, Yellow Medicine Counties

| | |
|---|--|
| Out-of-Pocket Max | \$6,700 annually, limit includes only Part A and B covered services |
| Health Plan Deductible | \$50 deductible |
| Hospital Inpatient | \$300 copay/day for days 1-4, \$0 copay/day for days 5-90, \$0 copay/lifetime reserve day |
| Physician/Outpatient | Medicare-covered benefits - 20% coinsurance/primary and specialist |
| Ambulance | 20% coinsurance/ground or air ambulance |
| Outpatient Surgery | 20% coinsurance/Medicare-covered visit to an ambulatory surgical center or outpatient hospital facility |
| Outpatient Mental Health | 20% coinsurance/Medicare-covered individual or group therapy visit, or partial hospitalization program services |
| Emergency/Urgent Care | Emergency: \$50 copay/each Medicare-covered visit Urgent Care: \$25 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Travel throughout the U.S. and its territories for up to 9 months and receive plan benefits at in-network cost sharing from any provider who accepts Medicare |
| X-rays, Lab & Diagnostic Tests | 0% coinsurance/Medicare-covered lab services, 20% coinsurance/Medicare-covered diagnostic procedures and tests, x-rays, diagnostic radiology services and therapeutic radiology services |
| Physical/Speech/Occupational Therapy | 20% coinsurance/Medicare-covered visit |
| Skilled Nursing Facility Care | Medicare-covered stays: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100, up to 100 days/benefit period. |
| Diabetic Supplies & Services | 20% coinsurance/testing supplies, diabetic footwear or inserts; \$0 copay/self-management training |
| DMEPOS | 20% coinsurance/Medicare-covered items, up to a \$35 copay/ one-month supply of insulin furnished through an external insulin pump. Medical deductible does not apply. |
| Dental | 20% coinsurance/Medicare-covered dental benefits |
| Chiropractic/Acupuncture | 20% coinsurance/Medicare-covered chiropractic service and Medicare-covered acupuncture service |
| Vision | 20% coinsurance/Medicare-covered diagnostic exam and Medicare-covered eyewear |
| Hearing | 20% coinsurance/Medicare-covered diagnostic exam |
| Medicare Part B Drugs | 20% coinsurance. Part B rebatable drugs may be subject to a lower coinsurance. |
| Discounts & Programs | HealthAdvocate Nurseline |



Medica Prime Solution Basic (H2450-032)

Cost Plan

Enrollment: 800-906-5432
Service: 800-234-8755 • TTY/TDD: 711
medica.com/medicare



Monthly Premium: \$95

| | |
|--------------------------|---|
| Medicare Part D Coverage | No, you can enroll in a separate Part D stand-alone plan for Part D coverage. |
|--------------------------|---|

Medica Prime Solution Basic with Rx (H2450-016)

Cost Plan

Enrollment: 800-906-5432
Service: 800-234-8755 • TTY/TDD: 711
medica.com/medicare



Monthly Premium: \$134

| | |
|--------------------------|--|
| Medicare Part D Coverage | Yes, but if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
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| Medicare Part D Deductible | \$0/tiers 1-2, \$545/tiers 3-5 |
|----------------------------|--------------------------------|

Medica Prime Solution Basic with Rx 2 (H2450-001)

Cost Plan

Enrollment: 800-906-5432
Service: 800-234-8755 • TTY/TDD: 711
medica.com/medicare



Monthly Premium: \$172.40

| | |
|--------------------------|--|
| Medicare Part D Coverage | Yes, but if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
|--------------------------|--|

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|----------------------------|-----|
| Medicare Part D Deductible | \$0 |
|----------------------------|-----|

PLAN DETAILS LISTED BELOW ARE THE SAME FOR ALL PLANS ABOVE.

Plan Area: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St. Louis, Stevens, Traverse, Yellow Medicine Counties

| | |
|--------------------------------------|--|
| Out-of-Pocket Max | \$3,400 annually |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$300/stay, no limit to the number of days covered |
| Physician/Outpatient | Medicare-covered benefits - \$0 copay/primary, \$15 copay/specialist |
| Ambulance | \$25 copay/ground ambulance, \$50 copay/air ambulance |
| Outpatient Surgery | \$50 copay/Medicare-covered surgery in an ambulatory surgical center, \$100 copay/Medicare-covered visit to an outpatient hospital facility |
| Outpatient Mental Health | \$0 copay/visit with other mental health professionals, \$15 copay/visit with psychiatrist, \$20 copay/partial hospitalization program services |
| Emergency/Urgent Care | Emergency: \$50 copay/Medicare-covered visit Urgent Care: \$0-\$20 copay/Medicare-covered visit |
| Travel Coverage | Travel throughout the U.S. and its territories for up to 9 months and receive plan benefits at in-network cost sharing from any provider that accepts Medicare, emergency care is covered worldwide |
| X-rays, Lab & Diagnostic Tests | Medicare-covered benefits: \$0 copay/lab services, \$0-\$15 copay/diagnostic procedures and tests, \$10 copay/x-rays, \$25-\$100 copay/diagnostic radiology services, \$25 copay/therapeutic radiology services |
| Physical/Speech/Occupational Therapy | \$15 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | Medicare-covered stays: \$0 copay/day for days 1-20, \$50 copay/day for days 21-100, up to 100 days/benefit period |
| Diabetic Supplies & Services | \$0 copay/testing supplies, 20% coinsurance/diabetic footwear or inserts; \$0 copay/self-management training |
| DMEPOS | 20% coinsurance/Medicare-covered items, up to a \$35 copay/one-month supply of insulin furnished through an external insulin pump. |
| Dental | \$0-\$15 copay/Medicare-covered dental benefits, up to \$300 reimbursement/all other dental services |
| Chiropractic/Acupuncture | \$15 copay/Medicare-covered chiropractic service, \$0-\$15 copay/Medicare-covered acupuncture service |
| Vision | \$0 copay/1 routine eye exam and up to 2 refractions/year, \$0 copay/Medicare-covered glaucoma and diabetic retinopathy screenings, prescription eyewear allowance of \$100/year, \$0-\$15 copay/Medicare-covered diagnostic exam, \$30 copay/Medicare-covered eyewear |
| Hearing | \$0 copay/1 routine hearing exam/year, hearing aid allowance of \$400/year, \$0-\$15 copay/Medicare-covered diagnostic exam |
| Medicare Part B Drugs | 20% coinsurance. Part B rebatable drugs may be subject to a lower coinsurance. |
| Discounts & Programs | In-Network: One Pass fitness & memory training program, HealthAdvocate Nurseline, \$0 e-visit from Amwell, \$50 quarterly allowance/eligible OTC health and wellness products, no rollover |



Medica Prime Solution Enhanced (H2450-033)

Cost Plan

Enrollment: 800-906-5432
 Service: 800-234-8755 • TTY/TDD: 711
medica.com/medicare



Monthly Premium: \$183

| | |
|---------------------------------|---|
| Medicare Part D Coverage | No, you can enroll in a separate Part D stand-alone plan for Part D coverage. |
|---------------------------------|---|



Medica Prime Solution Enhanced w/Rx 2 (H2450-002)

Cost Plan

Enrollment: 800-906-5432
 Service: 800-234-8755 • TTY/TDD: 711
medica.com/medicare



Monthly Premium: \$247.40

| | |
|-----------------------------------|--|
| Medicare Part D Coverage | Yes, but if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |

PLAN DETAILS LISTED BELOW ARE THE SAME FOR ALL PLANS ABOVE.

Plan Area: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St. Louis, Stevens, Traverse, Yellow Medicine Counties

| | |
|---|---|
| Out-of-Pocket Max | \$3,000 annually |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$0 copay/Medicare-covered hospital stay, \$0 copay/additional days, no limit to the number of days covered |
| Physician/Outpatient | Medicare-covered benefits - \$0 copay/primary, \$10 copay/specialist |
| Ambulance | \$0 copay/ground ambulance, \$50 copay/air ambulance |
| Outpatient Surgery | \$0 copay/Medicare-covered visit to an ambulatory surgical center; \$50 copay/Medicare-covered visit to an outpatient hospital facility |
| Outpatient Mental Health | \$0 copay/visit with other mental health professionals, \$10 copay/visit with psychiatrist, \$10 copay/partial hospitalization program services |
| Emergency/Urgent Care | Emergency: \$50 copay/Medicare-covered visit Urgent Care: \$0-\$10 copay/Medicare-covered visit |
| Travel Coverage | Travel throughout the U.S. and its territories for up to 9 months and receive plan benefits at in-network cost sharing from any provider that accepts Medicare, emergency care is covered worldwide |
| X-rays, Lab & Diagnostic Tests | Medicare-covered benefits: \$0 copay/lab services, \$0-\$10 copay/diagnostic procedures and tests, \$0 copay/x-rays, \$10-\$50 copay/diagnostic radiology services, \$10 copay/therapeutic radiology services |
| Physical/Speech/Occupational Therapy | \$10 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | Medicare-covered stays: \$0 copay/day for days 1-20, \$25 copay/day for days 21-100, up to 100 days/benefit period |
| Diabetic Supplies & Services | \$0 copay/testing supplies and diabetic footwear or inserts; \$0 copay/ self-management training |
| DMEPOS | 0% coinsurance/Medicare-covered items, \$0 copay/one-month supply of insulin furnished through an external insulin pump. |
| Dental | \$0-\$10 copay/Medicare-covered dental benefits, up to \$400 reimbursement for all other dental services |
| Chiropractic/Acupuncture | \$10 copay/Medicare-covered chiropractic service, \$0-\$10 copay/Medicare-covered acupuncture service |
| Vision | \$0 copay/1 routine eye exam and up to 2 refractions/year, \$0 copay/Medicare-covered glaucoma and diabetic retinopathy screenings, prescription eye wear allowance of \$200/year, \$0-\$10 copay/Medicare-covered diagnostic exam, \$30 copay for Medicare-covered eyewear |
| Hearing | \$0 copay/1 routine hearing exam/year, hearing aid allowance of \$400/year, \$0-\$10/Medicare-covered diagnostic exam |
| Medicare Part B Drugs | 20% coinsurance. Part B rebatable drugs may be subject to a lower coinsurance. |
| Discounts & Programs | In-Network: One Pass fitness & memory training program, HealthAdvocate Nurseline, \$0 e-visit from Amwell, \$50 quarterly allowance/eligible OTC health and wellness products, no rollover |

Medicare Advantage Plans

What You Need to Know

Medicare Advantage Plans are a type of Medicare health plan. Advantage Plans are offered by private companies that contract with Medicare to provide all your Medicare benefits. This type of plan is also known as Medicare Part C. You must be enrolled in Part A and Part B to enroll in an Advantage Plan.

- You can only enroll:
 - During your Initial Enrollment Period.
 - During the Medicare Open Enrollment Period.
 - When you are eligible for a Special Enrollment Period.
- Plans may require you to:
 - Use certain health care providers (provider network).
 - Have some services pre-approved and/or have a referral to see a specialist.
- Plans cover additional services not covered under Original Medicare.
- Services received outside the network may not be covered or costs could be higher.
- You must pay your Part B premium, the plan's premium and you will have additional out-of-pocket costs.
- Some plans are not available in all areas.
- See pages 17-18 for more information on Medicare Advantage Plans.

Prescription Drug Coverage

- Part D benefits are provided in most Medicare Advantage Plans.
- If you are enrolled in a Medicare Advantage HMO, HMO-POS, PPO or most MA-SNP Plans, you must get your Medicare Part D coverage through the plan.
- If you are enrolled in a Medicare Advantage Plan with Medicare Part D and you enroll in a Medicare Part D stand-alone plan, you will be DISENROLLED from your Medicare Advantage Plan and returned to Original Medicare.
- See the information on pages 21-24.



Call the Senior LinkAge Line at 800-333-2433 for free help with Medicare-related issues, including appeals and plan options.

AARP Medicare Advantage from UHC SI-0001 (H1278-007)



Advantage PPO Plan

Enrollment: 800-555-5757

Service: 844-867-3487 • TTY: 711

AARPMedicarePlans.com



Monthly Premium: \$0

| Plan Area: Lincoln, Murray, Nobles, Pipeston, Rock Counties | |
|---|--|
| Out-of-Pocket Max | \$4,900 annually/Medicare-covered services. Combined In- and Out-of-Network: \$8,900 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$370 copay/day for days 1-5, \$0 copay/day for days 6+, unlimited inpatient hospital stay days Out-of-Network: \$555 copay/day for days 1-10, \$0 copay/day for days 11+, unlimited inpatient hospital stay days |
| Physician/Outpatient | In-Network: \$0 copay/primary, \$40 copay/specialist Out-of-Network: \$15 copay/primary, \$60 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$320 copay/ambulatory surgical facility, \$0-\$370 copay/outpatient hospital facility, cost sharing for additional plan covered services will apply Outpatient Hospital Out-of-Network: \$0-\$555 copay |
| Outpatient Mental Health | In-Network: \$0 copay/group or individual therapy visit Out-of-Network: \$15 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit (\$0 copay worldwide), copays are waived if admitted within 24 Hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$215 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60 copay/therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays Out-of-Network: \$0-\$215 copay/diagnostic radiology services, \$30 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays |
| Physical/Speech/Occupational Therapy | In-Network: \$20 copay Out-of-Network: \$60 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-40, \$0 copay/day for days 41-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies and self-management training, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment and prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic. \$56 for Dental Platinum Package, \$0-50% coinsurance/comp, for up to \$1,500 per year for covered preventive and comprehensive dental services |
| Chiropractic/Acupuncture | In-Network: \$15 copay/Medicare-covered chiropractic services Out-of-Network: \$60 copay/Medicare-covered chiropractic services. Acupuncture services not covered |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/standard lenses and \$250 credit for frames or contact lenses every 2 years |
| Hearing | \$99-\$1,249 copay/each hearing aid device, limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/all tiers |
| Discounts & Programs | Virtual medical and mental health visits; NurseLine; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Philips Lifeline, PERS; Renew Active; \$40/quarter over-the-counter debit card and catalog, amount expires quarterly |

AARP Medicare Advantage from UHC FG-0002 (H7404-005)



Advantage PPO Plan

Enrollment: 800-555-5757

Service: 844-867-3487 • TTY: 711

AARPMedicarePlans.com



Monthly Premium: \$0

| | |
|---|--|
| Plan Area: Aitkin, Becker, Beltrami, Benton, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahnommen, Marshall, Meeker, Mille Lacs, Morrison, Norman, Otter Tail, Pennington, Pine, Polk, Red Lake, Roseau, St. Louis, Todd, Traverse, Wadena, Wilkin Counties | |
| Out-of-Pocket Max | \$6,300 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$450 copay/day for days 1-4, \$0 copay/day for days 5+, unlimited inpatient hospital stay days |
| Physician/Outpatient | Physician In- and Out-of-Network: \$0 copay/primary, \$45 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$450 copay/ambulatory surgical facility, \$0-\$450 copay/outpatient hospital facility, cost sharing for additional plan covered services will apply Outpatient Hospital Out-of-Network: \$0-\$450 copay |
| Outpatient Mental Health | \$15 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit (\$0 copay worldwide), copays are waived if admitted within 24 Hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$185 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60 copay/therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays Out-of-Network: \$0-\$185 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays |
| Physical/Speech/Occupational Therapy | In-Network: \$25 copay Out-of-Network: \$40 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-28, \$0 copay/day for days 29-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies and self-management training, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment and prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic; \$0-50% coinsurance/comprehensive dental services; \$1,500 benefit limit on covered preventive and comprehensive dental services; Dental Platinum Rider available for an additional \$56/month |
| Chiropractic/Acupuncture | In-Network: \$15 copay/Medicare-covered chiropractic services Out-of-Network: \$45 copay/Medicare-covered chiropractic services. Acupuncture services not covered. |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/standard lenses and \$250 credit for frames or contact lenses every 2 years |
| Hearing | \$99-\$1,249 copay/each hearing aid device, limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$445/tiers 3-5 |
| Discounts & Programs | Virtual medical and mental health visits; NurseLine; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Philips Lifeline, PERS; Renew Active; \$40/quarter over-the-counter debit card and catalog, amount expires quarterly |



AARP Medicare Advantage from UHC MN-0001 (H7404-001)



Advantage PPO Plan

Enrollment: 800-555-5757

Service: 844-867-3487 • TTY: 711

AARPMedicarePlans.com



Monthly Premium: \$0

| Plan Area: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright Counties | |
|--|---|
| Out-of-Pocket Max | In-Network: \$5,400 annually/Medicare-covered services Out-of-Network: \$7,900 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$295 copay/day for days 1-5, \$0 copay/day for days 6+, unlimited days Out-of-Network: \$475 copay/day for days 1-6, \$0 copay/day for days 7+, unlimited days |
| Physician/Outpatient | Physician In-Network or Out-of-Network: \$0 copay/primary, \$40 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$245 copay/ambulatory surgical facility, \$0-\$295 copay/outpatient hospital facility, cost sharing for additional plan covered services will apply Outpatient Hospital Out-of-Network: \$0-\$475 copay |
| Outpatient Mental Health | \$15 copay/group therapy visit or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit (\$0 copay worldwide); copays are waived if admitted within 24 Hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Passport benefit included |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$205 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60 copay/therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays Out-of-Network: \$0-\$205 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/ therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays |
| Physical/Speech/Occupational Therapy | In-Network: \$25 copay Out-of-Network: \$40 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-36, \$0 copay/day for days 37-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies and self-management training, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes/inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment, prosthetics Out-of-Network: 50% coinsurance/durable medical equipment, prosthetics |
| Dental | \$0 copay/preventive and diagnostic; \$0-50% coinsurance/comprehensive dental services; \$1,000 benefit limit on covered preventive and comprehensive dental services |
| Chiropractic/Acupuncture | In-Network: \$10 copay/Medicare-covered chiropractic and acupuncture services, 12 visits per year Out-of-Network: \$40 copay/Medicare-covered chiropractic and acupuncture services, 12 visits per year |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/eyewear every year, \$250 credit for contact lenses or eyeglasses (lenses/frames) every year |
| Hearing | \$99 - \$1,249 copay for each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/all tiers |
| Discounts & Programs | Virtual medical and mental health visits; NurseLine; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Philips Lifeline, PERS; Renew Active; \$40/quarter over-the-counter debit card and catalog, amount expires quarterly |

AARP Medicare Advantage from UHC MN-0003 (H7404-011)



Advantage PPO Plan

Enrollment: 800-555-5757

Service: 844-867-3487 • TTY: 711

AARPMedicarePlans.com



Monthly Premium: \$0

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|---|--|
| Plan Area: Blue Earth, Brown, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, McLeod, Martin, Mower, Nicollet, Olmsted, Renville, Rice, Sibley, Steele, Wabasha, Waseca, Watonwan, Winona Counties | |
| Out-of-Pocket Max | \$6,300 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$450 copay/day for days 1-4, \$0 copay/day for days 5+, unlimited inpatient hospital stay days Out-of-Network: \$595 copay/day for days 1-10, \$0 copay/day for days 11+, unlimited inpatient hospital stay days |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary, \$50 copay/specialist Physician Out-of-Network: \$0 copay/primary, \$60 copay/specialist |
| Ambulance | \$210 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$400 copay/ambulatory surgical facility, \$0-\$450 copay/outpatient hospital facility Outpatient Hospital Out-of-Network: \$0-\$495 copay |
| Outpatient Mental Health | \$15 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit (\$0 copay worldwide); copays are waived if admitted within 24 hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$140 copay/diagnostic radiology services, \$20 copay/diagnostic tests and procedures, \$60 copay/therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays Out-of-Network: \$0-\$140 copay/diagnostic radiology services, \$20 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays |
| Physical/Speech/Occupational Therapy | \$25 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-28, \$0 copay/day for days 29-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic brand monitoring supplies and self-management training, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment and prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive & diagnostic services. Dental Platinum Rider available for an additional \$56/month, \$0-50% coinsurance/comprehensive dental services, for up to \$1,500/year for covered preventive and comprehensive dental services |
| Chiropractic/Acupuncture | In-Network: \$10 copay/Medicare-covered chiropractic services Out-of-Network: \$60 copay/Medicare-covered chiropractic services. Acupuncture services not covered. |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/standard lenses and up to \$250 credit for frames or contact lenses every 2 years |
| Hearing | \$99 - \$1,249 copay/each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$395/tiers 3-5 |
| Discounts & Programs | Virtual medical and mental health visits; Nurse HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Philips Lifeline, PERS; Renew Active |

AARP Medicare Advantage Patriot No Rx FG-MA01 (H7404-015)



Advantage PPO Plan
 Enrollment: 800-555-5757
 Service: 844-867-3487 • TTY: 711
AARPMedicarePlans.com



Monthly Premium: \$0
\$75 Part B Premium Reduction

Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Blue Earth, Brown, Carlton, Carver, Cass, Chisago, Clay, Clearwater, Cook, Crow Wing, Dakota, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Le Sueur, McLeod, Mahnomon, Marshall, Martin, Meeke, Mille Lacs, Morrison, Mower, Nicollet, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Renville, Rice, Roseau, Scott, St. Louis, Sherburne, Sibley, Steele, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright Counties

| | |
|---|--|
| Out-of-Pocket Max | In-Network: \$4,900 annually/Medicare-covered services Combined In- and Out-of-Network: \$8,500 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$395 copay/day for days 1-7, \$0 copay/day for days 8+, unlimited inpatient hospital stay days Out-of-Network: \$495 copay/day for days 1-7, \$0 copay/day for days 8+, unlimited inpatient hospital stay days |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary, \$45 copay/specialist Physician Out-of-Network: \$0 copay/primary, \$60 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$345 copay/ambulatory surgical facility, \$0-\$395 copay/outpatient hospital facility Outpatient Hospital Out-of-Network: \$0-\$495 copay |
| Outpatient Mental Health | \$10 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit (\$0 copay worldwide); copays are waived if admitted within 24 Hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60/copay therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays Out-of-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology, \$0 copay/lab services, \$15 copay/outpatient x-rays |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay Out-of-Network: \$60 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-38, \$0 copay/day for days 39-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies and self-management training, 20% coinsurance for therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment and prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic services, \$0-50% coinsurance/comprehensive services for up to \$2,500 per year for covered preventive and comprehensive dental services |
| Chiropractic/Acupuncture | In-Network: \$15 copay/Medicare-covered chiropractic services Out-of-Network: \$60 copay/Medicare-covered chiropractic services. Acupuncture services not covered. |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/eyewear every year, \$100 credit for contact lenses or eyeglasses (lenses/frames) every year |
| Hearing | \$99-\$1,249 copay/each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Discounts & Programs | Virtual medical and mental health visits; Nursing HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Philips Lifeline, PERS; Renew Active; \$40/quarter over-the-counter debit card and catalog, amount expires quarterly |

AARP Medicare Advantage Patriot No Rx SI-MA01 (H1278-019)



Advantage PPO Plan

Enrollment: 800-555-5757

Service: 844-867-3487 • TTY: 711

AARPMedicarePlans.com



Monthly Premium: \$0
\$100 Part B Premium Reduction

| Plan Area: Lincoln, Murray, Nobles, Pipeston, Rock Counties | |
|---|--|
| Out-of-Pocket Max | \$4,900 annually/Medicare-covered services. Combined In- and Out-of-Network: \$8,900 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$395 copay/day for days 1-7, \$0 copay/day for days 8+, unlimited inpatient hospital stay days Out-of-Network: \$495 copay/day for days 1-7, \$0 copay/day for days 8+, unlimited inpatient hospital stay days |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary, \$45 copay/specialist Physician Out-of-Network: \$25 copay/primary, \$60 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$345 copay/ambulatory surgical facility, \$0-\$395 copay/outpatient hospital facility, cost sharing for additional plan covered services will apply Outpatient Hospital Out-of-Network: \$0-\$395 copay |
| Outpatient Mental Health | In-Network: \$10 copay/group or individual therapy visit Out-of-Network: \$25 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit (\$0 copay worldwide), copays are waived if admitted within 24 Hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60 copay/therapeutic radiology, \$0 copay/lab services, \$25 copay/outpatient x-rays Out-of-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology, \$0 copay/lab services, \$25 copay/outpatient x-rays |
| Physical/Speech/Occupational Therapy | \$40 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-40, \$0 copay/day for days 41-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies and self-management training, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment and prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic; \$0-50% coinsurance/comprehensive dental services; \$2,000 benefit limit on covered preventive and comprehensive dental services |
| Chiropractic/Acupuncture | In-Network: \$15 copay/Medicare-covered chiropractic services Out-of-Network: \$60 copay/Medicare-covered chiropractic services. Acupuncture services not covered. |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/standard lenses and \$100 credit for frames or contact lenses every 2 years |
| Hearing | \$99-\$1,249 copay/each hearing aid device, limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Discounts & Programs | Virtual medical and mental health visits; NurseLine; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Philips Lifeline; Renew Active; \$40/quarter over-the-counter debit card and catalog, amount expires quarterly |



AARP Medicare Advantage from UHC MN-0002 (H7404-002)



Advantage PPO Plan
 Enrollment: 800-555-5757
 Service: 844-867-3487 • TTY: 711
AARPMedicarePlans.com



Monthly Premium: \$38

| Plan Area: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright Counties | |
|--|--|
| Out-of-Pocket Max | In-Network: \$3,800 annually for Medicare-covered services Combined In- and Out-of-Network: \$5,750 annually for Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$395 copay/admit, unlimited inpatient hospital stay days Out-of-Network: \$495 copay/admit for unlimited days |
| Physician/Outpatient | Physician In-Network and Out-of-Network: \$0 copay/primary, \$30 copay/specialist |
| Ambulance | \$275 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$325 copay/ambulatory surgical facility, \$0-\$375 copay/outpatient hospital facility, cost sharing for additional plan covered services Outpatient Hospital Out-of-Network: \$0-\$475 copay, cost sharing/additional plan-covered service |
| Outpatient Mental Health | \$10 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$135 copay/visit (\$0 copay worldwide); copays are waived if admitted within 24 hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Passport benefit covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$25 copay/outpatient x-rays, \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60/copay therapeutic radiology Out-of-Network: \$0 copay/lab services, \$25 copay/outpatient x-rays, \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology |
| Physical/Speech/Occupational Therapy | \$30 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-26, \$0 copay/day for days 27-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment, prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic services, \$0-50% coinsurance/comprehensive services, for up to \$1,500 per year for covered preventive and comprehensive dental services |
| Chiropractic/Acupuncture | In-Network: \$10 copay/Medicare-covered chiropractic and acupuncture services, up to 12 visits per year Out-of-Network: \$30 copay/Medicare-covered chiropractic and acupuncture services |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/eyewear every year, \$150 credit for contact lenses or eyeglasses (lenses/frames) every year |
| Hearing | \$99 - \$1,249 copay for each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/all tiers |
| Discounts & Programs | Virtual medical and mental health visits; Nursing HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Renew Active; Philips LifeLine, PERS; \$45/quarter over-the-counter debit card and catalog, amount expires quarterly |

AARP Medicare Advantage from UHC FG-0001 (H7404-004)



Advantage PPO Plan

Enrollment: 800-555-5757

Service: 844-867-3487 • TTY: 711

AARPMedicarePlans.com



Monthly Premium: \$42.20

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| Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Blue Earth, Brown, Carlton, Carver, Cass, Chisago, Clay, Clearwater, Cook, Crow Wing, Dakota, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Le Sueur, McLeod, Mahnommen, Marshall, Martin, Meeker, Mille Lacs, Morrison, Mower, Nicollet, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Renville, Rice, Roseau, St. Louis, Scott, Sherburne, Sibley, Steele, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright Counties | |
| Out-of-Pocket Max | \$4,900 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$450 copay/day for days 1-5, \$0 copay/day for days 6+, unlimited inpatient hospital stay days |
| Physician/Outpatient | Physician In- and Out-of-Network: \$0 copay/primary, \$35 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$395 copay/ambulatory surgical facility, \$0-\$450 copay/outpatient hospital facility, cost sharing for additional plan covered services will apply Outpatient Hospital Out-of-Network: \$0-\$450 copay, cost sharing for additional plan covered services will apply |
| Outpatient Mental Health | \$0 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit (\$0 copay worldwide); copays are waived if admitted within 24 Hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$25 copay/outpatient x-rays, \$0-\$250 copay/diagnostic radiology services, \$20 copay/diagnostic tests and procedures, \$60/copay therapeutic radiology Out-of-Network: \$0 copay/lab services, \$25 copay/outpatient x-rays, \$0-\$250 copay/diagnostic radiology services, \$20 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology |
| Physical/Speech/Occupational Therapy | \$35 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-22, \$0 copay/day for days 23-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic brand monitoring supplies, 20% coinsurance for therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment and prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic services; \$0-50% coinsurance/comprehensive services, for up to \$1,500 per year for covered preventive and comprehensive dental services |
| Chiropractic/Acupuncture | In-Network: \$10 copay/Medicare-covered chiropractic services, up to 18 visits per year Out-of-Network: \$35 copay/Medicare-covered chiropractic services. Acupuncture services not covered. |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/eyewear and \$200 credit for contact lenses or eyeglasses (lenses/frames) every year |
| Hearing | \$99 - \$1,249 copay for each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$545/all tiers |
| Discounts & Programs | Virtual medical and mental health visits; Nursing HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Philips LifeLine, PERS; Renew Active; \$105/quarter over-the-counter debit card and catalog, amount expires quarterly |



AARP Medicare Advantage from UHC MN-0004 (H7404-012)



Advantage PPO Plan
 Enrollment: 800-555-5757
 Service: 844-867-3487 • TTY: 711
AARPMedicarePlans.com



Monthly Premium: \$58

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| Plan Area: Blue Earth, Brown, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, McLeod, Martin, Mower, Nicollet, Olmsted, Renville, Rice, Sibley, Steele, Wabasha, Waseca, Watonwan, Winona Counties | |
| Out-of-Pocket Max | \$4,900 annually for Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$390 copay/day for days 1-5, \$0 copay/day for days 6+, unlimited inpatient hospital stay days |
| Physician/Outpatient | Physician In- and Out-of-Network: \$0 copay/primary, \$40 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$290 copay/ambulatory surgical facility, \$0-\$390 copay/outpatient hospital facility, cost sharing for additional plan covered services will apply Outpatient Hospital Out-of-Network: \$0-\$390 copay, cost sharing for additional plan covered services will apply |
| Outpatient Mental Health | \$5 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit (\$0 copay worldwide); copays are waived if admitted in 24 hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$25 copay/service for outpatient x-rays, \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60/copay therapeutic radiology Out-of-Network: \$0 copay/lab services, \$25 copay/service for outpatient x-rays, \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology |
| Physical/Speech/Occupational Therapy | \$40 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-22, \$0 copay/day for days 23-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies and self-management training, 20% coinsurance for therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts, \$0 copay/self-management training |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment and prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic services, \$50 for Dental Platinum Package, \$0 copay-50% coinsurance/comprehensive services, for up to \$1,500 per year for covered preventive and comprehensive dental services. |
| Chiropractic/Acupuncture | In-Network: \$15 copay/Medicare-covered chiropractic services Out-of-Network: \$40 copay/Medicare-covered chiropractic services. Acupuncture services not covered. |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/standard lenses and \$150 credit for frames or contact lenses every 2 years |
| Hearing | \$99 - \$1,249 copay/each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2; \$295/tiers 3-5 |
| Discounts & Programs | Virtual medical and mental health visits; Nursing HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Renew Active, PERS; Philips LifeLine; \$40/quarter over-the-counter debit card and catalog, amount expires quarterly |

AARP Medicare Advantage from UHC FG-0003 (H7404-006)



Advantage PPO Plan

Enrollment: 800-555-5757

Service: 844-867-3487 • TTY: 711

AARPMedicarePlans.com



Monthly Premium: \$50

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| Plan Area: Aitkin, Becker, Beltrami, Benton, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomon, Marshall, Meeker, Mille Lacs, Morrison, Norman, Otter Tail, Pennington, Pine, Polk, Red Lake, Roseau, St. Louis, Todd, Traverse, Wadena, Wilkin Counties | |
| Out-of-Pocket Max | \$4,900 annually for Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$450 copay/day for days 1-5, \$0 copay/day for days 6+, unlimited inpatient hospital stay days |
| Physician/Outpatient | Physician In- and Out-of-Network: \$0 copay/primary, \$35 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$395 copay/ambulatory surgical facility, \$0-\$450 copay/outpatient hospital facility, cost sharing for additional plan covered services Outpatient Hospital Out-of-Network: \$0-\$450 copay, cost sharing/additional plan-covered service |
| Outpatient Mental Health | \$10 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit (\$0 copay worldwide), copays are waived if admitted within 24 hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60/copay therapeutic radiology, \$0 copay/lab services, \$25 copay/service for outpatient x-rays Out-of-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology, \$0 copay/lab services, \$25 copay/service for outpatient x-rays |
| Physical/Speech/Occupational Therapy | \$35 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-22, \$0 copay/day for days 23-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies, self-management training, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment, prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic services, \$0-50% coinsurance/comprehensive services, for up to \$1,000 per year for covered preventive and comprehensive dental services. |
| Chiropractic/Acupuncture | In-Network: \$10 copay/Medicare-covered chiropractic services, up to 12 visits per year Out-of-Network: \$35 copay/Medicare-covered chiropractic services. Acupuncture services not covered. |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/standard lenses and \$200 credit for frames or contact lenses every 2 years |
| Hearing | \$99-\$1,249 copay/each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2; \$295/tiers 3- 5 |
| Discounts & Programs | Virtual medical and mental health visits; Nursing HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Renew Active; Philips LifeLine, PERS; \$50/quarter over-the-counter debit card and catalog, amount expires quarterly |

AARP Medicare Advantage from UHC MN-0005 (H7404-014)



Advantage PPO Plan
 Enrollment: 800-555-5757
 Service: 844-867-3487 • TTY: 711
AARPMedicarePlans.com



Monthly Premium: \$66

| Plan Area: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright Counties | |
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| Out-of-Pocket Max | In-Network: \$2,900 annually/Medicare-covered services Combined In- and Out-of-Network: \$5,100 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$195 copay/admit, unlimited inpatient hospital stay days Out-of-Network: \$295 copay/admit for unlimited days |
| Physician/Outpatient | \$0 copay/primary, \$20 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$145 copay/ambulatory surgical facility, \$0-\$195 copay/outpatient hospital facility, cost sharing for additional plan covered services Outpatient Hospital Out-of-Network: \$0-\$295 copay, cost sharing/additional plan-covered service |
| Outpatient Mental Health | \$0 copay/group therapy visit or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$135 copay/visit (\$0 copay worldwide); copays are waived if admitted within 24 hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Passport benefit covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60/copy therapeutic radiology, \$0 copay/lab services, \$25 copay/outpatient x-rays Out-of-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology, \$0 copay/lab services, \$25 copay/outpatient x-rays |
| Physical/Speech/Occupational Therapy | \$20 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-23, \$0 copay/day for days 24-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment, prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic services, \$0-50% coinsurance/comprehensive services, for up to \$2,500 per year for covered preventive and comprehensive dental services. |
| Chiropractic/Acupuncture | In-Network: \$10 copay/Medicare-covered chiropractic services, \$10 copay/Medicare-covered acupuncture services, up to 12 visits per year Out-of-Network: \$20 copay/Medicare-covered chiropractic services, \$20 copay/Medicare-covered acupuncture services |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/standard lenses and \$200 credit for frames or contact lenses every 2 years |
| Hearing | \$99-\$1,249 copay for each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/all tiers |
| Discounts & Programs | Virtual medical and mental health visits; Nursing HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Renew Active; Philips LifeLine, PERS; \$50/quarter over-the-counter debit card and catalog, amount expires quarterly |

AARP Medicare Advantage from UHC FG-0004 (H7404-022)



Advantage PPO Plan

Enrollment: 800-555-5757

Service: 844-867-3487 • TTY: 711

AARPMedicarePlans.com



Monthly Premium: \$90

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| Plan Area: Aitkin, Becker, Beltrami, Benton, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomon, Marshall, Meeker, Mille Lacs, Morrison, Norman, Otter Tail, Pennington, Pine, Polk, Red Lake, Roseau, St. Louis, Todd, Traverse, Wadena, Wilkin Counties | |
| Out-of-Pocket Max | \$3,500 annually for Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$195 copay/admit, unlimited inpatient hospital stay days |
| Physician/Outpatient | \$0 copay/primary, \$25 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$145 copay/ambulatory surgical facility, \$0-\$195 copay/outpatient hospital facility, cost sharing for additional plan covered services Outpatient Hospital Out-of-Network: \$0-\$195 copay, cost sharing/additional plan-covered service |
| Outpatient Mental Health | \$0 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$135 copay/visit (\$0 copay worldwide), copays are waived if admitted within 24 hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60/copy therapeutic radiology, \$0 copay/lab services, \$25 copay/service for outpatient x-rays Out-of-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology, \$0 copay/lab services, \$25 copay/service for outpatient x-rays |
| Physical/Speech/Occupational Therapy | \$25 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-16, \$0 copay/day for days 17-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment, prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic services, \$0-50% coinsurance/comprehensive services, for up to \$1,250 per year for covered preventive and comprehensive dental services. |
| Chiropractic/Acupuncture | In-Network: \$10 copay/Medicare-covered chiropractic services Out-of-Network: \$25 copay/Medicare-covered chiropractic services, up to 12 visits per year. Acupuncture services not covered. |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/standard lenses and \$250 credit for frames or contact lenses every 2 years |
| Hearing | \$99-\$1,249 copay/each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/all tiers |
| Discounts & Programs | Virtual medical and mental health visits; Nursing HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Renew Active; Philips LifeLine, PERS; \$60/quarter over-the-counter debit card and catalog, amount expires quarterly |



AARP Medicare Advantage from UHC MN-0006 (H7404-023)



Advantage PPO Plan

Enrollment: 800-555-5757

Service: 844-867-3487 • TTY: 711

AARPMedicarePlans.com



Monthly Premium: \$108

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| Plan Area: Blue Earth, Brown, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, McLeod, Martin, Mower, Nicollet, Olmsted, Renville, Rice, Sibley, Steele, Wabasha, Waseca, Watonwan, Winona Counties | |
| Out-of-Pocket Max | \$3,800 annually for Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$300 copay/admit, unlimited inpatient hospital stay days Out-of-Network: \$500 copay/days 1-10, \$0 copay/days 11+ |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary, \$30 copay/specialist Physician Out-of-Network: \$0 copay/primary, \$60 copay/specialist |
| Ambulance | \$290 copay/ground or air ambulance, copays are not waived if admitted |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$250 copay/ambulatory surgical facility, \$0-\$300 copay/outpatient hospital facility, cost sharing for additional plan covered services Outpatient Hospital Out-of-Network: \$0-\$300 copay, cost sharing/additional plan-covered service |
| Outpatient Mental Health | \$0 copay/group or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$135 copay/visit (\$0 copay worldwide), copays are waived if admitted within 24 hours Urgent Care: \$40 copay/visit (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, \$60/copay therapeutic radiology, \$0 copay/lab services, \$25 copay/service for outpatient x-rays Out-of-Network: \$0-\$250 copay/diagnostic radiology services, \$50 copay/diagnostic tests and procedures, 40% coinsurance/therapeutic radiology, \$0 copay/lab services, \$25 copay/service for outpatient x-rays |
| Physical/Speech/Occupational Therapy | In-Network: \$30 copay Out-of-Network: \$60 copay |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: \$225 copay/day for days 1-17, \$0 copay/day for days 18-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic monitoring supplies, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 50% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment, prosthetics Out-of-Network: 50% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive and diagnostic services, \$0-50% coinsurance/comprehensive services, for up to \$1,000 per year for covered preventive and comprehensive dental services. |
| Chiropractic/Acupuncture | In-Network: \$15 copay/Medicare-covered chiropractic services Out-of-Network: \$60 copay/Medicare-covered chiropractic services. Acupuncture services not covered. |
| Vision | \$0 copay/1 routine eye exam every year; \$0 copay/standard lenses and \$200 credit for frames or contact lenses every 2 years |
| Hearing | \$99-\$1,249 copay/each hearing aid device; limited to 2 devices every year, \$0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-40% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/all tiers |
| Discounts & Programs | Virtual medical and mental health visits; Nursing HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Renew Active; Philips LifeLine, PERS; \$50/quarter over-the-counter debit card and catalog, amount expires quarterly |





Align ChoicePlus (H3186-002)

Advantage PPO Plan

Enrollment: 888-535-4831 • TTY: 711

Service: 888-278-6485 • TTY: 888-279-1549

align.sanfordhealthplan.com



Monthly Premium: \$0

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| Plan Area: Becker, Beltrami, Big Stone, Clay, Clearwater, Hubbard, Lac qui Parle, Mahnommen, Marshall, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Red Lake, Rock, Traverse, Wilkin Counties | |
| Out-of-Pocket Max | \$4,500 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$125 copay/day for days 1-4, \$0 for days 5-90 Out-of-Network: Call the plan for details. |
| Physician/Outpatient | In-Network: \$0 copay/primary or specialist Out-of-Network: \$10-90 copay or 20% coinsurance/primary or specialist |
| Ambulance | \$240 copay/Medicare-covered ground ambulance trip, contact the plan for cost sharing for air ambulance |
| Outpatient Surgery | In-Network: \$200 copay/visit Medicare-covered outpatient surgery performed in a hospital facility or ambulatory surgical center Out-of-Network: Call the plan for cost sharing |
| Outpatient Mental Health | In-Network: \$15-\$20 copay/Medicare-covered outpatient mental health service Out-of-Network: \$10-90 copay or 20% coinsurance/Medicare-covered outpatient mental health service |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$35 copay/visit |
| Travel Coverage | Call the plan for details. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$15 copay/outpatient x-ray; \$0 copay/outpatient lab services; \$0-\$325 copay/diagnostic radiology services Out-of-Network: \$10-\$600 copay or 20% coinsurance/oupatient x-ray, outpatient lab services and diagnostic radiology services Note: Prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$30 copay/occupational, physical, speech and language therapy visit Out-of-Network: \$10-90 copay or 20% coinsurance/occupational, physical, speech and language therapy visit |
| Skilled Nursing Facility Care | Call the plan for details. |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies Out-of-Network: 0-20% coinsurance per item |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 0-20% coinsurance per item Note: Prior authorization is required for certain DME and related supplies |
| Dental | Preventive: \$0 copay/oral exam, cleaning and x-rays, limits apply Comprehensive: \$0 copay/restorative services, endodontics, periodeontics, extractions, prosthodontics, other oral/maxillofacial surgery and other services, limits apply |
| Chiropractic/Acupuncture | Chiropractic services have some coverage. Acupuncture services not covered. |
| Vision | In-Network: \$0 copay/routine eye exam, \$0 copay for glasses/eyewear/contacts Out-of-Network: 0-50% coinsurance/eye exam, glasses/eyewear/contacts. Limits apply. |
| Hearing | In-Network: \$0 copay/hearing exams Out-of-Network: 0-50% coinsurance/hearing exams |
| Medicare Part B Drugs | In-Network: \$100 copay or 0-20% coinsurance Out-of-Network: 0-20% coinsurance Note: Prior authorization may be required. |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$200/tiers 3-5 |
| Discounts & Programs | Call the plan for details. |



