

2019 Medicare Advantage Plan Comparison Chart for Monroe County. Prepared by Lifespan 585-287-6413.

	EXCELLUS BLUE CHOICE PLANS				
BENEFIT	Phone: 800-659-1986 (Excellus Plans are Accepted at all Local Hospitals)				
	Select (HMO)	Advanced (HMO-POS)	Value (HMO)	Value Plus (HMO-POS)	Optimum (HMO-POS)
Medicare Star Rating (5 Stars Max.)	4.5	New Plan	4.5	4.5	4.5
Monthly Premium	\$0	\$35	\$74	\$152	\$250.40
Hospitalization - Inpatient	\$370/day days 1-5 >5 days @ \$0 (\$315 days 1-5 Mentl Health)	\$360/day days 1-5 >5 days @ \$0 (\$315 days 1-5 Mentl Health)	\$360/day days 1-5 >5 days @ \$0 (\$315 days 1-5 Mentl Health)	\$310/day days 1-5 >5 days @ \$0	\$285/day days 1-5 >5 days @ \$0
Hospital - Observation	20%	\$600	\$500	\$400	\$250
Skilled Nursing Facility for Rehab	Days 1-20 @ \$0 Days 21-100 \$172/day	Days 1-20 @ \$0 Days 21-100 \$172/day	Days 1-20 @ \$0 Days 21-100 \$172/day	Days 1-20 @ \$0 Days 21-100 \$172/day	Days 1-20 @ \$0 Days 21-100 \$172/day
Primary Care Physician / Specialist	\$15 / \$50	\$15 / \$50	\$10 / \$50	\$10 / \$45	\$10 / \$40
Chiropractic (Spinal Manipulation)	\$13	\$14	\$9	\$9	\$10
Outpatient - Hospital / Surgical Facil.	20% / 20%	\$600 / \$600	\$500 / \$500	\$400 / \$400	\$250 / \$250
Outpatient - Mental Health	20% (May Need Prior Auth.)	20% (May Need Prior Auth.)	20% (May Need Prior Auth.)	20% (May Need Prior Auth.)	20% (May Need Prior Auth.)
Ambulance	\$225	\$225	\$225	\$200	\$150
Emergency-Worldwide / Urgent-in US	\$90 / \$65	\$90 / \$50	\$90 / \$40	\$90 / \$40	\$90 / \$40
Durable Med Equip. & Prosthetics	20%	20%	20%	20%	20%
Diagnostic: Lab / Other Procedures	\$15	\$15	\$12	\$12	\$0
X - Rays (Standard)	\$55	\$50	\$50	\$50	\$40
Diag. Radiology (MRI, CT, PET, etc.)	20%	20%	20%	\$175	\$150
Radiation Therapy (co-pay may apply)	20%	20%	20%	20%	20%
Renal Dialysis -Office co-pay may apply	20%	20%	20%	20%	20%
Part B Drugs & Chemotherapy	20%	20%	20%	20%	20%
Part D Prescription Drug Retail Co-Pays (30 day supply - Discounts for mailorder)	\$0/\$15/\$47/\$100/26% (\$360 Deduct. Tiers 3-5)	\$0/\$15/\$47/\$100/27% (\$300 Deduct. Tiers 3-5)	\$0/\$15/\$47/\$100/28% (\$225 Deduct. Tiers 3-5)	\$0/\$15/\$47/\$100/33% (No Deductible)	\$0/\$12/\$47/\$100/33% (No Deductible)
Diabetic Monitoring Supplies	\$5 / 30 days @ Pref. Suppliers	\$5 / 30 days @ Pref. Suppliers	\$5 / 30 days @ Pref. Suppliers	\$5 / 30 days @ Pref. Suppliers	\$5 / 30 days @ Pref. Suppliers
Dental Coverage	No Coverage	\$0 copay up to Allowed Preventive Fee Schedule	\$0 copay up to Allowed Preventive Fee Sched.	\$0 copay up to Allowed Preventive Fee Sched.	\$0 copay up to Allowed Preventive Fee Sched.