Align ChoiceElite (H3186-001)

Advantage PPO Plan

Enrollment: 888-535-4831 • TTY: 711

Service: 888-278-6485 • TTY: 888-279-1549

align.sanfordhealthplan.com



Monthly Premium: \$60

Plan Area: Becker, Beltrami, Big Stone, Clay, Clearwater, Hubbard, Lac qui Parle, Mahnommen, Marshall, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Red Lake, Rock, Traverse, Wilkin Counties

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|---|--|
| Out-of-Pocket Max | \$2,750 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$50 copay/day for days 1-4, \$0 for days 5-90 Out-of-Network: Call the plan for details. |
| Physician/Outpatient | In-Network: \$0 copay/primary or specialist Out-of-Network: \$10-90 copay or 20% coinsurance/primary or specialist |
| Ambulance | \$200 copay/Medicare-covered ground ambulance trip, contact the plan for cost sharing for air ambulance |
| Outpatient Surgery | In-Network: \$150 copay/visit Medicare-covered outpatient surgery performed in a hospital facility or ambulatory surgical center Out-of-Network: Call the plan for cost sharing |
| Outpatient Mental Health | In-Network: \$10-\$30 copay/Medicare-covered outpatient mental health service Out-of-Network: \$10-90 copay or 20% coinsurance/Medicare-covered outpatient mental health service |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$30 copay/visit |
| Travel Coverage | Call the plan for details. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$15 copay/outpatient x-ray; \$0 copay/outpatient lab services; \$0-\$140 copay/diagnostic radiology services Out-of-Network: \$10-\$250 copay or 20% coinsurance/outpatient x-ray, outpatient lab services and diagnostic radiology services Note: Prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$30 copay/occupational, physical, speech and language therapy visit Out-of-Network: \$10-90 copay or 20% coinsurance/occupational, physical, speech and language therapy visit |
| Skilled Nursing Facility Care | Call the plan for details. |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies Out-of-Network: 0-20% coinsurance per item |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 0-20% coinsurance per item Note: Prior authorization is required for certain DME and related supplies |
| Dental | Preventive: \$0 copay/oral exam, cleaning and x-rays, limits apply Comprehensive: \$0 copay/restorative services, endodontics, periodontics, extractions, prosthodontics, other oral/maxillofacial surgery and other services, limits apply |
| Chiropractic/Acupuncture | Chiropractic services have some coverage. Acupuncture services not covered. |
| Vision | In-Network: \$0 copay/routine eye exam, \$0 copay for glasses/eyewear/contacts Out-of-Network: 0-50% coinsurance/eye exam, glasses/eyewear/contacts. Limits apply. |
| Hearing | In-Network: \$0 copay/hearing exams Out-of-Network: 0-50% coinsurance/hearing exams |
| Medicare Part B Drugs | In-Network: \$100 copay or 20% coinsurance/chemotherapy drugs, 20% coinsurance/other Part B drugs Out-of-Network: 0-20% coinsurance/chemotherapy drug or other Part B drugs Note: Prior authorization may be required. |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$200/tiers 3-5 |
| Discounts & Programs | Call the plan for details. |



Monthly Premium: \$0
\$100 Part B Premium Reduction

Plan Area: Anoka, Blue Earth, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, Le Sueur, McLeod, Meeker, Mille Lacs, Nicollet, Ramsey, Renville, Scott, Sibley, Steele, Waseca, Washington, Wright Counties

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|---|---|
| Out-of-Pocket Max | In-Network: \$4,500 annually Combined In- and Out-of-Network: \$7,000 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$250/day for days 1-5; \$0/day for days 6-90/medically-necessary covered inpatient stay; \$0 copay/additional days Out-of-Network: 30% coinsurance/medically-necessary covered inpatient stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary; \$35 copay/specialist Out-of-Network: 30% coinsurance/primary; \$50 copay/specialist |
| Ambulance | \$295 copay/Medicare-covered ground or air ambulance |
| Outpatient Surgery | In-Network: \$350 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$250 copay/ambulatory surgical center service Out-of-Network: \$500 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$450/ambulatory surgical center service |
| Outpatient Mental Health | In-Network: \$20 copay/individual or group mental health service Out-of-Network: \$50 copay/individual or group mental health service |
| Emergency/Urgent Care | Emergency Care: \$110 copay/visit, copay waived if admitted to the hospital Urgent Care: \$35 copay/Medicare-covered visit |
| Travel Coverage | \$110 copay/emergency or urgent care outside the U.S., emergency copay waived if admitted to the hospital, members can access in-network providers across the U.S. for routine or non-emergency care when they travel |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits - \$0 copay/lab service; \$15 copay/x-ray, diagnostic procedure and test; \$150 copay/diagnostic radiology service; 20% coinsurance/therapeutic radiology service Out-of-Network: \$35 copay/lab service; \$60 copay/x-ray, diagnostic procedure and test; \$250 copay/diagnostic radiology service; 30% coinsurance/therapeutic radiology service |
| Physical/Speech/Occupational Therapy | In-Network: \$35 copay/Medicare-covered occupational/physical/speech therapy service Out-of-Network: \$50 copay/Medicare-covered occupational/physical/speech therapy service |
| Skilled Nursing Facility Care | In-Network: \$0/day for days 1-20, \$203/day for days 21-43; \$0/day for days 44-100 for each stay Out-of-Network: 30% coinsurance/stay Note: prior authorization required, which is the provider's responsibility |
| Diabetic Supplies & Services | In-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; \$0 copay/self-management training and diabetic shoes and inserts Out-of-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; 30% coinsurance/self-management training; 20% coinsurance/diabetic shoes and inserts Note: 0% cost share for OneTouch/Lifescan supplies. Other brands are not covered unless medical exception is granted. If exception granted 20% coinsurance applies |
| DMEPOS | 20% coinsurance/Medicare-covered item, 0% continuous glucose monitor and supplies (prior auth required) |
| Dental | In-Network: \$35 copay/Medicare-covered dental service Out-of-Network: \$50 copay/Medicare-covered dental service Note: dental reimbursement of up to \$2,250/preventive and comprehensive dental services/year |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic or acupuncture service; \$20 copay/non-Medicare covered chiropractic or acupuncture service up to 18 chiropractic and 18 acupuncture visits/year |
| Vision | In-Network: \$0 copay/glaucoma screening and diabetic eye exam; \$35 copay/other Medicare-covered eye exam; \$0 copay/1 routine eye exam/year Out-of-Network: \$50 copay/Medicare-covered vision service; \$50 copay/1 routine eye exam/year Note: eyewear reimbursement up to \$200/contacts and glasses/year |
| Hearing | In-Network: \$35 copay/Medicare-covered hearing service; \$0 copay/1 routine hearing exam/year Out-of-Network: \$50 copay/Medicare-covered hearing service; 30% coinsurance/1 routine hearing exam/year; Hearing aids: Up to \$1,000 per ear per year through NationsHearing |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance Note: prior authorization may be required and is the provider's responsibility |
| Medicare Part D Coverage | No, if you enroll in a separate Part D stand-alone plan you will be disenrolled from this health plan |
| Discounts & Programs | Healthy Rewards Program, SilverSneakers, \$90 quarterly/over-the-counter drugs and supplies, meal benefit (14 meals/7 days post discharge) and 24/7 NurseLine, PERS included; Telehealth: in-network primary care, specialty care, mental health, urgent care, physical therapy, speech therapy, occupational therapy, substance abuse, opioid treatment services, diabetes self-management training, and kidney disease education services through a virtual visit are the same cost as an in-person visit, \$500 annual allowance to pay for out-of-pocket dental, vision, and hearing costs, Routine Podiatry Services: \$35 copay, 12 visits per year |



Monthly Premium: \$0
\$30 Part B Premium Reduction

| Plan Area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington, Wright Counties | |
|--|---|
| Out-of-Pocket Max | In-Network: \$4,500 annually Combined In- and Out-of-Network: \$7,000 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$350/day for days 1-5; \$0/day for days 6-90/medically-necessary covered inpatient stay; \$0 copay/additional days Out-of-Network: 30% coinsurance/medically-necessary covered inpatient stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary; \$35 copay/specialist Out-of-Network: 30% coinsurance/primary; \$50 copay/specialist |
| Ambulance | \$335 copay/Medicare-covered ground or air ambulance |
| Outpatient Surgery | In-Network: \$400 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$300 copay/ambulatory surgical center service Out-of-Network: \$500 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$450/ambulatory surgical center service |
| Outpatient Mental Health | In-Network: \$35 copay/individual or group mental health service Out-of-Network: \$50 copay/individual or group mental health service |
| Emergency/Urgent Care | Emergency Care: \$120 copay/visit, copay waived if admitted to the hospital Urgent Care: \$35 copay/Medicare-covered visit |
| Travel Coverage | \$120 copay/emergency or urgent care outside the U.S., emergency copay waived if admitted to the hospital, members can access in-network providers across the U.S. for routine or non-emergency care when they travel |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits - \$0 copay/lab service; \$25 copay/x-ray, diagnostic procedure and test; \$250 copay/diagnostic radiology service; 20% coinsurance/therapeutic radiology service Out-of-Network: \$35 copay/lab service; \$50 copay/x-ray, diagnostic procedure and test; \$350 copay/diagnostic radiology service; 30% coinsurance/therapeutic radiology service |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered occupational/physical/speech therapy service Out-of-Network: \$50 copay/Medicare-covered occupational/physical/speech therapy service |
| Skilled Nursing Facility Care | In-Network: \$0/day for days 1-20, \$203/day for days 21-43; \$0/day for days 44-100 for each stay Out-of-Network: 30% coinsurance/stay Note: prior authorization required, which is the provider's responsibility |
| Diabetic Supplies & Services | In-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; \$0 copay/selfmanagement training and diabetic shoes and inserts Out-of-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; 30% coinsurance/self-management training; 20% coinsurance/diabetic shoes and inserts Note: 0% cost share for OneTouch/Lifescan supplies. Other brands are not covered unless medical exception is granted. If exception granted 20% coinsurance applies |
| DMEPOS | 20% coinsurance/Medicare-covered item; 0% continuous glucose monitor and supplies (prior auth required) |
| Dental | In-Network: \$35 copay/Medicare-covered dental service Out-of-Network: \$50 copay/Medicare-covered dental service Note: dental reimbursement of up to \$2,550/preventive and comprehensive dental services/year |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic or acupuncture service; \$20 copay/non-Medicare covered chiropractic or acupuncture service up to 18 chiropractic and 18 acupuncture visits/year |
| Vision | In-Network: \$0 copay/glaucoma screening and diabetic eye exam; \$35 copay/other Medicare-covered eye exam; \$0 copay/1 routine eye exam/year Out-of-Network: \$50 copay/Medicare-covered vision service; \$50 copay/1 routine eye exam/year Note: eyewear reimbursement up to \$200/contacts and glasses/year |
| Hearing | In-Network: \$35 copay/Medicare-covered hearing service; \$0 copay/1 routine hearing exam/year Out-of-Network: \$50 copay/Medicare-covered hearing service; 30% coinsurance/1 routine hearing exam/year; Hearing aids: Up to \$500 per ear per year through NationsHearing |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance Note: prior authorization may be required and is the provider's responsibility |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2; \$400/tiers 3-5 |
| Discounts & Programs | Healthy Rewards Program, SilverSneakers, \$75 quarterly/over-the-counter drugs and supplies, meal benefit (14 meals/7 days post discharge) and 24/7 NurseLine; Telehealth: in-network primary care, specialty care, mental health, urgent care, physical therapy, speech therapy, occupational therapy, substance abuse, opioid treatment services, diabetes self-management training, and kidney disease education services through a virtual visit are the same cost as an in-person visit. up to \$1,200 every year for qualified non-participating fitness location enrollment and/or membership fees, health activity fees, health related supplies and health equipment. Routine Podiatry: \$35 copay for 12 visits per year. |



Plan Area: Anoka, Blue Earth, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, Le Sueur, McLeod, Meeker, Mille Lacs, Nicollet, Ramsey, Renville, Scott, Sibley, Steele, Waseca, Washington, Wright Counties

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|---|--|
| Out-of-Pocket Max | In-Network: \$3,800 annually Combined In- and Out-of-Network: \$5,750 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$250/day for days 1-5; \$0/day for days 6-90/medically-necessary covered inpatient stay; \$0 copay/additional days Out-of-Network: 30% coinsurance/medically-necessary covered inpatient stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary; \$35 copay/specialist Out-of-Network: 30% coinsurance/primary; \$50 copay/specialist. |
| Ambulance | \$305 copay/Medicare-covered ground or air ambulance |
| Outpatient Surgery | In-Network: \$275 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$250 copay/ambulatory surgical center service Out-of-Network: \$450 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$400/ambulatory surgical center service |
| Outpatient Mental Health | In-Network: \$35 copay/individual or group mental health service Out-of-Network: \$50 copay |
| Emergency/Urgent Care | Emergency Care: \$110 copay/visit, copay waived if admitted to the hospital Urgent Care: \$35 copay/Medicare-covered visit |
| Travel Coverage | \$110 copay/emergency or urgent care outside the U.S., emergency copay waived if admitted to the hospital, members can access in-network providers across the U.S. for routine or non-emergency care when they travel |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits: \$0 copay/lab service; \$15 copay/x-ray, diagnostic procedure and test; \$150 copay/diagnostic radiology service; 20% coinsurance/therapeutic radiology service Out-of-Network: \$35 copay/lab service; \$60 copay/x-ray, diagnostic procedure and test; \$250 copay/diagnostic radiology service; 30% coinsurance/therapeutic radiology service |
| Physical/Speech/Occupational Therapy | In-Network: \$25 copay/Medicare-covered occupational/physical/speech therapy service Out-of-Network: \$50 copay |
| Skilled Nursing Facility Care | In-Network: \$0/day for days 1-20, \$203/day for days 21-39; \$0/day for days 40-100 for each stay Out-of-Network: 30% coinsurance/stay Note: prior authorization required, which is the provider's responsibility |
| Diabetic Supplies & Services | In-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; \$0 copay/self-management training and diabetic shoes and inserts Out-of-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; 30% coinsurance/self-management training; 20% coinsurance/diabetic shoes and inserts Note: 0% cost share for OneTouch/Lifescan supplies, other brands are not covered unless medical exception is granted; if exception granted, 20% coinsurance applies |
| DMEPOS | 20% coinsurance/Medicare-covered item, 0% continuous glucose monitor and supplies (prior auth required) |
| Dental | In-Network: \$35 copay/Medicare-covered dental service Out-of-Network: \$50 copay/Medicare-covered dental service Note: Dental reimbursement of up to \$1,750/preventive and comprehensive dental service/year |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic or acupuncture service; \$20 copay/non-Medicare covered chiropractic or acupuncture service up to 18 chiropractic and 18 acupuncture visits/year |
| Vision | In-Network: \$0 copay/glaucoma screening and diabetic eye exam; \$35 copay/other Medicare-covered eye exam; \$0 copay/1 routine eye exam/year Out-of-Network: \$50 copay/Medicare-covered vision service; \$50 copay/1 routine eye exam/year Note: Eyewear reimbursement up to \$200/contacts and glasses/year |
| Hearing | In-Network: \$35 copay/Medicare-covered hearing service; \$0 copay/1 routine hearing exam/year Out-of-Network: \$50 copay/Medicare-covered hearing service; 30% coinsurance/1 routine hearing exam/year; Hearing aids: Up to \$500 per ear per year through NationsHearing |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance Note: Prior authorization may be required and is the provider's responsibility |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2; \$300/tiers 3-5 |
| Discounts & Programs | Healthy Rewards Program, SilverSneakers, \$75 quarterly/over-the-counter drugs and supplies, meal benefit (14 meals/7 days post discharge) and 24/7 NurseLine, PERS included; Telehealth: in-network primary care, specialty care, mental health, urgent care, physical therapy, speech therapy, occupational therapy, substance abuse, opioid treatment services, diabetes self-management training, and kidney disease education services through a virtual visit are the same cost as an in-person visit, Allina Health Aetna Medicare Payment Card \$200 added to a debit card quarterly for certain in- and out-of-network cost shares for covered medical services. Fitness Reimbursement: up to \$360 every year for qualified non-participating fitness location enrollment and/or membership fees, health activity fees, health related supplies and health equipment, Routine Podiatry Services: \$35 copay, 12 visits per year. |



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| Plan Area: Anoka, Blue Earth, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, Le Sueur, McLeod, Meeker, Mille Lacs, Nicollet, Ramsey, Renville, Scott, Sibley, Steele, Waseca, Washington, Wright Counties | |
| Out-of-Pocket Max | In-Network and Out-of-Network: \$3,650 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$350 copay/stay Out-of-Network: 20% coinsurance/medically-necessary covered inpatient stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary; \$25 copay/specialist Out-of-Network: \$25 copay/primary; \$25 copay/specialist |
| Ambulance | \$300 copay/Medicare-covered ground or air ambulance |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$250 copay/ambulatory surgical center service Out-of-Network: \$450 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$400/ambulatory surgical center service |
| Outpatient Mental Health | In-Network: \$25 copay/individual or group mental health service Out-of-Network: \$25 copay/individual or group mental health service |
| Emergency/Urgent Care | Emergency Care: \$110 copay/visit, copay waived if admitted to the hospital Urgent Care: \$25 copay/Medicare-covered visit |
| Travel Coverage | \$110 copay/emergency or urgent care outside the U.S., emergency copay waived if admitted to the hospital, members can access in-network providers across the U.S. for routine or non-emergency care when they travel |
| X-rays, Lab & Diagnostic Tests | Medicare-covered benefits - \$0 copay/lab service; \$10 copay/x-ray, diagnostic procedure and test; \$125 copay/diagnostic radiology service; 20% coinsurance/therapeutic radiology service |
| Physical/Speech/Occupational Therapy | In-Network: \$25 copay/Medicare-covered occupational/physical/speech therapy service Out-of-Network: \$45 copay/Medicare-covered occupational/physical/speech therapy service |
| Skilled Nursing Facility Care | In-Network: \$0/day for days 1-20, \$203/day for days 21-38; \$0/day for days 39-100 for each stay Out-of-Network: 20% coinsurance/stay Note: prior authorization required, which is the provider's responsibility |
| Diabetic Supplies & Services | In-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; \$0 copay/self-management training and diabetic shoes and inserts Out-of-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; 20% coinsurance/self-management training and diabetic shoes and inserts Note: 0% cost share for OneTouch/Lifescan supplies. Other brands are not covered unless medical exception is granted. If exception granted 20% coinsurance applies |
| DMEPOS | 20% coinsurance/Medicare-covered item, 0% Continuous Glucose Monitor and supplies (prior auth required) |
| Dental | In-Network: \$25 copay/Medicare-covered dental service Out-of-Network: \$25 copay/Medicare-covered dental service Note: dental reimbursement of up to \$1,250/preventive and comprehensive dental services/year |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic or acupuncture service; \$20 copay/non-Medicare covered chiropractic or acupuncture service up to 18 chiropractic and 18 acupuncture services/year |
| Vision | In-Network: \$0 copay/glaucoma screening and diabetic eye exam; \$25 copay/other eye exam; \$0 copay/1 routine eye exam/year Out-of-Network: \$25 copay/Medicare-covered vision service; \$0 copay/1 routine eye exam/year Note: eyewear reimbursement up to \$175/contacts and glasses/year |
| Hearing | \$25 copay/Medicare-covered hearing service; \$0 copay/1 routine hearing exam/year Hearing aids: Up to \$750 per ear per year through NationsHearing |
| Medicare Part B Drugs | 20% coinsurance Note: prior authorization may be required and is the provider's responsibility |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2; \$150/tiers 3- 5 |
| Discounts & Programs | Healthy Rewards Program, SilverSneakers, \$75 quarterly/over-the-counter drugs and supplies, meal benefit (14 meals/7 days post discharge), 24/7 NurseLine; Telehealth, PERS included: in-network primary care, specialty care, mental health, urgent care, physical therapy, speech therapy, occupational thereapy, substance abuse, opioid treatment services, diabetes self-management training, and kidney disease education services through a virtual visit are the same cost as an in-person visit. Plan provides an Extra Benefits card with a \$500 annual allowance to pay for out-of-pocket dental, vision, and hearing costs. Routine Podiatry Services: \$25 copay, 12 visits per year. |



Plan Area: Anoka, Blue Earth, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, Le Sueur, McLeod, Meeker, Mille Lacs, Nicollet, Ramsey, Renville, Scott, Sibley, Steele, Waseca, Washington, Wright Counties

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|---|--|
| Out-of-Pocket Max | In-Network: \$4,500 annually Combined In- and Out-of-Network: \$4,500 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$325/day for days 1-5; \$0/day for days 6-90/medically-necessary covered inpatient stay; \$0 copay/additional days Out-of-Network: 25% coinsurance/medically-necessary covered inpatient stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary; \$35 copay/specialist Out-of-Network: \$25 copay/primary; \$35 copay/specialist |
| Ambulance | \$300 copay/Medicare-covered ground or air ambulance |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$250 copay/ambulatory surgical center service Out-of-Network: \$450 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$400/ambulatory surgical center service |
| Outpatient Mental Health | In- or Out-of-Network: \$25 copay/individual or group mental health service |
| Emergency/Urgent Care | Emergency Care: \$110 copay/visit, copay waived if admitted to the hospital Urgent Care: \$35 copay/Medicare-covered visit |
| Travel Coverage | \$110 copay/emergency or urgent care outside the U.S., emergency copay waived if admitted to the hospital, members can access in-network providers across the U.S. for routine or non-emergency care when they travel |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits: \$0 copay/lab service; \$15 copay/x-ray, diagnostic procedure and test; \$140 copay/diagnostic radiology service; \$60 copay/therapeutic radiology service Out-of-Network: \$0 copay/lab service; \$15 copay/x-ray, diagnostic procedure and test; \$140 copay/diagnostic radiology service; 30% coinsurance/therapeutic radiology service |
| Physical/Speech/Occupational Therapy | In-Network: \$35 copay/Medicare-covered occupational/physical/speech therapy service Out-of-Network: \$45 copay/Medicare-covered occupational/physical/speech therapy service |
| Skilled Nursing Facility Care | In-Network: \$0/day for days 1-20, \$203/day for days 21-43; \$0/day for days 44-100 for each stay Out-of-Network: 25% coinsurance/stay Note: prior authorization required, which is the provider's responsibility |
| Diabetic Supplies & Services | In-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; \$0 copay/selfmanagement training and diabetic shoes and inserts Out-of-Network: 0%-20% coinsurance/test strips, lancets, lancing devices, monitors and solutions; 30% coinsurance/self-management training; 20% coinsurance/diabetic shoes and inserts Note: 0% cost share for OneTouch/Lifescan supplies, other brands are not covered unless medical exception is granted; if exception granted, 20% coinsurance applies |
| DMEPOS | 20% coinsurance/Medicare-covered item, 0% Continuous Glucose Monitor and supplies (prior auth required) |
| Dental | In-Network: \$35 copay/Medicare-covered dental service Out-of-Network: \$35 copay/Medicare-covered dental service Note: Dental reimbursement of up to \$1,450/preventive and comprehensive dental service/year |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic or acupuncture service; \$20 copay/non-Medicare covered chiropractic or acupuncture service up to 18 chiropractic and 18 acupuncture visits/year |
| Vision | In-Network: \$0 copay/glaucoma screening and diabetic eye exam; \$35 copay/other Medicare-covered eye exam; \$0 copay/1 routine eye exam/year Out-of-Network: \$35 copay/Medicare-covered vision service; \$35 copay/1 routine eye exam/year Note: Eyewear reimbursement up to \$250/contacts and glasses/year |
| Hearing | In-Network: \$35 copay/Medicare-covered hearing service; \$0 copay/1 routine hearing exam/year Out-of-Network: \$35 copay/Medicare-covered hearing service; \$35 copay/1 routine hearing exam/year; Hearing aids: Up to \$750 per ear per year through NationsHearing |
| Medicare Part B Drugs | 20% coinsurance Note: prior authorization may be required and is the provider's responsibility |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2; \$400/tiers 3-5 |
| Discounts & Programs | Healthy Rewards Program, SilverSneakers, \$90 quarterly/over-the-counter drugs and supplies, meal benefit (14 meals/7 days post discharge) and 24/7 NurseLine; Personal Emergency Response System included; Telehealth: in-network primary care, specialty care, mental health, urgent care, physical therapy, speech therapy, occupational therapy, substance abuse, opioid treatment services, diabetes self-management training, and kidney disease education services through a virtual visit are the same cost as an in-person visit; Routine podiatry- \$35 copay for 12 visits per year; Allina Health Aetna Medicare Assist program: Members with low income subsidy (Extra Help) may be eligible for \$0 Part D prescription drugs and \$75/quarter extra supports wallet to help pay for healthy foods, personal care items, pet care, transportation, utilities and rent/mortgage assistance |



Plan Area: Anoka, Blue Earth, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, Le Sueur, McLeod, Meeker, Mille Lacs, Nicollet, Ramsey, Renville, Scott, Sibley, Steele, Waseca, Washington, Wright Counties

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|---|---|
| Out-of-Pocket Max | In-Network and Out-of-Network: \$3,000 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$150 copay/each medically-necessary covered inpatient stay Out-of-Network: 20% coinsurance/medically-necessary covered inpatient stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary; \$20 copay/specialist Out-of-Network: Medicare-covered service; \$20 copay/visit |
| Ambulance | \$250 copay/Medicare-covered ground or air ambulance |
| Outpatient Surgery | In-Network: \$200 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$100 copay/ambulatory surgical center service Out-of-Network: \$400 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$350/ambulatory surgical center service |
| Outpatient Mental Health | In-Network: \$20 copay/individual or group mental health service Out-of-Network: \$20 copay/individual or group mental health service |
| Emergency/Urgent Care | Emergency Care: \$110 copay/visit, copay waived if admitted to the hospital Urgent Care: \$20 copay/Medicare-covered visit |
| Travel Coverage | \$110 copay/emergency or urgent care outside the U.S., emergency copay waived if admitted to the hospital, members can access in-network providers across the U.S. for routine or non-emergency care when they travel |
| X-rays, Lab & Diagnostic Tests | Medicare-covered benefits - \$0 copay/lab service; \$5 copay/x-ray, diagnostic procedure and test; \$75 copay/diagnostic radiology service; 20% coinsurance/therapeutic radiology service |
| Physical/Speech/Occupational Therapy | In-Network: \$20 copay/Medicare-covered occupational/physical/speech therapy service Out-of-Network: \$40 copay/Medicare-covered occupational/physical/speech therapy service |
| Skilled Nursing Facility Care | In-Network: \$0/day for days 1-20, \$203/day for days 21-35; \$0/day for days 36-100 for each stay Out-of-Network: 20% coinsurance/stay Note: prior authorization required, which the provider's responsibility |
| Diabetic Supplies & Services | In-Network: 0%-20% coinsurance/test strips, lancets, monitors, solutions and lancing devices; \$0 copay/self-management training, diabetic shoes and inserts Out-of-Network: 0%-20% coinsurance/test strips, lancets, monitors, solutions and lancing devices; 20% coinsurance/self-management training, diabetic shoes and inserts Note: 0% cost share for OneTouch/Lifescan supplies. Other brands are not covered unless medical exception is granted. If exception granted 20% coinsurance applies |
| DMEPOS | 20% coinsurance/Medicare-covered item, 0% Continuous Glucose Monitor and supplies (prior auth required) |
| Dental | \$20 copay/Medicare-covered dental service Note: dental reimbursement of up to \$2,000/preventive and comprehensive dental services/year |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic or acupuncture service; \$20 copay/non-Medicare covered chiropractic or acupuncture service up to 18 chiropractic and 18 acupuncture services/year |
| Vision | In-Network: \$0 copay/glaucoma screening and diabetic eye exam; \$20 copay/other eye exam; \$0 copay/1 routine eye exam/year Out-of-Network: \$20 copay/Medicare-covered vision service; \$0 copay/1 routine eye exam/year Note: eyewear reimbursement of up to \$225/contacts and eyeglasses/year |
| Hearing | In-Network: \$20 copay/Medicare-covered hearing service; \$0 copay/1 routine hearing exam/year Out-of-Network: \$20 copay/Medicare-covered hearing service; \$20 copay/1 routine hearing exam/year Hearing aids: up to \$1,000 per ear per year through NationsHearing |
| Medicare Part B Drugs | 20% coinsurance Note: prior authorization may be required and is the provider's responsibility |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | Healthy Rewards Program, SilverSneakers, \$90 quarterly/over-the-counter drugs and supplies, meal benefit (14 meals/7 days post discharge), and 24/7 NurseLine, PERS included; Telehealth: in-network primary care, specialty care, mental health, urgent care, physical therapy, speech therapy, occupational thereapy, substance abuse, opiod treatment services, diabetes self-management training, and kidney disease education services through a virtual visit are the same cost as an in-person visit. Plan provides an Extra Benefits card with a \$500 annual allowance to pay for out-of-pocket dental, vision, and hearing costs. Routine Podiatry Services: \$20 copay, 12 visits per year. |

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| Plan Area: Anoka, Blue Earth, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, Le Sueur, McLeod, Meeker, Mille Lacs, Nicollet, Ramsey, Renville, Scott, Sibley, Steele, Waseca, Washington, Wright Counties | |
| Out-of-Pocket Max | In-Network: \$2,800 annually Combined In- and Out-of-Network: \$4,000 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$150 copay/each medically-necessary covered inpatient stay Out-of-Network: 20% coinsurance/medically-necessary covered inpatient stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary; \$15 copay/specialist Out-of-Network: Medicare-covered services - \$20 copay/primary; \$35 copay/specialist |
| Ambulance | \$250 copay/Medicare-covered ground or air ambulance |
| Outpatient Surgery | In-Network: \$100 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$50 copay/ambulatory surgical center service Out-of-Network: \$350 copay/Medicare-covered outpatient surgery in an outpatient hospital facility; \$300/ambulatory surgical center service |
| Outpatient Mental Health | In-Network: \$15 copay/individual or group mental health service Out-of-Network: \$35 copay/individual or group mental health service |
| Emergency/Urgent Care | Emergency Care: \$110 copay/visit, copay is waived if you are admitted to the hospital Urgent Care: \$15 copay/Medicare-covered visit |
| Travel Coverage | \$110 copay/emergency or urgent care outside the U.S., emergency copay waived if admitted to the hospital, members can access in-network providers across the U.S. for routine or non-emergency care when they travel |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits: \$0 copay/lab service, x-ray, diagnostic procedure and test; \$50 copay/diagnostic radiology service; 20% coinsurance/therapeutic radiology service Out-of-Network: \$15 copay/lab, \$25 copay/x-ray diagnostic procedure and test, \$100 copay/diagnostic radiology, 20% coinsurance/therapeutic radiology |
| Physical/Speech/Occupational Therapy | In-Network: \$15 copay/Medicare-covered occupational/physical/speech therapy service Out-of-Network: \$35 copay/Medicare-covered occupational/physical/speech therapy service |
| Skilled Nursing Facility Care | In-Network: \$0/day for days 1-20, \$203/day for days 21-34; \$0/day for days 35-100 for each stay Out-of-Network: 20% coinsurance/stay Note: prior authorization required, which is the provider's responsibility |
| Diabetic Supplies & Services | In-Network: 0%-20% coinsurance/test strips, lancets, monitors, solutions and lancing devices; \$0 copay/self-management training, Medicare-covered diabetic shoes and inserts Out-of-Network: 0%-20% coinsurance/test strips, lancets, monitors, solutions and lancing devices; 20% coinsurance/self-management training, Medicare-covered diabetic shoes and inserts Note: 0% cost share for OneTouch/Lifescan supplies. Other brands are not covered unless medical exception is granted. If exception granted 20% coinsurance applies |
| DMEPOS | 20% coinsurance/Medicare-covered item, 0% Continuous Glucose Monitor and supplies (prior auth required) |
| Dental | In-Network: \$15 copay/Medicare-covered dental service Out-of-Network: \$35 copay/Medicare-covered dental service Note: dental reimbursement of up to \$2,250/preventive and comprehensive dental services/year |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic or acupuncture service; \$20 copay/non-Medicare covered chiropractic or acupuncture service up to 18 chiropractic and 18 acupuncture services/year |
| Vision | In-Network: \$0 copay/glaucoma screening and diabetic eye exam; \$15 copay/other Medicare-covered eye exam; \$0 copay/1 routine eye exam/year Out-of-Network: \$35 copay/Medicare-covered vision service; \$35 copay/1 routine eye exam/year Note: eyewear reimbursement of up to \$275/contacts and eyeglasses/year |
| Hearing | In-Network: \$15 copay/Medicare-covered hearing service; \$0 copay/1 routine hearing exam/year Out-of-Network: \$35 copay/Medicare-covered hearing service; 20% coinsurance/1 routine hearing exam/year Hearing aids: up to \$1,500 per ear per year through NationsHearing |
| Medicare Part B Drugs | 20% coinsurance Note: prior authorization may be required and is the provider's responsibility |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | Healthy Rewards Program, SilverSneakers, \$105 quarterly/over-the-counter drugs and supplies, meal benefit (14 meals/7 days post discharge), and 24/7 NurseLine, Personal Emergency Response System included; Telehealth: in-network primary care, specialty care, mental health, urgent care, physical therapy, speech therapy, occupational therapy, substance abuse, opioid treatment services, diabetes self-management training, and kidney disease education services through a virtual visit are the same cost as an in-person visit. Plan provides an Extra Benefits card with a \$500 annual allowance to pay for out-of-pocket dental, vision, and hearing costs. Routine Podiatry Services: \$20 copay, 12 visits per year |



Blue Cross Medicare Advantage Freedom Blue No Rx (H5959-018)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare



Monthly Premium: \$0

Up to \$100 Part B Premium Reduction

Plan Area: Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Grant, Hennepin, Houston, Hubbard, Isanti, Jackson, Kandiyohi, Kittson, Lac qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomon, Marshall, Martin, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Roseau, Scott, Sherburne, Stearns, Steele, Swift, Todd, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright Counties

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|---|---|
| Out-of-Pocket Max | In-Network: \$4,200 annually Combined Maximum Out-of-Pocket: \$7,500 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered services - \$200 copay/admit Out-of-Network: 40% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$30 copay/specialist, \$10 copay/non-surgical outpatient hospital facility services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Ambulance | In-or Out-of-Network: \$200 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$150 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$100 copay/visit for ambulatory surgical center services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$30 copay/Medicare-covered individual or group therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$35 copay/Medicare-covered visits Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, Medicare-covered x-rays, diagnostic colonoscopies and mammograms, \$20 copay/all other diagnostic procedures, \$70 copay/diagnostic radiology services, 15% coinsurance/therapeutic radiology services Out-of-Network: 40% coinsurance/Medicare-covered services, \$0 copay/labs Note: prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$30 copay/Medicare-covered amount for each physical/speech/occupational therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 for Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 15% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 40% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 40% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$30 copay/Medicare-covered dental services Out-of-Network: 40% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Comprehensive: 20% coinsurance/restorative, 20% coinsurance/endodontics, periodontics (not including cleaning), extractions, prosthodontics, other oral/maxillofacial surgery Maximum Dental Plan Benefit: \$2,500 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/each Medicare-covered and routine Non-Medicare chiropractic visit Out-of-Network: 40% coinsurance/Medicare-covered and routine Non-Medicare chiropractic visit, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/1 routine eye exam, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$250 allowance/non-Medicare-covered eyewear Out-of-Network: 40% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$599 copay/Advanced hearing aids, \$899 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 40% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps. Out-of-Network: 40% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan |
| Discounts & Programs | The SilverSneakers exercise and healthy aging program, e-visits online visits, 24-hour nurse advice line, \$100 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Core (H5959-013-1)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare



Monthly Premium: \$0

| Plan Area: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright Counties | |
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| Out-of-Pocket Max | In-Network: \$4,900 annually Combined Maximum Out-of-Pocket: \$7,900 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$300 copay/day for days 1-5; \$0 copay/days 6-90 for Medicare-covered services Out-of-Network: 45% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$40 copay/specialist, \$20 copay/non-surgical outpatient hospital facility services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Ambulance | In-Network: \$290 copay/ground and air ambulance Out-of-Network: \$300 copay/ground and air ambulance |
| Outpatient Surgery | In-Network: \$350 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$350 copay/visit for ambulatory surgical center services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$40 copay/Medicare-covered individual or group therapy visits Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$45 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$25 copay/all other diagnostic procedures, \$15 copay/Medicare-covered x-rays, \$110 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: 45% coinsurance/Medicare-covered services, \$0 copay/lab services Note: prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered amount for each physical/speech/occupational therapy visits Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 for Medicare-covered services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 20% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 45% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 45% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$50 copay/Medicare-covered dental services Out-of-Network: 45% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Maximum Dental Plan Benefit: \$2,000 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/each Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 45% coinsurance/Medicare-covered services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$275 allowance for non-Medicare-covered eyewear Out-of-Network: 45% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$699 copay/Advanced hearing aids, \$999 copay/Premium hearing aids, you must see TruHearing provider to use this benefit Out-of-Network: 45% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps. Out-of-Network: 45% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$350/tiers 3-5 |
| Discounts & Programs | SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$60 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Core (H5959-013-2)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare 



Monthly Premium: \$0

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| Plan Area: Becker, Beltrami, Benton, Big Stone, Brown, Cass, Chippewa, Clay, Clearwater, Cottonwood, Crow Wing, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Kittson, Lac qui Parle, Lake of the Woods, Lincoln, Lyon, Mahanomen, Marshall, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Redwood, Renville, Roseau, Stearns, Swift, Todd, Wadena, Wilkin Counties | |
| Out-of-Pocket Max | In-Network: \$4,900 annually Combined Maximum Out-of-Pocket: \$7,900 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$350 copay/day for days 1-5; \$0 copay/days 6-90 for Medicare-covered services Out-of-Network: 45% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$45 copay/specialist, \$20 copay/non-surgical outpatient hospital facility services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Ambulance | In-Network: \$290 copay/ground and air ambulance Out-of-Network: \$300 copay/ground and air ambulance |
| Outpatient Surgery | In-Network: \$400 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$350 copay/visit for ambulatory surgical center services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$45 copay/Medicare-covered individual or group therapy visits Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$45 copay/Medicare-covered visits Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$25 copay/all other diagnostic procedures, \$15 copay/Medicare-covered x-rays, \$110 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: 45% coinsurance/Medicare-covered services, \$0 copay/lab services Note: prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$45 copay/Medicare-covered amount for each physical/speech/occupational therapy visits Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 for Medicare-covered services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 20% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 45% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 45% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$50 copay/Medicare-covered dental services Out-of-Network: 45% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Maximum Dental Plan Benefit: \$2,000 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/each Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 45% coinsurance/Medicare-covered services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$275 allowance for non-Medicare-covered eyewear Out-of-Network: 45% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$699 copay/Advanced hearing aids, \$999 copay/Premium hearing aids, you must see TruHearing provider to use this benefit Out-of-Network: 45% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps. Out-of-Network: 45% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$350/tiers 3-5 |
| Discounts & Programs | SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$60 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Core (H5959-012)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare



Monthly Premium: \$40

| Plan Area: Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Houston, Martin, Mower, Nicollet, Olmsted, Steele, Wabasha, Waseca, Watonwan, Winona Counties | |
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| Out-of-Pocket Max | In-Network: \$6,700 annually Combined Maximum Out-of-Pocket: \$10,000 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$375 copay/day for days 1-5, \$0 copay/days 6-90 for Medicare-covered services Out-of-Network: 45% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$40 copay/specialist, \$20 copay/non-surgical outpatient hospital facility services Out-of-Network: 45% coinsurance/Medicare-covered services Note: Prior authorization may be required |
| Ambulance | In- or Out-of-Network: \$315 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$415 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$415 copay/visit for ambulatory surgical center services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$40 copay/Medicare-covered individual or group therapy visits Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$45 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$30 copay/all other diagnostic procedures, \$15 copay/Medicare-covered x-rays, \$125 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services. Out-of-Network: 45% coinsurance/Medicare-covered services, \$0 copay/labs Note: prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered amount for each physical/speech/occupational therapy visits Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 for Medicare-covered services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 20% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 45% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 45% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$50 copay/Medicare-covered dental services Out-of-Network: 45% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Maximum Dental Plan Benefit: \$2,000 |
| Chiropractic/Acupuncture | In-Network: \$15 copay/each Medicare-covered chiropractic visit, \$15 copay/acupuncture visit Out-of-Network: 45% coinsurance/Medicare-covered chiropractic services, \$15 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$125 allowance/non-Medicare-covered eyewear Out-of-Network: 45% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$699 copay/Advanced hearing aids, \$999 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 45% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps. Out-of-Network: 45% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$350/tiers 3-5 |
| Discounts & Programs | SilverSneakers exercise and healthy aging program, e-visits online visits, 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Comfort (H5959-015)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare



Monthly Premium: \$53

Plan Area: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright Counties

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| Out-of-Pocket Max | In-Network: \$3,700 annually Combined Maximum Out-of-Pocket: \$5,450 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered services - \$400 copay/admit Out-of-Network: 40% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$40 copay/specialist, \$20 copay/non-surgical outpatient hospital facility services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Ambulance | In-or Out-of-Network: \$250 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$275 copay/visit for ambulatory surgical center services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$40 copay/Medicare-covered individual or group therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$45 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$10 copay/Medicare-covered X-rays, \$25 copay/all other diagnostic procedures, \$100 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: 40% coinsurance/Medicare-covered services, \$0 copay/labs Note: Prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered each physical/speech/occupational therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/per day for days 21-100 for Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 20% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 40% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 40% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$30 copay/Medicare-covered dental services Out-of-Network: 40% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Comprehensive: 30% coinsurance/restorative, 50% coinsurance/endodontics, periodontics (not including cleaning), extractions, prosthodontics, other oral/maxillofacial surgery Maximum Dental Plan Benefit: \$2,000 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 40% coinsurance/Medicare-covered chiropractic services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$125 allowance/non-Medicare-covered eyewear Out-of-Network: 40% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$599 copay/Advanced hearing aids, \$899 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 40% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps. Out-of-Network: 40% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$300/tiers 3-5 |
| Discounts & Programs | The SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Comfort (H5959-016)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare



Monthly Premium: \$64

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| Plan Area: Becker, Beltrami, Benton, Big Stone, Brown, Cass, Chippewa, Clay, Clearwater, Cottonwood, Crow Wing, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Kittson, Lac qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomon, Marshall, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Redwood, Renville, Roseau, Stearns, Swift, Todd, Wadena, Wilkin Counties | |
| Out-of-Pocket Max | In-Network: \$3,800 annually Combined Maximum Out-of-Pocket: \$5,750 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered services - \$400 copay/admit Out-of-Network: 40% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$45 copay/specialist, \$20 copay/non-surgical outpatient hospital facility services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Ambulance | In-or Out-of-Network: \$250 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$275 copay/visit for ambulatory surgical center services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$45 copay/Medicare-covered individual or group therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$45 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$10 copay/Medicare-covered X-rays, \$30 copay/all other diagnostic procedures, \$100 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: 40% coinsurance/Medicare-covered services, \$0 copay/labs Note: Prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$45 copay/Medicare-covered each physical/speech/occupational therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/per day for days 21-100 for Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 20% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 40% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 40% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$30 copay/Medicare-covered dental services Out-of-Network: 40% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Comprehensive: 30% coinsurance/restorative, 50% coinsurance/endodontics, periodontics (not including cleaning), extractions, prosthodontics, other oral/maxillofacial surgery Maximum Dental Plan Benefit: \$1,500 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 40% coinsurance/Medicare-covered chiropractic services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$125 allowance/non-Medicare-covered eyewear Out-of-Network: 40% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$599 copay/Advanced hearing aids, \$899 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 40% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps Out-of-Network: 40% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$350/tiers 3-5 |
| Discounts & Programs | The SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Choice (H5959-014-1)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare 



Monthly Premium: \$96

| Plan Area: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright Counties | |
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| Out-of-Pocket Max | In-Network: \$3,000 annually Combined Maximum Out-of-Pocket: \$5,150 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered services - \$200 copay/admit Out-of-Network: 40% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$35 copay/specialist, \$10 copay/non-surgical outpatient hospital facility services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Ambulance | In- or Out-of-Network: \$250 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$175 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$150 copay/visit for ambulatory surgical center services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$35 copay/Medicare-covered individual or group therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$40 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$10 copay/Medicare covered X-rays, \$25 copay/all other diagnostic procedures, \$100 copay/diagnostic radiology services, 15% coinsurance/therapeutic radiology services Out-of-Network: 40% coinsurance/Medicare-covered services, \$0 copay/labs Note: Prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$35 copay/Medicare-covered each physical/speech/occupational therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/per day for days 21-100 for Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 15% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 40% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 40% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$30 copay/Medicare-covered dental services Out-of-Network: 40% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Comprehensive: 30% coinsurance/restorative, 50% coinsurance/endodontics, periodontics (not including cleaning), extractions, prosthodontics, other oral/maxillofacial surgery Maximum Dental Plan Benefit: \$2,000 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 40% coinsurance/Medicare-covered chiropractic services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$200 allowance/non-Medicare-covered eyewear Out-of-Network: 40% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$599 copay/Advanced hearing aids, \$899 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 40% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps Out-of-Network: 40% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | The SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Choice (H5959-014-2)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare



Monthly Premium: \$106

Plan Area: Becker, Beltrami, Benton, Big Stone, Brown, Cass, Chippewa, Clay, Clearwater, Cottonwood, Crow Wing, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Kittson, Lac qui Parle, Lake of the Woods, Lincoln, Lyon, Mahanomen, Marshall, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Redwood, Renville, Roseau, Stearns, Swift, Todd, Wadena, Wilkin Counties

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|---|---|
| Out-of-Pocket Max | In-Network: \$3,100 annually Combined Maximum Out-of-Pocket: \$5,150 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered services - \$250 copay/admit Out-of-Network: 40% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$40 copay/specialist, \$10 copay/non-surgical outpatient hospital facility services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Ambulance | In- or Out-of-Network: \$250 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$175 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$150 copay/visit for ambulatory surgical center services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$40 copay/Medicare-covered individual or group therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$40 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$10 copay/Medicare covered X-rays, \$25 copay/all other diagnostic procedures, \$100 copay/diagnostic radiology services, 15% coinsurance/therapeutic radiology services Out-of-Network: 40% coinsurance/Medicare-covered services, \$0 copay/labs Note: Prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered each physical/speech/occupational therapy visits Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/per day for days 21-100 for Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 15% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 40% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 40% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$30 copay/Medicare-covered dental services Out-of-Network: 40% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Comprehensive: 30% coinsurance/restorative, 50% coinsurance/endodontics, periodontics (not including cleaning), extractions, prosthodontics, other oral/maxillofacial surgery Maximum Dental Plan Benefit: \$1,500 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 40% coinsurance/Medicare-covered chiropractic services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$150 allowance/non-Medicare-covered eyewear Out-of-Network: 40% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$599 copay/Advanced hearing aids, \$899 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 40% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps Out-of-Network: 40% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | The SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |



Blue Cross Medicare Advantage Choice (H5959-009)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare



Monthly Premium: \$146

Plan Area: Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Houston, Martin, Mower, Nicollet, Olmsted, Steele, Wabasha, Waseca, Watonwan, Winona Counties

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|---|---|
| Out-of-Pocket Max | In-Network: \$3,500 annually Combined Maximum Out-of-Pocket: \$5,150 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered services - \$250 copay/admit Out-of-Network: 45% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$35 copay/specialist, \$10 copay/non-surgical outpatient hospital facility services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Ambulance | In- or Out-of-Network: \$250 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$250 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$225 copay/visit for ambulatory surgical center services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$35 copay/Medicare-covered individual or group therapy visits Outpatient Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$40 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$10 copay/Medicare-covered X-rays, \$25 copay/all other diagnostic procedures, \$100 copay/diagnostic radiology services, 15% coinsurance/therapeutic radiology services Out-of-Network: 45% coinsurance/Medicare-covered services, \$0 copay/labs Note: prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$35 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 for Medicare-covered services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 15% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 45% coinsurance/self-management training, total cost for Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 45% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$30 copay/Medicare-covered dental services Out-of-Network: 45% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Comprehensive: 30% coinsurance/restorative, 50% coinsurance/endodontics, periodontics (not including cleaning), extractions, prosthodontics, other oral/maxillofacial surgery Maximum Dental Plan Benefit: \$2,000 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/each Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 45% coinsurance/Medicare-covered chiropractic services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$125 allowance/non-Medicare-covered eyewear Out-of-Network: 45% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$599 copay/Advanced hearing aids, \$899 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 45% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps Out-of-Network: 45% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | The SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Complete (H5959-010-1)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare



Monthly Premium: \$186

| Plan Area: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright Counties | |
|--|---|
| Out-of-Pocket Max | In-Network: \$2,900 annually Combined Maximum Out-of-Pocket: \$5,100 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered services - \$150 copay/admit Out-of-Network: 40% coinsurance/per stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$20 copay/specialist, \$0 copay/non-surgical outpatient hospital facility services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Outpatient Mental Health | In-Network: \$20 copay/Medicare-covered individual or group therapy visits Outpatient Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Ambulance | In- or Out-of-Network: \$200 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$150 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$125 copay/visit for ambulatory surgical center services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$30 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$5 copay/Medicare-covered X-rays, \$10 copay/all other diagnostic procedures, \$50 copay/diagnostic radiological services, 10% coinsurance/therapeutic radiology services Out-of-Network: 40% coinsurance/Medicare-covered services, \$0 copay/labs Note: prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$20 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 for Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 15% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 40% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 40% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$20 copay/Medicare-covered dental services Out-of-Network: 40% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings/2 oral exams/1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Comprehensive: 30% coinsurance/restorative, 50% coinsurance/endodontics, periodontics (not including cleaning), extractions, prosthodontics, other oral/maxillofacial surgery Maximum Dental Plan Benefit: \$2,000 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/each Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 40% coinsurance/Medicare-covered chiropractic services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$225 allowance/non-Medicare-covered eyewear Out-of-Network: 40% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$499 copay/Advanced hearing aids, \$799 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 40% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps Out-of-Network: 40% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | The SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Complete (H5959-010-2)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare 



Monthly Premium: \$222

Plan Area: Becker, Beltrami, Benton, Big Stone, Brown, Cass, Chippewa, Clay, Clearwater, Cottonwood, Crow Wing, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Kittson, Lac qui Parle, Lake of the Woods, Lincoln, Lyon, Mahanomen, Marshall, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Redwood, Renville, Roseau, Stearns, Swift, Todd, Wadena, Wilkin Counties

| | |
|---|---|
| Out-of-Pocket Max | In-Network: \$2,900 annually Combined Maximum Out-of-Pocket: \$5,100 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered services - \$150 copay/admit Out-of-Network: 40% coinsurance/per stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$20 copay/specialist, \$0 copay/non-surgical outpatient hospital facility services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Outpatient Mental Health | In-Network: \$20 copay/Medicare-covered individual or group therapy visits Outpatient Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Ambulance | In-or Out-of-Network: \$200 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$150 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$125 copay/visit for ambulatory surgical center services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$30 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$5 copay/Medicare-covered X-rays, \$10 copay/all other diagnostic procedures, \$50 copay/diagnostic radiological services, 10% coinsurance/therapeutic radiology services Out-of-Network: 40% coinsurance/Medicare-covered services, \$0 copay/labs Note: prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$20 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 for Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 15% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 40% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 40% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$20 copay/Medicare-covered dental services Out-of-Network: 40% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings/2 oral exams/1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Comprehensive: 30% coinsurance/restorative, 50% coinsurance/endodontics, periodontics (not including cleaning), extractions, prosthodontics, other oral/maxillofacial surgery Maximum Dental Plan Benefit: \$2,000 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/each Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 40% coinsurance/Medicare-covered chiropractic services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$200 allowance/non-Medicare-covered eyewear Out-of-Network: 40% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$499 copay/Advanced hearing aids, \$799 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 40% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps. Out-of-Network: 40% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | The SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |

Blue Cross Medicare Advantage Complete (H5959-011)

Advantage PPO Plan

Enrollment: 877-662-2583

Service: 800-711-9865 • TTY: 711

bluecrossmn.com/medicare



Monthly Premium: \$222

| Plan Area: Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Houston, Martin, Mower, Nicollet, Olmsted, Steele, Wabasha, Waseca, Watonwan, Winona Counties | |
|--|---|
| Out-of-Pocket Max | In-Network: \$2,900 annually Combined Maximum Out-of-Pocket: \$5,100 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered services - \$150 copay/admit Out-of-Network: 45% coinsurance/stay for Medicare-covered services Note: prior authorization may be required |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$20 copay/specialist, \$0 copay/non-surgical outpatient hospital facility services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Ambulance | In- or Out-of-Network: \$200 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: \$150 copay/Medicare-covered surgeries performed and services received in an outpatient hospital facility, \$125 copay/visit for ambulatory surgical center services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for certain services provided in the outpatient setting |
| Outpatient Mental Health | In-Network: \$20 copay/Medicare-covered individual or group therapy visits Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required for some services |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit Urgent Care: \$30 copay/Medicare-covered visit Worldwide Emergency Care: \$90 copay, 20% coinsurance/worldwide emergency transportation Worldwide Urgent Care: \$90 copay |
| Travel Coverage | Coverage when you are outside of Minnesota for up to 12 months |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, diagnostic colonoscopies and mammograms, \$5 copay/Medicare-covered X-rays, \$10 copay/all other diagnostic procedures, \$50 copay/diagnostic radiological services, 10% coinsurance/therapeutic radiology services Out-of-Network: 45% coinsurance/Medicare-covered services, \$0 copay/labs Note: prior authorization may be required |
| Physical/Speech/Occupational Therapy | In-Network: \$20 copay/Medicare-covered amount for each physical/speech/occupational therapy visits Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 for Medicare-covered services Out-of-Network: 45% coinsurance/Medicare-covered services Note: prior authorization may be required |
| Diabetic Supplies & Services | In-Network: \$0 copay/self-management training, diabetic supplies, 15% coinsurance/Medicare-covered therapeutic shoes or inserts Out-of-Network: 45% coinsurance/self-management training, Medicare-covered diabetic supplies, Medicare-covered therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered durable medical equipment item and related supplies Out-of-Network: 45% coinsurance/Medicare-covered durable medical equipment item and related supplies Note: prior authorization may be required |
| Dental | In-Network: \$20 copay/Medicare-covered dental services Out-of-Network: 45% coinsurance/Medicare-covered dental Preventive: \$0 copay/2 cleanings, 2 oral exams, 1 x-ray, 2 periodontal cleaning, 2 fluoride treatments Comprehensive: 30% coinsurance/restorative, 50% coinsurance/endodontics, periodontics (not including cleaning), extractions, prosthodontics, other oral/maxillofacial surgery Maximum Dental Plan Benefit: \$2,000 |
| Chiropractic/Acupuncture | In-Network: \$20 copay/each Medicare-covered chiropractic visit, \$20 copay/each acupuncture visit Out-of-Network: 45% coinsurance/Medicare-covered chiropractic services, \$20 copay/acupuncture services Note: prior authorization may be required |
| Vision | In-Network: \$0 copay/2 routine eye exams, 1 annual glaucoma screening for people at risk, diabetic retinopathy exams, eyewear after cataract, \$0 copay/Medicare-covered exams to diagnose and treat diseases and conditions of the eye, \$200 allowance/non-Medicare-covered eyewear Out-of-Network: 45% coinsurance/Medicare-covered services |
| Hearing | In-Network: \$0 copay/each Medicare-covered diagnostic hearing exam, \$0 copay/2 routine hearing exams per year, \$499 copay/Advanced hearing aids, \$799 copay/Premium hearing aids, you must see a TruHearing provider to use this benefit Out-of-Network: 45% coinsurance/Medicare-covered visit |
| Medicare Part B Drugs | In-Network: 20% coinsurance, \$35 cap for one-month supply of insulin for use in pumps Out-of-Network: 45% coinsurance Note: prior authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | The SilverSneakers exercise and healthy aging program, E-visits Online Visits, 24-hour nurse advice line, \$50 quarterly/over-the-counter drugs and supplies, 2 medically-tailored meals per day for 14 days at no extra cost following an authorized inpatient or skilled nursing facility discharge |



| Plan Area: St. Louis County | |
|---|---|
| Out-of-Pocket Max | In-Network: \$4,400 annually/Medicare-covered services Combined In- and Out-of-Network: \$6,500 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$300 copay/day for days 1-5, then 100% covered/admission for Medicare-covered stays Out-of-Network: 40% coinsurance/Medicare-covered stays |
| Physician/Outpatient | In-Network: In person or telehealth for Medicare-covered services - \$10 copay/primary, \$50 copay/specialist Out-of-Network: \$50 copay/primary, \$80 copay/specialist, other services 40% coinsurance/Medicare-covered services |
| Ambulance | \$350 copay/Medicare-covered transports |
| Outpatient Surgery | In-Network: \$395 copay/Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services |
| Outpatient Mental Health | In-and Out-of-Network: \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered visit in the U.S. Out-of-Network: 40% coinsurance/most non-emergency Medicare-covered services at a provider who accepts Medicare in the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: 20% coinsurance/diagnostic tests and x-rays, \$0 copay/lab services Out-of-Network: 40% coinsurance/Medicare-covered services, \$0 copay/lab services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/visit for Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, no prior hospitalization stay is required; \$203 copay/day for days 21-100 Out-of-Network: 40% coinsurance/Medicare-covered services |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/certain glucose monitors, test strips and lancets, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions Out-of-Network: 40% coinsurance/Medicare-covered services |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered item Out-of-Network: 40% coinsurance/Medicare-covered item |
| Dental | \$900 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids and prescription eyewear. Network does not apply to eligible dental services. |
| Chiropractic/Acupuncture | Chiropractic In-Network: \$20 copay/covered visits for Medicare-covered services Acupuncture In-Network: \$10 copay from a qualified primary care physician, \$50 copay from a qualified specialist/Medicare-covered services and rules Chiropractic/Acupuncture Out-of-Network: 40% coinsurance/Medicare-covered services |
| Vision | In-Network: \$0 copay/annual routine eye exam; \$35 copay/diagnostic eye exams Out-of-Network: 40% coinsurance/annual routine eye exam; diagnostic eye exams. \$900 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids and prescription eyewear. Network does not apply for the purchase of prescription eyewear. |
| Hearing | In-Network: \$0 copay/routine hearing exam; \$50 copay diagnostic hearing exam Out-of-Network: 40% coinsurance/routine hearing exam and diagnostic hearing exam. \$900 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids and prescription eyewear. Network does not apply for the purchase of hearing aids. |
| Medicare Part B Drugs | In-Network: 20% coinsurance/Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services |
| Medicare Part D Coverage | Yes, if you enroll in a stand-alone Medicare Part D plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tier 1, \$345/tiers 2-5 |
| Discounts & Programs | One Pass fitness program or health club savings program, 24/7 nurse line, 20% discounts on skin care products and services, eyewear, and new hearing aids through Essentia Health; \$75 allowance twice a year/over-the-counter benefit, e-visits through Essentia MyChart |

EssentiaCare Secure (H8783-001)

Advantage PPO Plan

Enrollment: 855-432-7027

Service: 855-432-7025 • TTY: 800-688-2534

UCare.org



Monthly Premium: \$19

| Plan Area: Aitkin, Becker, Carlton, Cass, Clay, Crow Wing, Hubbard, Itasca, Lake, Pine, St. Louis Counties | |
|--|---|
| Out-of-Pocket Max | In-Network: \$4,500 annually/Medicare-covered services Combined In- and Out-of-Network: \$5,500 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$300 copay/day for days 1-5, then 100% covered/admission for Medicare-covered stays Out-of-Network: 40% coinsurance/Medicare-covered stays |
| Physician/Outpatient | In-Network: In person or telehealth for Medicare-covered services - \$0 copay/primary, \$45 copay/specialist Out-of-Network: \$45 copay/primary; \$75 copay/specialist; other services 40% coinsurance/Medicare-covered services |
| Ambulance | \$375 copay/Medicare-covered transports |
| Outpatient Surgery | In-Network: \$350 copay/Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services |
| Outpatient Mental Health | In-and Out-of-Network: \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered visit in the U.S. Out-of-Network: 40% coinsurance/most non-emergency Medicare-covered services at a provider who accepts Medicare in the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: 10% coinsurance/diagnostic tests and x-rays with max of \$150/day, \$0 copay/lab services Out-of-Network: 40% coinsurance/Medicare-covered services; \$0 copay/lab services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/visit for Medicare-covered visits Out-of-Network: 40% coinsurance/Medicare-covered services |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, no prior hospitalization stay is required; \$203 copay/day for days 21-100 Out-of-Network: 40% coinsurance/Medicare-covered services |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/certain glucose monitors, test strips and lancets, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions Out-of-Network: 40% coinsurance/Medicare-covered services |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered item Out-of-Network: 40% coinsurance/Medicare-covered item |
| Dental | In-Network: 1 oral exam, 1 routine teeth cleaning/year; 1 set of bitewing x-rays per year, fluoride treatments, 1 periodontal maintenance cleaning, optional restorative dental for \$25/month, up to \$2,000 annual plan maximum on routine coverage. Additional \$2,000 plan maximum with optional coverage. Out-of-Network: includes covered services from a licensed provider, you must submit for reimbursement and pay the difference |
| Chiropractic/Acupuncture | Chiropractic In-Network: \$20 copay/covered visits for Medicare-covered services Acupuncture In-Network: \$0 copay from a qualified primary care physician, \$45 copay from a qualified specialist/Medicare-covered services and rules Chiropractic/Acupuncture Out-of-Network: 40% coinsurance/Medicare-covered services |
| Vision | In-Network: \$0 copay/annual routine eye exam, \$45 copay/diagnostic eye exams, \$100 allowance on eyewear Out-of-Network: 40% coinsurance/annual routine eye exam; diagnostic eye exams |
| Hearing | In-Network: \$0 copay/routine hearing exam; \$45 copay diagnostic hearing exam Out-of-Network: 40% coinsurance/routine hearing exam and diagnostic hearing exam |
| Medicare Part B Drugs | In-Network: 20% coinsurance/Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services |
| Medicare Part D Coverage | Yes, if you enroll in a stand-alone Medicare Part D plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$295/tiers 3-5 |
| Discounts & Programs | One Pass fitness program or health club savings program; 24/7 nurse line; 20% discount on skin care products and services, eyewear, and new hearing aids through Essentia Health; \$75 allowance twice a year/over-the-counter benefit, e-visits through Essentia MyChart |

EssentiaCare Grand (H8783-002)

Advantage PPO Plan

Enrollment: 855-432-7027

Service: 855-432-7025 • TTY: 800-688-2534

UCare.org



Monthly Premium: \$79

| Plan Area: Aitkin, Becker, Carlton, Cass, Clay, Crow Wing, Hubbard, Itasca, Lake, Pine, St. Louis Counties | |
|--|---|
| Out-of-Pocket Max | In-Network: \$3,000 annually/Medicare-covered services Combined In- and Out-of-network: \$4,500 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$250 copay/stay, then 100% covered/admission for Medicare-covered stays Out-of-Network: 40% coinsurance/Medicare-covered stays |
| Physician/Outpatient | In-Network: In person or telehealth for Medicare-covered services - \$0 copay/primary, \$30 copay/specialist Out-of-Network: \$40 copay/primary, \$75 copay/specialist; other services 40% coinsurance/Medicare-covered services |
| Ambulance | \$300 copay/Medicare-covered transports |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services |
| Outpatient Mental Health | In-and Out-of-Network: \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered visit in the U.S. Out-of-Network: 40% coinsurance/most non-emergency Medicare-covered services at a provider who accepts Medicare in the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: 10% coinsurance/diagnostic tests and x-rays, with a max of \$50/day, \$0 copay/lab services Out-of-Network: 40% coinsurance/Medicare-covered services, \$0 copay/lab services |
| Physical/Speech/Occupational Therapy | In-Network: \$30 copay/visit for Medicare-covered visits Out-of-Network: 40% coinsurance/Medicare-covered services |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, \$125 copay/day for days 21-100 Out-of-Network: 40% coinsurance/Medicare-covered services |
| Diabetic Supplies & Services | In-Network: Certain glucose monitors, test strips and lancets paid in full, 20% coinsurance/continuous blood glucose monitors, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions Out-of-Network: 40% coinsurance/Medicare-covered services |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered item Out-of-Network: 40% coinsurance/Medicare-covered item |
| Dental | In-Network: 1 oral exam, 1 routine teeth cleaning/year, 1 set of bitewing x-rays per year, fluoride treatments, 1 periodontal maintenance cleaning, optional restorative dental for \$25/month, up to \$2,000 annual plan maximum on routine coverage. Additional \$2,000 plan maximum with optional coverage. Out-of-Network: includes covered services from a licensed provider, you must submit for reimbursement and pay the difference |
| Chiropractic/Acupuncture | Chiropractic In-Network: \$15 copay/each visit for Medicare-covered services Acupuncture In-Network: \$0 copay from a qualified primary care physician, \$30 copay from a qualified specialist/Medicare-covered services and rules Chiropractic/Acupuncture Out-of-Network: 40% coinsurance/Medicare-covered services |
| Vision | In-Network: \$0 copay/annual routine eye exam, \$35 copay/diagnostic eye exam, \$200 allowance on eyewear Out-of-Network: 40% coinsurance/annual routine eye exam; diagnostic eye exams |
| Hearing | In-Network: \$0 copay/routine hearing exam; \$35 copay diagnostic hearing exam, \$500 annual hearing aid allowance Out-of-Network: 40% coinsurance/routine hearing exam and diagnostic hearing exam, hearing aid allowance, 50% coinsurance/up to a maximum of \$500 |
| Medicare Part B Drugs | In-Network: 20% coinsurance /Medicare-covered services Out-of-Network: 40% coinsurance/Medicare-covered services |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-5 |
| Discounts & Programs | One Pass fitness program or health club savings program, 24/7 nurse line; 20% discounts on skin care products and services, eyewear, and new hearing aids through Essentia Health; \$75 allowance twice a year/over-the-counter benefit, e-visits through Essentia MyChart |



HealthPartners Journey Pace (H4882-009-001)

Advantage PPO Plan

Enrollment: 844-363-8979

Service: 866-233-8734 • TTY: 711

healthpartners.com/medicare



Monthly Premium: \$0

Plan Area: Anoka, Benton, Carver, Chisago, Dakota, Douglas, Hennepin, Isanti, Kandiyohi, Meeker, Morrison, Pope, Ramsey, Redwood, Scott, Sherburne, Stearns, Swift, Todd, Wadena, Washington, Wright Counties

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| Out-of-Pocket Max | In-Network: \$5,200 annually Combined In- and Out-of-Network: \$8,950 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$300/day for days 1-5; \$0/day for days 6+ (unlimited days) Out-of-Network: 30% coinsurance/stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary, \$40 copay/specialist; \$0 copay/web or phone visits Out-of-Network: Medicare-covered services - 30% coinsurance/primary or specialist, 30% coinsurance for web/phone-based technologies |
| Ambulance | \$260 copay/ground transportation in the U.S., 20% coinsurance/air transportation in the U.S.; 20% coinsurance/ground transportation outside the U.S. |
| Outpatient Surgery | In-Network: \$375 copay/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility Out-of-Network: 30% coinsurance/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility |
| Outpatient Mental Health | In-Network: \$40 copay/Medicare-covered individual therapy visit, \$20 copay/Medicare-covered group therapy visit Out-of-Network: 30% coinsurance/Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside the U.S. Urgent Care: \$40 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside of the U.S. |
| Travel Coverage | In-Network: \$0 copay/individual medical health risk and safety counseling specific to travel. Out-of-Network: 30% coinsurance/ individual medical health risk and safety counseling specific to travel. Note: Plan coverage and in-network cost sharing when using Medicare providers while traveling outside Minnesota for at least 1 month (no more than 9 consecutive months). You must use Medicare providers and contact Member Services to activate this benefit. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$20 copay/diagnostic procedures and tests, x-rays, \$75 copay/therapeutic radiology services, \$150 copay/diagnostic radiology services Out-of-Network: 30% coinsurance/lab services, diagnostic procedures and tests, x-rays, therapeutic radiology services, diagnostic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: 30% coinsurance/Medicare-covered physical/speech/occupational therapy visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stay - \$0 copay/day for days 1-20, \$203 copay/day for days 21-80, \$0 copay/day for days 81-100 Out-of-Network: 30% coinsurance/day for days 1-100 for each Medicare-covered stay |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, \$0 copay/self-management training Out-of-Network: 30% coinsurance/monitoring supplies, therapeutic shoes, inserts, self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered item Out-of-Network: 30% coinsurance/Medicare-covered item |
| Dental | In-Network: \$0 copay/Medicare-covered benefits, optional comprehensive dental available for an additional monthly premium Out-of-Network: 30% coinsurance/Medicare covered benefits 50% coinsurance/preventive dental services. Combined In- and Out-of-Network: \$2,000 allowance/year for preventive dental services |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered visit Out-of-network: 30% coinsurance/Medicare-covered visit Acupuncture: In-Network: \$40 copay/Medicare-covered visit or non-Medicare covered visit. Out-of-network: 30% coinsurance/Medicare-covered or non-Medicare covered visit |
| Vision | In-Network: \$0 copay/routine eye exam per year, \$40 copay/diagnostic eye exam Out-of-Network: 30% coinsurance/routine eye exam per year, diagnostic eye exam Combined In-Network and Out-of-Network: \$575 allowance/year for non-Medicare covered prescription eyewear and other services in a prepaid MasterCard® called HealthPartners Choice Card |
| Hearing | In-Network: \$0 copay/routine hearing exam, \$40 copay/diagnostic hearing exam, \$499, \$699 or \$999 copay/hearing aid from a TruHearing provider (up to 1 per ear per year) Out-of-network: 30% coinsurance/routine hearing exam per year, diagnostic hearing exam |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$300/tiers 3-5 |
| Discounts & Programs | SilverSneakers, Medication Therapy Management, Assist America worldwide emergency travel logistics, CareLine Service registered nurse line, Viruwell 24/7 online clinic care, \$75 quarterly allowance/OTC medications and health related items, \$575 allowance/year for non-Medicare covered services in a HealthPartners Choice Card |



HealthPartners Journey Pace (H4882-009-002)

Advantage PPO Plan

Enrollment: 844-363-8979

Service: 866-233-8734 • TTY: 711

healthpartners.com/medicare



Monthly Premium: \$0

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| Plan Area: Aitkin, Becker, Beltrami, Big Stone, Carlton, Cass, Chippewa, Clay, Clearwater, Cook, Crow Wing, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, McLeod, Mille Lacs, Murray, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Red Lake, Renville, Rice, Rock, Roseau, Sibley, Stevens, St. Louis, Traverse, Wilkin, Yellow Medicine Counties | |
| Out-of-Pocket Max | In-Network: \$6,000 annually Combined In- and Out-of-Network: \$8,950 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$300/day for days 1-5; \$0/day for days 6+ (unlimited days) Out-of-Network: 30% coinsurance/stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary, \$40 copay/specialist; \$0 copay/web or phone visits Out-of-Network: Medicare-covered services - 30% coinsurance/primary or specialist, 30% coinsurance for web/phone-based technologies |
| Ambulance | \$260 copay/ground transportation in the U.S., \$300 copay/air transportation in the U.S.; 20% coinsurance/ground transportation outside the U.S. |
| Outpatient Surgery | In-Network: \$375 copay/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility Out-of-Network: 30% coinsurance/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility |
| Outpatient Mental Health | In-Network: \$40 copay/Medicare-covered individual therapy visit, \$20 copay/Medicare-covered group therapy visit Out-of-Network: 30% coinsurance/Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside the U.S. Urgent Care: \$50 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside of the U.S. |
| Travel Coverage | In-Network: \$0 copay/individual medical health risk and safety counseling specific to travel. Out-of-Network: 30% coinsurance/ individual medical health risk and safety counseling specific to travel. Note: Plan coverage and in-network cost sharing when using Medicare providers while traveling outside Minnesota for at least 1 month (no more than 9 consecutive months). You must use Medicare providers and contact Member Services to activate this benefit. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$25 copay/diagnostic procedures and tests, x-rays, \$75 copay/therapeutic radiology services, \$200 copay/diagnostic radiology services Out-of-Network: 30% coinsurance/lab services, diagnostic procedures and tests, x-rays, therapeutic radiology services, diagnostic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: 30% coinsurance/Medicare-covered physical/speech/occupational therapy visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stay - \$0 copay/day for days 1-20, \$203 copay/day for days 21-80, \$0 copay/day for days 81-100 Out-of-Network: 30% coinsurance/day for days 1-100 for each Medicare-covered stay |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, \$0 copay/self-management training Out-of-Network: 30% coinsurance/monitoring supplies, therapeutic shoes, inserts, self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered item Out-of-Network: 30% coinsurance/Medicare-covered item |
| Dental | In-Network: \$0 copay/Medicare-covered benefits, optional comprehensive dental available for an additional monthly premium Out-of-Network: 30% coinsurance/Medicare covered benefits 50% coinsurance/preventive dental services. Combined In- and Out-of-Network: \$2,000 allowance/year for preventive dental services |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered visit Out-of-network: 30% coinsurance/Medicare-covered visit Acupuncture: In-Network: \$40 copay/Medicare-covered or non-Medicare covered visit. Out-of-network: 30% coinsurance/Medicare-covered or non-Medicare covered visit |
| Vision | In-Network: \$0 copay/routine eye exam per year, \$40 copay/diagnostic eye exam Out-of-Network: 30% coinsurance/routine eye exam per year, diagnostic eye exam Combined In-Network and Out-of-Network: \$300 allowance/year for non-Medicare covered prescription eyewear and other services in a prepaid MasterCard called HealthPartners Choice Card. |
| Hearing | In-Network: \$0 copay/routine hearing exam, \$40 copay/diagnostic hearing exam, \$499, \$699 or \$999 copay/hearing aid from a TruHearing provider (up to 1 per ear per year) Out-of-network: 30% coinsurance/routine hearing exam per year, diagnostic hearing exam |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$300/tiers 3-5 |
| Discounts & Programs | SilverSneakers, Medication Therapy Management, Assist America worldwide emergency travel logistics, CareLine Service registered nurse line, Viruwell 24/7 online clinic care, \$30 quarterly allowance/OTC medications and health related items, \$300 allowance/year for non-Medicare covered services in a HealthPartners Choice Card |



HealthPartners Journey Stride (H4882-011-001)

Advantage PPO Plan

Enrollment: 844-363-8979

Service: 866-233-8734 • TTY: 711

healthpartners.com/medicare



Monthly Premium: \$49

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| Plan Area: Anoka, Benton, Carver, Chisago, Dakota, Douglas, Hennepin, Isanti, Kandiyohi, Meeker, Morrison, Pope, Ramsey, Redwood, Scott, Sherburne, Stearns, Swift, Todd, Wadena, Washington, Wright Counties | |
| Out-of-Pocket Max | In-Network: \$3,900 annually Combined In- and Out-of-Network: \$6,000 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$250/day for days 1-5, \$0/day for days 6+ (unlimited days) Out-of-Network: 20% coinsurance/stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary, \$35 copay/specialist; \$0 copay/web or phone visits Out-of-Network: Medicare-covered services - \$60 copay/primary and specialist; 20% coinsurance/web or phone visit |
| Ambulance | \$250 copay/ground transportation in the U.S., 20% coinsurance/air transportation in the U.S., 20% coinsurance/ground transportation outside of the U.S. |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility Out-of-Network: 20% coinsurance/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility |
| Outpatient Mental Health | In-Network: \$35 copay/Medicare-covered individual therapy visit, \$17.50 copay/Medicare-covered group therapy visit Out-of-Network: \$60 copay/Medicare-covered individual therapy visit, \$30 copay/Medicare-covered group |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside the U.S. Urgent Care: \$40 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside of the U.S. |
| Travel Coverage | In-Network: \$0 copay/individual medical health risk and safety counseling specific to travel. Out-of-Network: \$60 copay/ individual medical health risk and safety counseling specific to travel. Note: Plan coverage and in-network cost sharing when using Medicare providers while traveling outside Minnesota for at least 1 month (no more than 9 consecutive months). You must use Medicare providers and contact Member Services to activate this benefit. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$20 copay/x-rays, diagnostic procedures and tests, \$75 copay/therapeutic radiology services, \$150 copay/diagnostic radiology services Out-of-Network: 20% coinsurance/lab services, diagnostic procedures and tests, x-rays, therapeutic radiology services, diagnostic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$35 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: \$60 copay/Medicare-covered physical/speech/occupational therapy visit |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20 for each Medicare-covered stay, \$203 copay/day for days 21-100 for each Medicare-covered stay Out-of-Network: 20% coinsurance/day for days 1-100 for each Medicare-covered stay |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, \$0 copay/self-management training Out-of-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered item Out-of-Network: 20% coinsurance/Medicare-covered item |
| Dental | In-Network: \$0 copay/Medicare covered benefits, preventive dental services, optional comprehensive dental available for an additional monthly premium Out-of-Network: 20% coinsurance/Medicare covered benefits, 50% coinsurance/preventive dental services Combined In- and Out-of-Network: \$2,000 allowance/year for preventive dental services |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered visit Out-of-network: \$20 copay/Medicare-covered visit Acupuncture: In-Network: \$35 copay/Medicare-covered visit and non-Medicare covered visit Out-of-network: \$60 copay/Medicare-covered and non-Medicare covered visit |
| Vision | In-Network: \$0 copay/routine eye exam per year, \$35 copay/diagnostic eye exam Out-of-Network: 20% coinsurance/routine eye exam per year, diagnostic eye exam Combined In-Network and Out-of-Network: \$475 allowance/year for non-Medicare covered prescription eyewear and other services in a prepaid MasterCard called HealthPartners Choice Card |
| Hearing | In-Network: \$0 copay/routine hearing exam, \$35 copay/diagnostic hearing exam, \$499, \$699 or \$999 copay/hearing aid from a TruHearing provider (up to 1 per ear per year) Out-of-network: 20% coinsurance/routine hearing exam per year, diagnostic hearing exam |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$300/tiers 3-5 |
| Discounts & Programs | SilverSneakers, Medication Therapy Management, Assist America worldwide emergency travel logistics, CareLine Service registered nurse line, Viruwel 24/7 online clinic care, \$50 quarterly allowance/OTC medications and health related items, \$475 allowance/year for non-Medicare covered services in a HealthPartners Choice Card |



HealthPartners Journey Stride (H4882-011-002)

Advantage PPO Plan

Enrollment: 844-363-8979

Service: 866-233-8734 • TTY: 711

healthpartners.com/medicare



Monthly Premium: \$59

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| Plan Area: Aitkin, Becker, Beltrami, Big Stone, Carlton, Cass, Chippewa, Clay, Clearwater, Cook, Crow Wing, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahanomen, Marshall, McLeod, Mille Lacs, Murray, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Red Lake, Renville, Rice, Rock, Roseau, Sibley, St. Louis, Stevens, Traverse, Wilkin, Yellow Medicine Counties | |
| Out-of-Pocket Max | In-Network: \$4,200 annually Combined In- and Out-of-Network: \$6,000 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$275/day for days 1-5, \$0/day for days 6+ (unlimited days) Out-of-Network: 20% coinsurance/stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary, \$35 copay/specialist; \$0 copay/web or phone visits Out-of-Network: Medicare-covered services - \$60 copay/primary and specialist; 20% coinsurance/web or phone visits |
| Ambulance | \$250 copay/ground transportation in the U.S., \$300 copay/air transportation in the U.S., 20% coinsurance/ground transportation outside of the U.S. |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility Out-of-Network: 20% coinsurance/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility |
| Outpatient Mental Health | In-Network: \$35 copay/Medicare-covered individual therapy visit, \$17.50 copay/Medicare-covered group therapy visit Out-of-Network: \$60 copay/Medicare-covered individual therapy visit, \$30 copay/Medicare-covered group |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside the U.S. Urgent Care: \$40 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside of the U.S. |
| Travel Coverage | In-Network: \$0 copay/individual medical health risk and safety counseling specific to travel. Out-of-Network: \$60 copay/ individual medical health risk and safety counseling specific to travel. Note: Plan coverage and in-network cost sharing when using Medicare providers while traveling outside Minnesota for at least 1 month (no more than 9 consecutive months). You must use Medicare providers and contact Member Services to activate this benefit. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$20 copay/x-rays, diagnostic procedures and tests, \$75 copay/therapeutic radiology services, \$150 copay/diagnostic radiology services Out-of-Network: 20% coinsurance/lab services, diagnostic procedures and tests, x-rays, therapeutic radiology services, diagnostic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$35 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: \$60 copay/Medicare-covered physical/speech/occupational therapy visit |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-20 for each Medicare-covered stay, \$203 copay/day for days 21-100 for each Medicare-covered stay Out-of-Network: 20% coinsurance/day for days 1-100 for each Medicare-covered stay |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, \$0 copay/self-management training Out-of-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered item Out-of-Network: 20% coinsurance/Medicare-covered item |
| Dental | In-Network: \$0 copay/Medicare covered benefits, preventive dental services, optional comprehensive dental available for an additional monthly premium Out-of-Network: 20% coinsurance/Medicare covered benefits, 50% coinsurance/preventive dental services Combined In- and Out-of-Network: \$2,000 allowance/year for preventive dental services |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered visit Out-of-network: \$20 copay/Medicare-covered visit Acupuncture: In-Network: \$35 copay/Medicare-covered visit and non-Medicare covered visit Out-of-network: \$60 copay/Medicare-covered and non-Medicare covered visit |
| Vision | In-Network: \$0 copay/routine eye exam per year, \$35 copay/diagnostic eye exam Out-of-Network: 20% coinsurance/routine eye exam per year, diagnostic eye exam Combined In-Network and Out-of-Network: \$300 allowance/year for non-Medicare covered prescription eyewear and other services in a prepaid MasterCard called HealthPartners Choice Card |
| Hearing | In-Network: \$0 copay/routine hearing exam, \$35 copay/diagnostic hearing exam, \$499, \$699 or \$999 copay/hearing aid from a TruHearing provider (up to 1 per ear per year) Out-of-network: 20% coinsurance/routine hearing exam per year, diagnostic hearing exam |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$300/tiers 3-5 |
| Discounts & Programs | SilverSneakers, Medication Therapy Management, Assist America worldwide emergency travel logistics, CareLine Service registered nurse line, Viruwell 24/7 online clinic care, \$40 quarterly allowance/OTC medications and health related items, \$300 allowance/year for non-Medicare covered services in a HealthPartners Choice Card |