Hearing Exam / Hearing Aid Allow.	\$45 Routine / \$50 Diagnos. \$699 or \$999 copay for Aid	\$45 Routine / \$50 Diagnos. \$699 or \$999 copay for Aid	\$45 Routine / \$50 Diagnos. \$699 or \$999 copay for Aid	\$45 Routine / \$50 Diagnos. \$699 or \$999 copay for Aid	\$45 Routine / \$50 Diagnos. \$699 or \$999 copay for Aid
Routine Vision Exam / Glasses Allow.	\$50 Exam / No Allow.	\$0 Exam / \$50 Allow./yr	\$50 Exam / \$75 Allow.	\$45 / \$75 Allow./yr	\$40 / \$120 Allow./yr.
Health Clubs / Wellness Programs	\$25/yr Silver & Fit \$150 Allow. For Non-Partic.	\$25/yr Silver & Fit \$150 Allow. For Non-Partic.	\$25/yr Silver & Fit \$150 Allow. For Non-Partic.	\$25/yr Silver & Fit \$150 Allow. For Non-Partic.	\$25/yr Silver & Fit \$150 Allow. For Non-Partic.
Travel Benefits - Out of Network	Emergency Only	30% co-pay (OoN) (\$3000 Max Benefit)	Emergency Only	30% co-pay (OoN) (\$3000 Max Benefit)	30% co-pay (OoN) (\$3000 Max Benefit)
Maximum Out of Pocket Expense (After which Plan pays 100%) Excludes premiums, drugs and uncovered costs	\$6,700	\$6,700 In Network	\$6,700	\$6,700 In Network	\$6,700 In Network

Note: The information provided is current as of Oct. 8, 2018. Please refer to documents provided by each plan for the most detailed and up-to-date information.

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BENEFIT	MVP HEALTH CARE Plans Phone: 800-324-3899			WELLCARE VALUE HMO
	(MVP Plans are Accepted at all Local Hospitals)			Phone: 866-527-0056
	Gold Secure HMP-POS	WellSelect PPO	Preferred Gold HMO-POS	URMC Hospitals Not In Network
Medicare Star Rating (5 Stars Max.)	4.5	4.5	4.5	TBD 2019. 3 in 2018
Monthly Premium	\$25.00	\$73.00	\$196.50	\$58/mo. w/ \$125 Deductible
Hospitalization - Inpatient	Days 1-5 @ \$350/day >5 days @ \$0 Mental Health Hosp. Days 1-3 @ \$495 > 3 Days @ \$0	Days 1-5 @ \$350 (\$315 Mentl. Hlth.) >5 days @ \$0 (IN Network) 40% (Out of Network)	Days 1-5 @ \$350/day > 5 days @ \$0 Mental Hlth. Hosp. Days 1-5 @ \$295 >5 Days @ \$0	Days 1-3 @ 575/ day >3 days @ \$0 Mental Hlth Days 1-4 @ \$405/day > 4 days @ \$0
Hospital - Observation	\$300/Stay	\$300 (IN) - 40% (OUT)	\$300/Stay	\$90 via Emergency - 20% Otherwise
Skilled Nursing Facility for Rehab	Days 1-20 @ \$0 Days 21-100 \$172/day	(IN) Days 1-20 @ \$0 Days 21-100 \$172/day (OUT) 40%	Days 1-20 @ \$0 Days 21-100 \$172/day	Days 1-20 @ \$0 Days 21-100 \$164.50/day
Primary Care Physician / Specialist	\$15 / \$50	\$15 / \$50 (IN) - \$60 / \$60 (OUT)	\$15 / \$40	\$5 / \$40
Chiropractic (Spinal Manipulation)	\$20	\$20 (IN) - \$20 (OUT)	\$20 (50% for Acupuncture)	\$0 for Unlimited Visits
Outpatient - Hospital / Surgical Facil.	\$400 / \$300	\$400/\$300 (IN)- 40% OUT	\$300 / \$150	20% / \$100
Outpatient - Mental Health	\$40 (Need Authorization)	\$40 (In) - \$60 (Out) (Need Authoriz.)	\$40 (Need Authorization)	\$40
Ambulance	\$200	\$200	\$150	\$200
Emergency-Worldwide / Urgent-in US	\$90 / \$65	\$90 / \$50	\$90 / \$50	\$90 / \$25
Durable Med Equip. & Prosthetics	20%	20% (IN) - 40% (OUT)	20%	20%
Diagnostic: Lab / Other Procedures	\$10 / \$20	\$10 / \$20 (IN) - 40% (OUT)	\$10 / \$10	\$0 / \$20 or \$50
X - Rays (Standard)	\$60	\$60 (IN) - \$60 (OUT)	\$40	\$0