HealthPartners Journey Dash (H4882-010-001)

Advantage PPO Plan

Enrollment: 844-363-8979

Service: 866-233-8734 • TTY: 711

healthpartners.com/medicare



Monthly Premium: \$84

Plan Area: Anoka, Benton, Carver, Chisago, Dakota, Douglas, Hennepin, Isanti, Kandiyohi, Meeker, Morrison, Pope, Ramsey, Redwood, Scott, Sherburne, Stearns, Swift, Todd, Wadena, Washington, Wright Counties

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|---|--|
| Out-of-Pocket Max | In-Network: \$3,000 annually Combined In- and Out-of-Network: \$5,150 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$200/stay Out-of-Network: 20% coinsurance/stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary, \$30 copay/specialist; \$0 copay/web or phone visits Out-of-Network: Medicare-covered services - \$50 copay/primary and specialist; 20% coinsurance/web or phone visits |
| Ambulance | \$250 copay/ground transportation in the U.S., 20% coinsurance/air transportation in the U.S., 20% coinsurance/ground transportation outside of the U.S. |
| Outpatient Surgery | In-Network: \$200 copay/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility Out-of-Network: 20% coinsurance/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility |
| Outpatient Mental Health | In-Network: \$30 copay/Medicare-covered individual therapy visit, \$15 copay/Medicare-covered group therapy visit Out-of-Network: \$50 copay/Medicare-covered individual therapy visit, \$25 copay/Medicare-covered group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside the U.S. Urgent Care: \$30 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside of the U.S. |
| Travel Coverage | In-Network: \$0 copay/individual medical health risk and safety counseling specific to travel. Out-of-Network: \$50 copay/ individual medical health risk and safety counseling specific to travel. Note: Plan coverage and in-network cost sharing when using Medicare providers while traveling outside Minnesota for at least 1 month (no more than 9 consecutive months). You must use Medicare providers and contact Member Services to activate this benefit. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$20 copay/diagnostic procedures and tests, x-rays, \$75 copay/therapeutic radiology services, \$125 copay/diagnostic radiology services Out-of-Network: 20% coinsurance/lab services, diagnostic procedures and tests, x-rays, therapeutic radiology services, diagnostic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$30 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: \$50 copay/Medicare-covered physical/speech/occupational therapy visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stay - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 20% coinsurance/day for days 1-100 for each Medicare-covered stay |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, \$0 copay/self-management training Out-of-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, self-management training |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | In-Network: \$0 copay/Medicare covered benefits Out-of-Network: 20% coinsurance/Medicare covered benefits, 50% coinsurance/preventive dental services Combined In- and Out-of-Network: \$2,250 allowance/year for dental services |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered visit Out-of-network: \$20 copay/Medicare-covered visit Acupuncture: In-Network: \$30 copay/Medicare-covered and non-Medicare covered visit Out-of-network: \$50 copay/Medicare-covered and non-Medicare covered visit |
| Vision | In-Network: \$0 copay/routine eye exam per year, \$30 copay/diagnostic eye exam Out-of-Network: 20% coinsurance/routine eye exam per year, diagnostic eye exam Combined In-Network and Out-of-Network: \$500 eyewear allowance/year and other non-medicare covered services in a prepaid MasterCard® called HealthPartners Choice Card |
| Hearing | In-Network: \$0 copay/routine hearing exam, \$30 copay/diagnostic hearing exam, \$399, \$599 or \$899 copay/hearing aid from a TruHearing provider (up to 1 per ear per year) Out-of-network: 20% coinsurance/routine hearing exam and diagnostic hearing exam |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-3, \$250/tiers 4-5 |
| Discounts & Programs | SilverSneakers, Medication Therapy Management, Assist America worldwide emergency travel logistics, CareLine Service registered nurse line, Viruwell 24/7 online clinic care, \$50 quarterly allowance/OTC medications and health related items, \$500 allowance/year for non-Medicare covered services in a HealthPartners Choice Card |



HealthPartners Journey Dash (H4882-010-002)

Advantage PPO Plan

Enrollment: 844-363-8979

Service: 866-233-8734 • TTY: 711

healthpartners.com/medicare



Monthly Premium: \$96

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| Plan Area: Aitkin, Becker, Beltrami, Big Stone, Carlton, Cass, Chippewa, Clay, Clearwater, Cook, Crow Wing, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnommen, Marshall, McLeod, Mille Lacs, Murray, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Red Lake, Renville, Rice, Rock, Roseau, Sibley, St. Louis, Stevens, Traverse, Wilkin, Yellow Medicine Counties | |
| Out-of-Pocket Max | In-Network: \$3,200 annually Combined In- and Out-of-Network: \$5,150 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$200/stay Out-of-Network: 20% coinsurance/stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary, \$30 copay/specialist; \$0 copay/web or phone visits Out-of-Network: Medicare-covered services - \$50 copay/primary and specialist; 20% coinsurance/web or phone visits |
| Ambulance | \$250 copay/ground transportation in the U.S., \$300 copay/air transportation in the U.S., 20% coinsurance/ground transportation outside of the U.S. |
| Outpatient Surgery | In-Network: \$200 copay/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility Out-of-Network: 20% coinsurance/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility |
| Outpatient Mental Health | In-Network: \$30 copay/Medicare-covered individual therapy visit, \$15 copay/Medicare-covered group therapy visit Out-of-Network: \$50 copay/Medicare-covered individual therapy visit, \$25 copay/Medicare-covered group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside the U.S. Urgent Care: \$30 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside of the U.S. |
| Travel Coverage | In-Network: \$0 copay/individual medical health risk and safety counseling specific to travel. Out-of-Network: \$50 copay/ individual medical health risk and safety counseling specific to travel. Note: Plan coverage and in-network cost sharing when using Medicare providers while traveling outside Minnesota for at least 1 month (no more than 9 consecutive months). You must use Medicare providers and contact Member Services to activate this benefit. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$20 copay/diagnostic procedures and tests, x-rays, \$75 copay/therapeutic radiology services, \$125 copay/diagnostic radiology services Out-of-Network: 20% coinsurance/lab services, diagnostic procedures and tests, x-rays, therapeutic radiology services, diagnostic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$30 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: \$50 copay/Medicare-covered physical/speech/occupational therapy visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stay - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 20% coinsurance/day for days 1-100 for each Medicare-covered stay |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, \$0 copay/self-management training Out-of-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, self-management training |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | In-Network: \$0 copay/Medicare covered benefits, optional comprehensive dental available for an additional monthly premium Out-of-Network: 20% coinsurance/Medicare covered benefits, 50% coinsurance/preventive dental services Combined In- and Out-of-Network: \$2,000 allowance/year for dental services |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered visit Out-of-network: \$20 copay/Medicare-covered visit Acupuncture: In-Network: \$30 copay/Medicare-covered and non-Medicare covered visit Out-of-network: \$50 copay/Medicare-covered and non-Medicare covered visit |
| Vision | In-Network: \$0 copay/routine eye exam per year, \$30 copay/diagnostic eye exam Out-of-Network: 20% coinsurance/routine eye exam per year, diagnostic eye exam Combined In-Network and Out-of-Network: \$150 eyewear allowance/year |
| Hearing | In-Network: \$0 copay/routine hearing exam, \$30 copay/diagnostic hearing exam, \$399, \$599 or \$899 copay/hearing aid from a TruHearing provider (up to 1 per ear per year) Out-of-network: 20% coinsurance/routine hearing exam and diagnostic hearing exam |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-3, \$250/tiers 4-5 |
| Discounts & Programs | SilverSneakers, Medication Therapy Management, Assist America worldwide emergency travel logistics, CareLine Service registered nurse line, Viruwell 24/7 online clinic care, \$50 quarterly allowance/OTC medications and health related items |



HealthPartners Journey Steady (H4882-003)

Advantage PPO Plan

Enrollment: 844-363-8979

Service: 866-233-8734 • TTY: 711

healthpartners.com/medicare



Monthly Premium: \$134

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| Plan Area: Anoka, Benton, Carver, Chisago, Dakota, Douglas, Hennepin, Isanti, Kandiyohi, Meeker, Morrison, Pope, Ramsey, Redwood, Scott, Sherburne, Stearns, Swift, Todd, Wadena, Washington, Wright Counties | |
| Out-of-Pocket Max | In-Network: \$2,800 annually Combined In- and Out-of-Network: \$5,100 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$175/stay Out-of-Network: 20% coinsurance/stay |
| Physician/Outpatient | In-Network: Medicare-covered services - \$0 copay/primary, \$25 copay/specialist; \$0 copay/web or phone visits Out-of-Network: Medicare-covered services - \$40 copay/primary and specialist; 20% coinsurance/web or phone visits |
| Ambulance | \$200 copay/ground transportation in the U.S., 20% coinsurance/air transportation in the U.S., 20% coinsurance/ground transportation outside of the U.S. |
| Outpatient Surgery | In-Network: \$150 copay/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility Out-of-Network: 20% coinsurance/Medicare-covered visits to an ambulatory surgical center or outpatient hospital facility |
| Outpatient Mental Health | In-Network: \$25 copay/Medicare-covered individual therapy visit, \$12.50 copay/Medicare-covered group therapy visit Out-of-Network: \$40 copay/Medicare-covered individual therapy visit, \$20 copay/Medicare-covered group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside the U.S. Urgent Care: \$30 copay/Medicare-covered visit in the U.S., 20% coinsurance/visit outside of the U.S. |
| Travel Coverage | In-Network: \$0 copay/individual medical health risk and safety counseling specific to travel. Out-of-Network: \$40 copay/ individual medical health risk and safety counseling specific to travel. Note: Plan coverage and in-network cost sharing when using Medicare providers while traveling outside Minnesota for at least 1 month (no more than 9 consecutive months). You must use Medicare providers and contact Member Services to activate this benefit. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/lab services, \$20 copay/diagnostic procedures and tests, x-rays, \$75 copay/therapeutic radiology services, \$75 copay/diagnostic radiology services Out-of-Network: 20% coinsurance/lab services, diagnostic procedures and tests, x-rays, therapeutic radiology services, diagnostic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$25 copay/Medicare-covered physical/speech/occupational therapy visit Out-of-Network: \$40 copay/Medicare-covered physical/speech/occupational therapy visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stay - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 20% coinsurance/day for days 1-100 for each Medicare-covered stay |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, \$0 copay/self-management training Out-of-Network: 20% coinsurance/monitoring supplies, therapeutic shoes, inserts, self-management training |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | In-Network: \$0 copay/Medicare covered benefits, preventive dental services (1 oral exam and cleaning per year and 1 bitewing x-ray every 2 years); optional comprehensive dental available for an additional monthly premium Out-of-Network: 20% coinsurance/Medicare covered benefits, 40% coinsurance/preventive dental services Combined In- and Out-of-Network: \$1,000 allowance/year for preventive dental services |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered visit Out-of-network: \$20 copay/Medicare-covered visit Acupuncture: In-Network: \$25 copay/Medicare-covered and non-Medicare covered visit Out-of-network: \$40 copay/Medicare-covered and non-Medicare covered visit |
| Vision | In-Network: \$0 copay/1 routine eye exam per year, \$25 copay/diagnostic eye exam Out-of-Network: 20% coinsurance/1 routine eye exam per year, diagnostic eye exam Combined In-Network and Out-of-Network: \$350 allowance/year for non-Medicare covered prescription eyewear |
| Hearing | In-Network: \$0 copay/routine hearing exam, \$25 copay/diagnostic hearing exam, \$399, \$599 or \$899 copay/hearing aid from a TruHearing provider (up to 2 per ear per year) Out-of-Network: 20% coinsurance/routine hearing exam per year, diagnostic hearing exam |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$300/tiers 3-5 |
| Discounts & Programs | SilverSneakers, Medication Therapy Management, Assist America worldwide emergency travel logistics, CareLine Service registered nurse line, Viruwel 24/7 online clinic care |



Humana Gold Plus (H6622-073)

Advantage HMO-POS Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

humana-medicare.com



Monthly Premium: \$0

| Plan Area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington Counties | |
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| Out-of-Pocket Max | In-Network: \$4,900 annually/Medicare-covered services Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered inpatient stays - \$350 copay/day for days 1-5, \$0 copay/day for days 6-90 |
| Physician/Outpatient | Physician In-Network: Medicare-covered benefits - \$0 copay/primary, \$45 copay/specialist |
| Ambulance | Medicare-covered benefits - \$300 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | Hospital In-Network: \$350 copay/Medicare-covered surgery services at an outpatient hospital |
| Outpatient Mental Health | In-Network: \$45-\$95 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit, copay waived if admitted within 24 hours Urgent Care: \$60 copay/Medicare-covered visit |
| Travel Coverage | \$120 copay/Medicare-covered visit, worldwide coverage, copay waived if admitted within 24 hours |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits - \$0-\$45 copay/lab services, \$0-\$95 copay/diagnostic procedures and tests, \$0-\$125 copay/x-rays, \$0-\$350 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered occupational/physical/speech therapy |
| Skilled Nursing Facility Care | In-Network: Medicare-covered Skilled Nursing Care - \$10 copay/day for days 1-20, \$203 copay/day for days 21-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/Medicare-covered benefits, self-management training, \$0 copay or 10%-20% coinsurance/ monitoring supplies, \$0 copay/diabetic shoes and inserts |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered equipment and supplies |
| Dental | In-Network: \$45 copay/Medicare-covered benefits Routine Dental: \$0 copayment/scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years; comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years; complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years; crown, root canal, root canal retreatment up to 1 per tooth per lifetime; bitewing x-rays, intraoral x-rays up to 1 set(s) per year; adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year; emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year; periodontal maintenance up to 4 per year; \$0 copayment/amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. \$2,500 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered services Acupuncture In-Network: \$45 copay/Medicare-covered services |
| Vision | In-Network: \$45 copay/Medicare-covered vision services, \$0 copay/diabetic eye exam, glaucoma screening, post-cataract eyewear Routine vision: \$0 copay/routine exam up to 1 per year, \$100 maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, \$150 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. |
| Hearing | In-Network: \$45 copay/Medicare-covered hearing services Routine hearing: \$0 copay/routine hearing exams up to 1 per year, \$0 copay/follow-up provider visits up to unlimited per year, \$699 copay/each Advanced level hearing aid up to 1 per ear per year, \$999 copay/each Premium level hearing aid up to 1 per ear per year Note: Includes 80 batteries per aid and 3 year warranty, Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase |
| Medicare Part B Drugs | In-Network: 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$350/tiers 3-5 |
| Discounts & Programs | Go365 by Humana Rewards, SilverSneakers program, meal benefit, over the counter drugs and supplies (\$40 quarterly) |



HumanaChoice (H5216-275)

Advantage PPO Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

humana-medicare.com



Monthly Premium: \$0

Plan Area: Aitkin; Anoka; Becker; Beltrami; Benton; Carlton; Carver; Cass; Clay; Crow Wing; Dakota; Hennepin; Hubbard; Isanti; Itasca; Koochiching; Lake; Lake of the Woods; Mahnommen; McLeod; Meeker; Mille Lacs; Norman; Otter Tail; Pennington; Ramsey; Red Lake; Roseau; Scott; St. Louis; Todd; Wadena; Washington; Wright Counties

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| Out-of-Pocket Max | In-Network: \$4,500 annually/Medicare-covered services Combined In- and Out-of-Network: \$9,550 annually/Medicare-covered services Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$750 Note: All services received from in-network primary care physician's office, specialist's office, and lab services do not apply to the combined in-network and out-of-network deductible. Services not covered by Original Medicare, ambulance services, emergency room services, urgently needed services at urgent care centers, immunizations (flu & pneumonia), Medicare-covered preventive services, diabetic monitoring supplies, chemotherapy drugs and administration, diagnostic colonoscopy, diagnostic mammography, and Medicare Part B-covered drugs do not apply to the combined in-network and out-of-network deductible. |
| Hospital Inpatient | In-Network: For Medicare-covered inpatient stays - \$400 copay/day for days 1-4, \$0 copay/day for days 5-90 Out-of-Network: 50% coinsurance |
| Physician/Outpatient | Physician In-Network: Medicare-covered benefits - \$0 copay/primary, \$45 copay/specialist Physician Out-of-Network: 50% coinsurance/Medicare-covered primary or specialist |
| Ambulance | Medicare-covered benefits - \$300 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | Hospital In-Network: \$400 copay/Medicare-covered surgery services at an outpatient hospital Hospital Out-of-Network: 50% coinsurance/Medicare-covered surgery services at an outpatient hospital |
| Outpatient Mental Health | In-Network: \$45-\$95 copay/Medicare-covered individual or group visits Out-of-Network: 50% coinsurance/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit, copay waived if admitted within 24 hours Urgent Care: \$60 copay/Medicare-covered visit |
| Travel Coverage | \$120 copay/Medicare-covered visit, worldwide coverage, copay waived if admitted within 24 hours |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits - \$0-\$45 copay/lab services, \$0-\$95 copay/diagnostic procedures and tests, \$0-\$125 copay/x-rays, \$0-\$400 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: Medicare-covered benefits - 50% coinsurance/lab services, 50% coinsurance/diagnostic procedures and tests, 50% coinsurance/x-rays, 50% coinsurance/diagnostic radiology services, 50% coinsurance/therapeutic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered occupational/physical/speech therapy Out-of-Network: 50% coinsurance/Medicare-covered occupational/physical/speech therapy |
| Skilled Nursing Facility Care | In-Network: Medicare-covered Skilled Nursing Care - \$10 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 50% coinsurance/Medicare-covered Skilled Nursing Care |
| Diabetic Supplies & Services | In-Network: \$0 copay/Medicare-covered benefits, self-management training, \$0 copay or 10%-20% coinsurance/monitoring supplies, \$0 copay/diabetic shoes and inserts Out-of-Network: 50% coinsurance/Medicare-covered benefits, self-management training, 30% coinsurance/monitoring supplies, 30% OON for Prosthetic Provider place of treatment for diabetic shoes and inserts; 50% for DME Provider |
| Dental | In-Network: \$45 copay/Medicare-covered dental services Out-of-Network: 50% coinsurance/Medicare-covered services Routine Dental: \$0 copay/scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years, \$0 copay/comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years, \$0 copay/complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years, \$0 copay/crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime, \$0 copay/bitewing x-rays, intraoral x-rays up to 1 set(s) per year, \$0 copay/adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year, \$0 copay/emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year, \$0 copay/periodontal maintenance up to 4 per year, \$0 copay/amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year, \$3,000 combined maximum benefit coverage amount per year for all preventive and comprehensive benefits |
| DMEPOS | 5% coinsurance/Medicare-covered equipment and supplies |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic services, \$45 copay/Medicare-covered acupuncture services Out-of-Network: 50% copay/Medicare-covered chiropractic services, 50% copay/Medicare-covered acupuncture services, limit 20 acupuncture visits per year |

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| Vision | In-Network: \$45 copay/Medicare-covered vision services, \$0 copay/diabetic eye exam, glaucoma screening, post-cataract eyewear Out-of-Network: 50% coinsurance/Medicare-covered vision services, 50% coinsurance/diabetic eye exam, glaucoma screening, post-cataract eyewear Routine Vision: \$0 copay/routine eye exam up to 1 per year, \$40 max benefit coverage/year for routine exam, \$250 max benefit coverage/year for contact lenses or eyeglasses - lenses and frames, \$300 max benefit coverage/year at PLUS Provider for contact lenses or eyeglasses - lenses and frames, fitting for eyeglasses - lenses and frames. Maximum benefit coverage amount is limited to 1 time use/year. |
| Hearing | In-Network: \$45 copay/Medicare-covered hearing services Out-of-Network: 50% coinsurance/Medicare-covered services Routine Hearing: \$0 copayment/routine hearing exams up to 1 per year, follow-up provider visits up to unlimited per year; \$99 copayment/each Advanced level hearing aid up to 1 per ear per year; \$399 copayment/each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty. Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. TruHearing provider must be used for in- and out-of-network hearing aid benefit. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| Medicare Part B Drugs | In-Network: 10% coinsurance/Medicare-covered Part B drugs Out-of-Network: 50% coinsurance/Medicare-covered Part B drugs |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$325/tiers 3-5 |
| Discounts & Programs | Go365 by Humana Rewards, SilverSneakers program, meal benefit, over the counter drugs and supplies (\$50 max quarterly) |



800-333-2433



Humana Honor PPO (H5216-278-001)

Advantage PPO Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

humana-medicare.com



Monthly Premium: \$0

Up to \$70 Part B Premium Reduction

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| <p>Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Clay, Clearwater, Crow Wing, Dakota, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Hennepin, Houston, Hubbard, Isanti, Itasca, Kanabec, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomon, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Polk, Ramsey, Red Lake, Renville, Rice, Rock, Roseau, Scott, Sibley, St. Louis, Steele, Todd, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright Counties</p> | |
| Out-of-Pocket Max | In-Network: \$4,900 annually/Medicare-covered services Combined In- and Out-of-Network: \$8,950 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered inpatient stays - \$295 copay/day for days 1-6, \$0 copay/day for days 7-90, \$0 copay/each additional hospital day Out-of-Network: 50% coinsurance/Medicare-covered hospital stay |
| Physician/Outpatient | Physician In-Network: Medicare-covered benefits - \$10 copay/primary, \$45 copay/specialist Physician Out-of-Network: Medicare-covered benefits - 50% coinsurance/primary or specialist |
| Ambulance | Medicare-covered benefits - \$300 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered outpatient surgery services at an outpatient hospital Out-of-Network: 50% coinsurance/Medicare-covered surgery services at an outpatient hospital |
| Outpatient Mental Health | In-Network: \$45-\$55 copay/Medicare-covered individual or group visits Out-of-Network: 50% coinsurance/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$120 copay/each Medicare-covered visit, copay waived if admitted within 24 hours Urgent Care: \$60 copay/Medicare-covered visit |
| Travel Coverage | \$120 copay/Medicare-covered visit, worldwide coverage, copay waived if admitted to the hospital within 24 hours for the same condition |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits - \$0-\$40 copay/lab services, \$0-\$60 copay/diagnostic procedures and tests, \$10-\$125 copay/x-rays, \$0-\$300 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: Medicare-covered benefits - 50% coinsurance/lab services, diagnostic procedures and tests, x-rays, diagnostic radiology services, therapeutic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered occupational/physical/speech therapy Out-of-Network: 50% coinsurance/Medicare-covered occupational/physical/speech therapy |
| Skilled Nursing Facility Care | In-Network: Medicare-covered Skilled Nursing Care - \$10 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 50% coinsurance/Medicare-covered Skilled Nursing Care |
| Diabetic Supplies & Services | In-Network: \$0 copay or 10%-20% coinsurance/diabetic monitoring supplies, cost share may vary depending on where service is provided Out-of-Network: 50% coinsurance |
| DMEPOS | In-Network: 3%-20% coinsurance/Medicare-covered equipment and supplies Out-of-Network: 10%-50% coinsurance/Medicare-covered equipment and supplies |
| Dental | In-Network: \$45 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services Routine Dental: \$2,500 annual allowance for non-Medicare covered preventive and comprehensive dental services. Note: The allowance cannot be used on cosmetic services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| Chiropractic/Acupuncture | Chiropractic In-Network: \$20 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services Acupuncture In-Network: \$45 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services |
| Vision | In-Network: \$45 copay/Medicare-covered vision benefits, \$0 copay/diabetic eye exam, glaucoma screening, post-cataract eyewear Out-of-Network: 50% coinsurance/Medicare-covered vision benefits, 50% coinsurance/diabetic eye exam, glaucoma screening, post-cataract eyewear Routine Vision: \$0 copay/routine exam up to 1 per year, \$75 combined maximum benefit coverage amount per year for routine exam. \$150 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. |

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| Hearing | In-Network: \$45 copay/Medicare-covered hearing benefits Out-of-Network: 50% coinsurance/Medicare-covered hearing services Routine Hearing: \$0 copayment/fitting, routine hearing exams up to 1 per year, \$699 copayment/Advanced level hearing aid up to 1 per ear per year, \$999 copayment/Premium level hearing aid up to 1 per ear per year. \$0 copay/follow-up provider visits. Note: includes 80 batteries per aid and 3 year warranty, fitting and adjustments covered for 1 year after TruHearing hearing aid purchase |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 50% coinsurance |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan |
| Discounts & Programs | Go365 by Humana Rewards, SilverSneakers program, over-the-counter drugs and supplies (\$100 quarterly), meal benefit |



800-333-2433



Humana Honor PPO (H5216-354)

Advantage PPO Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

humana-medicare.com



Monthly Premium: \$0

Up to \$100 Part B Premium Reduction

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| Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Clay, Clearwater, Crow Wing, Dakota, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Hennepin, Houston, Hubbard, Isanti, Itasca, Kanabec, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomon, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Polk, Ramsey, Red Lake, Renville, Rice, Rock, Roseau, Scott, Sibley, St. Louis, Steele, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright, Yellow Medicine Counties | |
| Out-of-Pocket Max | In-Network: \$4,900 annually/Medicare-covered services Combined In- and Out-of-Network: \$9,550 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered inpatient stays - \$295 copay/day for days 1-6, \$0 copay/day for days 7-90, \$0 copay/each additional hospital day Out-of-Network: 50% coinsurance/Medicare-covered hospital stay |
| Physician/Outpatient | Physician In-Network: Medicare-covered benefits - \$10 copay/primary, \$45 copay/specialist Physician Out-of-Network: Medicare-covered benefits - 50% coinsurance/primary or specialist |
| Ambulance | Medicare-covered benefits - \$300 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered outpatient surgery services at an outpatient hospital Out-of-Network: 50% coinsurance/Medicare-covered surgery services at an outpatient hospital |
| Outpatient Mental Health | In-Network: \$45-\$55 copay/Medicare-covered individual or group visits Out-of-Network: 50% coinsurance/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$120 copay/each Medicare-covered visit, copay waived if admitted within 24 hours Urgent Care: \$60 copay/Medicare-covered visit |
| Travel Coverage | \$120 copay/Medicare-covered visit, worldwide coverage, copay waived if admitted to the hospital within 24 hours for the same condition |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits \$0-\$40 copay/lab services, \$0-\$60 copay/diagnostic procedures and tests, \$10-\$125 copay/x-rays, \$0-\$300 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: Medicare-covered benefits - 50% coinsurance/lab services, diagnostic procedures and tests, x-rays, diagnostic radiology services, therapeutic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered occupational/physical/speech therapy Out-of-Network: 50% coinsurance/Medicare-covered occupational/physical/speech therapy |
| Skilled Nursing Facility Care | In-Network: Medicare-covered Skilled Nursing Care - \$10 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 50% coinsurance/Medicare-covered Skilled Nursing Care |
| Diabetic Supplies & Services | In-Network: \$0 copay or 10%-20% coinsurance/diabetic monitoring supplies, cost share may vary depending on where service is provided Out-of-Network: 50% coinsurance |
| DMEPOS | In-Network: 20% coinsurance/medical supplies and equipment Out-of-Network: 20% coinsurance/durable medical equipment, 50% coinsurance/medical supplies |
| Dental | In-Network: \$45 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services. Plan covers up to \$1,000 allowance every year for non-Medicare covered preventive and comprehensive dental services. You are responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire. Your benefit can be used for most dental treatments such as: preventive dental services, such as exams, routine cleanings, etc.; basic dental services, such as fillings, extractions, etc., major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. Note: The allowance cannot be used on cosmetic services and implants. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services Acupuncture: In-Network: \$45 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services |

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| Vision | In-Network: \$45 copay/Medicare-covered vision benefits, \$0 copay/diabetic eye exam, glaucoma screening, post-cataract eyewear Out-of-Network: 50% coinsurance/Medicare-covered vision benefits, 50% coinsurance/diabetic eye exam, glaucoma screening, post-cataract eyewear Routine Vision: \$0 copay/routine exam up to 1 per year, \$75 combined maximum benefit coverage amount per year for routine exam. \$150 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses lenses and frames. \$200 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. Maximum benefit coverage amount is limited to one time use per year. |
| Hearing | In-Network: \$45 copay/Medicare-covered hearing benefits Out-of-Network: 50% coinsurance/Medicare-covered hearing services Routine Hearing: \$0 copayment/fitting, routine hearing exams up to 1 per year, \$699 copayment/Advanced level hearing aid up to 1 per ear per year, \$999 copayment/Premium level hearing aid up to 1 per ear per year. \$0 copay/follow-up provider visits. Note: includes 80 batteries per aid and 3 year warranty, fitting and adjustments covered for 1 year after TruHearing hearing aid purchase |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 50% coinsurance |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan |
| Discounts & Programs | Go365 by Humana Rewards, SilverSneakers program, over-the-counter drugs and supplies (\$60 quarterly), meal benefit |



800-333-2433



Humana Gold Choice (H8145-006)

Advantage PFFS Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

humana-medicare.com



Monthly Premium: \$40

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| Plan Area: Blue Earth, Brown, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Martin, Mower, Nicollet, Olmsted, Rice, Sibley, Steele, Wabasha, Waseca, Winona Counties | |
| Out-of-Pocket Max | Combined In- and Out-of-Network: \$6,700 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | Medicare-covered inpatient stays - \$150 copay/day for days 1-7, \$0 copay/day for days 8-90, \$0 copay/each additional hospital day |
| Physician/Outpatient | Medicare-covered benefits - \$0 copay/primary, \$50 copay/specialist |
| Ambulance | \$300 copay, 20% coinsurance/air ambulance |
| Outpatient Surgery | \$300 copay/Medicare-covered outpatient surgery services at an outpatient hospital, \$250 copay/Medicare-covered outpatient surgery services at a surgical center |
| Outpatient Mental Health | \$40-\$95 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$55 copay/Medicare-covered visit |
| Travel Coverage | Call the plan for details. |
| X-rays, Lab & Diagnostic Tests | Medicare-covered benefits - \$100 copay/lab services, \$0-\$95 copay/diagnostic procedures and tests, \$0-\$125 copay/x-rays, \$0-\$300 copay/diagnostic radiology services |
| Physical/Speech/Occupational Therapy | \$40 copay/Medicare-covered occupational/physical/speech therapy |
| Skilled Nursing Facility Care | Medicare-covered Skilled Nursing Care - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 |
| Diabetic Supplies & Services | \$0 copay or 10%-20% coinsurance |
| DMEPOS | 20% coinsurance/Medicare-covered equipment and supplies |
| Dental | \$50 copay/Medicare-covered dental benefits, limits apply. Mandatory supplemental hearing benefit covers up to \$4,000 allowance every year for non-Medicare covered preventive and comprehensive dental services. You are responsible for any amount above the dental coverage limit. Any amount unused at the end of the year will expire. Your benefit can be used for most dental treatments such as preventive dental services, such as exams, routine cleanings, etc.; basic dental services, such as fillings, extractions, etc.; major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges, implants, etc. Note: the allowance cannot be used on cosmetic services. |
| Chiropractic/Acupuncture | \$15 copay/Medicare-covered chiropractic services, \$50 copay/Medicare-covered acupuncture services |
| Vision | \$50 copay/Medicare-covered vision benefits Note: \$0 copay/routine exam up to 1 per year, \$40 combined maximum benefit coverage amount per year for routine exam, \$250 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, \$300 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year |
| Hearing | \$50 copay/Medicare-covered hearing benefits, \$0 copay/routine hearing exams up to 1 per year, \$0 copay/follow-up provider visits up to unlimited per year, \$699 copay/each Advanced level hearing aid up to 1 per ear per year, \$999 copay/each Premium level hearing aid up to 1 per ear per year, Note: Includes 80 batteries per aid and 3 year warranty, unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. |
| Medicare Part B Drugs | In-Network: \$0-20% coinsurance Out-of-Network: 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$545/tiers 3, 4 & 5 |
| Discounts & Programs | Go365 by Humana Rewards for completing preventive health screenings and activities, SilverSneakers, over-the-counter drugs and supplies, meal benefit; \$175 quarterly/over-the-counter drugs and supplies |



Humana Value Plus (H5216-176)

Advantage PPO Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

Humana-medicare.com



Monthly Premium: \$41.70

Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Brown, Carlton, Carver, Cass, Clay, Clearwater, Crow Wing, Dakota, Hennepin, Hubbard, Isanti, Itasca, Kanabec, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Lincoln, Lyon, Mahnomon, Marshall, McLeod, Meeker, Mille Lacs, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Ramsey, Red Lake, Renville, Rock, Roseau, Scott, Sibley, St. Louis, Todd, Traverse, Wabasha, Wadena, Washington, Watonwan, Wilkin, Wright, Yellow Medicine Counties

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| Out-of-Pocket Max | In-Network: \$6,700 annually/Medicare-covered services Combined In- and Out-of-Network: \$13,300 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | Combined In- and Out-of-Network: \$226 Part B deductible Note: In-Network only: ambulance services, chemotherapy drugs and administration, diabetic monitoring supplies, Medicare Part B covered drugs, Part A services (IP, skilled nursing and home health). Both in-network and out-of-network: emergency room services, Medicare covered preventive services, services not covered by Original Medicare, urgently needed services at urgent care centers |
| Hospital Inpatient | In-Network: \$2,080 copay/Medicare-covered hospital stay Out-of-Network: 50% coinsurance/Medicare-covered hospital stay |
| Physician/Outpatient | Physician In-Network: Medicare-covered benefits - 20% coinsurance/primary or specialist Physician Out-of-Network: 50% coinsurance/covered primary or specialist |
| Ambulance | \$300 copay/Medicare-covered ground and air ambulance |
| Outpatient Surgery | In-Network: 20% coinsurance/covered surgery services at an outpatient hospital Out-of-Network: 50% coinsurance/covered surgery services at an outpatient hospital |
| Outpatient Mental Health | In-Network: 20% coinsurance/Medicare-covered individual or group visits Out-of-Network: 50% coinsurance/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit, copay waived if admitted within 24 hours Urgent Care: 20% coinsurance/Medicare-covered visit |
| Travel Coverage | \$100 copay/covered ER visit worldwide with copay waived if admitted to the hospital within 24 hours |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0-\$30 copay or 20% coinsurance/lab services, \$0 copay or 20% coinsurance/diagnostic procedures and tests, \$50 copay or 20% coinsurance/x-rays, \$0-\$300 copay to 20% coinsurance/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: 50% coinsurance/Medicare-covered lab services, diagnostic procedures and tests, x-rays, diagnostic radiology services and therapeutic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: 20% coinsurance/Medicare-covered occupational/physical/speech therapy Out-of-Network: 50% coinsurance/Medicare-covered occupational/physical/speech therapy |
| Skilled Nursing Facility Care | In-Network: Medicare-covered care \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 50% coinsurance/Medicare-covered Skilled Nursing Care |
| Diabetic Supplies & Services | In-Network: \$0 copay Out-of-Network: \$0 copay or 50% coinsurance |
| DMEPOS | 20% coinsurance/Medicare-covered equipment and supplies |
| Dental | In-Network: 20% coinsurance/Medicare-covered benefits Out-of-Network: 50% coinsurance/Medicare-covered benefits Routine Dental: \$0 copay/scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years, \$0 copay/comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years, \$0 copay/complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years, \$0 copay/crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime, \$0 copay/bitewing x-rays, intraoral x-rays up to 1 set(s) per year, \$0 copay/adjustments to dentures, denture rebase, denture relines, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year, \$0 copay/emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year, \$0 copay/periodontal maintenance up to 4 per year, \$0 copay/amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year, \$1,000 combined maximum benefit coverage amount per year for all preventive and comprehensive benefits. |
| Chiropractic/Acupuncture | Chiropractic In-Network: 20% coinsurance/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services Acupuncture In-Network: 20% coinsurance/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services |

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| Vision | In-Network: 20% coinsurance/covered vision benefits, \$0 copay/diabetic eye exam, glaucoma screening, post-cataract eyewear Out-of-Network: 50% coinsurance/covered vision benefits, diabetic eye exam, glaucoma screening, post-cataract eyewear Routine Vision: \$0 copay/routine exam, up to 1/year, \$75 max benefit coverage amount/year for routine exam, \$100 max benefit amount/year for eyeglasses/contact lenses. \$150 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. |
| Hearing | In-Network: 20% coinsurance/Medicare-covered hearing benefits Out-of-Network: 50% coinsurance/Medicare-covered hearing services Routine Hearing: \$0 copay/routine hearing exams up to 1 per year, \$0 copay/follow-up provider visits up to unlimited per year, \$99 copay/each Advanced level hearing aid up to 1 per ear per year, \$399 copay/each Premium level hearing aid up to 1 per ear per year Note: Includes 80 batteries per aid and 3 year warranty, unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. |
| Medicare Part B Drugs | In-Network: \$0 or 20% coinsurance Out-of-Network: \$0 or 50% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a stand-alone Part D plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$545 |
| Discounts & Programs | Go365 by Humana Rewards, SilverSneakers, \$100 quarterly/over-the-counter drugs and supplies with rollover, meal benefit, enhanced nutrition therapy |



800-333-2433



HumanaChoice (H5216-359)

Advantage PPO Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

humana-medicare.com



Monthly Premium: \$55

Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Blue Earth, Carlton, Carver, Cass, Clay, Clearwater, Crow Wing, Dakota, Fillmore, Hennepin, Houston, Hubbard, Isanti, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Mahnomon, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Norman, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Rice, Roseau, Scott, St. Louis, Steele, Todd, Wadena, Washington, Wilkin, Winona, Wright Counties

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| Out-of-Pocket Max | In-Network: \$5,900 annually/Medicare-covered service Combined In- and Out-of-Network: \$8,850 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered Inpatient stays - \$360 copay/day for days 1-5, \$0 copay/day for days 6-90, \$0 copay/each additional hospital day Out-of-Network: 50% coinsurance/Medicare-covered hospital stay |
| Physician/Outpatient | Physician In-Network: Medicare-covered benefits - \$15 copay/primary, \$45 copay/specialist Physician Out-of-Network: Medicare-covered benefits - 50% coinsurance/primary or specialist |
| Ambulance | Medicare-covered benefits - \$300 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | In-Network: \$300 copay/Medicare-covered surgery services at an outpatient hospital, \$250 copay/Medicare-covered surgery at a surgical center Out-of-Network: 50% coinsurance/Medicare-covered surgery services at an outpatient hospital or surgical center |
| Outpatient Mental Health | In-Network: \$40-\$95 copay/Medicare-covered individual or group visits Out-of-Network: 50% coinsurance/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit, copay waived if admitted within 24 hours Urgent Care: \$60 copay/Medicare-covered visit |
| Travel Coverage | \$120 copay/Medicare-covered visit, worldwide coverage, copay waived if admitted to the hospital within 24 hours for the same condition |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits - \$0-\$10 copay/lab services, \$0-\$95 copay/diagnostic procedures and tests, \$15-\$125 copay/x-rays, \$0-\$300 copay/diagnostic radiology services Out-of-Network: 50% coinsurance/Medicare-covered lab services, 50% coinsurance/diagnostic procedures and tests, x-rays and diagnostic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered occupational/physical/speech therapy Out-of-Network: 50% coinsurance/Medicare-covered occupational/physical/speech therapy |
| Skilled Nursing Facility Care | In-Network: Medicare-covered Skilled Nursing Care - \$10 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 50% coinsurance/Medicare-covered Skilled Nursing Care |
| Diabetic Supplies & Services | In-Network: \$0 copay or 10%-20% coinsurance/diabetic monitoring supplies, cost share may vary depending on where service is provided Out-of-Network: 50% coinsurance |
| DMEPOS | In-Network: 17%-20% coinsurance/Medicare-covered equipment and supplies Out-of-Network: 20%-50% coinsurance/Medicare-covered equipment and supplies |
| Dental | In-Network: \$45 copay/Medicare-covered dental benefits Out-of-Network: 50% coinsurance/Medicare-covered dental services Routine Dental: \$0 copay/comprehensive oral evaluation or periodontal exam up to 1 every 3 years. \$0 copay/panoramic film or diagnostic x-rays up to 1 every 5 years. \$0 copay/bitewing x-rays, intraoral x-rays up to 1 set(s) per year. \$0 copay/emergency diagnostic exam up to 1 per year. \$0 copay/fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. \$0 copay/periodontal maintenance up to 4 per year. \$0 copay/necessary anesthesia with covered service up to unlimited per year. \$25 copayment per tooth for amalgam and/or composite filling up to 2 per year. \$1000 combined maximum benefit coverage amount per year for preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services Acupuncture: In-Network: \$45 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services. Limit 20 acupuncture visits per year. |

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| Vision | In-Network: \$45 copay/Medicare-covered vision benefits, \$0 copay/diabetic eye exam, glaucoma screening, post-cataract eyewear Out-of-Network: 50% coinsurance/Medicare-covered vision benefits, diabetic eye exam, glaucoma screening, post-cataract eyewear Routine Vision: \$0 copay/routine exam up to 1 per year, \$75 combined maximum benefit coverage amount per year for routine exam, \$100 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, \$150 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year, maximum benefit coverage amount is limited to one time use per year. |
| Hearing | In-Network: \$45 copay/Medicare-covered hearing benefits Out-of-Network: 50% coinsurance/Medicare-covered hearing services Routine Hearing: \$0 copay/routine hearing exams up to 1 per year, \$0 copay/for follow-up provider visits up to unlimited per year, \$699 copay/each Advanced level hearing aid up to 1 per ear per year, \$999 copay/each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty, unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 50% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$400/tiers 3-5 |
| Discounts & Programs | Go365 by Humana Rewards for completing preventive health screenings and activities, SilverSneakers, \$25 quarterly/over-the-counter drugs and supplies, meal benefit |



800-333-2433



HumanaChoice (H5216-092)

Advantage PPO Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

humana-medicare.com



Monthly Premium: \$79

Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Clay, Clearwater, Crow Wing, Dakota, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Hennepin, Houston, Hubbard, Isanti, Itasca, Kanabec, Kittson, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnommen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Polk, Ramsey, Red Lake, Renville, Rice, Rock, Roseau, Scott, Sibley, St. Louis, Steele, Todd, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright Counties

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| Out-of-Pocket Max | In-Network: \$6,700 annually/Medicare-covered services Combined In- and Out-of-Network: \$13,300 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | Combined In- and Out-of-Network: \$240 Note: The following services listed are excluded from the combined in-network and out-of-network Part B deductible: In-Network only: ambulance services, chemotherapy drugs and administration, diabetic monitoring supplies, Medicare Part B covered drugs, Part A Services (IP, Skilled Nursing and Home Health), Both In-Network and Out-of-Network: emergency room services, Medicare covered, preventive services, services not covered by Original Medicare, Urgently Needed Services at Urgent Care Centers |
| Hospital Inpatient | Medicare-covered Inpatient stays - \$362 copay/day for days 1-7 \$0 copay/day for days 8-90 |
| Physician/Outpatient | Physician In-Network: Medicare-covered benefits - \$20 copay/primary, \$50 copay/specialist Physician Out-of-Network: 50% coinsurance/Medicare-covered primary or specialist |
| Ambulance | Medicare-covered benefits - \$300 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | 20% coinsurance/Medicare-covered surgery services at an outpatient hospital |
| Outpatient Mental Health | In-Network: 19%-20% coinsurance/Medicare-covered individual or group visits Out-of-Network: 50% coinsurance/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit, copay waived if admitted within 24 hours Urgent Care: \$55 copay/Medicare-covered visit |
| Travel Coverage | \$100 copay/Medicare-covered visit, worldwide coverage, copay waived if admitted to the hospital within 24 hours for the same condition |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits - \$0 copay/primary care or specialist office, 20% coinsurance/all other labs, \$0-\$55 copay or 20% coinsurance/diagnostic procedures and tests, \$20-\$55 copay or 20% coinsurance for x-rays, \$0-\$200 copay or 20% coinsurance/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: 50% coinsurance/Medicare-covered lab services, diagnostic procedures and tests, x-rays, diagnostic radiology services and therapeutic radiology services |
| Physical/Speech/Occupational Therapy | 20% coinsurance/Medicare-covered occupational/physical/speech therapy |
| Skilled Nursing Facility Care | Medicare-covered Skilled Nursing Care - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay or 10%-20% coinsurance Out-of-Network: 50% coinsurance Note: cost share may vary depending on where service is provided |
| DMEPOS | 20% coinsurance/Medicare-covered equipment and supplies |
| Dental | In-Network: \$50 copay/Medicare-covered dental benefits Out-of-Network: 50% coinsurance/Medicare-covered dental services Note: \$0 copay/comprehensive oral evaluation or periodontal exam up to 1 every 3 years, \$0 copay/panoramic film or diagnostic x-rays up to 1 every 5 years, \$0 copay/bitewing x-rays, intraoral x-rays up to 1 set(s) per year, \$0 copay/emergency diagnostic exam up to 1 per year, \$0 copay/fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year, \$0 copay/periodontal maintenance up to 4 per year, \$0 copay/necessary anesthesia with covered service up to unlimited per year. |
| Chiropractic/Acupuncture | Chiropractic: 20% coinsurance/Medicare-covered services Acupuncture In-Network: \$50 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services. Limit 20 acupuncture visits per year. |
| Vision | In-Network: \$50 copay/Medicare-covered vision benefits Out-of-Network: 50% coinsurance/Medicare-covered vision services Note: \$0 copay/routine exam up to 1 per year, \$75 combined maximum benefit coverage amount per year for routine exam, \$100 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, \$150 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year |
| Hearing | In-Network: \$50 copay/Medicare-covered hearing benefits Out-of-Network: 50% coinsurance/Medicare-covered hearing services. \$0 copay/routine hearing exams up to 1 per year, \$0 copay/follow-up provider visits up to unlimited per year, \$699 copay/each Advanced level hearing aid up to 1 per ear per year, \$999 copay/each Premium level hearing aid up to 1 per ear per year, Note: Includes 80 batteries per aid and 3 year warranty, unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 20%-50% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$545/tiers 3, 4 & 5 |
| Discounts & Programs | Go365 by Humana Rewards for completing preventive health screenings and activities, SilverSneakers |



HumanaChoice (H5216-397)

Advantage PPO Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

humana-medicare.com



Monthly Premium: \$69

Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Carlton, Carver, Cass, Clay, Clearwater, Crow Wing, Dakota, Fillmore, Hennepin, Houston, Hubbard, Isanti, Itasca, Kanabec, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahanomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Ramsey, Red Lake, Renville, Rice, Rock, Roseau, Scott, St. Louis, Steele, Todd, Traverse, Wadena, Washington, Wilkin, Winona, Wright, Yellow Medicine Counties

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|---|---|
| Out-of-Pocket Max | In-Network: \$3,500 annually/Medicare-covered services Combined In- and Out-of-Network: \$5,750 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: Medicare-covered Inpatient stays - \$400 copay/day for days 1-4 \$0 copay/day for days 5-90 Out-of-Network: 50% coinsurance/Medicare-covered stays |
| Physician/Outpatient | Physician In-Network: Medicare-covered benefits - \$0 copay/primary, \$35 copay/specialist Physician Out-of-Network: 50% coinsurance/Medicare-covered primary or specialist |
| Ambulance | Medicare-covered benefits - \$300 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | Outpatient In-Network: \$300 copay/Medicare-covered surgery services at an outpatient hospital, \$250 copay/Medicare-covered surgery services at an ambulatory surgical center Outpatient Out-of-Network: 50% coinsurance/Medicare-covered surgery services at an outpatient hospital |
| Outpatient Mental Health | In-Network: \$35-\$85 copay/Medicare-covered individual or group visits Out-of-Network: 50% coinsurance/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$135 copay/Medicare-covered visit, copay waived if admitted within 24 hours Urgent Care: \$65 copay/Medicare-covered visit |
| Travel Coverage | Call the plan for details. |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits - \$0-\$10 copay/lab services, \$0-\$85 copay/diagnostic procedures and tests, \$0-\$125 copay/x-rays, \$0-\$400 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: 50% coinsurance/Medicare-covered lab services, diagnostic procedures and tests, x-rays, diagnostic radiology services and therapeutic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay for Medicare-covered occupational, physical and speech therapy Out-of-Network: 50% coinsurance for Medicare-covered occupational, physical and speech therapy |
| Skilled Nursing Facility Care | In-Network: Medicare-covered Skilled Nursing Care - \$20 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 50% coinsurance/Medicare-covered Skilled Nursing Care |
| Diabetic Supplies & Services | In-Network: \$0 copay or 10%-20% coinsurance Out-of-Network: 30% coinsurance Note: cost share may vary depending on where service is provided |
| DMEPOS | 20% coinsurance/Medicare-covered equipment and supplies |
| Dental | In-Network: \$35 copay/Medicare-covered dental benefits Out-of-Network: 50% coinsurance/Medicare-covered dental services Note: \$0 copay/comprehensive oral evaluation or periodontal exam up to 1 every 3 years, \$0 copay/panoramic film or diagnostic x-rays up to 1 every 5 years, \$0 copay/bitewing x-rays, intraoral x-rays up to 1 set(s) per year, \$0 copay/emergency diagnostic exam up to 1 per year, \$0 copay/fluoride treatment, emergency treatment for pain, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year, \$0 copay/periodontal maintenance up to 4 per year, \$0 copay/necessary anesthesia with covered service up to unlimited per year, \$0 copay/scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years, \$0 copay/complete dentures, crown recementation, panoramic film or diagnostic xrays, partial dentures up to 1 every 5 years, \$0 copay/crown, other restorative services - core buildup and prefabricated post and core, root canal, root canal retreatment up to 1 per tooth per lifetime, \$0 copay/amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. \$4,000 combined maximum benefit coverage amount per year for all preventive and comprehensive benefits. |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic services, \$35 copay/Medicare-covered acupuncture services Out-of-Network: 50% coinsurance/Medicare-covered chiropractic and acupuncture services |
| Vision | In-Network: \$35 copay/Medicare-covered vision benefits Out-of-Network: 50% coinsurance/Medicare-covered vision services Note: \$0 copay/routine exam up to 1 per year, \$40 combined maximum benefit coverage amount per year for routine exam, \$250 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, \$300 maximum benefit coverage amount per year at PLUS Provider for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year |
| Hearing | In-Network: \$35 copay/Medicare-covered hearing benefits Out-of-Network: 50% coinsurance/Medicare-covered hearing services. \$0 copay/routine hearing exams up to 1 per year, \$0 copay/follow-up provider visits up to unlimited per year, \$99 copay/each Advanced level hearing aid up to 1 per ear per year, \$399 copay/each Premium level hearing aid up to 1 per ear per year, Note: Includes 80 batteries per aid and 3 year warranty, unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 50% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-3, \$250/tiers 4&5 |
| Discounts & Programs | Go365 by Humana Rewards for completing preventive health screenings and activities, SilverSneakers, \$75 quarterly/over-the-counter drugs and supplies with rollover, meal benefit |



HumanaChoice (H5216-063)

Advantage PPO Plan

Enrollment: 800-833-2364

Service: 800-457-4708 • TTY: 711

humana-medicare.com



Monthly Premium: \$99

Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Carlton, Carver, Cass, Clay, Clearwater, Crow Wing, Dakota, Fillmore, Hennepin, Houston, Hubbard, Isanti, Itasca, Kanabec, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Seuer, Lincoln, Lyon, Mahnomon, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Murray, Nobles, Norman, Otter Tail, Pennington, Pine, Pipestone, Polk, Ramsey, Red Lake, Renville, Rice, Rock, Roseau, Scott, St. Louis, Steele, Todd, Traverse, Wadena, Washington, Wilkin, Winona, Wright, Yellow Medicine Counties

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| Out-of-Pocket Max | In-Network: \$2,800 annually/Medicare-covered services Combined In- and Out-of-Network: \$5,750 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$150 copay/admission for Medicare-covered stays Out-of-Network: 50% coinsurance/Medicare-covered stays |
| Physician/Outpatient | Physician In-Network: Medicare-covered benefits - \$0 copay/primary, \$25 copay/specialist Physician Out-of-Network: 50% coinsurance/Medicare-covered primary or specialist |
| Ambulance | Medicare-covered benefits - \$300 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | Outpatient In-Network: \$300 copay/Medicare-covered surgery services at an outpatient hospital, \$250 copay/Medicare-covered surgery services at an ambulatory surgical center Outpatient Out-of-Network: 50% coinsurance/Medicare-covered surgery services at an outpatient hospital |
| Outpatient Mental Health | In-Network: \$25-\$85 copay/Medicare-covered individual or group visits Out-of-Network: 50% coinsurance/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$135 copay/Medicare-covered visit, copay waived if admitted within 24 hours Urgent Care: \$65 copay/Medicare-covered visit |
| Travel Coverage | \$135 copay/Medicare-covered visit, worldwide coverage, copay waived if admitted to the hospital within 24 hours for the same condition |
| X-rays, Lab & Diagnostic Tests | In-Network: Medicare-covered benefits - \$0-\$10 copay/lab services, \$0-\$85 copay/diagnostic procedures and tests, \$0-\$125 copay/x-rays, \$0-\$300 copay/diagnostic radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: 50% coinsurance/Medicare-covered lab services, diagnostic procedures and tests, x-rays, diagnostic radiology services and therapeutic radiology services |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay for Medicare-covered occupational, physical and speech therapy Out-of-Network: 50% coinsurance for Medicare-covered occupational, physical and speech therapy |
| Skilled Nursing Facility Care | In-Network: Medicare-covered Skilled Nursing Care - \$20 copay/day for days 1-20, \$203 copay/day for days 21-100 Out-of-Network: 20% coinsurance/Medicare-covered Skilled Nursing Care |
| Diabetic Supplies & Services | In-Network: \$0 copay or 10%-20% coinsurance/diabetic monitoring supplies, cost share may vary depending on where service is provided Out-of-Network: 50% coinsurance |
| DMEPOS | 20% coinsurance/Medicare-covered equipment and supplies |
| Dental | In-Network: \$25 copay/Medicare-covered dental benefits Out-of-Network: 50% coinsurance/Medicare-covered dental services Routine Dental: \$0 copay/comprehensive oral evaluation or periodontal exam up to 1 every 3 years, \$0 copay/panoramic film or diagnostic x-rays up to 1 every 5 years, \$0 copay/bitewing x-rays, intraoral x-rays up to 1 set(s) per year, \$0 copay/emergency diagnostic exam up to 1 per year, \$0 copay/fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year, \$0 copay/periodontal maintenance up to 4 per year, \$0 copay/necessary anesthesia with covered service up to unlimited per year. |
| Chiropractic/Acupuncture | Chiropractic: In-Network: \$20 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services Acupuncture: In-Network: \$25 copay/Medicare-covered services Out-of-Network: 50% coinsurance/Medicare-covered services Note: Limit of 20 acupuncture visits per year combined in- and out-of-network |
| Vision | In-Network: \$25 copay/Medicare-covered vision benefits, \$0 copay/diabetic eye exam, glaucoma screening, post-cataract eyewear Out-of-Network: 50% coinsurance/Medicare-covered vision benefits, 50% coinsurance/diabetic eye exam, glaucoma screening, post-cataract eyewear Routine vision: \$0 copay/routine exam up to 1 per year, \$75 combined maximum benefit coverage amount per year for routine exam, \$100 combined maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames, eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year, maximum benefit coverage amount is limited to one time use per year, benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

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| Hearing | In-Network: \$25 copay/Medicare-covered hearing benefits Out-of-Network: 50% coinsurance/Medicare-covered hearing services Routine Hearing: \$0 copay/routine hearing exams up to 1 per year, \$0 copay/follow-up provider visits up to unlimited per year, \$699 copay/each Advanced level hearing aid up to 1 per ear per year, \$999 copay/each Premium level hearing aid up to 1 per ear per year. Note: Includes 80 batteries per aid and 3 year warranty, unlimited follow-up provider visits during first year following TruHearing hearing aid purchase. |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 20-50% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | Go365 by Humana Rewards, SilverSneakers program, \$50 quarterly/over-the-counter drugs and supplies, unused funds roll over to the next quarter and expire at the end of the year; meal benefit |



800-333-2433



Medica Advantage Solution (H6154-001)

Advantage HMO-POS Plan

Enrollment: 800-918-2416

Service: 866-269-6804 • TTY: 711

medica.com/medicare



Monthly Premium: \$0

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| Plan Area: Anoka, Becker, Carver, Cass, Chippewa, Chisago, Crow Wing, Dakota, Douglas, Hennepin, Hubbard, Isanti, Kandiyohi, Otter Tail, Pope, Ramsey, Renville, Scott, Sherburne, Stearns, Swift, Todd, Wadena, Washington, Wright Counties | |
| Out-of-Pocket Max | In Network: \$5,500 annually/Medicare-covered services Out-of-Network: \$7,500 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$350 copay/day for days 1-5, \$0 copay/day for days 6-90, \$0 copay/additional hospital days |
| Physician/Outpatient | Medicare-covered benefits - \$0 copay/primary, \$45 copay/specialist |
| Ambulance | \$265 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | \$395 copay/outpatient surgery at outpatient hospital facility, \$320 copay/procedure at an ambulatory surgical center, \$350 copay/day for observation services |
| Outpatient Mental Health | \$40 copay/each Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit inside the U.S., copay waived if admitted within 1 day Urgent Care: \$0-40 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Receive all plan covered services at in-network cost sharing while traveling outside the state for no more than 6 consecutive months. Members call to activate benefit. Emergency Care Worldwide: 20% coinsurance/emergency care services and emergency ground transportation Out-of-Network Services: 40%/most Medicare-covered services through the POS benefit in the U.S. and its territories at any provider who accepts Medicare |
| X-rays, Lab & Diagnostic Tests | 0% coinsurance/Medicare-covered lab services, 20% coinsurance/Medicare-covered diagnostic procedures and tests, x-rays, diagnostic radiology services and therapeutic radiology services, \$150/day max per service |
| Physical/Speech/Occupational Therapy | \$40 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | Medicare-covered stays - \$0 copay/day for days 1-20, \$203 copay/day for days 21-48, \$0 copay/days 49-100 |
| Diabetic Supplies & Services | \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 20% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training |
| DMEPOS | 20% coinsurance/Medicare-covered items |
| Dental | 20% coinsurance/Medicare-covered dental benefits, up to a \$400 allowance for non-Medicare-covered dental services each year from a licensed dentist by using Health+ by Medica card at time of payment |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic visit; \$0-\$45 copay/Medicare-covered acupuncture visit |
| Vision | \$0 copay/1 routine eye exam per year, Medicare-covered eyewear, diabetic retinopathy exam and glaucoma screening; up to a \$100 allowance for non-Medicare-covered eyewear each year by using Health+ by Medica card at time of payment, \$45 copay/Medicare covered diagnostic exam |
| Hearing | \$0 copay/1 routine hearing test per year; \$0 copay/fitting-evaluations for hearing aids; \$549 or \$799 copay/hearing aid when using the EPIC Hearing network, \$25 copay/Medicare-covered diagnostic hearing and balance evaluations |
| Medicare Part B Drugs | 20% coinsurance, Part B rebatable drugs may be subjected to a lower coinsurance; \$35 copay/month for Part B insulin through external infusion pump |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$545/tiers 3-5 |
| Discounts & Programs | One Pass™ Fitness program, \$40 quarterly/over-the-counter allowance can be used for health and wellness products by using Health+ by Medica card at participating retailers, online and over the phone, 24/7 HealthAdvocate nursesline, \$0 copay/e-visit from virtuwell, Health+ by Medica Card |



Medica Advantage Solution (H8889-009)

Advantage PPO Plan

Enrollment: 800-918-2416

Service: 866-269-6804 • TTY: 711

medica.com/medicare



Monthly Premium: \$0
\$60 Part B Premium Reduction

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| Plan Area: Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Grant, Hennepin, Houston, Hubbard, Isanti, Jackson, Kandiyohi, Kittson, Lac qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnommen, Marshall, Martin, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Roseau, Scott, Sherburne, Stearns, Steele, Swift, Todd, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright Counties | |
| Out-of-Pocket Max | Combined In- and Out-of-Network: \$4,900 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$245 copay/day for days 1-6, \$0 copay/day for days 7-90, \$0 copay/additional hospital days |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$30 copay/specialist Out-of-Network: \$30 copay/primary, \$50 copay/specialist |
| Ambulance | \$265 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | In-Network: \$0-\$250 copay/surgery at outpatient hospital, \$0-\$175 copay/procedure at an ambulatory surgical center, \$245 copay/day for observation services Out-of-Network: \$0-\$300 copay/surgery at outpatient hospital, \$0-\$225 copay/procedure at an ambulatory surgical center, \$295 copay/day for observation services |
| Outpatient Mental Health | In-Network: \$30 copay/each Medicare-covered individual or group therapy visit Out-of-Network: \$50 copay/each Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit inside the U.S., copay waived if admitted within 1 day Urgent Care: \$0-\$45 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Receive all plan covered services at in-network cost sharing while traveling outside the state for no more than 6 consecutive months. Members call to activate benefit. Emergency Care Worldwide: 20% coinsurance/emergency care services and emergency ground transportation |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, \$15 copay/outpatient x-rays, \$0-\$70 copay/diagnostic radiology services, \$0-\$70/diagnostic tests and procedures, \$60 copay/therapeutic radiology |
| Physical/Speech/Occupational Therapy | In-Network: \$30 copay/Medicare-covered visit Out-of-Network: \$50 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays - \$0 copay/day for days 1-20, \$203 copay/day for days 21-45, \$0 copay/days 46-100 Out-of-Network: Medicare-covered stays - \$100 copay/day for days 1-20, \$203 copay/day for days 21-45, \$0 copay/days 46-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 20% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training Out-of-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 30% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered items Out-of-Network: 30% coinsurance |
| Dental | In-Network: \$0-\$30 copay/Medicare-covered dental benefits, up to a \$1,000 allowance for non-Medicare-covered dental services each year from a licensed dentist by using Health+ by Medica card at time of payment Out-of-Network: \$0-\$50 copay/Medicare-covered dental benefits |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit; \$0-\$30 copay/Medicare-covered acupuncture visit Out-of-Network: \$40 copay/Medicare-covered chiropractic visit; \$30-\$50 copay/Medicare-covered acupuncture visit |
| Vision | In-Network: \$0 copay/1 routine eye exam per year, Medicare-covered diabetic retinopathy exam and glaucoma screening, and Medicare-covered eyewear; up to a \$200 allowance for non-Medicare-covered eyewear/year, by using Health+ by Medica card at time of payment, \$30 copay/Medicare-covered diagnostic exam Out-of-Network: \$0 copay/1 routine eye exam per year, Medicare-covered diabetic retinopathy exam and glaucoma screening, and Medicare-covered eyewear, \$50 copay/Medicare-covered diagnostic exams |
| Hearing | In-Network: \$0 copay/1 routine hearing test per year; \$0 copay/fitting-evaluations for hearing aids; \$549 or \$799 copay/hearing aid when using EPIC Hearing network, \$0-\$25 copay/Medicare-covered diagnostic hearing and balance evaluations Out-of-Network: \$0-\$40 copay/Medicare-covered diagnostic hearing and balance evaluations |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance. Part B rebatable drugs may be subjected to a lower coinsurance; \$35 copay/month for Part B insulin through external infusion pump. |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan |
| Discounts & Programs | One Pass™ Fitness program, \$75 quarterly/over-the-counter allowance can be used for health and wellness products by using Health+ by Medica card at participating retailers, online and over the phone, 24/7 HealthAdvocate Nurseline, Health+ by Medica Card. |



Medica Advantage Solution (H8889-005)

Advantage PPO Plan

Enrollment: 800-918-2416

Service: 866-269-6804 • TTY: 711

medica.com/medicare



Monthly Premium: \$0

Plan Area: Anoka, Becker, Beltrami, Benton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Crow Wing, Dakota, Douglas, Grant, Hennepin, Hubbard, Isanti, Kandiyohi, Kittson, Lake of the Woods, Mahnommen, Marshall, Morrison, Norman, Otter Tail, Pennington, Polk, Pope, Ramsey, Red Lake, Renville, Roseau, Scott, Sherburne, Stearns, Swift, Todd, Wadena, Washington, Wilkin, and Wright Counties

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| Out-of-Pocket Max | In Network: \$3,700 annually/Medicare-covered services Combined In- and Out-of-Network: \$5,700 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$350 copay/day, days 1-5; \$0 copay/day for days 6-90; \$0 copay/additional hospital days Out-of-Network: \$425 copay/day, days 1-5; \$0 copay/day for days 6-90; \$0 copay/additional hospital days |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$35 copay/specialist Out-of-Network: \$20 copay/primary; \$50 copay/specialist |
| Ambulance | \$265 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | In-Network: \$0-\$395 copay/surgery at outpatient hospital facility, \$0-\$320 copay/procedure at an ambulatory surgical center, \$350 copay/day for observation services Out-of-Network: \$0-\$475 copay/surgery at outpatient hospital, \$0-\$400 copay/procedure at an ambulatory surgical center, \$425 copay/day for observation services |
| Outpatient Mental Health | In-Network: \$35 copay/each Medicare-covered individual or group therapy visit Out-of-Network: \$50 copay/each Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit inside the U.S., copay waived if admitted within 1 day Urgent Care: \$0-\$45 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Receive all plan covered services at in-network cost sharing while traveling outside the state for no more than 6 consecutive months. Members call to activate benefit. Emergency Care Worldwide: 20% coinsurance/emergency care services and emergency ground transportation |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, \$15 copay/outpatient x-rays, \$0-\$95 copay/diagnostic radiology services, \$0-\$95/diagnostic tests and procedures, \$60 copay/therapeutic radiology |
| Physical/Speech/Occupational Therapy | In-Network: \$35 copay/Medicare-covered visit Out-of-Network: \$50 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays - \$0 copay/day for days 1-20, \$203 copay/day for days 21-39, \$0 copay/days 40-100 Out-of-Network: Medicare-covered stays - \$100 copay/day for days 1-20, \$203 copay/day for days 21-39, \$0 copay/days 40-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 20% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training Out-of-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 30% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered items Out-of-Network: 30% coinsurance |
| Dental | In-Network: \$0-\$35 copay/Medicare-covered dental benefits, up to a \$750 allowance for non-Medicare-covered dental services each year from a licensed dentist by using Health+ by Medica card at time of payment Out-of-Network: \$20-\$50 copay/Medicare-covered dental benefits |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit; \$0-\$35 copay/Medicare-covered acupuncture visit Out-of-Network: \$40 copay/Medicare-covered chiropractic visit; \$20-\$50 copay/Medicare-covered acupuncture visit |
| Vision | In-Network: \$0 copay/1 routine eye exam per year, Medicare-covered eyewear, Medicare-covered diabetic retinopathy exam and glaucoma screening; up to a \$200 allowance for non-Medicare-covered eyewear each year by using Health+ by Medica card at time of payment; \$35 copay/Medicare-covered diagnostic exam Out-of-Network: \$0 copay/1 routine eye exam per year, Medicare-covered glaucoma screening, and Medicare-covered eyewear, \$20/Medicare-covered diabetic retinopathy exam, \$50 copay/Medicare-covered diagnostic exams |
| Hearing | In-Network: \$0 copay/1 routine hearing test per year; \$0 copay/fitting-evaluations for hearing aids; \$549 or \$799 copay/hearing aid when using the EPIC Hearing network. \$0-25 copay/ Medicare-covered diagnostic hearing and balance evaluations Out-of-Network: \$20-\$40 copay/Medicare-covered diagnostic hearing and balance evaluations |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance Part B rebatable drugs may be subjected to a lower coinsurance; \$35 copay/month for Part B insulin through external infusion pump |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$345/tiers 3-5 |
| Discounts & Programs | One Pass™ Fitness program, \$75 quarterly/over-the-counter allowance can be used for health and wellness products by using Health+ by Medica card at participating retailers, online and over the phone, 24/7 HealthAdvocate Nurseline, \$0 copay/e-visit from virtuwel, Health+ by Medica Card. |



Medica Advantage Solution (H8889-008)

Advantage PPO Plan

Enrollment: 800-918-2416

Service: 866-269-6804 • TTY: 711

medica.com/medicare



Monthly Premium: \$33

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|---|---|
| Plan Area: Big Stone, Blue Earth, Brown, Cottonwood, Dodge, Faribault, Fillmore, Freeborn, Houston, Jackson, Lac qui Parle, Lincoln, Lyon, Martin, Mower, Murray, Nicollet, Nobles, Olmsted, Redwood, Steele, Wabasha, Waseca, Watonwan, Winona Counties | |
| Out-of-Pocket Max | In-Network: \$5,500 annually/Medicare-covered services Combined In- and Out-of-Network: \$7,900 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$395 copay/day for days 1-5, \$0 copay/day for days 6-90, covers 90 days each benefit period, \$0 copay/lifetime reserve day Out-of-Network: \$445 copay/day for days 1-5, \$0 copay/day for days 6-90, covers 90 days each benefit period, \$0 copay/lifetime reserve day |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$50 copay/specialist Out-of-Network: \$20 copay/primary; \$55 copay/specialist |
| Ambulance | \$265 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | In-Network: \$0-\$425 copay/surgery at outpatient hospital, \$0-\$350 copay/procedure at an ambulatory surgical center, \$395 copay/day for observation services Out-of-Network: \$0-\$475 copay/surgery at outpatient hospital, \$0-\$400 copay/procedure at an ambulatory surgical center, \$445 copay/day for observation services |
| Outpatient Mental Health | In-Network: \$40 copay/each Medicare-covered individual or group therapy visit Out-of-Network: \$55 copay/each Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit inside the U.S., copay waived if admitted within 1 day Urgent Care: \$30-\$50 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Receive all plan covered services at in-network cost sharing while traveling outside the state for no more than 6 consecutive months. Members call to activate benefit. Emergency Care Worldwide: 20% coinsurance/emergency care services and emergency ground transportation |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, \$15 copay/outpatient x-rays, \$0-\$70 copay/diagnostic radiology services, \$0-\$70/diagnostic tests and procedures, \$60 copay/therapeutic radiology |
| Physical/Speech/Occupational Therapy | In-Network: \$40 copay/Medicare-covered visit Out-of-Network: \$55 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays - \$0 copay/day for days 1-20, \$203 copay/day for days 21-48, \$0 copay/days 49-100 Out-of-Network: Medicare-covered stays - \$100 copay/day for days 1-20, \$203 copay/day for days 21-48, \$0 copay/days 49-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 20% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training Out-of-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 30% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered items Out-of-Network: 30% coinsurance |
| Dental | In-Network: \$0-\$50 copay/Medicare-covered dental benefits, up to a \$400 allowance for non-Medicare-covered dental services each year from a licensed dentist, by using Health+ by Medica card at time of payment Out-of-Network: \$20-\$55 copay/Medicare-covered dental benefits |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit; \$0-\$50 copay/Medicare-covered acupuncture visit Out-of-Network: \$40 copay/Medicare-covered chiropractic visit; \$20-\$55 copay/Medicare-covered acupuncture visit |
| Vision | In-Network: \$0 copay/1 routine eye exam per year, Medicare-covered diabetic retinopathy exam and glaucoma screening, and Medicare-covered eyewear; up to a \$100 allowance for non-Medicare-covered eyewear/year by using Health+ by Medica card at time of payment, \$50 copay/Medicare-covered diagnostic exam Out-of-Network: \$0 copay/1 routine eye exam per year, Medicare-covered glaucoma screening, and Medicare-covered eyewear, \$20 copay/Medicare-covered diabetic retinopathy exam, \$55 copay/Medicare-covered diagnostic exams |
| Hearing | In-Network: \$0 copay/1 routine hearing test per year; \$0 copay/fitting-evaluations for hearing aids; \$549 or \$799 copay/hearing aid when using EPIC Hearing network, \$0-\$25 copay/Medicare-covered diagnostic hearing and balance evaluations Out-of-Network: \$20-\$40 copay/Medicare-covered diagnostic hearing and balance evaluations |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance. Part B rebatable drugs may be subjected to a lower coinsurance; \$35 copay/month for Part B insulin through external infusion pump. |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$445/tiers 3-5 |
| Discounts & Programs | One Pass™ Fitness program, \$50 quarterly/over-the-counter allowance can be used for health and wellness products by using Health+ by Medica card at participating retailers, online and over the phone, 24/7 HealthAdvocate Nurseline, \$0 copay/e-visit from virtuwel, Health+ by Medica Card. |



Medica Advantage Solution (H8889-001)

Advantage PPO Plan

Enrollment: 800-918-2416

Service: 866-269-6804 • TTY: 711

medica.com/medicare



Monthly Premium: \$85

| Plan Area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington Counties | |
|--|---|
| Out-of-Pocket Max | In-Network: \$2,800 annually/Medicare-covered services Combined In- and Out-of-Network: \$5,100 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$150 copay/stay Out-of-Network: \$200 copay/stay |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$25 copay/specialist Out-of-Network: \$15 copay/primary; \$40 copay/specialist |
| Ambulance | \$265 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | In-Network: \$0-\$200 copay/surgery at outpatient hospital, \$0-\$125 copay/procedure at an ambulatory surgical center, \$150 copay/stay for observation services Out-of-Network: \$0-\$250 copay/surgery at outpatient hospital, \$0-\$175 copay/procedure at an ambulatory surgical center, \$200 copay/stay for observation services |
| Outpatient Mental Health | In-Network: \$25 copay/each Medicare-covered individual or group therapy visit Out-of-Network: \$40 copay/each Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$90 copay/Medicare-covered visit inside the U.S., copay waived if admitted within 1 day Urgent Care: \$0-\$40 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Receive all plan covered services at in-network cost sharing while traveling outside the state for no more than 6 consecutive months. Members call to activate benefit. Emergency Care Worldwide: 20% coinsurance/emergency care services and emergency ground transportation |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, \$15 copay/outpatient x-rays, \$0-\$70 copay/diagnostic radiology services, \$0-\$70/diagnostic tests and procedures, \$60 copay/therapeutic radiology |
| Physical/Speech/Occupational Therapy | In-Network: \$25 copay/Medicare-covered visit Out-of-Network: \$40 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays - \$0 copay/day for days 1-20, \$203 copay/day for days 21-34, \$0 copay/days 35-100 Out-of-Network: Medicare-covered stays - \$100 copay/day for days 1-20, \$203 copay/day for days 21-34, \$0 copay/days 35-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 20% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training Out-of-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 30% coinsurance /therapeutic shoes or inserts, \$0 copay/diabetes self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered items Out-of-Network: 30% coinsurance |
| Dental | In-Network: \$0-\$25 copay/Medicare-covered dental benefits, up to a \$1,000 allowance for non-Medicare-covered dental services each year from a licensed dentist by using Health+ by Medica card at time of payment Out-of-Network: \$0-\$40 copay/Medicare-covered dental benefits |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit; \$0-\$25 copay/Medicare-covered acupuncture visit Out-of-Network: \$40 copay/Medicare-covered chiropractic visit; \$15-\$40 copay/Medicare-covered acupuncture visit |
| Vision | In-Network: \$0 copay/1 routine eye exam per year, Medicare-covered diabetic retinopathy exam and glaucoma screening, and Medicare-covered eyewear; up to a \$300 allowance for non-Medicare-covered eyewear each year by using Health+ by Medica card at time of payment, \$25 copay/Medicare-covered diagnostic exam Out-of-Network: \$0 copay/1 routine eye exam per year, Medicare-covered diabetic retinopathy exam and glaucoma screening, and Medicare-covered eyewear, \$40 copay/Medicare-covered diagnostic exams |
| Hearing | In-Network: \$0 copay/1 routine hearing test per year, \$0 copay/fitting-evaluations for hearing aids; \$549 or \$799 copay/hearing aid when using EPIC Hearing network, \$0-\$25 copay/Medicare-covered diagnostic hearing and balance evaluations from any provider Out-of-Network: \$0-\$40 copay/Medicare-covered diagnostic hearing and balance evaluations |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance. Part B rebatable drugs may be subjected to a lower coinsurance; \$35 copay/month for Part B insulin through external infusion pump |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-3, \$245/tiers 4-5 |
| Discounts & Programs | One Pass™ Fitness program, \$75 quarterly/over-the-counter allowance can be used for health and wellness products by using Health+ by Medica card at participating retailers, online and over the phone, 24/7 HealthAdvocate Nurseline, \$0 copay/e-visit from virtuwel , Health+ by Medica Card. |



Medica Advantage Solution (H8889-002)

Advantage PPO Plan

Enrollment: 800-918-2416

Service: 866-269-6804 • TTY: 711

medica.com/medicare



Monthly Premium: \$95

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| Plan Area: Becker, Beltrami, Benton, Cass, Chippewa, Chisago, Clay, Clearwater, Crow Wing, Douglas, Grant, Hubbard, Isanti, Kandiyohi, Kittson, Lake of the Woods, Mahnomon, Marshall, Morrison, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Renville, Roseau, Sherburne, Stearns, Swift, Todd, Wadena, Wilkin, Wright Counties | |
| Out-of-Pocket Max | In-Network: \$2,800 annually/Medicare-covered services Combined In- and Out-of-Network: \$5,100 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$200 copay/stay Out-of-Network: \$300 copay/stay |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$25 copay/specialist Out-of-Network: \$15 copay/primary; \$40 copay/specialist |
| Ambulance | \$290 copay/ground and air ambulance |
| Outpatient Surgery | In-Network: \$0-\$250 copay/surgery at outpatient hospital. \$0-\$175 copay/procedure at an ambulatory surgical center, \$200 copay/stay for observation services Out-of-Network: \$0-\$300 copay/surgery at outpatient hospital, \$0-\$225 copay/procedure at an ambulatory surgical center, \$300 copay/stay for observation services |
| Outpatient Mental Health | In-Network: \$25 copay/each Medicare-covered individual or group therapy visit and per day for partial hospitalization program services Out-of-Network: \$40 copay/each Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit inside the U.S., copay waived if admitted within 1 day Urgent Care: \$0-\$40 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Receive all plan covered services at in-network cost sharing while traveling outside the state for no more than 6 consecutive months. Members call to activate benefit. Emergency Care Worldwide: 20% coinsurance/emergency care services and emergency ground transportation |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, \$15 copay/outpatient x-rays, \$0-\$70 copay/diagnostic radiology services, \$0-\$70/diagnostic tests and procedures, \$60 copay/therapeutic radiology |
| Physical/Speech/Occupational Therapy | In-Network: \$25 copay/Medicare-covered visit Out-of-Network: \$40 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays - \$0 copay/day for days 1-20, \$203 copay/day for days 21-34, \$0 copay/days 35-100 Out-of-Network: Medicare-covered stays - \$100 copay/day for days 1-20, \$203 copay/day for days 21-34, \$0 copay/days 35-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 20% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training Out-of-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 30% coinsurance /therapeutic shoes or inserts, \$0 copay/diabetes self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered items Out-of-Network: 30% coinsurance |
| Dental | In-Network: \$0-\$25 copay/Medicare-covered dental benefits, up to a \$1,000 allowance for non-Medicare-covered dental services each year from a licensed dentist by using Health+ by Medica card at time of payment Out-of-Network: \$0-\$40 copay/Medicare-covered dental benefits |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit; \$0-\$25 copay/Medicare-covered acupuncture visit Out-of-Network: \$40 copay/Medicare-covered chiropractic visit; \$15-\$40 copay/Medicare-covered acupuncture visit |
| Vision | In-Network: \$0 copay/1 routine eye exam per year, Medicare-covered eyewear, up to a \$300 allowance for non-Medicare-covered eyewear each year by using Health+ by Medica card at time of payment, \$25 copay/Medicare-covered diagnostic exam Out-of-Network: \$0 copay/1 routine eye exam per year, Medicare-covered diabetic retinopathy exam and glaucoma screening, and Medicare-covered eyewear, \$40 copay/Medicare-covered diagnostic exams |
| Hearing | In-Network: \$0 copay/1 routine hearing test per year; \$0/fitting-evaluations for hearing aids; \$549 or \$799 copay/hearing aid when using the EPIC Hearing network, \$0-\$25 copay/Medicare-covered diagnostic hearing and balance evaluations Out-of-Network: \$0-\$40 copay/Medicare-covered diagnostic hearing and balance evaluations |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance. Part B rebatable drugs may be subjected to a lower coinsurance; \$35 copay/month for Part B insulin through external infusion pump |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-3, \$245/tiers 4-5 |
| Discounts & Programs | One Pass™ Fitness program, \$75 quarterly/over-the-counter allowance can be used for health and wellness products by using Health+ by Medica card at participating retailers, online and over the phone, 24/7 HealthAdvocate Nurseline, \$0 copay/e-visit from virtuwel, Health+ by Medica Card. |



Medica Advantage Solution (H8889-004)

Advantage PPO Plan

Enrollment: 800-918-2416

Service: 866-269-6804 • TTY: 711

medica.com/medicare



Monthly Premium: \$141

Plan Area: Big Stone, Blue Earth, Brown, Cottonwood, Dodge, Faribault, Fillmore, Freeborn, Houston, Jackson, Lac qui Parle, Lincoln, Lyon, Martin, Mower, Murray, Nicollet, Nobles, Olmsted, Redwood, Steele, Wabasha, Waseca, Watonwan, Winona Counties

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|---|---|
| Out-of-Pocket Max | In-Network: \$4,900 annually/Medicare-covered services Combined In- and Out-of-Network: \$7,500 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$295 copay/stay Out-of-Network: \$345 copay/stay |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$35 copay/specialist Out-of-Network: \$20 copay/primary; \$50 copay/specialist |
| Ambulance | \$265 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | In-Network: \$0-\$295 copay/surgery at outpatient hospital, \$0-\$220 copay/procedure at an ambulatory surgical center, \$295 copay/stay for observation services Out-of-Network: \$0-\$345 copay/surgery at outpatient hospital, \$0-\$270 copay/procedure at an ambulatory surgical center, \$345 copay/stay for observation services |
| Outpatient Mental Health | In-Network: \$35 copay/each Medicare-covered individual or group therapy visit Out-of-Network: \$50 copay/each Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$120 copay/Medicare-covered visit inside the U.S., copay waived if admitted within 1 day Urgent Care: \$0-\$40 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Receive all plan covered services at in-network cost sharing while traveling outside the state for no more than 6 consecutive months. Members call to activate benefit. Emergency Care Worldwide: 20% coinsurance/emergency care services and emergency ground transportation |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, \$15 copay/outpatient x-rays, \$0-\$70 copay/diagnostic radiology services, \$0-\$70/diagnostic tests and procedures, \$60 copay/therapeutic radiology |
| Physical/Speech/Occupational Therapy | In-Network: \$35 copay/Medicare-covered visit Out-of-Network: \$50 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays - \$0 copay/day for days 1-20, \$203 copay/day for days 21-45, \$0 copay/days 46-100 Out-of-Network: Medicare-covered stays - \$100 copay/day for days 1-20, \$203 copay/day for days 21-45, \$0 copay/days 46-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 20% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training Out-of-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 30% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered items Out-of-Network: 30% coinsurance |
| Dental | In-Network: \$0-\$35 copay/Medicare-covered dental benefits, up to a \$500 allowance for non-Medicare-covered dental services each year from a licensed dentist by using Health+ by Medica card at time of payment Out-of-Network: \$20-\$50 copay/Medicare-covered dental benefits |
| Chiropractic/Acupuncture | In-Network: \$20 copay/Medicare-covered chiropractic visit; \$0-\$35 copay/Medicare-covered acupuncture visit Out-of-Network: \$40 copay/Medicare-covered chiropractic visit; \$20-\$50 copay/Medicare-covered acupuncture visit |
| Vision | In-Network: \$0 copay/1 routine eye exam per year, Medicare-covered diabetic retinopathy exam and glaucoma screening, and Medicare-covered eyewear; up to a \$100 allowance by using Health+ by Medica card at time of payment for non-Medicare-covered eyewear/year, \$35 copay/Medicare-covered diagnostic exam Out-of-Network: \$0 copay/1 routine eye exam per year, Medicare-covered glaucoma screening, and Medicare-covered eyewear, \$20/Medicare-covered diabetic retinopathy exam, \$50 copay/Medicare-covered diagnostic exams |
| Hearing | In-Network: \$0 copay/1 routine hearing test per year, \$0 copay/fitting-evaluations for hearing aids, \$549 or \$799 copay/hearing aid when using the EPIC Hearing network, \$0-\$25 copay/Medicare-covered diagnostic hearing and balance evaluations Out-of-Network: \$20-\$40 copay/Medicare-covered diagnostic hearing and balance evaluations |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 30% coinsurance. Part B rebatable drugs may be subjected to a lower coinsurance; \$35 copay/month for Part B insulin through external infusion pump |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$345/tiers 3-5 |
| Discounts & Programs | One Pass™ Fitness program, \$50 quarterly/over-the-counter allowance can be used for health and wellness products by using Health+ by Medica card at participating retailers, online and over the phone, 24/7 HealthAdvocate Nurseline, \$0 copay/e-visit from virtuwel, Health+ by Medica Card. |