Diag. Radiology (MRI, CT, PET, etc.)	\$150	\$100 (IN) - 40% (OUT)	\$100	\$150
Radiation Therapy (co-pay may apply)	20%	20% (IN) - 40% (OUT)	20%	\$45 or 20% at Hospital
Renal Dialysis -Office co-pay may apply	20%	20% (IN) - 20% (OUT)	20%	20%
Part B Drugs & Chemotherapy	20%	20% (IN) - 40% (OUT)	20%	20%
Part D Prescription Drug Retail Co-Pays (30 day supply - Discounts for mailorder)	\$1/\$12/\$47/27%/25% \$400 Deductible for Tiers 3-5	\$1/\$12/\$47/27%/25% (\$400 Deductible for Tiers 3-5)	\$0/\$10/\$40/27%/33% (No Drug Deductible)	\$0/\$12/\$47/48%/33% (No Drug Deductible)
Diabetic Monitoring Supplies	10% Preferred Supplier 20% Others (w/Authoriation)	10% or 20% w/Authorization (IN) 40% (OUT)	10% Preferred Supplier 20% Others (w/Authoriation)	20%
Dental Coverage	Separate Policy Available for Additional \$17.34/mo.	\$240 Prevention Allowance	\$300 / yr Allowance for any Dental Service	\$500 Comprehensive Allowance
Hearing Exam / Hearing Aid Allow.	\$20 Routine / \$50 Diagnostic \$699 or \$999 copay for Aid	Exam \$20 or \$50 (IN) - \$60 (OUT) / \$699 or \$999 copay for Aid	\$20 Routine / \$40 Diagnostic \$499 or \$799 copay for Aid	Routine Exam \$0 / \$40 Diagnostic \$350 Allowance for 1 Aid
Routine Vision Exam / Glasses Allow.	\$20 / No glasses Allowance	\$20 (IN) - \$60 (OUT)/No Glasses	\$20 / \$175 Glasses / 2 yrs	\$0 / \$100 Glasses Allowance
Health Clubs / Wellness Programs	\$0 for Silver Sneakers Plus \$75 Wellness Reward	\$0 for Silver Sneakers Plus \$75 Wellness Reward	\$0 for Silver Sneakers Plus \$75 Wellness Reward	\$0 for Silver Sneakers
Travel Benefits - Out of Network	30% copay Out of Netwrk (\$2500 Maximum Benefit)	\$60 Office Visit Out of Network 40% of Other OoN Costs	30% copay Out of Network (\$4000 Maximum Benefit)	Emergency Only
Maximum Out of Pocket Expense (After which Plan pays 100%) Excludes premiums, drugs and uncovered costs	\$6700 In Network	\$6,700 (IN) \$10,000 (IN and OUT)	\$6700 In Network	\$6,700

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	AETNA PLANS Phone: 833-859-6031 (RRH Hospitals not in Network)	WELLCARE PLANS - 866-527-0056 (URMC Hospitals not in Network)		
BENEFIT	Premier PPO Plan	Elite PPO Plan	Wellcare Today's Option	Wellcare Today's Option
		* \$1000 Deduct. for Major & OoN Items	Advantage Plus 550B PPO	Advantage Plus 150A PPO
Medicare Star Rating (5 Stars Max.)	4	4	4	4
Monthly Premium	\$42.00	\$0 (* With Deductibles)	\$10.60	\$140.00
Hospitalization - Inpatient	(IN) Days 1-5 @\$360/da. >5 days @ \$0 (OUT) Days 1-5 @\$360/da. >5 da. @ \$0 (IN) Mntl Hlth \$1528 /Stay - (OUT) 20%	* (IN) \$650/ Stay - (OUT) \$650/ Stay * (IN) Mntl. Hlth. \$1528/Stay - (OUT) 20%	(IN) Days 1-5 \$295 /day; Then \$0 (URMC Hospitals not in Ntwrk) (OUT) Days 1-7 \$300 /da;Then \$0	(IN) \$500 per STAY (URMC Hospitals. not in Ntwrk.) (OUT) Days 1-7 \$300/da.;Then \$0
Hospital - Observation	\$40 + Copays to \$350 (IN) - \$350 (OUT)	* \$40 + Copays to \$300 (IN) - \$350 (OUT)	\$90 or \$300 (IN) - 30% (OUT)	\$120 or \$200 (IN) - 30% (OUT)