Medica Advantage Solution (H8889-003)

Advantage PPO Plan

Enrollment: 800-918-2416

Service: 866-269-6804 • TTY: 711

medica.com/medicare



Monthly Premium: \$195

| Plan Area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington Counties | |
|--|---|
| Out-of-Pocket Max | In-Network: \$2,800 annually/Medicare-covered services Combined In- and Out-of-Network: \$5,100 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$100 copay/stay Out-of-Network: \$175 copay/stay |
| Physician/Outpatient | In-Network: Medicare-covered benefits - \$0 copay/primary, \$10 copay/specialist Out-of-Network: \$10 copay/primary; \$25 copay/specialist |
| Ambulance | \$100 copay/ground ambulance, 20% coinsurance/air ambulance |
| Outpatient Surgery | In-Network: \$0-\$100 copay/surgery at outpatient hospital. \$0-\$50 copay/procedure at an ambulatory surgical center, \$100 copay/stay for observation services Out-of-Network: \$0-\$150 copay/surgery at outpatient hospital, \$0-\$100 copay/procedure at an ambulatory surgical center, \$175 copay/stay for observation service |
| Outpatient Mental Health | In-Network: \$10 copay/each Medicare-covered individual or group therapy visit Out-of-Network: \$25 copay/each Medicare-covered individual or group therapy visit |
| Emergency/Urgent Care | Emergency Care: \$90 copay/Medicare-covered visit inside the U.S., copay waived if admitted within 1 day Urgent Care: \$0-\$10 copay/Medicare-covered visit in the U.S. |
| Travel Coverage | Receive all plan covered services at in-network cost sharing while traveling outside the state for no more than 6 consecutive months. Members call to activate benefit. Emergency Care Worldwide: 20% coinsurance/emergency care services and emergency ground transportation |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, outpatient x-rays, and therapeutic radiology, \$0-\$50 copay/diagnostic radiology services, \$0-\$50/diagnostic tests and procedures |
| Physical/Speech/Occupational Therapy | In-Network: \$10 copay/Medicare-covered visit Out-of-Network: \$25 copay/Medicare-covered visit |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays - \$0 copay/day for days 1-20, \$150 copay/day for days 21-40, \$0 copay/days 41-100 Out-of-Network: Medicare-covered stays - \$100 copay/day for days 1-20, \$150 copay/day for days 21-40, \$0 copay/days 41-100 |
| Diabetic Supplies & Services | In-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 20% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training Out-of-Network: \$0 copay/diabetic testing supplies from LifeScan™ and Roche, 20% coinsurance/therapeutic shoes or inserts, \$0 copay/diabetes self-management training |
| DMEPOS | In-Network: 20% coinsurance/Medicare-covered items Out-of-Network: 20% coinsurance |
| Dental | In-Network: \$0-\$10 copay/Medicare-covered dental benefits, up to a \$1,000 allowance for non-Medicare-covered dental services each year from a licensed dentist by using Health+ by Medica card at time of payment Out-of-Network: \$0-\$25 copay/Medicare-covered dental benefits |
| Chiropractic/Acupuncture | In-Network: \$10 copay/Medicare-covered chiropractic visit; \$0-\$10 copay/Medicare-covered acupuncture visit Out-of-Network: \$25 copay/Medicare-covered chiropractic visit; \$10-\$25 copay/Medicare-covered acupuncture visit |
| Vision | In-Network: \$0 copay/1 routine eye exam per year; \$0 copay/Medicare-covered diabetic retinopathy exam and glaucoma screening, Medicare-covered eyewear; up to a \$300 allowance for non-Medicare-covered eyewear each year by using Health+ by Medica card at time of payment; \$10 copay/Medicare-covered diagnostic exam Out-of-Network: \$0 copay/1 routine eye exam per year, Medicare-covered diabetic retinopathy exam and glaucoma screening, and Medicare-covered eyewear, \$25 copay/Medicare-covered diagnostic exams |
| Hearing | In-Network: \$0 copay/1 routine hearing test per year; \$0 copay/fitting-evaluations for hearing aids; \$549 or \$799 copay/hearing aid when using EPIC Hearing network, \$0-\$10 copay/Medicare-covered diagnostic hearing and balance evaluations Out-of-Network: \$0-\$25 copay/Medicare-covered diagnostic hearing and balance evaluations |
| Medicare Part B Drugs | In-Network: 20% coinsurance Out-of-Network: 20% coinsurance. Part B rebatable drugs may be subjected to a lower coinsurance; \$35 copay/month for Part B insulin through external infusion pump |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-5 |
| Discounts & Programs | One Pass™ Fitness program, \$75 quarterly/over-the-counter allowance can be used for health and wellness products by using Health+ by Medica card at participating retailers, online and over the phone, 24/7 HealthAdvocate Nurseline, \$0 copay/e-visit from virtuwell, Health+ by Medica Card. |



Gundersen MN Quartz Medicare Advantage Core D (H9834-006)

Advantage HMO Plan

Enrollment: 800-394-5566

Service: 800-394-5566 • TTY: 711

QuartzBenefits.com/MedicareAdvantage



Monthly Premium: \$0

| Plan Area: Fillmore, Houston, Wabasha, Winona Counties | |
|--|--|
| Out-of-Pocket Max | \$5,900 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$270 copay/day for days 1-6, \$0 copay/additional hospital days |
| Physician/Outpatient | \$25 copay/primary, \$55 copay/specialist |
| Ambulance | \$350 copay/Medicare-covered transports |
| Outpatient Surgery | \$350 copay/surgery, \$0 copay/minor surgical procedures |
| Outpatient Mental Health | \$50 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Worldwide emergency care: \$120 copay Worldwide Urgent Care: \$60 copay |
| Travel Coverage | You may receive all plan covered services at in-network cost for up to 6 months when you travel domestically outside of Wisconsin, Illinois, Minnesota, or Iowa. |
| X-rays, Lab & Diagnostic Tests | \$160 copay/diagnostic radiology services (such as MRIs, CT scans), \$20 copay/diagnostic tests and procedures per day, \$20 copay/lab services per day, \$20 copay/outpatient x-rays, \$65 copay/therapeutic radiology services (such as radiation treatment for cancer) |
| Physical/Speech/Occupational Therapy | \$40 copay/Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays - \$0 copay/day for days 1-20, \$178 copay/day for days 21-100 |
| Diabetic Supplies & Services | \$0 copay/preferred supplies and self-management training, 20% coinsurance/therapeutic shoes and inserts |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | \$50 copay/Medicare-covered dental exam, \$850 limit/reimbursement for combined preventive and comprehensive dental services, Note: May purchase an additional \$1,000 of dental coverage for \$36/month. |
| Chiropractic/Acupuncture | \$20 copay/visit |
| Vision | \$0-\$25 copay/exam to diagnose and treat diseases and conditions of the eye, \$0 copay/initial routine eye exam annually, \$600 provided through the Quartz CashCard toward the purchase of vision hardware |
| Hearing | \$10 copay/annual routine hearing exam, \$1,000 provided for 2 hearing aids every 2 years |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-2&6, \$300/tiers 3-5 |
| Discounts & Programs | Over-the-counter benefit program for eligible over-the-counter medications, health and wellness items, first-aid supplies, and other qualifying items, purchase in-store or online, \$25 is automatically reloaded to card every three months, Memory Fitness, Non-emergent transportation: Quartz CashCard provides \$600 toward non-emergent transportation to medical appointments. Help with certain chronic conditions: Members with chronic conditions (such as diabetes, high blood pressure, congestive heart failure, and obesity), and who are enrolled in a care management program, may be eligible for extra benefits, such as continuous glucose monitors, blood pressure cuffs, scales, keytone readers, etc. |



800-333-2433



Gundersen MN Quartz Medicare Advantage Value (H9834-004)

Advantage HMO Plan

Enrollment: 800-394-5566

Service: 800-394-5566 • TTY: 711

QuartzBenefits.com/MedicareAdvantage



Monthly Premium: \$0

| | |
|---------------------------------|--|
| Dental | \$40 copay/Medicare-covered dental exam, \$1,000 limit/reimbursement for combined preventive and comprehensive dental services Note: May purchase an additional \$1,000 of dental coverage for \$36/month |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |



Gundersen MN Quartz Medicare Advantage Value D (H9834-003)

Advantage HMO Plan

Enrollment: 800-394-5566

Service: 800-394-5566 • TTY: 711

QuartzBenefits.com/MedicareAdvantage



Monthly Premium: \$48

| | |
|-----------------------------------|--|
| Dental | \$40 copay/Medicare-covered dental exam, \$1,250 limit/reimbursement for combined preventive and comprehensive dental services Note: May purchase an additional \$1,000 of dental coverage for \$36/month |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-2&6, \$250/tiers 3-5 |

PLAN DETAILS LISTED BELOW ARE THE SAME FOR BOTH PLANS ABOVE.

| | |
|---|---|
| Plan Area: Fillmore, Houston, Wabasha, Winona Counties | |
| Out-of-Pocket Max | \$3,450 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$225 copay/day for days 1-5, \$0 copay/additional hospital days |
| Physician/Outpatient | \$15 copay/primary, \$45 copay/specialist |
| Ambulance | \$300 copay/Medicare-covered transports |
| Outpatient Surgery | \$200 copay/surgery, \$0 copay/minor surgical procedures |
| Outpatient Mental Health | \$40 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Worldwide emergency care: \$120 copay Worldwide Urgent Care: \$40 copay |
| Travel Coverage | You may receive all plan covered services at in-network cost for up to 6 months when you travel domestically outside of Wisconsin, Illinois, Minnesota, or Iowa. |
| X-rays, Lab & Diagnostic Tests | \$85 copay/diagnostic radiology services (such as MRIs, CT scans), \$8 copay/diagnostic tests and procedures per day, \$10 copay/lab services per day, \$10 copay/outpatient x-rays, \$45 copay/therapeutic radiology services (such as radiation treatment for cancer) |
| Physical/Speech/Occupational Therapy | \$30 copay/Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays - \$0 copay/day for days 1-20, \$150 copay/day for days 21-100 |
| Diabetic Supplies & Services | \$0 copay/preferred supplies and self-management training, 20% coinsurance/therapeutic shoes and inserts |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Chiropractic/Acupuncture | \$15 copay/visit |
| Vision | \$0-\$25 copay/exam to diagnose and treat diseases and conditions of the eye, \$0 copay/initial routine eye exam annually, \$750 provided through the Quartz CashCard toward the purchase of vision hardware |
| Hearing | \$0 copay/annual routine hearing exam, \$1,250 provided for 2 hearing aids every 2 years. |
| Medicare Part B Drugs | 20% coinsurance |
| Discounts & Programs | Over-the-counter benefit program for eligible over-the-counter medications, health and wellness items, first-aid supplies, and other qualifying items, purchase in-store or online, \$25 is automatically reloaded to card every three months, Memory Fitness Non-emergent transportation: Quartz CashCard provides \$750 toward non-emergent transportation to medical appointments. Help with certain chronic conditions: Members with chronic conditions (such as diabetes, high blood pressure, congestive heart failure, and obesity), and who are enrolled in a care management program, may be eligible for extra benefits, such as continuous glucose monitors, blood pressure cuffs, scales, keytone readers, etc. |



Gundersen MN Quartz Medicare Advantage Elite (H9834-005)

Advantage HMO Plan

Enrollment: 800-394-5566

Service: 800-394-5566 • TTY: 711

QuartzBenefits.com/MedicareAdvantage



Monthly Premium: \$120

| | |
|---------------------------------|--|
| Dental | \$30 copay/Medicare-covered dental exam, \$1,200 limit/reimbursement for combined preventive and comprehensive dental services Note: May purchase an additional \$1,000 of dental coverage for \$36/month |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |



Gundersen MN Quartz Medicare Advantage Elite D (H9834-001)

Advantage HMO Plan

Enrollment: 800-394-5566

Service: 800-394-5566 • TTY: 711

QuartzBenefits.com/MedicareAdvantage



Monthly Premium: \$157

| | |
|-----------------------------------|--|
| Dental | \$30 copay/Medicare-covered dental exam, \$1,550 limit/reimbursement for combined preventive and comprehensive dental services Note: May purchase an additional \$1,000 of dental coverage for \$36/month |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1-2&6, \$200/tiers 3-5 |

PLAN DETAILS LISTED BELOW ARE THE SAME FOR BOTH PLANS ABOVE.

Plan Area: Fillmore, Houston, Wabasha, Winona Counties

| | |
|---|---|
| Out-of-Pocket Max | \$3,000 annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$250 copay/admission with a \$750 limit |
| Physician/Outpatient | \$5 copay/primary, \$35 copay/specialist |
| Ambulance | \$275 copay/Medicare-covered transports |
| Outpatient Surgery | \$150 copay/surgery, \$0 copay/minor surgical procedures |
| Outpatient Mental Health | \$35 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Worldwide Emergency Care: \$120 copay Worldwide Urgent Care: \$30 copay |
| Travel Coverage | You may receive all plan covered services at in-network cost for up to 6 months when you travel domestically outside of Wisconsin, Illinois, Minnesota, or Iowa. |
| X-rays, Lab & Diagnostic Tests | \$60 copay/diagnostic radiology services (such as MRIs, CT scans), \$4 copay/diagnostic tests and procedures per day, \$5 copay/lab services per day, \$5 copay/outpatient x-rays, \$25 copay/therapeutic radiology services (such as radiation treatment for cancer) |
| Physical/Speech/Occupational Therapy | \$15 copay/Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays - \$0 copay/day for days 1-20, \$150 copay/day for days 21-100 |
| Diabetic Supplies & Services | \$0 copay/preferred supplies and self-management training, 20% coinsurance/therapeutic shoes and inserts |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Chiropractic/Acupuncture | \$10 copay/visit |
| Vision | \$0-\$10 copay/exam to diagnose and treat diseases and conditions of the eye, \$0 copay/initial routine eye exam annually, \$1000 provided through the Quartz CashCard toward the purchase of vision hardware |
| Hearing | \$0 copay/annual routine hearing exam, \$1,500 provided for 2 hearing aids every 2 years. |
| Medicare Part B Drugs | 15% coinsurance |
| Discounts & Programs | Over-the-counter benefit program for eligible over-the-counter medications, health and wellness items, first-aid supplies, and other qualifying items, purchase in-store or online, \$25 is automatically reloaded to card every three months, Memory Fitness, Non-emergent transportation: Quartz CashCard provides \$1000 toward non-emergent transportation to medical appointments. Help with certain chronic conditions: Members with chronic conditions (such as diabetes, high blood pressure, congestive heart failure, and obesity), and who are enrolled in a care management program, may be eligible for extra benefits, such as continuous glucose monitors, blood pressure cuffs, scales, keytone readers, etc. |



UCare Value Plus (H2459-030)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$0
\$50 Part B Premium Reduction

| Plan Area: All 87 Minnesota counties | |
|---|---|
| Out-of-Pocket Max | \$5,500 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | Medicare-covered stays - \$150 copay/day for days 1-5, then 100% covered, per admission |
| Physician/Outpatient | Medicare-covered services - \$0 copay/primary, \$45 copay/specialist, includes telehealth visits for Medicare-approved services at same copays |
| Ambulance | \$200 copay/Medicare-covered transports |
| Outpatient Surgery | \$250 copay/Medicare-covered services; \$225 copay/Medicare-covered services at an ambulatory surgery center |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit in U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits; Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered services at urgent care centers in U.S. Point-of-Service Benefit: In-network copay for primary and specialist visits when seeing providers who accept Medicare, 20% coinsurance/many other services throughout U.S. |
| X-rays, Lab & Diagnostic Tests | \$0 copay/labs; 20% coinsurance for diagnostic tests, x-rays up to max of \$75/day |
| Physical/Speech/Occupational Therapy | \$40 copay/visit for Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays, per benefit period - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100. No prior hospitalization is required. |
| Diabetic Supplies & Services | \$0 coinsurance/certain glucose monitors, test strips and lancets, 20% coinsurance on continuous blood glucose monitors, covers 1 pair of the therapeutic shoes and inserts per calendar year if you meet certain conditions |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | 1 oral exam, 1 routine teeth cleaning, 1 set of bitewing x-rays per year and fluoride application included, 1 periodontal maintenance cleaning, optional Choice Dental \$25/month, up to \$2,000 annual plan maximum on routine coverage. Additional \$2,000 plan maximum with optional coverage. |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic visits, must use a network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$45 copay from a qualified specialist |
| Vision | \$0 copay/annual routine eye exam, \$45 copay/diagnostic eye exams, \$100 annual eyewear allowance |
| Hearing | TruHearing aids are available in both Advanced (\$699 copay/aid) and Premium (\$999 copay/aid) models |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$15 discount/3 community education classes offered in MN, \$75 allowance twice a year for over-the-counter benefit |



800-333-2433



UCare Your Choice (H8070-001)

Advantage PPO Plan

Enrollment: 833-951-3194

Service: 833-951-3183 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$0
\$39 Part B Premium Reduction

| Plan Area: All 87 Minnesota counties | |
|---|---|
| Out-of-Pocket Max | Combined In- and Out-of-Network: \$4,900 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$350 copay/day for days 1-5, then 100% covered/admission for Medicare-covered stays Out-of-Network: \$500 copay/day for days 1-5, then 100% covered/admission for Medicare-covered stays |
| Physician/Outpatient | \$0 copay/primary; \$40 copay/specialist - in-person or telehealth for Medicare-covered services Note: copayment is the same both In-Network and Out-of-Network |
| Ambulance | \$300 copay/Medicare-covered transports |
| Outpatient Surgery | In-Network: \$400 copay/Medicare covered services; \$375 copay/Medicare covered services at an ambulatory surgery center Out-of-Network: \$600 copay/Medicare covered services |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits Note: copayment is the same both In-Network and Out-of-Network |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit within the U.S. Network does not apply |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered visit in the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$25 copay/diagnostic tests and x-rays; \$65 copay/therapeutic radiology; \$100 copay/diagnostic radiology; \$0 copay/lab services Out-of-Network: 30% coinsurance/Medicare-covered services; \$0 copay/lab services |
| Physical/Speech/Occupational Therapy | \$40 copay/visit for Medicare-covered services Note: copayment is the same both In-Network and Out-of-Network |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100; no prior hospitalization stay is required Out-of-Network: 30% coinsurance/Medicare-covered services |
| Diabetic Supplies & Services | 20% coinsurance/certain glucose monitors, test strips and lancets, continuous blood glucose monitors, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions Note: coinsurance is the same both In-Network and Out-of-Network |
| DMEPOS | 20% coinsurance/Medicare-covered item Note: coinsurance is the same both In-Network and Out-of-Network |
| Dental | \$1,200 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids, and prescription eyewear. Network does not apply to eligible dental services |
| Chiropractic/Acupuncture | Chiropractic In-Network: \$20 copay/covered visits for Medicare-covered services Chiropractic Out-of-Network: 30% coinsurance/Medicare-covered services Acupuncture: covered for chronic low back pain, based on Medicare criteria - primary/specialist copays apply Note: acupuncture copayment is the same both In-Network and Out-of-Network |
| Vision | \$0 copay/annual routine eye exam; \$40 copay/diagnostic eye exam Note: copayment is the same both In-Network and Out-of-Network, \$1,200 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids, and prescription eyewear. Network does not apply for the purchase of prescription eyewear. |
| Hearing | \$0 copay/routine hearing exam; \$40 copay/diagnostic hearing exam Note: copayment is the same both In-Network and Out-of-Network, \$1,200 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids, and prescription eyewear. Network does not apply for the purchase of hearing aids. |
| Medicare Part B Drugs | In-Network: 20% coinsurance/Medicare-covered services Out-of-Network: 30% coinsurance/Medicare-covered services |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Part D Deductible | \$0/all tiers |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$75 allowance twice a year for over-the-counter benefit |



UCare Aware (H2459-029)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$5

Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Carlton, Carver, Cass, Chisago, Clay, Clearwater, Cook, Crow Wing, Dakota, Douglas, Grant, Hennepin, Hubbard, Isanti, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomon, Marshall, Mille Lacs, Morrison, Norman, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Roseau, St. Louis, Scott, Sherburne, Stearns, Todd, Wadena, Washington, Wilkin, Wright Counties

| | |
|---|--|
| Out-of-Pocket Max | \$5,400 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | Medicare-covered stays - \$250 copay/day for days 1-5, then 100% covered, per admission |
| Physician/Outpatient | Medicare-covered services - \$0 copay/primary, \$45 copay/specialist, includes telehealth visits for Medicare-approved services at same copays |
| Ambulance | \$275 copay/Medicare-covered transports |
| Outpatient Surgery | \$300 copay/Medicare-covered services; \$275 copay/Medicare-covered services at an ambulatory surgery center |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit in U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered services at urgent care centers in U.S. Point-of-Service Benefit: In-network copay for primary and specialist visits when seeing providers who accept Medicare, 20% coinsurance/many other services throughout U.S. |
| X-rays, Lab & Diagnostic Tests | \$0 copay/labs; 20% coinsurance for diagnostic tests, x-rays up to a maximum of \$75/day |
| Physical/Speech/Occupational Therapy | \$40 copay/visit for Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays, per benefit period - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100; No prior hospitalization stay is required |
| Diabetic Supplies & Services | 20% coinsurance/glucose monitors, test strips and lancets, covers 1 pair of the therapeutic shoes and inserts per calendar year if you meet certain conditions |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | \$600 annual dental allowance |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic visits, must use a network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$45 copay from a qualified specialist |
| Vision | \$0 copay/annual routine eye exam; \$45 copay/diagnostic eye exams; \$150 annual eyewear allowance |
| Hearing | TruHearing aids are available in both Advanced (\$699 copay/aid) and Premium (\$999 copay/aid) models |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tier 1, \$295/tiers 2 -5. |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$15 discount/3 community education classes offered in MN, \$75 allowance twice a year for over-the-counter benefit |



800-333-2433



UCare Value (H2459-001)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$19

| Plan Area: All 87 Minnesota counties | |
|---|---|
| Out-of-Pocket Max | \$3,400 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | Medicare-covered stays - \$200 copay/stay, then 100% covered, per admission |
| Physician/Outpatient | Medicare-covered stays - \$0 copay/primary, \$35 copay/specialist, includes telehealth visits for Medicare-approved services at same copays |
| Ambulance | \$100 copay/Medicare-covered transports |
| Outpatient Surgery | \$250 copay/Medicare-covered services; \$225 copay/Medicare-covered services at an ambulatory surgery center |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit within U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered services at urgent care centers in U.S. Point-of-Service Benefit: In-network copays for primary and specialist visits when seeing providers who accept Medicare, plus 20% coinsurance for many other services, throughout U.S. |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, 10% coinsurance/diagnostic tests, x-rays up to a max of \$50 per day |
| Physical/Speech/Occupational Therapy | \$35 copay/Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, \$125 copay/day for days 21-100; No prior hospitalization stay is required |
| Diabetic Supplies & Services | Certain glucose monitors, test strips and lancets paid in full, 20% for continuous blood glucose monitors, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | Routine and restorative dental included, up to \$2,000 annual plan maximum |
| Chiropractic/Acupuncture | \$10 copay/Medicare-covered chiropractic visits, must use a network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$35 copay from a qualified specialist |
| Vision | \$0 copay/annual routine eye exam, \$35 copay/diagnostic eye exams, \$150 annual eyewear allowance |
| Hearing | TruHearing aids are available in both Advanced (\$599 copay/aid) and Premium (\$899 copay/aid) models |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | No, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$15 discount on 3 community education classes offered in MN, \$75 allowance twice a year for over-the-counter benefit. |



800-333-2433



UCare Essentials Rx (H2459-023-1)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$38

Plan Area: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Stearns, Washington, Wright Counties



UCare Essentials Rx (H2459-023-2)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$56

Plan Area: Aitkin, Becker, Beltrami, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Douglas, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomon, Marshall, Morrison, Norman, Otter Tail, Pennington, Pine, Polk, Red Lake, Roseau, St. Louis, Todd, Wadena, Wilkin Counties

PLAN DETAILS LISTED BELOW ARE THE SAME FOR BOTH PLANS ABOVE.

| | |
|---|---|
| Out-of-Pocket Max | \$3,800 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | Medicare-covered stays - \$400 copay/stay, then 100% covered, per admission |
| Physician/Outpatient | Medicare-covered services - \$0 copay/primary, \$45 copay/specialist, includes telehealth visits for Medicare-approved services at same copays |
| Ambulance | \$250 copay/Medicare-covered transports |
| Outpatient Surgery | \$300 copay/Medicare-covered services; \$275 copay/Medicare-covered services at an ambulatory surgery center |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit within the U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits; \$45 copay/Medicare-covered services at urgent care centers in U.S. Point-of-Service Benefit: In-network copays for primary and specialist visits when seeing providers who accept Medicare, plus 20% coinsurance for many other services, throughout U.S. |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, 10% coinsurance for diagnostic tests and x-rays up to a max of \$75 per day |
| Physical/Speech/Occupational Therapy | \$40 copay/Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100; No prior hospitalization stay is required |
| Diabetic Supplies & Services | 20% coinsurance/glucose monitors, test strips and lancets, covers 1 pair of the therapeutic shoes and inserts per calendar year if you meet certain conditions |
| DMEPOS | 20% coinsurance for the cost of each Medicare-covered item |
| Dental | 1 oral exam, 1 routine teeth cleaning, 1 set of bitewing x-rays per year and fluoride application included, 1 periodontal maintenance cleaning, optional Choice Dental/\$25 per month, up to \$2,000 annual plan maximum on routine coverage. Additional \$2,000 plan maximum with optional coverage. |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic visits, must use a network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$45 copay from a qualified specialist |
| Vision | \$0 copay/annual routine eye exam, \$45 copay/diagnostic eye exams; \$150 annual eyewear allowance |
| Hearing | TruHearing aids are available in both Advanced (\$699 copay/aid) and Premium (\$999 copay/aid) models |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tiers 1&2, \$295/tiers 3-5. |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$15 discount on 3 community education classes offered in MN, \$75 allowance twice a year for over-the-counter benefit |



UCare Your Choice Plus (H8070-002)

Advantage PPO Plan

Enrollment: 833-951-3194

Service: 833-951-3183 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$56

Plan Area: Aitkin, Anoka, Becker, Beltrami, Benton, Carlton, Carver, Cass, Chisago, Clay, Clearwater, Cook, Crow Wing, Dakota, Douglas, Grant, Hennepin, Hubbard, Isanti, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahnommen, Marshall, Mille Lacs, Morrison, Norman, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Roseau, Scott, Sherburne, St. Louis, Stearns, Todd, Wadena, Washington, Wilkin, Wright Counties

| | |
|---|---|
| Out-of-Pocket Max | Combined In- and Out-of-Network: \$3,000 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$200 copay/stay, then 100% covered/admission for Medicare-covered stays Out-of-Network: \$800 copay/stay, then 100% covered/admission for Medicare-covered stays |
| Physician/Outpatient | \$0 copay/primary; \$30 copay/specialist - in person or telehealth for Medicare-covered services Note: copayment is the same both In-Network and Out-of-Network |
| Ambulance | \$275 copay/Medicare-covered transports |
| Outpatient Surgery | In-Network: \$200 copay/Medicare covered services; \$175 copay/Medicare covered services at an ambulatory surgery center Out-of-Network: \$300 copay/Medicare covered services |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits Note: copayment is the same both In-Network and Out-of-Network |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit within the U.S. Network does not apply |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered visit in the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$15 copay/x-rays; \$20 copay/diagnostic tests; \$65 copay/therapeutic radiology; \$75 copay/diagnostic radiology; \$0 copay/lab services Out-of-Network: 30% coinsurance/Medicare-covered services; \$0 copay/lab services |
| Physical/Speech/Occupational Therapy | \$30 copay/visit for Medicare-covered services Note: copayment is the same both In-Network and Out-of-Network |
| Skilled Nursing Facility Care | In-Network: Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100; no prior hospitalization stay is required Out-of-Network: 30% coinsurance/Medicare-covered services |
| Diabetic Supplies & Services | 20% coinsurance/certain glucose monitors, test strips and lancets, continuous blood glucose monitors, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions Note: coinsurance is the same both In-Network and Out-of-Network |
| DMEPOS | 20% coinsurance/Medicare-covered item Note: coinsurance is the same both In-Network and Out-of-Network |
| Dental | \$2,000 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids, and prescription eyewear. Network does not apply to eligible dental services |
| Chiropractic/Acupuncture | Chiropractic In-Network: \$20 copay/covered visits for Medicare-covered services Chiropractic Out-of-Network: 30% coinsurance/Medicare-covered services Acupuncture: covered for chronic low back pain, based on Medicare criteria - primary/specialist copays apply Note: acupuncture copayment is the same both In-Network and Out-of-Network |
| Vision | \$0 copay/annual routine eye exam; \$30 copay/diagnostic eye exam Note: copayment is the same both In-Network and Out-of-Network, \$2,000 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids, and prescription eyewear. Network does not apply for the purchase of prescription eyewear. |
| Hearing | \$0 copay/routine hearing exam; \$30 copay/diagnostic hearing exam Note: copayment is the same both In-Network and Out-of-Network, \$2,000 flexible benefit allowance to use on one or a combination of eligible dental, hearing aids, and prescription eyewear. Network does not apply for the purchase of hearing aids. |
| Medicare Part B Drugs | In-Network: 20% coinsurance/Medicare-covered services Out-of-Network: 30% coinsurance/Medicare-covered services |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Part D Deductible | \$0/all tiers |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$75 allowance twice a year for over-the-counter benefit |



UCare Standard (H2459-024)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$56

| | |
|---|---|
| Plan Area: Big Stone, Blue Earth, Brown, Chippewa, Cottonwood, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Jackson, Kandiyohi, Lac qui Parle, Le Sueur, Lincoln, Lyon, Martin, McLeod, Meeker, Mower, Murray, Nicollet, Nobles, Olmsted, Pipestone, Pope, Redwood, Renville, Rice, Rock, Sibley, Steele, Stevens, Swift, Traverse, Wabasha, Waseca, Watonwan, Winona, Yellow Medicine Counties | |
| Out-of-Pocket Max | \$6,000 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | Medicare-covered stays - \$500 copay/day for days 1-3, then 100% covered, per admission |
| Physician/Outpatient | Medicare-covered services - \$0 copay/primary, \$40 copay/specialist, includes telehealth visits for Medicare-approved services at same copays |
| Ambulance | \$375 copay/Medicare-covered services |
| Outpatient Surgery | \$300 copay/Medicare-covered services; \$275 copay/Medicare-covered services at an ambulatory surgery center |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$40 copay/Medicare-covered visit within the U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$40 copay/Medicare-covered services at urgent care centers in U.S. Point-of-Service Benefit: In-network copays for primary and specialist visits when seeing providers who accept Medicare, plus 20% coinsurance for many other services, throughout U.S. |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, 10% coinsurance/diagnostic tests, x-rays up to a max of \$100 per day |
| Physical/Speech/Occupational Therapy | \$40 copay/visit for Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100; No prior hospitalization stay is required |
| Diabetic Supplies & Services | 20% coinsurance glucose monitors, test strips and lancets, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | 1 oral exam, 1 routine teeth cleaning, 1 set of bitewing x-rays per year and fluoride application included, 1 periodontal maintenance cleaning, optional Choice Dental/\$25 per month, up to \$2,000 annual plan maximum on routine coverage. Additional \$2,000 plan maximum with optional coverage. |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic visits, must use a network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$40 copay from a qualified specialist |
| Vision | \$0 copay/annual routine eye exam, \$40 copay/diagnostic eye exams; \$100 annual eyewear allowance |
| Hearing | TruHearing aids are available in both Advanced (\$699 copay/aid) and Premium (\$999 copay/aid) models |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tier 1, \$480/tiers 2-5 |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$15 discount on 3 community education classes offered in MN, \$75 allowance twice a year for over-the-counter benefit |



800-333-2433



UCare Complete (H2459-026-1)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$83

Plan Area: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Stearns, Washington, Wright Counties

| | |
|---------------------------|---|
| Out-of-Pocket Max | \$3,000 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Hospital Inpatient | Medicare-covered stays - \$150 copay/stay, then 100% covered, per admission |



UCare Complete (H2459-026-3)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$88

Plan Area: Aitkin, Becker, Beltrami, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Douglas, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahanomen, Marshall, Morrison, Norman, Otter Tail, Pennington, Pine, Polk, Red Lake, Roseau, St. Louis, Todd, Wadena, Wilkin Counties

| | |
|---------------------------|---|
| Out-of-Pocket Max | \$3,200 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Hospital Inpatient | Medicare-covered stays - \$150 copay/stay, then 100% covered, per admission |



UCare Complete (H2459-026-4)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$133

Plan Area: Big Stone, Blue Earth, Brown, Chippewa, Cottonwood, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Jackson, Kandiyohi, Lac qui Parle, Le Sueur, Lincoln, Lyon, Martin, McLeod, Meeker, Mower, Murray, Nicollet, Nobles, Olmsted, Pipestone, Pope, Redwood, Renville, Rice, Rock, Sibley, Steele, Stevens, Swift, Traverse, Wabasha, Waseca, Watonwan, Winona, Yellow Medicine Counties

| | |
|---------------------------|---|
| Out-of-Pocket Max | \$5,300 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Hospital Inpatient | Medicare-covered stays - \$300 copay/stay, then 100% covered, per admission |

PLAN DETAILS LISTED BELOW ARE THE SAME FOR ALL PLANS ABOVE.

| | |
|---|---|
| Health Plan Deductible | \$0 |
| Physician/Outpatient | Medicare-covered services - \$0 copay/primary, \$30 copay/specialist, includes telehealth visits for Medicare-approved services at same copays |
| Ambulance | \$275 copay/Medicare-covered transports |
| Outpatient Surgery | \$250 copay/Medicare-covered services; \$225 copay/Medicare-covered services at an ambulatory surgery center |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit within the U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered services at urgent care centers in U.S. Point-of-Service Benefit: In-network copays for primary and specialist visits when seeing providers who accept Medicare, plus 20% coinsurance for many other services, throughout U.S. |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, 10% coinsurance for diagnostic tests, x-rays up to a max of \$75 per day |
| Physical/Speech/Occupational Therapy | \$30 copay/visit for Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays, per benefit period - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100; No prior hospitalization stay is required |

| | |
|---|--|
| Diabetic Supplies & Services | 10% coinsurance/certain glucose monitors, test strips and lancets, 20% coinsurance/continuous blood glucose monitors, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | Routine and restorative dental included, up to \$2,000 annual plan maximum |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic visits, must use a network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$30 copay from a qualified specialist |
| Vision | \$0 copay/annual routine eye exam, \$30 copay/diagnostic eye exams, \$200 annual eyewear benefit |
| Hearing | TruHearing aids are available in both Advanced (\$599 copay/aid) and Premium (\$899 copay/aid) models |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tier 1, \$235/tiers 3 – 5. |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$15 discount on 3 community education classes offered in MN, \$75 allowance twice a year for over-the-counter benefit |



800-333-2433



UCare Classic (H2459-021-1)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$161

Plan Area: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Stearns, Washington, Wright Counties

| | |
|---------------------------------|---|
| Out-of-Pocket Max | \$2,800 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Chiropractic/Acupuncture | \$0 copay/Medicare-covered chiropractic visits, must use network chiropractor; acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$20 copay from a qualified specialist; 12 additional routine acupuncture visits at \$20 copay per visit |

UCare Classic (H2459-021-2)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$204

Plan Area: Aitkin, Becker, Carlton, Cass, Clay, Cook, Crow Wing, Hubbard, Kanabec, Lake, Morrison, Pine, St. Louis Counties

| | |
|---------------------------------|---|
| Out-of-Pocket Max | \$2,800 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Chiropractic/Acupuncture | \$0 copay/Medicare-covered chiropractic visits, must use network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$20 copay from a qualified specialist |

UCare Classic (H2459-021-3)

Advantage HMO-POS Plan

Enrollment: 877-523-1518

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$206

Plan Area: Blue Earth, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, Mower, Nicollet, Olmsted, Rice, Steele, Wabasha, Waseca, Watonwan, Winona Counties

| | |
|---------------------------------|---|
| Out-of-Pocket Max | \$4,200 annually/Medicare-covered services. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Chiropractic/Acupuncture | \$0 copay/Medicare-covered chiropractic visits, must use network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$20 copay from a qualified specialist |

PLAN DETAILS LISTED BELOW ARE THE SAME FOR ALL PLANS ABOVE.

| | |
|---|---|
| Health Plan Deductible | \$0 |
| Hospital Inpatient | Medicare-covered stays - \$125 copay/stay, then 100% covered, per admission |
| Physician/Outpatient | Medicare-covered services - \$0 copay/primary, \$20 copay/specialist, includes telehealth visits for Medicare-approved services at same copays |
| Ambulance | \$225 copay/Medicare-covered transports |
| Outpatient Surgery | \$150 copay/Medicare-covered services; \$125 copay/Medicare-covered services at an ambulatory surgery center |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit within U.S. |
| Travel Coverage | Worldwide Emergency Care: \$100 copay/emergency and urgent care visits Worldwide Urgent Care: \$100 copay/emergency and urgent care visits, \$45 copay/Medicare-covered services at urgent care centers in U.S. Point-of-Service Benefit: In-network copays for primary and specialist visits when seeing providers who accept Medicare, plus 20% coinsurance for many other services, throughout U.S. |
| X-rays, Lab & Diagnostic Tests | \$0 copay |

| | |
|--|--|
| Physical/Speech/ Occupational Therapy | \$20 copay/Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays, per benefit period - \$0 copay/day for days 1-20, \$100 copay/day for days 21-100; No prior hospitalization stay is required |
| Diabetic Supplies & Services | \$0 copay/certain glucose monitors, test strips and lancets, 20% coinsurance for continuous blood glucose monitors, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions |
| DMEPOS | 20% coinsurance/Medicare-covered durable medical equipment, 10% coinsurance/Medicare-covered prosthetic devices |
| Dental | \$0 copay/preventive services including 2 oral exams, 3 routine teeth or periomaintenance cleanings, 1 set of bitewing x-rays/year, full mouth x-rays every 5 years, fluoride applications included, optional Classic Choice Dental/\$25 per month, up to \$2,500 annual plan maximum on routine coverage. Additional \$2,500 plan maximum with optional coverage. |
| Vision | \$0 copay/annual routine eye exam, \$20 copay/diagnostic eye exams, \$200 annual eyewear benefit |
| Hearing | TruHearing aids are available in both Advanced (\$499 copay/aid) and Premium (\$799 copay/aid) models |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/all tiers |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$15 discount on 3 community education classes offered in MN, \$75 allowance twice a year for over-the-counter benefit, medication reconciliation post-discharge, Mom's Meals provides 28 home delivered meals for 14 days for members with CHF, post-discharge |



800-333-2433



Care Wise: M Health Fairview & North Memorial (H0422-003)

Advantage HMO-POS Plan

Enrollment: 855-432-7029

Service: 888-618-2595 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$0
\$25 Part B Premium Reduction

| Plan Area: Anoka, Chisago, Dakota, Hennepin, Isanti, Ramsey, Washington Counties | |
|--|--|
| Out-of-Pocket Max | \$5,800/Medicare-covered services annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$350 copay/day (days 1-5), then 100% covered per admission/Medicare-covered stays |
| Physician/Outpatient | Medicare-covered services - \$0 copay/primary, \$45 copay/specialist, includes telehealth visits for Medicare-approved services at same copays |
| Ambulance | \$300 copay/Medicare-covered transports |
| Outpatient Surgery | \$395 copay/Medicare-covered services |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit within the U.S. |
| Travel Coverage | Worldwide: \$100 copay/emergency and urgent care visits Out-of-Network: Most other Medicare-covered services from any Medicare provider out-of-network are covered at 75% of the Medicare-approved amount up to certain limits (some exclusions apply) |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, 20% coinsurance/diagnostic tests, x-rays |
| Physical/Speech/Occupational Therapy | \$40 copay/visit for Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100; no prior hospitalization stay is required |
| Diabetic Supplies & Services | 20% coinsurance |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | \$850 allowance |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic visits, must use a network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$45 copay from a qualified specialist |
| Vision | \$0 copay/annual routine eye exam, \$50 copay/diagnostic eye exams, \$100 annual eyewear benefit |
| Hearing | TruHearing aids are available in both Advanced (\$699 copay/aid) and Premium (\$999 copay/aid) models |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tier 1, \$480/tiers 2-5 |
| Discounts & Programs | One Pass fitness benefit; UCare 24/7 nurse line; \$15 discount on 3 community education classes offered in MN; \$75 allowance twice a year for over-the-counter benefit, e-visits through M Health Fairview MyChart, Caregiver Assurance support calls, UCare Wellness Advisor visits |



800-333-2433



Care Core: M Health Fairview & North Memorial (H0422-001)

Advantage HMO-POS Plan

Enrollment: 855-432-7029

Service: 888-618-2595 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$28

| Plan Area: Anoka, Chisago, Dakota, Hennepin, Isanti, Ramsey, Washington Counties | |
|--|--|
| Out-of-Pocket Max | \$5,500/Medicare-covered services annually. Out-of-pocket max only applies to services and supplies covered under Medicare Part A and Part B. |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$250 copay/day for days 1-5, then 100% covered per admission/Medicare-covered stays |
| Physician/Outpatient | Medicare-covered services - \$0 copay/primary, \$40 copay/specialist, includes telehealth visits for Medicare-approved services at same copays |
| Ambulance | \$300 copay/Medicare-covered transports |
| Outpatient Surgery | \$250 copay/Medicare-covered services |
| Outpatient Mental Health | \$0 copay/Medicare-covered individual or group visits |
| Emergency/Urgent Care | Emergency Care: \$100 copay/Medicare-covered visit Urgent Care: \$45 copay/Medicare-covered visit within the U.S. |
| Travel Coverage | Worldwide: \$100 copay/emergency and urgent care visits Out-of-Network: Most other Medicare-covered services from any Medicare provider out-of-network are covered at 75% of the Medicare-approved amount up to certain limits (some exclusions apply) |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab services, 10% coinsurance/diagnostic tests, x-rays up to a max of \$150 per day |
| Physical/Speech/Occupational Therapy | \$40 copay/visit for Medicare-covered visits |
| Skilled Nursing Facility Care | Medicare-covered stays per benefit period - \$0 copay/day for days 1-20, \$203 copay/day for days 21-100; no prior hospitalization stay is required |
| Diabetic Supplies & Services | 10% coinsurance/certain glucose monitors, test strips and lancets, 20% continuous blood glucose monitors, covers 1 pair of therapeutic shoes and inserts per calendar year if you meet certain conditions with a 10% coinsurance |
| DMEPOS | 20% coinsurance/Medicare-covered item |
| Dental | Routine and restorative dental included, up to \$2,000 annual plan maximum |
| Chiropractic/Acupuncture | \$20 copay/Medicare-covered chiropractic visits, must use a network chiropractor; Acupuncture for chronic low back pain up to 12 visits in 90 days for people who meet certain conditions with a \$0 copay from a qualified primary care physician or \$40 copay from a qualified specialist |
| Vision | \$0 copay/annual routine eye exam, \$40 copay/diagnostic eye exams, \$100 annual eyewear benefit |
| Hearing | TruHearing aids are available in both Advanced (\$699 copay/aid) and Premium (\$999 copay/aid) models |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0/tier, \$295/tiers 3-5 |
| Discounts & Programs | One Pass fitness benefit, UCare 24/7 nurse line, \$15 discount/3 community education classes offered in MN, \$75 allowance twice a year for over-the-counter benefit, e-visits through M Health Fairview MyChart, Caregiver Assurance support calls, UCare Wellness Advisor visits |



800-333-2433

Medicare Advantage Special Needs Plans

What You Need to Know

Medicare Advantage Special Needs Plans (MA-SNP) are a type of Medicare health plan specifically designed to provide targeted care to people with certain diseases or characteristics.