Skilled Nursing Facility for Rehab	(IN) Days 1-20 @ \$0 (IN) Days 21-100 @\$172/day (OUT) @20%	(IN) Days 1-20 @ \$0/day * (IN) Days 21-100 @\$172/day (OUT) @20%	(IN and Out) Days 1-20 @ \$0/day (IN) Days 21-100 @\$165 /day (OUT) Days 21- 100 @ \$250/day	(IN and OUT) Days 1-20 @ \$0 (IN) Days 21-100 @ \$150/Day (OUT) Days 21-100 @ \$200 / Day
Primary Care Physician / Specialist	\$15 / \$40 (IN) - \$40 / 20% (OUT)	\$15 / \$40 (IN) - \$45 / \$45 (OUT)	\$10 / \$35 (IN) - \$25 / \$60 (OUT)	\$0 / \$25 (IN) - \$10 / \$35 (OUT)
Chiropractic (Spinal Manipulation)	\$20 (IN) - 20% (OUT)	\$20 (IN) - 20% (OUT)	\$20 (IN) - 30% (OUT)	\$20 (IN) - 30% (OUT)
Outpatient - Hospital / Surgical Facil.	\$350 (IN) - \$350 (OUT)	* \$300 (IN) - \$350 (OUT)	\$300 / \$250 (IN) - 30% (OUT)	\$200 / \$150 (IN) - 30% (OUT)
Outpatient - Mental Health	\$40 (IN) - 20% (OUT)	\$40 (IN) - 20% (OUT)	\$40 (IN) - 30% (OUT)	\$30 (IN) - 30% (OUT)
Ambulance	\$265 (IN & OUT)	\$230 (IN & OUT)	\$300 (IN & OUT)	\$300 (IN & OUT)
Emergency-Worldwide / Urgent-in US	\$90 / \$40	\$90 / \$40	\$90 / \$35	\$120 / \$35
Durable Med Equip. & Prosthetics	20% (IN) - 20% (OUT)	20% (IN) - (20% (OUT)	20% (IN) - 30% (OUT)	20% (IN) - 30% (OUT)
Diagnostic: Lab / Other Procedures	\$5 / \$40 (IN) - \$10 / 20% (OUT)	\$0 / \$40 (IN) - \$20 / 20% (OUT)	\$0 / \$0 (IN) - 30% (OUT)	\$0 / \$0 (IN) - 30% (OUT)
X - Rays (Standard)	\$50 (IN) - 20% (OUT)	\$50 (IN) - 20% (OUT)	\$15 (IN) - 30% (OUT)	\$15 (IN) - 30% (OUT)
Diag. Radiology (MRI, CT, PET, etc.)	\$250 (IN) - 20% (OUT)	20% (IN) - 20% (OUT)	\$100 to \$200 (IN) - 30% (OUT)	\$100 to \$200 (IN) - 30% (OUT)
Radiation Therapy (co-pay may apply)	20% (IN) - 20% (OUT)	* 20% (IN) - 20% (OUT)	20% (IN) - 30% (OUT)	20% (IN) - 30% (OUT)
Renal Dialysis -Office co-pay may apply	20% (IN) - 20% (OUT)	* 20% (IN) - 20% (OUT)	20% (IN) - 30% (OUT)	20% (IN) - 30% (OUT)
Part B Drugs & Chemotherapy	20% (IN) - 20% (OUT)	20% (IN) - 20% (OUT)	20% (IN) - 30% (OUT)	20% (IN) - 30% (OUT)
Part D Prescription Drug Retail Co-Pays (30 day supply - Discounts for mailorder)	\$2/\$5/\$47/\$100/29% At Preferred Pharmacies (\$195 Drug Deductible Tiers 3-5)	\$2/\$5/\$47/\$100/29% At Preferred Pharmacies (\$195 Drug Deductible Tiers 3-5)	\$2/\$7/\$37/\$90/33% (At Preferred Pharmacies) (No Deductible)	\$0/\$5/\$35/\$75/33% (At Preferred Pharmacies) (No Deductible)
Diabetic Monitoring Supplies	\$0 - @ OneTouch / Lifescan 20% Other Suppliers (w/ Exception)	\$0 - @ OneTouch / Lifescan 20% Other Suppliers (w/ Exception)	\$0 (IN) - 30% (OUT)	\$0 (IN) - 30% (OUT)
Dental Coverage	\$350 Comprehensive Allowance at Any dentist	Optional Dental Rider Available for \$21/mo. (\$1000 Max Benefit)	\$0 to 20% copay (IN) 20%-40% w/ \$100 Deductible (OUT) \$500/yr. Maximum benefit	\$0 to 20% copay (IN) 20%-40% w/ \$100 Deductible (OUT) \$500/yr. Maximum benefit
Hearing Exam / Hearing Aid Allow.	Routine Exam \$0 (IN) - 20% (OUT) No Hearing Aid Allowance	Routine Exam \$0 (IN) - \$45 (OUT) \$500 /yr Hearing Aid Allowance	Exam \$0 (IN) - 50% (OUT) \$750 Aid Allowance	Exam \$0 (IN) - 50% (OUT) \$750 Aid Allowance
Routine Vision Exam / Glasses Allow.	\$0 (IN) / 20% (OUT) - \$125 Allow./yr.	\$0 (IN) / 20% (OUT)- \$200 Allow. / yr	\$0 (IN) - 30% (OUT) / \$100 Allow.	\$0 (IN) - 30% (OUT) / \$100 Allow.