Details

- Members may be assigned a care coordinator to help them get health care and support services.
- Plans may require you to use certain health care providers (provider network).
- Services received outside the network may not be covered.

Types of MA-SNPs Available in Minnesota

- Minnesota Senior Health Options (MSHO)
 - A program for people age 65 and older who are on Medical Assistance (Minnesota's Medicaid program) and enrolled in Medicare Part A and Part B.
 - Combines Parts A, B and D with Medical Assistance.
- Special Needs Basic Care (SNBC)
 - A program for people with disabilities ages 18-64 who have Medical Assistance.
 - Some plans also coordinate with Parts A, B and D for people on Medicare.
- Institutional Special Needs Plans
 - Plans for people who have had or are expected to need the level of services provided in certain types of facilities, such as a long-term care facility.
 - Some plans offer an option to cover Part A, Part B and Part D services under the plan, for those on Medicare.

Prescription Drug Coverage

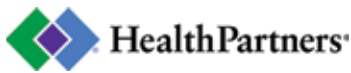
- Most MA-SNPs provide Part D prescription drug coverage because special needs individuals must have access to prescription drugs to manage and control their health care needs.
- If you are enrolled in a Medicare Advantage Special Needs Plan with Part D and you enroll in a Part D stand-alone plan, you will be DISENROLLED from your Medicare Advantage Special Needs Plan and returned to Original Medicare.



Call the Senior LinkAge Line at 800-333-2433 for free help with Medicare-related issues, including appeals and plan options.

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

| Plan Area: All 87 Minnesota Counties | |
|---|---|
| Enrollment Requirements | Limited to people who are age 65 and older, enrolled in Medicaid with both Medicare Part A and Part B |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Not covered, except in limited situations |
| Physician/Outpatient | Physician In-Network: \$0 copay/Medicare or Medicaid-covered primary care or specialist visits Physician Out-of-Network: Not covered, except in limited situations Hospital In-Network: \$0 copay/each Medicare or Medicaid-covered outpatient hospital facility or ambulatory surgical center visit Hospital Out-of-Network: Not covered, except in limited situations |
| Ambulance | \$0 copay/Medicare or Medicaid-covered services |
| Outpatient Surgery | In-Network: \$0 copay/Medicare or Medicaid medically needed services in the outpatient department of a hospital and ambulatory surgical centers |
| Outpatient Mental Health | In-Network: \$0 copay/Medicare or Medicaid-covered individual or group therapy visit Out-of-Network: Not covered, except in limited situations |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare or Medicaid-covered services Urgently Needed Care: \$0 copay/Medicare or Medicaid-covered services |
| Travel Coverage | Out-of-area services are covered for emergencies, post-stabilization care, medically-necessary urgent care when you are outside the plan service area and covered services that are not available in the plan service area; no coverage outside the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/Medicare or Medicaid-covered lab services, diagnostic procedures, tests, x-rays, diagnostic radiology services, therapeutic radiology services Out-of-Network: Not covered, except in limited situations |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay/Medicare or Medicaid-covered occupational/physical/speech and language pathology therapy Out-of-Network: Not covered, except in limited situations |
| Skilled Nursing Facility Care | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Not covered, except in limited situations |
| Diabetic Supplies & Services | In-Network: \$0 copay/Medicare or Medicaid-covered self-management training, services and supplies For people with severe diabetic foot disease, plan will pay: 1 pair of therapeutic custom-molded shoes (including inserts) and 2 extra pairs of inserts each calendar year OR 1 pair of depth shoes and 3 pairs of inserts each year (not including the non-customized removable inserts provided with such shoes), fitting the therapeutic custom-molded shoes or depth shoes |
| DMEPOS | In-Network: \$0 copay/Medicare or Medicaid-covered items Out-of-Network: Not covered, except in limited situations |
| Dental | In-Network: \$0 copay/Medicare or Medicaid-covered dental benefits Out-of-Network: Not covered, except in limited situations Note: covers 1 electric toothbrush and 1 package of 3 electric toothbrush replacement heads, 1 dental root planing and scaling every 2 years, 2 dental crown per year (2 teeth/year), 1 root canal per lifetime, 1 root canal re-treat per tooth per lifetime |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare or Medicaid-covered benefits Out-of-Network: Not covered, except in limited situations |
| Vision | In-Network: \$0 copay/Medicare or Medicaid-covered vision benefits Out-of-Network: Not covered, except in limited situations. Eyeglass lens upgrades (progressive (no-line) lenses, anti-glare coating, photo-chromatic lens tinting), up to 2 lenses/year |
| Hearing | \$0 copay/Medicare or Medicaid-covered benefits |
| Medicare Part B Drugs | In-Network: \$0 deductible Out-of-Network: Does not apply |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | SilverSneakers; stop smoking support; BlueRide SM rides to your doctor, pharmacy, SilverSneakers location; health and wellness classes; Alcoholics or Narcotics Anonymous; \$750 safety items; activity tracker; 24-hour nurse line; Doctor on Demand; 50 disposable face masks; six washable incontinence pads; meals after a hospital or nursing home stay; meals for chronic conditions in a nursing facility or customized living or adult foster care; additional podiatry services; personal emergency response system; music therapy for members in a facility with mental health-related needs; six round-trip rides per month for groceries; medication dispenser for chronic conditions; wheelchair/walker safety; 1 animatronic pet for members with a cognitive impairment; \$150/quarter allowance for over-the-counter items from a CVS catalog; Certified Community Health Worker after a hospital or nursing home stay. Additional benefits for members with chronic health conditions - household support: \$120 monthly allowance/to help pay for your utility bills and rent, blood pressure monitor: 1 monitor to track your blood pressure, caregiver emergency planning: an in-depth care plan to be activated if the caregiver can no longer care for their loved one |



HealthPartners MN Senior Health Options MSHO (H2422-002)

Advantage HMO-Special Needs Plan 65+

Enrollment: 877-713-8215

Service: 888-820-4285 • TTY: 711

healthpartners.com/msho

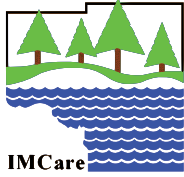


Monthly Premium: \$0

| Plan Area: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, Sherburne, Stearns, Washington, Wright Counties | |
|---|--|
| Enrollment Requirements | Participation in the program is limited to people who are age 65 and older; eligible for Medical Assistance and Medicare Parts A and B; and live in the service area. |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 annual deductible, 100% coverage/Medicare or Medicaid services Out-of-Network: Not covered, except in limited situations |
| Physician/Outpatient | Physician In-Network: \$0 copay/Medicare or Medicaid-covered primary care visits, 100% coverage/Medicare or Medicaid-covered network urgent care and specialist doctor visits Physician Out-of-Network: Not covered, except in limited situations Hospital In-Network: \$0 copay/Medicare or Medicaid-covered ambulatory surgical center visit and outpatient hospital facility visit Hospital Out-of-Network: Not covered, except in limited situations |
| Ambulance | 100% coverage/Medicare or Medicaid-covered services |
| Outpatient Surgery | Outpatient Surgery In-Network: \$0 copay/Medicare or Medicaid-covered ambulatory surgical center visit and outpatient hospital facility visit Outpatient Surgery Out-of-Network: Not covered, except in limited situations |
| Outpatient Mental Health | In-Network: \$0 copay/Medicare or Medicaid-covered individual or group therapy visit, individual or group therapy visit with a psychiatrist; or partial hospitalization program services Outpatient Out-of-Network: Not covered, except in limited situations |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare or Medicaid-covered ER visits Urgently Needed Care: 100% coverage for Medicare or Medicaid-covered services |
| Travel Coverage | No coverage outside the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: 100% coverage/Medicare or Medicaid-covered lab services, diagnostic procedures and tests, diagnostic radiology services, x-rays and therapeutic radiology services Out-of-Network: Not covered, except in limited situations |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay for Medicare or Medicaid-covered visits Out-of-Network: Not covered, except in limited situations |
| Skilled Nursing Facility Care | In-Network: No prior hospital stay is required, 100% coverage/Medicare or Medicaid-covered services, covers up to 100 days each Medicare Part A benefit period. For Medicaid-covered stays - covers up to 180 days of nursing facility room and board, after that, Medical Assistance provides coverage. Out-of-Network: Not covered, except in limited situations |
| Diabetic Supplies & Services | \$0 copay/monitoring supplies, therapeutic shoes or insert and self-management training |
| DMEPOS | In-Network: \$0 copay/Medicare or Medicaid-covered items Out-of-Network: Not covered, except in limited situations |
| Dental | In-Network: \$0 copay/Medicare or Medicaid-covered dental benefits, offers additional comprehensive dental benefits Out-of-Network: Not covered, except in limited situations |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare or Medicaid-covered benefits Out-of-Network: Not covered, except in limited situations |
| Vision | \$0 copay/Medicare and Medicaid-covered services |
| Hearing | \$0 copay/Medicare and Medicaid-covered services |
| Medicare Part B Drugs | In-Network: \$0 yearly deductible, \$0 copay Out-of-Network: No coverage |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | In-Network: Contact Member Services for information on additional available benefits services |



800-333-2433



Itasca Medical Care IM Classic MSHO (H2417-001)

Advantage HMO-Special Needs Plan 65+

Enrollment: 800-843-9536

Service: 800-843-9536 • TTY: 800-627-3529

imcare.org



Monthly Premium: \$0

| Plan Area: Itasca county | |
|---|---|
| Enrollment Requirements | Participation in the program is limited to people who are age 65 and older, enrolled in Medicaid with both Medicare Part A and Part B and live in the service area |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | Covered, no copays, standard coinsurance |
| Physician/Outpatient | Physician: Covered, no copays, standard coinsurance Hospital: Covered, no copays, standard coinsurance |
| Ambulance | Covered, no copays, no coinsurance |
| Outpatient Surgery | Covered, no copays, standard coinsurance |
| Outpatient Mental Health | Covered, no copays, standard coinsurance |
| Emergency/Urgent Care | Emergency: Covered, no copays, no coinsurance, no referral required Urgently Needed Care: Covered, no copays, no coinsurance, no referral required |
| Travel Coverage | Covered |
| X-rays, Lab & Diagnostic Tests | Covered, no copays, standard coinsurance |
| Physical/Speech/Occupational Therapy | Covered, no copays, standard coinsurance |
| Skilled Nursing Facility Care | Covered, no copays, standard coinsurance |
| Diabetic Supplies & Services | Covered, no copays, standard coinsurance |
| DMEPOS | Covered, no copays, standard coinsurance |
| Dental | Covered, no copays, standard coinsurance |
| Chiropractic/Acupuncture | Covered, no copays, standard coinsurance |
| Vision | Covered, no copays, standard coinsurance |
| Hearing | Covered, no copays, standard coinsurance |
| Medicare Part B Drugs | Covered, no copays, standard coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | Fitness benefits, Medical safety devices, Health education and promotion programs, Medication storage devices, expanded dental benefits, additional over the counter (OTC) benefits |



800-333-2433



Medica AccessAbility Solution Enhanced SNBC (H9952-001)

Advantage HMO-Special Needs Plan <65

Enrollment: 800-266-2157

Service: 888-347-3630 • TTY: 711

medica.com/enhanced



Monthly Premium: \$0

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|---|--|
| Plan Area: Aitkin, Anoka, Becker, Carlton, Carver, Chisago, Cook, Crow Wing, Dakota, Fillmore, Freeborn, Hennepin, Isanti, Kandiyohi, Kanabec, Kittson, Koochiching, Lake, Le Sueur, Mahnomon, Mille Lacs, Morrison, Murray, Nicollet, Norman, Olmsted, Ramsey, Red Lake, Rice, Rock, Scott, Sherburne, St. Louis, Todd, Wadena, Washington, Wilkin, Wright Counties | |
| Enrollment Requirements | Participation in the program is limited to people who are ages 18-64, enrolled in Medicaid with both Medicare Part A and Part B, live in the service area, and are certified disabled |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay/Medicare or Medicaid-covered stay Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary care visit for Medicare or Medicaid-covered benefits Hospital In-Network: \$0 copay/Medicare or Medicaid-covered outpatient facility and ambulatory surgical center visits Physician or Hospital Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Ambulance | \$0 copay/Medicare or Medicaid-covered services |
| Outpatient Surgery | In-Network: \$0 copay/Medicare or Medicaid-covered outpatient surgery services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Outpatient Mental Health | In-Network: \$0 copayment/Medicare or Medicaid-covered individual or group therapy visit, individual or group therapy visit with a psychiatrist, or partial hospitalization program services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare or Medicaid-covered ER visits Urgently Needed Care: \$0 copay/Medicare or Medicaid-covered urgent-care visits |
| Travel Coverage | Does not apply |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/Medicare or Medicaid-covered diagnostic tests, x-rays, lab services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay/Medicare or Medicaid-covered visits Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Skilled Nursing Facility Care | In-Network: No prior hospital stay is required. 100% coverage/Medicare or Medicaid-covered services, covers up to 100 days of nursing facility room and board. After that period, Medical Assistance provides continuing coverage. \$0 copay/Medicare or Medicaid-covered professional services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Diabetic Supplies & Services | \$0 copay/Medicare or Medicaid-covered items and services |
| DMEPOS | In-Network: \$0 copay/Medicare or Medicaid-covered items Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Dental | In-Network: \$0 copay/Medicare or Medicaid-covered dental benefits Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care Note: \$0 copay/enhanced dental services, 1 full mouth x-rays per 5 years, 1 additional periodic exam per year, 1 additional root canal per tooth per lifetime, 1 root canal retreatment per tooth per lifetime, 1 outreach call per year from a trained Delta Dental staff to educate on oral health, assist to schedule a dental visit and offer a home-delivered electric toothbrush kit once per 3 years. |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare or Medicaid-covered benefits Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Vision | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care Note: \$0 copay/covered eyewear upgrade of an anti-glare lens coating on up 2 lenses per 24 months |

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|-----------------------------------|--|
| Hearing | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Medicare Part B Drugs | In-Network: \$0 yearly deductible, \$0 copay Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Medicare Part D Coverage | Yes, \$0 for all covered Part D drugs. If you enroll in a separate Medicare Part D stand-alone plan you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | \$0 copay/all additional benefits: One Pass fitness center memberships with additional online resources that includes unlimited memory fitness training from BrainHQ and available home fitness kit, unlimited public transportation or volunteer/taxi transportation up to 3 times/week to One Pass fitness locations, personalized telephonic tobacco cessation coaching to include home-delivered nicotine replacement therapy, 24/7 HealthAdvocate telephonic support service, Ovia Health digital applications to support pregnancy, Healthy Savings Healthy Foods allowance of \$20/month at participating grocery stores. |



800-333-2433



Medica DUAL Solution MSHO (H2458-002)

Advantage HMO-Special Needs Plan 65+

Enrollment: 800-266-2157

Service: 888-347-3630 • TTY: 711

medica.com/DUALSolution



Monthly Premium: \$0

Plan Area: Aitkin, Anoka, Becker, Benton, Blue Earth, Carlton, Carver, Cass, Chisago, Clay, Crow Wing, Dakota, Faribault, Fillmore, Hennepin, Houston, Isanti, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Mahnommen, Marshall, Mille Lacs, Morrison, Mower, Nicollet, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Rice, Roseau, Scott, Sherburne, St. Louis, Stearns, Todd, Wadena, Washington, Watonwan, Wilkin, Winona, Wright Counties

| | |
|---|--|
| Enrollment Requirements | Participation in the program is limited to people who are age 65 and older, enrolled in Medicaid with both Medicare Part A and Part B and live in the service area |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay/each Medicare or Medicaid-covered stay Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary care visit for Medicare or Medicaid-covered benefits Hospital In-Network: \$0 copay/Medicare or Medicaid-covered outpatient facility and ambulatory surgical center visits Physician and Hospital Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care Note: \$0 copay/unlimited routine foot care, includes hygienic/preventive maintenance of nails/feet of ambulatory members |
| Ambulance | \$0 copay/Medicare or Medicaid-covered services |
| Outpatient Surgery | \$0 copay/Medicare or Medicaid-covered outpatient surgery services |
| Outpatient Mental Health | In-Network: \$0 copayment/Medicare or Medicaid-covered individual or group therapy visit, individual or group therapy visit with a psychiatrist, or partial hospitalization program services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare or Medicaid-covered ER visits Urgently Needed Care: \$0 copay/Medicare or Medicaid-covered urgent-care visits |
| Travel Coverage | Does not apply |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/Medicare or Medicaid-covered diagnostic tests, x-rays and lab services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay/Medicare or Medicaid-covered visits Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Skilled Nursing Facility Care | In-Network: No prior hospital stay is required, 100% coverage/Medicare or Medicaid-covered services, covers up to 180 days of nursing facility room and board. After that period, Medical Assistance provides continuing coverage. \$0 copay/Medicare or Medicaid-covered professional services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Diabetic Supplies & Services | \$0 copay/Medicare or Medicaid-covered items and services |
| DMEPOS | In-Network: \$0 copay/Medicare or Medicaid-covered items Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Dental | In-Network: \$0 copay/Medicare or Medicaid-covered dental benefits Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care Note: \$0 copay/enhanced dental services, 1 restorative crown on any 1 tooth per year, 1 full mouth x-rays per 5 years, 1 additional periodic exam per year, 1 additional root canal per tooth per lifetime, 1 root canal retreatment per tooth per lifetime, 1 outreach call per year from a trained Delta Dental staff to educate on oral health and assist to schedule a dental visit. |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare or Medicaid-covered benefits Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |

| | |
|-----------------------------------|--|
| Vision | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care Note: \$0 copay/covered eyewear upgrade of an anti-glare lens coating on up two lenses per 24 months |
| Hearing | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Medicare Part B Drugs | In-Network: \$0 yearly deductible, \$0 copay Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically-necessary care |
| Medicare Part D Coverage | Yes, \$0 for all covered Part D drugs. If you enroll in a separate Medicare Part D stand-alone plan you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | \$0 copay/all additional benefits: One Pass fitness center memberships with additional online resources and available home fitness kit, CogniFit online memory fitness program, a Reemo Smartwatch activity tracker with online portal to view data and with available personal emergency response system, CVS mail order allowance of \$200/every 3 months for over the counter items, telephonic tobacco cessation coaching, 24/7 telephonic support service, personalized in-home health coaching program by community health workers, hospital readmission prevention program, Healthy Savings Healthy Foods allowance of \$150/month at participating grocery stores, Pearson online life skills courses, and Healthy Savings utility bill allowance of \$100/month, 1 round trip ride/day to One Pass fitness and Healthy Foods grocery locations, for eligible members with certain chronic conditions: FOODRx staple foods program with monthly home delivery and Reemo telemonitoring that includes remote blood pressure cuff and body weight scale. |



800-333-2433



Prime Health Complete (H2926-001)

Advantage HMO-Special Needs Plan <65

Enrollment: 877-600-4913

Service: 877-600-4913 • TTY: 800-627-3529

primewest.org/phc



Monthly Premium: \$0

| | |
|--|--|
| Plan Area: Beltrami, Big Stone, Chippewa, Clearwater, Cottonwood, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Lac qui Parle, Lincoln, Lyon, McLeod, Meeker, Nobles, Pipestone, Pope, Redwood, Renville, Stevens, Swift, Traverse, Yellow Medicine Counties | |
| Enrollment Requirements | Participation in the program is limited to people who are ages 18 - 64, enrolled in Medicaid with both Medicare Part A and Part B, live in the service area, and are certified disabled. |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Physician/Outpatient | Physician In-Network: \$0 copay/Medicare- or Medicaid-covered services. No referral is required for any network health care providers. Physician Out-of-Network: Plan authorization required for out-of-network providers. Hospital Outpatient In-Network: \$0 copay/Medicare- or Medicaid-covered ambulatory surgical center visits or outpatient hospital facility visits. Plan authorization may be required. Hospital Outpatient Out-of-Network: Plan authorization required for out-of-network providers. |
| Ambulance | \$0 copay/Medicare- or Medicaid-covered medically necessary ambulance services. You do not need a plan authorization and you do not have to be in-network. |
| Outpatient Surgery | In-Network: \$0 copay/Medicare- or Medicaid-covered outpatient surgery services. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Outpatient Mental Health | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Out-of-Network: Medicare- or Medicaid-covered services that cannot be provided within network will be covered. |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare- or Medicaid-covered emergency room visits. Urgently Needed Care: \$0 copay/Medicare- or Medicaid-covered urgent-care visits. |
| Travel Coverage | Except for emergency or urgent care, services received out-of-network are not covered without a plan authorization; no coverage outside the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/Medicare- or Medicaid-covered x-rays, lab services, and diagnostic tests. Plan authorization may be required. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Out-of-Network: Medicare- or Medicaid-covered services that cannot be provided within network will be covered. |
| Skilled Nursing Facility Care | In-Network: \$0 copay/Medicare- or Medicaid-covered medically necessary services. For combined Medicare- and Medicaid-covered visits, up to 100 days of nursing facility room and board is covered. After that, the State Medicaid plan provides coverage. Plan authorization may be required. Out-of-Network: Plan authorization required for out-of-network providers. |
| Diabetic Supplies & Services | \$0 copay/Medicare- or Medicaid-covered items and services. Plan authorization may be required. As a supplemental benefit, a home-delivered meals program is covered for members with diabetes for up to 6 consecutive months per 12-month period. |
| DMEPOS | In-Network: \$0 copay/Medicare- or Medicaid-covered items. Plan authorization may be required. As a supplemental benefit, one electronically automated dispensing pillbox every 3 years is covered. Out-of-Network: Plan authorization required for out-of-network providers. |
| Dental | In-Network: \$0 copay/Medicare- or Medicaid-covered dental services. As a supplemental benefit, one additional replacement set of dentures every 6 years and one porcelain crown per calendar year up to a limit of \$1,500 are covered. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare- or Medicaid-covered services. As a supplemental benefit, additional medically necessary chiropractic manipulations are covered. An additional 20 units of acupuncture per year are covered with plan authorization. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Vision | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Plan authorization may be required. As a supplemental benefit, polarization, tints, scratch-resistant coating, and antiglare coating with a limit of \$100 per year is covered, as well as \$300 for progressive lenses. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Hearing | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Plan authorization may be required for hearing aids. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |

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| Medicare Part B Drugs | \$0 copay. Plan authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | \$0 copay/all additional benefits: Alternative therapies for traditional medicine/ceremonial purposes for American Indian members up to \$100 per calendar year. Gym membership reimbursement up to \$30 per month. 3 health-related education classes per calendar year. Home and bathroom safety devices/modifications up to \$3,000 per year for members living in the community. 30 OTC 4% lidocaine patches per month when prescribed for pain. PERS for members with history/risk of falls who do not meet nursing home level of care. Wigs for hair loss related to chemotherapy up to \$500 per calendar year. One electric toothbrush and 3 replacement heads per year. COVID-19 test kits, up to \$25 per month. One wheelchair/walker pouch per year for members who use a wheelchair or walker. Support for caregivers of members with memory loss or Alzheimer's. Home-delivered meals for members with heart failure for up to 6 consecutive months per 12-month period. \$185 per month healthy food allowance for members with certain chronic conditions. 14 days of home-delivered meals following discharge to home/homelike setting from surgery or inpatient hospitalization; limited to 4 discharges per year. Non-medical and non-emergency common carrier transportation up to 60 round trip miles per day to fitness centers, AA, NA, and health-related classes. Routine foot care of 1 visit per month not related to a specific diagnosis already covered by Medicare. |



800-333-2433



PrimeWest Senior Health Complete (H2416-001)

Advantage HMO-Special Needs Plan 65+

Enrollment: 800-366-2906

Service: 800-366-2906 • TTY: 800-627-3529

primewest.org/pwshc



Monthly Premium: \$0

Plan Area: Beltrami, Big Stone, Chippewa, Clearwater, Cottonwood, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Lac qui Parle, Lincoln, Lyon, McLeod, Meeker, Nobles, Pipestone, Pope, Redwood, Renville, Stevens, Swift, Traverse, Yellow Medicine Counties

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| Enrollment Requirements | Participation in the program is limited to people who are age 65 or over, enrolled in Medicaid with both Medicare Part A and Part B, and live in the service area. |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Physician/Outpatient | Physician In-Network: \$0 copay/Medicare- or Medicaid-covered services. No referral is required for any network health care providers. Physician Out-of-Network: Plan authorization required for out-of-network providers. Hospital Outpatient In-Network: \$0 copay/Medicare- or Medicaid-covered ambulatory surgical center visits or outpatient hospital facility visits. Plan authorization may be required. Hospital Outpatient Out-of-Network: Plan authorization required for out-of-network providers. |
| Ambulance | \$0 copay/Medicare- or Medicaid-covered medically necessary ambulance services. You do not need a plan authorization and you do not have to be in-network. |
| Outpatient Surgery | In-Network: \$0 copay/Medicare- or Medicaid-covered outpatient surgery services. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Outpatient Mental Health | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Out-of-Network: Medicare- or Medicaid-covered services that cannot be provided within network will be covered. |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare- or Medicaid-covered emergency room visits. Urgently Needed Care: \$0 copay/Medicare- or Medicaid-covered urgent-care visits. |
| Travel Coverage | Except for emergency or urgent care, services received out-of-network are not covered without a plan authorization; no coverage outside the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/Medicare- or Medicaid-covered x-rays, lab services, and diagnostic tests. Plan authorization may be required. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Out-of-Network: Medicare- or Medicaid-covered services that cannot be provided within network will be covered. |
| Skilled Nursing Facility Care | In-Network: \$0 copay/Medicare- or Medicaid-covered medically necessary services. For combined Medicare- and Medicaid-covered visits, up to 180 days of nursing facility room and board is covered. After that, the State Medicaid plan provides coverage. Plan authorization may be required. Out-of-Network: Plan authorization required for out-of-network providers. |
| Diabetic Supplies & Services | \$0 copay/Medicare- or Medicaid-covered items and services. Plan authorization may be required. As a supplemental benefit, a home-delivered meals program is covered for members with diabetes for up to 6 consecutive months per 12-month period. |
| DMEPOS | In-Network: \$0 copay/Medicare- or Medicaid-covered items. Plan authorization may be required. As a supplemental benefit, one electronically automated dispensing pillbox every 3 years is covered. Out-of-Network: Plan authorization required for out-of-network providers. |
| Dental | In-Network: \$0 copay/Medicare- or Medicaid-covered dental services. As a supplemental benefit, one additional replacement set of dentures every 6 years and one porcelain crown per calendar year up to a limit of \$1,500 are covered. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare- or Medicaid-covered services. As a supplemental benefit, additional medically necessary chiropractic manipulations are covered. An additional 20 units of acupuncture per year are covered with plan authorization. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Vision | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Plan authorization may be required. As a supplemental benefit, polarization, tints, scratch-resistant coating, and antiglare coating with a limit of \$100 per year is covered, as well as \$300 for progressive lenses. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |

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| Hearing | In-Network: \$0 copay/Medicare- or Medicaid-covered services. Plan authorization may be required for hearing aids. Out-of-Network: Requires plan authorization unless a medical emergency, urgently needed service, or a network provider cannot provide the medically necessary care. |
| Medicare Part B Drugs | \$0 copay. Plan authorization may be required |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | \$0 copay/all additional benefits: Alternative therapies for traditional medicine/ceremonial purposes for American Indian members up to \$100 per calendar year. Gym membership reimbursement up to \$30 per month. 3 health-related education classes per calendar year. Home and bathroom safety devices/modifications up to \$3,000 per year for members living in the community. 30 OTC 4% lidocaine patches per month when prescribed for pain. PERS for members with history/risk of falls who do not meet nursing home level of care. Wigs for hair loss related to chemotherapy up to \$500 per calendar year. One electric toothbrush and 3 replacement heads per year. Up to \$60 per month for select OTC items. One wheelchair or walker pouch per year for members who use a wheelchair or walker. Support for caregivers of members with memory loss or Alzheimer's. Home-delivered meals for members with heart failure for up to 6 consecutive months per 12-month period. \$185 per month healthy food allowance for members with certain chronic conditions. 14 days of home-delivered meals following discharge to home/homelike setting from surgery or inpatient hospitalization; limited to 4 discharges per year. Non-medical and non-emergency common carrier transportation up to 60 round trip miles per day to fitness centers, AA, NA, and health-related classes. Routine foot care of 1 visit per month not related to a specific diagnosis already covered by Medicare. |



800-333-2433

| Plan Area: Brown, Dodge, Goodhue, Kanabec, Sibley, Steele, Wabasha, Waseca Counties | |
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| Enrollment Requirements | Participation in the program is limited to people who are under age 65, enrolled in Medicaid with both Medicare Part A and Part B, live in the service area, and are certified disabled |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay/deductible for Medicare- or Medicaid-covered services. No referral is required for any network health care providers, doctors, specialists, or hospitals. No additional cost sharing for professional services. Plan notification of admission is required for admissions in Minnesota, Iowa, North Dakota, South Dakota, and Wisconsin. Admissions in all other states require plan authorization. Out-of-Network: Plan authorization required for out-of-state providers |
| Physician/Outpatient | Physician In-Network: \$0 copay/Medicare- or Medicaid-covered primary care or specialist visits. No referral is required for any network health care providers. Physician Out-of-Network: Plan authorization required for out-of-network providers Hospital In-Network: \$0 copay/Medicare- or Medicaid-covered ambulatory surgical center or outpatient hospital facility visits. Prior authorization may be required Hospital Out-of-Network: Plan authorization may be required for out-of-network providers |
| Ambulance | \$0 copay/Medicare- or Medicaid-covered ambulance services |
| Outpatient Surgery | \$0 copay/Medicare- or Medicaid-covered outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers, prior authorization may be required |
| Outpatient Mental Health | In-Network: \$0 copay/Medicare- or Medicaid-covered individual or group therapy visits, individual or group therapy visits with a psychiatrist, partial hospitalization program services, prior authorization may be required Out-of-Network: Plan authorization may be required for out-of-network providers |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare- or Medicaid-covered ER visits Urgently Needed Care: \$0 copay/Medicare- or Medicaid-covered urgently needed care visits, if admitted to the hospital within 3 days for the same condition, pay \$0 for the urgently needed care visit |
| Travel Coverage | Except for emergency or urgent care, services received out-of-network are not covered without a prior authorization, no coverage outside the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/Medicare- or Medicaid-covered lab services, diagnostic procedures and tests, x-rays, diagnostic radiology services, therapeutic radiology services, prior authorization may be required Out-of-Network: Plan authorization may be required for out-of-network providers |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay/Medicare- and Medicaid-covered occupational therapy, physical therapy, speech therapy, language pathology visits, prior authorization may be required Out-of-Network: Plan authorization required for out-of-network providers |
| Skilled Nursing Facility Care | In-Network: For combined Medicare- and Medicaid-covered stays, notification is required, plan cover up to 100 days of nursing facility room and board. After that, Medicaid fee-for-service provides coverage. Out-of-Network: Plan authorization required for out-of-network providers |
| Diabetic Supplies & Services | \$0 copay/Medicare- or Medicaid-covered self-management training, services and supplies, including monitoring supplies, therapeutic shoes, inserts, prior authorization may be required |
| DMEPOS | In-Network: \$0 copay/Medicare- or Medicaid-covered items, prior authorization may be required Out-of-Network: Plan authorization may be required for out-of-network providers |
| Dental | \$0 copay/Medicare- or Medicaid-covered dental services, prior authorization may be required |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare- or Medicaid-covered visits Out-of-Network: Plan authorization may be required for out-of-network providers |
| Vision | \$0 copay/Medicare- or Medicaid-covered vision services, eye exams, eyeglasses (including repairs and replacement for loss, theft or damage) and more |
| Hearing | \$0 copay/Medicare- or Medicaid-covered hearing services, hearing and balance tests, plan authorization required for hearing aids |
| Medicare Part B Drugs | \$0 copay |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | In-Network: BeActive Fitness Program, 24-hour nurse advice line, up to \$15 off the registration fee for up to 5 community education classes per year, tobacco cessation assistance, rewards program for preventive care, home delivered meals and rehab stay at nursing facility after hospitalization, porcelain dental crown, eyewear lens upgrades, personal emergency response system |



| Plan Area: Brown, Dodge, Goodhue, Kanabec, Sibley, Steele, Wabasha, Waseca Counties | |
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| Enrollment Requirements | Participation in the program is limited to people who are age 65 and older, enrolled in Medicaid with both Medicare Part A and Part B and live in the service area |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay/Medicare- or Medicaid-covered services, no referral is required for any network health care providers, doctors, specialists, or hospitals. Plan notification of admission is required for admissions in Minnesota, Iowa, North Dakota, South Dakota, and Wisconsin. Admissions in all other states require plan authorization. Out-of-Network: Plan authorization required for out-of-state providers |
| Physician/Outpatient | Physician In-Network: \$0 copay/Medicare- or Medicaid-covered primary care or specialist visits. No referral is required for any network health care providers. Physician Out-of-Network: Plan authorization required for out-of-network providers Hospital In-Network: \$0 copay/Medicare- or Medicaid-covered ambulatory surgical center visits or outpatient hospital facility visits, prior authorization may be required Hospital Out-of-Network: Plan authorization may be required for out-of-network providers |
| Ambulance | \$0 copay/Medicare- or Medicaid-covered ambulance services |
| Outpatient Surgery | \$0 copay/Medicare- or Medicaid-covered outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers, prior authorization may be required |
| Outpatient Mental Health | In-Network: \$0 copay/Medicare- or Medicaid-covered individual or group therapy visits, or individual or group therapy visits with a psychiatrist, partial hospitalization program services, prior authorization may be required Out-of-Network: Plan authorization may be required for out-of-network providers |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare- or Medicaid-covered ER visits Urgently Needed Care: \$0 copay/Medicare- or Medicaid-covered urgently needed care visits. If admitted to the hospital within 3 days for the same condition, pay \$0 for the urgently needed care visit |
| Travel Coverage | Except for emergency or urgent care, services received out-of-network are not covered without a prior authorization, no coverage outside the U.S. |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/Medicare- or Medicaid-covered lab services, diagnostic procedures and tests, x-rays, diagnostic radiology services, therapeutic radiology services, prior authorization may be required Out-of-Network: Plan authorization may be required for out-of-network providers |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay/Medicare- and Medicaid-covered medically-necessary physical/occupational/speech/language pathology services, prior authorization may be required Out-of-Network: Plan authorization required for out-of-network providers |
| Skilled Nursing Facility Care | In-Network: For combined Medicare- and Medicaid-covered stays, notification is required, and the plan covers up to 180 days of nursing facility room and board. After that, Medicaid fee-for-service provides coverage. No additional cost sharing for professional services Out-of-Network: Plan authorization required for out-of-network providers |
| Diabetic Supplies & Services | \$0 copay/Medicare- or Medicaid-covered self-management training, services and supplies, monitoring supplies, therapeutic shoes and inserts, prior authorization may be required |
| DMEPOS | In-Network: \$0 copay/Medicare- or Medicaid-covered items, prior authorization may be required Out-of-Network: Plan authorization may be required for out-of-network providers |
| Dental | \$0 copay/Medicare- or Medicaid-covered dental services, prior authorization may be required |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare- or Medicaid-covered benefits Out-of-Network: Plan authorization may be required for out-of-network providers |
| Vision | \$0 copay/Medicare- or Medicaid-covered vision services, eye exams, eyeglasses (including repairs and replacement for loss, theft or damage) and more |
| Hearing | \$0 copay/for Medicare- or Medicaid-covered hearing services, hearing and balance tests, plan authorization required for hearing aids |
| Medicare Part B Drugs | \$0 copay |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | In-Network: BeActive Fitness Program, 24-hour nurse advice line, up to \$15 off the registration fee for up to 5 community education classes per year, tobacco cessation assistance, rewards program for preventive care, home delivered meals after hospitalization and rehab stay at nursing facility, personal emergency response system benefit, porcelain dental crown, eyewear lens upgrades, home & safety devices or modifications |



UCare Connect + Medicare SNBC (H5937-001)

Advantage HMO-Special Needs Plan <65

Enrollment: 800-707-1711

Service: 855-260-9707 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$0

Plan Area: Aitkin, Anoka, Becker, Benton, Blue Earth, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Cook, Cottonwood, Crow Wing, Dakota, Faribault, Fillmore, Freeborn, Hennepin, Houston, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnommen, Marshall, Martin, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Redwood, Rice, Rock, Roseau, Scott, Sherburne, Stearns, St. Louis, Swift, Todd, Wadena, Washington, Watonwan, Wilkin, Winona, Wright, Yellow Medicine Counties

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| Enrollment Requirements | Participation in the program is limited to people who are between the ages of 18 and 65, enrolled in Medicaid with both Medicare Part A and Part B, live in the service area, and are certified disabled |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay/Medicare or Medicaid-covered services, except in an emergency, health care provider must tell the plan of hospital admission Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Physician/Outpatient | Physician In-Network: \$0 copay/Medicare or Medicaid-covered services Hospital In-Network: \$0 copay/Medicare or Medicaid-covered services, except in an emergency, health care provider must tell the plan of hospital admission Physician and Hospital Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Ambulance | \$0 copay/Medicare or Medicaid-covered medically-necessary ambulance services |
| Outpatient Surgery | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Outpatient Mental Health | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare or Medicaid-covered ER visits Urgently Needed Care: \$0 copay/Medicare or Medicaid-covered services |
| Travel Coverage | Does not apply |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/Medicare or Medicaid-covered services, lab tests, x-rays or other pictures, screening tests Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Skilled Nursing Facility Care | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Diabetic Supplies & Services | \$0 copay/Medicare or Medicaid-covered services |
| DMEPOS | In-Network: \$0 copay/Medicare or Medicaid-covered items Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Dental | In-Network: \$0 copay/Medicare or Medicaid-covered services, plan offers additional dental benefits Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered Note: Porcelain or porcelain fused to high noble metal crown (2/year), 1 crown repair/year, electric toothbrush (1 every 3 years), electric toothbrush replacement heads (1 package of 2/year), UCare Dental Connection provides coordination of dental services, transportation and interpreter services |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered. Routine Chiropractic up to 12 visits/year includes exams and treatment of extremities for members with musculoskeletal disorders, Acupuncture up to 12 additional visits/year for acute low back pain. |
| Vision | In-Network: \$0 copay/exams, eyeglasses, anti-glare lens coating, 1/year; photochromic (“transition”) lens tinting, 1/year; progressive (no-line) lenses, 1/year. |
| Hearing | In-Network: \$0 copay/hearing screenings and hearing aids Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Medicare Part B Drugs | \$0 copay |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |

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| Medicare Part D Deductible | \$0 |
| Discounts & Programs | <p>In-Network: Activity Tracker (includes PERS functionality) with 24/7 call-for-help, step and heart rate tracking and built-in GPS, 1/year, Activity Tracker Blood Pressure monitor plan covers 1/year for members with hypertension diagnosis and must be Activity Tracker user, OTC \$60/quarter for purchase of select catalogue OTC items online or by phone, \$15 discount on community education classes, One Pass access to more than 23,000 participating fitness locations, Connect to Wellness Kit for at-home fitness, up to 3 round-trip rides/week to a participating health club, 1 round trip ride/day to Alcoholics Anonymous and/or Narcotics Anonymous meetings for members assessed as having a substance use disorder, up to 1 ride/week to participating healthy food allowance grocery stores for members with hypertension, diabetes, CHF, and ischemic heart disease, podiatry services for routine foot care (not related to a specific diagnosis already covered by Medicare) limits apply, quit smoking and vaping program, Healthy Food \$50 monthly allowance for purchase of healthy foods and produce at participating stores for members with hypertension, diabetes or lipid disorders, medication toolkit, Therapeutic Massage 6 visits/year for members with back pain, neck and shoulder pain, headache, carpal tunnel syndrome, osteoarthritis, and fibromyalgia</p> |