Health Clubs / Wellness Programs	\$0 Silver Sneakrs @ Participating Health Clubs	\$0 Silver Sneakrs @ Participating Health Clubs	\$0 Silver Sneakers \$25 OTC Allowance \$0 Medical Alert Sys.	\$0 Silver Sneakers \$10 OTC Allowance \$0 Medical Alert Sys.
Travel Benefits - Out of Network	Aetna Explorer Plan or the Plan's Out of Network Rates	Aetna Explorer Plan or the Plan's Out of Network Rates	The Plan's Out of Network Rates	The Plan's Out of Network Rates
Maximum Out of Pocket Expense (After which Plan pays 100%) Excludes premiums, drugs and uncovered costs	\$6,700 (IN) \$10,000 (IN & OUT Combined)	\$6,700 (IN) \$10,000 (IN & OUT Combined)	\$6,700 (IN) \$6700 (IN) & (OUT) Combined	\$3,400 (IN) \$3,400 (IN) & (OUT) Combined

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2019 Medicare Advantage Plan Comparison Chart for Monroe County. Prepared by Lifespan 585-287-6413.

BENEFIT	UNITED HEALTH CARE PLANS (Accepted at all Local Hospitals) Phone: 800-555-5757			
	AARP Medicare Complete HMO	Complete Choice PPO Plan 1 (IN) and (OUT) of Network Costs	Complete Choice PPO Plan 3 (IN) and (OUT) of Network Costs	Complete Choice PPO Plan 4 (IN) and (OUT) of Network Costs
Medicare Star Rating (5 Stars Max.)	3.5	3.5	3.5	3.5
Monthly Premium	\$0	\$16	\$46 / mo.	\$76 / mo.
Hospitalization - Inpatient	\$415/day, days 1-4 >4 days @ \$0	(IN) Days 1-4 @ \$395 / Day; > 4 days @ \$0 (OUT) Days 1-20 @ \$500 / day; >20 days @ \$0	(IN) Days 1-4 @ \$360 / Day; > 4 days @ \$0 (OUT) Days 1-20 @ \$500/ day; >20 days @ \$0	(IN) Days 1-4 @ \$295 / Day; > 4 days @ \$0 (OUT) Days 1-20 @ \$500/ day; >20 days @ \$0
Hospital - Observation	\$415 / Day	\$325 /Day (IN) - 40% (OUT)	\$295 /day (IN) - 40% (OUT)	\$250 /day (IN) - 40% (OUT)
Skilled Nursing Facility for Rehab	Days 1-20 @ \$0 Days 21-62 @ \$160/day Days 63-100 @ \$0/day	(IN) Da. 1-20 @\$0 - (OUT) Da. 1-40 @\$250/day (IN) Da. 21-62 @ \$160 / Day (IN) Da. 63-100 @ \$0 - (OUT) >Da. 41-100 @\$0	(IN) Da. 1-20 @\$0 - (OUT) Da. 1-40 @\$250/day (IN) Da. 21-62 @ \$160 / Da (IN) Da. 63-100 @ \$0 - (OUT) >Da. 41-100 @\$0	(IN) Da. 1-20 @\$0 - (OUT) Da. 1-40 @\$250/day (IN) Da. 21-54 @ \$160/Da (IN) Da. 55-100 @ \$0 - (OUT) >Da. 41-100 @\$0
Primary Care Physician / Specialist	\$15 / \$50	\$10 / \$45 (IN) - \$50 / \$75 (OUT)	\$10 / \$35 (IN) - \$50 / \$75 (OUT)	\$5 / \$30 (IN) - \$50 / \$75 (OUT)
Chiropractic (Spinal Manipulation)	\$20	\$20 (IN) - \$75 (OUT)	\$20 (IN) - \$75 (OUT)	\$20 (IN) - \$75 (OUT)