800-333-2433



UCare's Minnesota Senior Health Options MSHO (H2456-002)

Advantage HMO-Special Needs Plan 65+

Enrollment: 800-707-1711

Service: 866-280-7202 • TTY: 800-688-2534

ucare.org



Monthly Premium: \$0

Plan Area: Aitkin, Anoka, Becker, Benton, Blue Earth, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Cook, Cottonwood, Crow Wing, Dakota, Dodge, Faribault, Fillmore, Freeborn, Hennepin, Houston, Isanti, Jackson, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnommen, Marshall, Martin, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Ramsey, Red Lake, Redwood, Rice, Rock, Roseau, Scott, Sherburne, St. Louis, Stearns, Swift, Todd, Wabasha, Wadena, Washington, Watonwan, Winona, Wright, Yellow Medicine Counties

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| Enrollment Requirements | Participation in the program is limited to people who are age 65 and older, enrolled in Medicaid with both Medicare Part A and Part B and live in the service area |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay/Medicare or Medicaid-covered services. Except in an emergency, health care provider must tell the plan of hospital admission. Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Physician/Outpatient | Physician In-Network: \$0 copay/Medicare or Medicaid-covered primary care or specialist doctor visits. Hospital In-Network: \$0 copay/Medicare or Medicaid-covered services. Except in an emergency, health care provider must tell the plan of hospital admission. Physician and Hospital Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Ambulance | \$0 copay/Medicare or Medicaid-covered medically-necessary ambulance services |
| Outpatient Surgery | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Outpatient Mental Health | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Emergency/Urgent Care | Emergency: \$0 copay/Medicare or Medicaid-covered ER visits Urgently Needed Care: \$0 copay/Medicare or Medicaid-covered services |
| Travel Coverage | Does not apply |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay/Medicare- or Medicaid-covered services, lab tests, x-rays or other pictures, screening tests Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay/Medicare or Medicaid-covered services. There may be limits on physical therapy, occupational therapy and speech therapy services. If so, there may be exceptions to these limits. Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Skilled Nursing Facility Care | In-Network: \$0 copay/Medicare or Medicaid-covered services, no prior hospital stay is required Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Diabetic Supplies & Services | \$0 copay for supplies or services, supplies to monitor blood glucose. For people with diabetes who have severe diabetic foot disease, the plan will pay for the following: 1 pair of therapeutic custom-molded shoes (including inserts) and 2 extra pairs of inserts each calendar year or 1 pair of depth shoes and 3 pairs of inserts each year (not including the non-customized removable inserts provided with such shoes). The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. The plan will pay for training to help you manage diabetes, in some cases. |
| DMEPOS | In-Network: \$0 copay/Medicare or Medicaid-covered items Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Dental | In-Network: \$0 copay/Medicare or Medicaid-covered dental services. The plan contains additional benefits. Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered, 2 porcelain or porcelain fused to high noble metal crowns/year, 1 crown repair/year, tissue conditioning for dentures, 1 electric toothbrush/three years, 1 package of 2 electric toothbrush replacement heads/calendar year |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare or Medicaid-covered services Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered. routine chiropractic up to 12 visits/year includes exams and treatment of extremities |
| Vision | In-Network: \$0 copay/exams, eyeglasses; anti-glare lens coating, 1/year, photochromic ("transition") lens tinting, 1/year; progressive (no-line) lenses 1/year |
| Hearing | In-Network: \$0 copay/hearing screenings, hearing aids Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |

| | |
|-----------------------------------|--|
| Medicare Part B Drugs | In-Network: \$0 copay Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | OTC \$60/quarter for purchase of select catalogue OTC items online or by phone, One Pass access to fitness locations, Juniper health management and wellness classes, smartwatch – activity tracker, Strong & Stable Kit, medication tool kit, \$15 discount on community ed classes, quit smoking and vaping program, post-hospital discharge meals, medication reconciliation, caregiver training and support, available to members who qualify: \$50/month for payment of utility bills, \$60 Healthy Food monthly allowance, rides to Healthy Food Allowance participating grocery stores, memory support kit, Grandpad electronic tablet, activity tracker, blood pressure monitor, stress & anxiety kit, bath and home safety items, PERS, Therapeutic Massage 6 visits/year, Additional acupuncture up to 12 visits/year, Up to 12 additional routine chiropractic visits per year for members with musculoskeletal disorder. |



800-333-2433



UCare Advocate Choice (H2459-031)

Advantage HMO-Special Needs Plan Institutional

Enrollment: 877-671-1054

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org/advocate



Monthly Premium: \$0

Plan Area: Anoka, Benton, Blue Earth, Carver, Chisago, Dakota, Douglas, Freeborn, Hennepin, Hubbard, Isanti, Mille Lacs, Morrison, Otter Tail, Pope, Ramsey, Rice, Scott, Sherburne, Stearns, Washington, Wright Counties

| | |
|---|---|
| Enrollment Requirements | Have Medicare Part A and Part B; live in a participating facility within the 22-county service area; receive or qualify for a nursing-home level of care in a skilled nursing, assisted living or memory care facility |
| Out-of-Pocket Max | \$4,500 |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$0 copay days 1-5; \$275 copay days 6-10; \$0 copay days 11-90; unlimited hospital coverage |
| Physician/Outpatient | \$0 copay/primary care doctor visits, \$395 copay/stay for each Medicare-covered outpatient hospital service, \$365 copay/observation stay |
| Ambulance | \$275 copay |
| Outpatient Surgery | \$395 copay/each for Medicare-covered outpatient surgery. \$370 copay/Medicare-covered surgery at an ambulatory surgery center |
| Outpatient Mental Health | \$0 copay/facility where member lives, facility where member lives, partial hospitalization |
| Emergency/Urgent Care | Emergency: \$90 copay, waived if admitted for inpatient hospital stay within 24 hours Urgently Needed Care: \$45 copay |
| Travel Coverage | Does not apply |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab and bloodwork, 20% coinsurance/diagnostic tests including x-rays, MRIs and CT scans |
| Physical/Speech/Occupational Therapy | \$30 copay |
| Skilled Nursing Facility Care | 100 days covered; \$0 copay per day, days 1-20; \$170 copay per day, days 21-100; does not require 3-day hospital stay |
| Diabetic Supplies & Services | 20% coinsurance/blood glucose monitor, testing supplies; 0% all other supplies, shoes, inserts, self-management training |
| DMEPOS | 20% coinsurance/DME; 10% coinsurance/prosthetics orthotics |
| Dental | Up to \$600/year for medically-necessary non-cosmetic, nonexperimental dental services not covered by Medicare |
| Chiropractic/Acupuncture | 20% coinsurance |
| Vision | 20% coinsurance/Medicare-covered exams; \$0 copay/routine eye exam; \$200 annual eyewear allowance |
| Hearing | Hearing exams 20% coinsurance/Medicare-covered exams; \$0 copay/routine exams; \$400 hearing aid allowance; \$0 copay/unlimited fittings per year |
| Medicare Part B Drugs | In-Network: \$0 copay Out-of-Network: Medicare or Medicaid-covered services that cannot be provided within network will be covered |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0/tier 1&2, \$125/tiers 3-5 |
| Discounts & Programs | \$500 transportation allowance per year to approved locations within service area; over-the-counter drug benefit of \$75 twice a year to purchase items such as cough drops, first aid supplies, pain relief and sinus medications; no-cost dental kit with an electric toothbrush/3 years and 2 replacement heads per year; telemonitoring scale for members with CHF; Strong & Stable fall prevention kit |



800-333-2433



UCare Advocate Plus (H2459-032)

Advantage HMO-Special Needs Plan Institutional

Enrollment: 877-671-1054

Service: 877-523-1515 • TTY: 800-688-2534

ucare.org/advocate



Monthly Premium: \$29

| Plan Area: Anoka, Benton, Blue Earth, Carver, Chisago, Dakota, Douglas, Freeborn, Hennepin, Hubbard, Isanti, Mille Lacs, Morrison, Otter Tail, Pope, Ramsey, Rice, Scott, Sherburne, Stearns, Washington, Wright Counties | |
|---|--|
| Enrollment Requirements | Have Medicare Part A and Part B; live in a participating facility within the 22-county service area; Receive or qualify for a nursing-home level of care in a skilled nursing, assisted living or memory care facility |
| Out-of-Pocket Max | \$3,850 |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$0 copay days 1-5; \$250 copay days 6-10; \$0 copay days 11-90; unlimited hospital coverage |
| Physician/Outpatient | \$0 copay/primary care doctor visits, \$295 copay/stay for each Medicare-covered outpatient hospital service, \$265 copay/observation stay |
| Ambulance | \$250 copay |
| Outpatient Surgery | \$295 copay/each for Medicare-covered outpatient surgery, \$270 copay/Medicare-covered surgery at an ambulatory surgery center |
| Outpatient Mental Health | \$0 copay/facility where member lives, outside facility where member lives, partial hospitalization |
| Emergency/Urgent Care | Emergency: \$90 copay, waived if admitted for inpatient hospital stay within 24 hours Urgently Needed Care: \$45 copay |
| Travel Coverage | Does not apply |
| X-rays, Lab & Diagnostic Tests | \$0 copay/lab and bloodwork, 20% coinsurance/diagnostic tests including x-rays, MRIs and CT scans. \$75 daily maximum |
| Physical/Speech/Occupational Therapy | \$20 copay |
| Skilled Nursing Facility Care | 100 days covered; \$0 copay per day, days 1-20; \$170 copay per day, days 21-100; does not require 3-day hospital stay |
| Diabetic Supplies & Services | 20% blood glucose monitor, testing supplies; 0% all other supplies, shoes, inserts, self-management training |
| DMEPOS | 20% coinsurance/DME; 10% coinsurance/prosthetics orthotics |
| Dental | Up to \$700/year for medically-necessary non-cosmetic, nonexperimental dental services not covered by Medicare |
| Chiropractic/Acupuncture | \$20 copay/Medicare covered services |
| Vision | 20% coinsurance/Medicare-covered exams; \$0 copay/routine eye exam; \$225 annual eyewear allowance |
| Hearing | Hearing exams 20% coinsurance/Medicare-covered exams; \$0 copay/routine exams; \$550 hearing aid allowance; \$0 copay/unlimited fittings per year |
| Medicare Part B Drugs | 20% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. |
| Medicare Part D Deductible | \$0/all tiers |
| Discounts & Programs | \$500 transportation allowance per year to approved locations within service area; over-the-counter drug benefit of \$75 twice a year to purchase items such as cough drops, first aid supplies, pain relief and sinus medications; no-cost dental kit with an electric toothbrush/3 years and 2 replacement heads per year; Strong & Stable fall prevention kit, telemonitoring scale for members with CHF, unlimited routine foot care (does not require a specific diagnosis) |



800-333-2433



UHC Dual Complete MN-Y001 (H7778-001)

Advantage HMO-Special Needs Plan <65

Enrollment: 888-834-3721

Service: 844-368-5888 • TTY: 711

UHCCommunityPlan.com



Monthly Premium: \$0

| Plan Area: Scott, St. Louis Counties | |
|---|--|
| Enrollment Requirements | Participation in the program is limited to people who are between the ages of 18 and 65, enrolled in Medicaid with both Medicare Part A and Part B, live in the service area, and are certified disabled or are receiving services under the DD waiver from your county. |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay Out-of-Network: not covered |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary or specialist visit Physician Out-of-Network: not covered |
| Ambulance | In-Network: \$0 copay/ground or air ambulance Out-of-Network: not covered |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0 copay Outpatient Hospital Out-of-Network: not covered |
| Outpatient Mental Health | In-Network: \$0 copay/individual or group therapy visits |
| Emergency/Urgent Care | Emergency Care: \$0 copay Urgently Needed Services: \$0 copay |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay Out-of-Network: not covered |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay Out-of-Network: not covered |
| Skilled Nursing Facility Care | In-Network: \$0 copay Out-of-Network: not covered |
| Diabetic Supplies & Services | In-Network: \$0 copay Out-of-Network: not covered |
| DMEPOS | In-Network: \$0 copay Out-of-Network: not covered |
| Dental | \$0 copay/preventive, diagnostic services and comprehensive services |
| Chiropractic/Acupuncture | Not covered |
| Vision | In-Network: \$0 copay/routine eye exam, contact lenses and eyeglasses (frames and lenses) Out-of-Network: not covered |
| Hearing | In-Network: \$0 copay/hearing exam, \$2,000 allowance for hearing aids every year Out-of-Network: not covered |
| Medicare Part B Drugs | In-Network: \$0 copay Out-of-Network: not covered |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | Virtual medical and mental health visits; Nursing HotLine Package; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Renew Active; Philips LifeLine, PERS; \$225/month over-the-counter, food allowance and utilities combined credit, amount expires monthly |



800-333-2433



UHC Dual Complete MN-Y002 (H0845-001)

Advantage HMO-Special Needs Plan 65+

Enrollment: 888-834-3721

Service: 844-368-5888 • TTY: 711

UHCCommunityPlan.com



Monthly Premium: \$0

| Plan Area: St. Louis County | |
|---|---|
| Enrollment Requirements | Participation in the program is limited to people who are age 65 and older, enrolled in Medicaid with both Medicare Part A and Part B and live in the service area |
| Out-of-Pocket Max | Does not apply |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$0 copay Out-of-Network: not covered |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary or specialist visit Physician Out-of-Network: not covered |
| Ambulance | In-Network: \$0 copay/ground or air ambulance Out-of-Network: not covered |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0 copay Outpatient Hospital Out-of-Network: not covered |
| Outpatient Mental Health | In-Network: \$0 copay/individual or group therapy visits |
| Emergency/Urgent Care | Emergency Care: \$0 copay Urgently Needed Services: \$0 copay |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: \$0 copay Out-of-Network: not covered |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay Out-of-Network: not covered |
| Skilled Nursing Facility Care | In-Network: \$0 copay Out-of-Network: not covered |
| Diabetic Supplies & Services | In-Network: \$0 copay Out-of-Network: not covered |
| DMEPOS | In-Network: \$0 copay Out-of-Network: not covered |
| Dental | Not covered |
| Chiropractic/Acupuncture | Not covered |
| Vision | Not covered |
| Hearing | \$0 copay/hearing exam, up to 1 per year |
| Medicare Part B Drugs | In-Network: \$0 copay Out-of-Network: not covered |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan. |
| Medicare Part D Deductible | \$0 |
| Discounts & Programs | Virtual medical and mental health visits; NurseLine; meal benefit package (up to 28 meals for 14 days, unlimited times per year); Philips Lifeline, PERS; Renew Active; \$180/quarter over-the-counter debit card and catalog, amount expires quarterly |



800-333-2433



UHC Care Advantage MN-E001 (H0710-047)

Advantage PPO-Special Needs Plan

Enrollment: 888-834-3721

Service: 844-867-3487 • TTY: 711

UHC.com/Medicare



Monthly Premium: \$42.20

| Plan Area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, St. Louis, Washington Counties | |
|---|--|
| Enrollment Requirements | Institutional Special Needs Plan designed specifically for people who live in a contracted institution for 90 days or longer |
| Out-of-Pocket Max | In-Network: \$1,600 annually for Medicare-covered services Out-of-Network: \$5,100 annually for Medicare-covered services |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | In-Network: \$200 copay/day for days 1-7, \$0 copay/day for days 8+, unlimited inpatient hospital stay days Out-of-Network: 30% coinsurance/admit |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary or specialists Physician Out-of-Network: 30% coinsurance/primary or specialists |
| Ambulance | \$100 copay/ground or air ambulance, copays are waived if admitted within 24 Hours |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0-\$175 copay, cost sharing for additional plan covered services will apply Outpatient Hospital Out of-Network: 30% coinsurance, cost sharing for additional plan covered services will apply |
| Outpatient Mental Health | In-Network: \$15 copay/group therapy visit, \$25 copay/individual therapy visit Out-of-Network: 30% coinsurance/group therapy or individual therapy visit |
| Emergency/Urgent Care | Emergency Care: \$90 copay/visit (\$0 copay worldwide); copays are waived if admitted within 24 Hours Urgently Needed Services: \$40 copay (\$0 copay worldwide) |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In-Network: 20% coinsurance/diagnostic radiology services, diagnostic tests and procedures, therapeutic radiology, \$0 copay/lab services and outpatient x-rays Out-of-Network: 30% coinsurance/diagnostic radiology services, diagnostic tests and procedures, therapeutic radiology, and outpatient x-rays, \$0 copay/lab services |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay Out-of-Network: 30% coinsurance |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-100 Out-of-Network: 30% coinsurance/admit |
| Diabetic Supplies & Services | In-Network: \$0 copay/monitoring supplies, 20% coinsurance/therapeutic shoes or inserts Out-of-Network: 30% coinsurance/monitoring supplies, therapeutic shoes or inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment, \$0 copay-20% coinsurance/prosthetics Out-of-Network: 30% coinsurance/durable medical equipment and prosthetics |
| Dental | \$0 copay/preventive exam, cleaning every 6 months; \$0 copay/comprehensive, up to \$2,400/year for covered preventive and comprehensive dental services |
| Chiropractic/Acupuncture | In-Network: \$0 copay/Medicare-covered chiropractic services Out-of-Network: 30% coinsurance/Medicare-covered chiropractic services. Acupuncture services not covered |
| Vision | In-Network: \$0 copay/1 routine eye exam every year, \$0 copay/eyewear every year (up to \$200 for lenses, frames or contact lenses) Out-of-Network: 30% coinsurance/1 routine eye exam every year, \$0 copay/eyewear every year |
| Hearing | UnitedHealthcare Hearing: \$2,000 allowance for hearing aids every year, 0 copay/hearing exam, 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-30% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Part D stand-alone plan, you will be disenrolled from this health plan |
| Medicare Part D Deductible | \$0/all tiers |
| Discounts & Programs | \$210/quarter over-the-counter debit card or mail order, amount expires annually |



800-333-2433



UHC Nursing Home Plan MN-F001 (H0710-041)

Advantage PPO-Special Needs Plan

Enrollment: 888-834-3721

Service: 844-867-3487 • TTY: 711

UHC.com/Medicare



Monthly Premium: \$38.30

| Plan Area: Anoka, Carver, Dakota, Hennepin, Ramsey, St. Louis, Scott, Washington Counties | |
|---|---|
| Enrollment Requirements | Institutional Special Needs Plan designed specifically for people who live in a contracted institution for 90 days or longer |
| Out-of-Pocket Max | In-Network: \$2,000 annually for Medicare-covered services Out-of-Network: \$5,600 annually for Medicare-covered services |
| Health Plan Deductible | \$0 |
| Hospital Inpatient | \$1,628 copay/admit |
| Physician/Outpatient | Physician In-Network: \$0 copay/primary, \$0-20% coinsurance/specialist Physician Out-of-Network: 30% coinsurance |
| Ambulance | 20% coinsurance/ground or air ambulance, copays are waived if admitted within 24 Hours |
| Outpatient Surgery | Outpatient Hospital In-Network: \$0 copay-20% coinsurance including observation services, cost sharing for additional plan covered services will apply Outpatient Hospital Out-of-Network: 30% coinsurance, cost sharing for additional plan covered services will apply |
| Outpatient Mental Health | In-Network: \$0-20% coinsurance Out-of-Network: 30% coinsurance |
| Emergency/Urgent Care | Emergency Care: \$100 copay/visit, if you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the emergency copay Urgently Needed Services: \$40 copay |
| Travel Coverage | Not covered |
| X-rays, Lab & Diagnostic Tests | In Network: \$0 copay/lab services, x-rays; \$0-20% coinsurance/diagnostic tests, procedures and radiology services, 20% coinsurance/therapeutic radiology services Out-of-Network: \$0 copay/lab services, x-rays; 30% coinsurance/diagnostic radiology services, diagnostic procedures and test, therapeutic radiology services, x-rays |
| Physical/Speech/Occupational Therapy | In-Network: \$0 copay Out-of-Network: 30% coinsurance |
| Skilled Nursing Facility Care | In-Network: \$0 copay/day for days 1-100 Out-of-Network: 30% coinsurance/admit |
| Diabetic Supplies & Services | In-Network: 20% coinsurance/monitoring supplies, therapeutic shoes or inserts Out-of-Network: 30% coinsurance/monitoring supplies, therapeutic shoes, inserts |
| DMEPOS | In-Network: 20% coinsurance/durable medical equipment, \$0 copay-20% coinsurance/prosthetics Out-of-Network: 30% coinsurance/durable medical equipment, prosthetics |
| Dental | \$0 copay/preventive exam, cleaning every 6 months; \$0 copay/comprehensive, up to \$3,250/year for covered preventive and comprehensive dental services |
| Chiropractic/Acupuncture | In-Network: \$0-20% coinsurance/Medicare-covered chiropractic services Out-of-Network: 30% coinsurance/Medicare-covered chiropractic services. Acupuncture services not covered |
| Vision | In-Network: \$0 copay/1 routine eye exam every year, \$0 copay/eyewear every year (up to \$250 for lenses, frames or contact lenses) Out-of-Network: 30% coinsurance/1 routine eye exam every year, \$0 copay/eyewear every year |
| Hearing | UnitedHealthcare Hearing: \$2,000 allowance for hearing aids every year, \$0 copay/hearing exam, up to 1 per year |
| Medicare Part B Drugs | In-Network: 0-20% coinsurance Out-of-Network: 0-30% coinsurance |
| Medicare Part D Coverage | Yes, if you enroll in a separate Medicare Part D stand-alone plan, you will be disenrolled from this plan. \$35 cap/month on insulins available on the plan formulary. |
| Medicare Part D Deductible | \$545/all tiers |
| Discounts & Programs | \$315/Quarter over-the-counter debit card or mail order, amount expires annually |



800-333-2433

Medicare Part D Stand-Alone Drug Plans

What You Need to Know

Medicare Part D stand-alone drug plans are insurance plans for outpatient prescription drugs. Plans are offered by private insurance companies with a Medicare contract. You must be enrolled in either Medicare Part A or Part B to enroll in a Part D plan.

- You can enroll:
 - During your Initial Enrollment Period
 - During the Medicare Open Enrollment Period
 - When you are eligible for a Special Enrollment Period
- Plans are available in all 87 counties in Minnesota.
- Plans must cover both brand-name and generic medications.
- Each plan has a list of medications that are covered, this is called a formulary.
- Plans can limit access to certain medications using:
 - Prior authorization: Before the drug is covered, your medical provider must show the drug is medically necessary.
 - Quantity limits: Limits on how much medication you can get during a specified time period.
 - Step therapy: Before the drug is covered, you will be expected to try one or more similar drugs that are lower in cost
- If you do not enroll in Part D when you are first eligible and you do not have other creditable prescription drug coverage you may pay a premium penalty when you do enroll.
- See pages 22-24 for more information on Part D.



Call the Senior LinkAge Line at 800-333-2433 for free help with Medicare, including appeals and plan options.

2024 Minnesota Medicare Part D Stand-Alone Drug Plans

To find out whether your medications are covered under a specific plan use the Medicare Plan Finder Tool at [medicare.gov](https://www.medicare.gov), contact the plan directly or call the Senior LinkAge Line at 800-333-2433.

| Company | Phone Numbers | Monthly Premium | Medicare Part D Deductible | Discounts & Programs |
|---|--|-----------------|-------------------------------------|--|
| AARP MedicareRx from UnitedHealthCare | | | | aarpmedicareplans.com |
| AARP MedicareRx Basic* (S5921-370) | Enrollment: 888-867-5564 Service: 866-460-8854 TTY: 711 | \$38.50 | \$545 | Hearing Aid discount through UnitedHealthcare Hearing |
| AARP MedicareRx Walgreens (S5921-406) | Enrollment: 800-753-8004 Service: 866-870-3470 TTY: 711 | \$62.00 | \$0/tier 1, \$410/tiers 2-5 | |
| AARP MedicareRx Preferred (S5820-024) | Enrollment: 888-867-5564 Service: 866-867-5575 TTY: 711 | \$103.80 | \$0 | |
| Aetna Medicare Solutions | | | | AetnaMedicare.com |
| SilverScript Smart Saver (S5601-200) | Enrollment: 833-526-2445 Service: 866-235-5660 TTY: 711 | \$5.30 | \$280/tiers 2-5 | Does not apply |
| SilverScript Choice* (S5601-050) | | \$41.00 | \$545 | |
| SilverScript Plus (S5601-051) | | \$92.60 | \$200/tiers 3-5 | |
| Cigna Healthcare | | | | Cigna.com/Part-D |
| Cigna Saver Rx (S5617-375) | Enrollment: 800-735-1459 Service: 800-222-6700 TTY: 711 | \$20.30 | \$0/tiers 1 & 2; \$545/tiers 3-5 | Special savings on vision, hearing, nutrition, fitness, alternative medicine, financial coaching and more |
| Cigna Secure Rx (S5617-123) | | \$59.20 | \$545 | |
| Cigna Extra Rx (S5617-270) | | \$80.70 | \$0/tiers 1&2; \$145/tiers 3-5 | |
| Clear Spring Health | | | | clearspringhealthcare.com |
| Clear Spring Health Value Rx* (S6946-022) | Enrollment: 877-364-4566 Service: 877-317-6082 TTY: 800-899-2114 | \$28.80 | \$545 | Does not apply |
| Humana | | | | humana-medicare.com |
| Humana Walmart Value Rx Plan (S5884-204) | Enrollment: 800-706-0872 Service: 800-281-6918 TTY: 711 | \$38.00 | \$0/tier 1&2, \$545/tiers 3-5 | Call plan for details You won't pay more than \$35 for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier |
| Humana Basic Rx Plan (S5884-145) | | \$44.50 | \$545/all tiers | |
| Humana Premier Rx Plan (S5884-171) | | \$95.20 | \$0/tier 1, 2&6, \$200/tiers 3-5 | |

*Benchmark Plan. See page 24 for more information.

| Company | Phone Numbers | Monthly Premium | Medicare Part D Deductible | Discounts & Programs |
|---|---|-----------------|-----------------------------------|--|
| BlueCross BlueShield Minnesota | | | | YourMedicareSolutions.com |
| MedicareBlue Rx Select (S5743-008) | Enrollment: 877-662-2583 Service: 888-832-0075 TTY: 711 | \$20.20 | \$0/tier 1&2, \$545/tier 3-5 | Call plan for details |
| MedicareBlue Rx Standard (S5743-001) | | \$76.40 | \$0/tier 1&2, \$545/tier 3-5 | |
| MedicareBlue Rx Premier (S5743-004) | | \$123.50 | \$0 | |
| Mutual of Omaha | | | | mutualofomaharx.com |
| Mutual of Omaha Rx Essential (S7126-127) | Enrollment: 800-961-9006 TTY/Enrollment: 711 Service: 855-864-6797 TTY/Service: 800-716-3231 | \$22.90 | \$0/tier 1, \$545/tiers 2-5 | Does not apply |
| Mutual of Omaha Rx Plus* (S7126-024) | | \$40.90 | \$0/tiers 1&2, \$545/tiers 3-5 | |
| Mutual of Omaha Rx Premier (S7126-094) | | \$70.30 | \$349 | |
| Wellcare | | | | wellcare.com |
| Wellcare Value Script (S4802-158) | Enrollment: 888-293-5151 TTY: 711 | \$0.50 | \$0/tier 1&2, \$545/tiers 3-6 | Does not apply |
| Wellcare Classic* (S4802-089) | | \$39.40 | \$545/tiers 1-6 | |
| Wellcare Medicare Rx Value Plus (S4802-228) | | \$79.00 | \$0 | |

*Benchmark Plan. See page 24 for more information.



800-333-2433

Glossary

Advance Beneficiary Notice of Noncoverage (ABN)

In Original Medicare, a notice that a doctor, supplier or provider gives a person with Medicare before furnishing an item or service if the doctor, supplier or provider believes that Medicare may deny payment is called an ABN. In this situation, if you aren't given an ABN before you get the item or service and Medicare denies payment, then you may not have to pay for it. If you are given an ABN and you sign it, you'll probably have to pay for the item or service if Medicare denies payment.

Advance Directive

A written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a living will and a durable power of attorney for health care.

Appeal

The action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan or your Medicare Prescription Drug Plan. You have the right to appeal if Medicare, your Medicare health plan or your Medicare drug plan denies one of these:


- A request for a health care service, supply, item or prescription drug that you think you should be able to get
- A request for payment of a health care service, supply, item or prescription drug you already received
- A request to change the amount you must pay for a health care service, supply, item or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item or prescription drug you think you still need.

Assignment

An agreement by your doctor, provider or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service and not to bill you for any more than the Medicare deductible and coinsurance.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)

A type of QIO (a group of doctors and other health care experts under contract with Medicare) that reviews complaints and quality of care for people with Medicare. The BFCC-QIO makes sure there is consistency in the case review process while taking into consideration local factors and needs, including general quality of care and medical necessity. Contact Minnesota's BFCC-QIO (Livanta) at livantaqio.com , call 888-524-9900, or 888-985-8775 (TTY).

Benefit Period

A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Catastrophic Coverage

After you reach your total out-of-pocket maximum for the year, you automatically get catastrophic coverage.

Coinsurance

The amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage.

Coordination of Benefits

A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.

Copayment

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit or prescription drug.

A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

Cost Sharing

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit or prescription drug. This amount can include copayments, coinsurance and/or deductibles.

Coverage Gap (Medicare Prescription Drug Coverage)

The coverage gap, or donut hole, begins after the total cost of your medication (what you paid and what the plan paid combined) reaches a specified dollar amount for that year. Once you are in the coverage gap, you will receive a 75% discount on your medication. During the coverage gap, your costs may be higher than they were during the initial coverage phase, where you may have been paying less than 25% of the cost for your medications.

Creditable Prescription Drug Coverage

Prescription drug coverage (for example, from an employer or union) that is as good as or better than Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Deductible

The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan or your other insurance begins to pay.

Donut Hole

See Coverage Gap above.

Durable Medical Equipment

Certain medical equipment, like a wheelchair or hospital bed, that's ordered by your doctor for use in the home.

Employer or Union Retiree Plans

Plans that give health and/or drug coverage to employees, former employees and their families. These plans are offered to people through their (or a spouse's) current or former employer or employee organization.

End-Stage Renal Disease (ESRD)

Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Extra Help

A Medicare program, also known as Low-Income Subsidy (LIS), to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles and coinsurance.

Formulary

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

Generic Drug

A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand name drugs.

Grievance

A complaint about the way your Medicare health plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person at the plan has behaved towards you.

Group Health Plan

A health plan offered by an employer or employee organization that provides health coverage to employees and their families.

The size of the employer determines if Medicare is the primary or secondary insurance. In general, Medicare is the primary payer when you have a small group health plan. The definition of a small (or large) employer depends on the reason for Medicare eligibility.

Small Group Health Plan

- Less than 20 employees (if you are eligible for Medicare because you are age 65)
- Less than 100 employees (if you are eligible for Medicare because of a disability)

There are exceptions to these rules. If you are uncertain of how your group health plan is classified, contact your employer.

Guaranteed Issue Rights

Rights you have in certain situations when insurance companies are required by law to sell or offer you certain Medigap policies. In these situations, an insurance company can't deny you certain Medigap policies or place conditions on them, like exclusions for pre-existing conditions and can't charge you more for certain Medigap policies because of a past or present health problem.

Guaranteed Renewable Policy

Insurance policies that can't be terminated by the insurance company unless you make untrue statements to the insurance company, commit fraud or don't pay your premiums. All Medigap policies issued since 1992 are guaranteed renewable.

Health Care Provider

A person or organization that's licensed to give health care. Doctors, nurses and hospitals are examples of health care providers.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Standard for Privacy of Individually Identifiable Health Information (also called the Privacy Rule) of HIPAA assures your health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.

Homebound

To be homebound means you have trouble leaving your home without help (like using a cane, wheelchair, walker, crutches, special transportation or help from another person) because of an illness or injury, or leaving your home isn't recommended because of your condition and you're normally unable to leave your home because it's a major effort. You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like attending religious services. You can still get home health care if you attend adult day care.

Home Health Care

Health care services and supplies a doctor decides you may receive in your home under a plan of care established by your doctor. Medicare only covers home health care on a limited basis as ordered by your doctor.

Hospice

A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

Hospital Outpatient Setting

A part of a hospital where you get outpatient services, like an emergency department, observation unit, surgery center or pain clinic.

Income-Related Monthly Adjustment Amount (IRMAA)

If you have higher income, the law requires an adjustment to your monthly Medicare Part B and Medicare Part D premiums. This adjustment is called IRMAA. Higher-income people pay higher premiums. This affects less than 5% of people with Medicare.

Initial Coverage Limit

Once you've met your yearly deductible, you'll pay a copayment or coinsurance for each covered drug until you reach the year's out-of-pocket maximum.

In-Network

Doctors, hospitals, pharmacies and other health care providers that have agreed to provide members of a certain insurance plan with services and supplies at a discounted price. In some insurance plans, your care is only covered if you get it from in-network doctors, hospitals, pharmacies and other health care providers.

Inpatient Care

Health care that you get when you're admitted to a health care facility, like a hospital or skilled nursing facility.

Lifetime Reserve Days

In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Limiting Charge

In Original Medicare, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to durable medical equipment in Minnesota. All other Minnesota medical providers are required to accept assignment.

Living Will

A written legal document, also called a medical directive or advance directive. It shows what type of treatments you want, or don't want, in case you can't speak for yourself. Usually, this document only comes into effect if you're unconscious.

Long-Term Care

Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, like dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. People may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care.

Long-Term Care Ombudsman

Long-Term Care Ombudsmen are advocates for residents of nursing homes, board and care homes, assisted living facilities and similar adult care facilities. They work to resolve problems of individual residents and to bring about changes at the local, state and national levels that will improve residents' care and quality of life. They may be able to provide information about home health agencies in your area.

Medicaid

A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Assistance (MA)

Minnesota's Medicaid program. It provides health care coverage to over 700,000 low-income Minnesotans each month. Most enrollees get their health care through health plans. The rest receive care on a fee-for-service basis, with providers billing the state directly for services provided.

Medically Necessary

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medicare

Medicare is a federal health insurance program for people 65 and older, certain younger people with disabilities and people with End-Stage Renal Disease (ESRD).

Medicare Medical Savings Account

A type of Medicare Advantage Plan that combines a high-deductible health plan and a medical savings account. Plans do not include coverage for Medicare Part D, but you may add a stand-alone Part D plan.

Medicare Administrative Contractor (MAC)

A company that processes claims for Medicare.

Medicare Advantage Plan (Part C)

A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Advantage Prescription Drug Plan

A Medicare Advantage Plan that offers Medicare prescription drug coverage (Part D), Part A and Part B benefits in one plan.

Medicare-Approved Amount

In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare-Approved Supplier

A company, person or agency that's been certified by Medicare to give you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

Medicare-Certified Provider

A health care provider (like a home health agency, hospital, nursing home or dialysis facility) that's been approved by Medicare. Providers are approved or certified by Medicare if they've passed an inspection conducted by a state government agency. Medicare only covers care given by providers who are certified.

Medicare Cost Plan

A type of Medicare health plan available in Minnesota. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under Original Medicare.

Medicare Health Maintenance Organization (HMO) Plan

A type of Medicare Advantage Plan. In most HMOs, you can only go to doctors, specialists or hospitals on the plan's list except in an emergency. Most HMOs also require you to get a referral from your primary care physician.

Medicare Health Plan

Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans and Demonstration/Pilot Programs.

Medicare Part A (Hospital Insurance)

Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

Medicare Part B (Medical Insurance)

Part B covers certain doctors' services, outpatient care, medical supplies and preventive services.

Medicare Part B-ID

Part B-ID covers immunosuppressive drugs for people with End-Stage Renal Disease who have lost Part B coverage because of a successful kidney transplant while on Medicare (after 36 months).

Medicare Preferred Provider Organization (PPO) Plan

A type of Medicare Advantage Plan in which you pay less if you use doctors, hospitals and other health care providers that belong to the plan's network. You can use doctors, hospitals and providers outside of the network for an additional cost.

Medicare Prescription Drug Coverage (Part D)

Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

Medicare Prescription Drug Plan (Part D)

Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medicare Private Fee-For-Service (PFFS) Plan

A type of Medicare Advantage Plan (Part C) in which you can generally go to any doctor or hospital you could go to if you had Original Medicare if the doctor or hospital agrees to treat you. The plan determines how much it will pay doctors and hospitals and how much you must pay when you receive care. A PFFS Plan is very different than Original Medicare and you must follow the plan rules carefully when you go for health care services. When you're in a PFFS Plan, you may pay more or less for Medicare-covered benefits than in Original Medicare.

Medicare Savings Program

A Medicaid program that helps people with limited income and resources pay some or all their Medicare Part A and B premiums, deductibles and coinsurance.

Medicare SELECT

A type of Medigap policy that may require you to use hospitals, and in some cases, doctors within its network to be eligible for full benefits.

Medicare Special Needs Plan (SNP)

A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, like those who have both Medicare and Medical Assistance, who live in a nursing home or have certain chronic medical conditions. Minnesota has a SNP for people aged 65 and older who are eligible for Medical Assistance and enrolled in Medicare Parts A and B called Minnesota Senior Health Options (MSHO).

Medicare Summary Notice (MSN)

A notice you get after the doctor, other health care provider or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider or supplier billed for, the Medicare-approved amount, how much Medicare paid and what you must pay.

Medigap Basic Benefits

Benefits that all Medigap policies must cover, including Part A and Part B coinsurance amounts, blood and additional hospital benefits not covered by Original Medicare.

Medigap Open Enrollment Period

A one-time-only for most people, six-month period when federal law allows you to buy any Medigap policy you want that's sold in your state. In the state of Minnesota, this period starts the first month that you're covered under Part B. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems.

Medigap Policy

Medicare Supplement Insurance sold by private insurance companies to fill gaps in Original Medicare coverage.

Minnesota Insulin Safety Net Program

Created to help Minnesotans who face difficulty affording their insulin. The program has two parts. The urgent need program and the continuing need program. In the urgent need program people who are eligible can receive a 30-day supply of insulin immediately at their pharmacy for no more than \$35.00. In the continuing need program people who are eligible can receive up to a year supply of insulin for no more than \$50.00 per 90-day refill. For more information go to mninsulin.org.

Modified Adjusted Gross Income (MAGI)

Your adjusted gross income plus any tax-exempt Social Security, interest or foreign income you have.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Original Medicare

Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

Out-of-Network

A benefit that may be provided by your Medicare Advantage Plan. Generally, this benefit gives you the choice to get plan services from outside of the plan's network of health care providers. In some cases, your out-of-pocket costs may be higher for an out-of-network benefit.

Out-of-Pocket Costs

Health or prescription drug costs that you must pay on your own because they aren't covered by Medicare or other insurance.

Outpatient Hospital Care

Medical or surgical care you get from a hospital when your doctor hasn't written an order to admit you to the hospital as an inpatient. Outpatient hospital care may include emergency department services, observation services, outpatient surgery, lab tests or x-rays. Your care may be considered outpatient hospital care even if you spend the night at the hospital.

Penalty

An amount added to your monthly premium for Part B or a Medicare drug plan (Part D) if you don't join when you're first eligible. You pay this higher amount if you have Medicare. There are some exceptions.

Physical Therapy

Treatment of an injury or a disease by mechanical means, like exercise, massage, heat and light treatment.

Point-of-Service Option

In a Health Maintenance Organization (HMO), this option lets you use doctors and hospitals outside the plan for an additional cost.

Preferred Pharmacy

A pharmacy that's part of a Medicare drug plan's network. You pay lower out-of-pocket costs if you get your prescription drugs from a preferred pharmacy instead of a non-preferred pharmacy.

Premium

The periodic payment to Medicare, an insurance company or a health care plan for health or prescription drug coverage.

Preventive Services

Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include pap tests, flu shots and screening mammograms).

Primary Care Doctor

The doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Prior Authorization

Approval that you must get from a Medicare drug plan before you fill your prescription in order for the prescription to be covered by your plan. Your Medicare drug plan may require prior authorization for certain drugs.

Referral

A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Respite Care

Temporary care provided in a nursing home, hospice inpatient facility or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.

Secondary Payer

The insurance policy, plan or program that pays second on a claim for medical care. This could be Medicare, Medical Assistance or other insurance depending on the situation.

Service Area

A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Care

Care, such as certain intravenous injections, that can only be given by a registered nurse or doctor.

Skilled Nursing Facility (SNF)

A nursing facility with the staff and equipment to give skilled nursing care, and in most cases, skilled rehabilitative services and other related health services.

Skilled Nursing Facility Care

Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a SNF.

Social Security Credits

You qualify for Social Security benefits by earning Social Security credits when you work in a job and pay Social Security taxes. Social Security credits are based on the amount of your earnings. You can earn up to the maximum of four credits per year.

Speech-Language Therapy (Speech-Language Pathology Services)

Treatment that helps you strengthen or regain speech, language and swallowing skills.

State Health Insurance Assistance Program (SHIP)

A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Step Therapy

A coverage rule used by some Medicare Prescription Drug Plans that requires you to try one or more similar, lower cost drugs to treat your condition before the plan will cover the prescribed drug.

Supplemental Security Income (SSI)

A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind or age 65 and older. SSI benefits aren't the same as Social Security retirement or disability benefits.

Telemedicine

Medical or other health services given to a patient using a communications system (like a computer, phone or television) by a practitioner in a location different than the patient's.

Tiers

Most Medicare Part D plans offer tier-based pricing. This means that drugs are grouped into categories called tiers. The cost of the drugs varies by tier. In general, a drug in a lowered number tier will cost you less than a drug in a higher numbered tier.

TRICARE

A health care program for active-duty and retired uniformed services members and their families.

TRICARE FOR LIFE (TFL)

Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 and older, their eligible family members and survivors and certain former spouses.



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