Outpatient - Hospital / Surgical Facil.	\$415	\$325 (IN) - 40% (OUT)	\$295 (IN) - 40% (OUT)	\$250 (IN) - 40% (OUT)
Outpatient - Mental Health	\$40 or \$30	\$40 or \$30 (IN) - \$45 or \$35 (OUT)	\$40 or \$30 (IN) - \$45 or \$35 (OUT)	\$40 or \$30 (IN) - \$45 or \$35 (OUT)
Ambulance	\$250	\$250	\$250	\$250
Emergency-Worldwide / Urgent-in US	\$90 / \$30 (IN) \$40 (OUT)	\$90 / \$30 (IN) - \$90 / \$40 (OUT)	\$90 / \$30 (IN) - \$90 / \$40 (OUT)	\$90 / \$30 (IN) - \$90 / \$40 (OUT)
Durable Med Equip. & Prosthetics	20%	20% (IN) - 50% & 40% (OUT)	20% (IN) - 50% & 40% (OUT)	20% (IN) - 50% & 40% (OUT)
Diagnostic: Lab / Other Procedures	\$7/ 20%	\$10 / 20% (IN) - \$10 / 40% (OUT)	\$10 / 20% (IN) - \$10 / 40% (OUT)	\$10 / 20% (IN) - \$10 / 40% (OUT)
X - Rays (Standard)	\$14	\$14 (IN) - \$21 (OUT)	\$14 (IN) - \$21 (OUT)	\$14 (IN) - \$21 (OUT)
Diag. Radiology (MRI, CT, PET, etc.)	20%	20% (IN) - 40% (OUT)	20% (IN) - 40% (OUT)	20% (IN) - 40% (OUT)
Radiation Therapy (co-pay may apply)	20%	20% (IN) - 40% (OUT)	20% (IN) - 40% (OUT)	20% (IN) - 40% (OUT)
Renal Dialysis -Office co-pay may apply	20%	20% (IN) - 20% (OUT)	20% (IN) - 20% (OUT)	20% (IN) - 20% (OUT)
Part B Drugs & Chemotherapy	20%	20% (IN) - 40% (OUT)	20% (IN) - 40% (OUT)	20% (IN) - 40% (OUT)
Part D Prescription Drug Retail Co-Pays (30 day supply - Discounts for mailorder)	\$3/\$12/\$47/\$100/25% (\$395 Deductible Tiers 3-5) Limited OoN Pharm, Cvrq.	\$3/\$12/\$47/\$100/26% (\$350 Deductible Tiers 3-5) Limited Out of Network Pharm. Coverage	\$3/\$12/\$47/\$100/27% (\$275 Deductible Tiers 3-5) Limited Out of Network Pharm. Coverage	\$3/\$12/\$47/\$100/30% (\$150 Deductible Tiers 3-5) Limited Out of Network Pharm. Coverage
Diabetic Monitoring Supplies	\$0 for Specific Brands	\$0 for Specific Brands (IN) - 40%(OUT)	\$0 for Specific Brands (IN) - 40%(OUT)	\$0 for Specific Brands (IN) - 40%(OUT)
Dental Coverage	\$39 /mo for Dental Rider \$1000 Max Benefit \$100 Deductible	Optional \$39 / mo. for a Dental Rider (with \$100 Deductible and \$1000 Max Benefit)	Preventive Allow 2x / yr. \$0 (IN) - 50% (OUT) Optional \$32 / mo. for a Dental Rider (w/ \$100 Deductible and \$1000 Max Benefit)	Preventive Allow 2x / yr. \$0 (IN) - 50% (OUT) Optional \$32 / mo. for a Dental Rider (w/ \$100 Deductible and \$1000 Max Benefit)
Hearing Exam / Hearing Aid Allow.	\$15 Exam \$330-\$380 copay for Aid	\$10 Exam (IN) / \$75 Exam (OUT) \$300 - \$2025 copay on Aid per yr.	\$10 Exam (IN) / \$75 Exam (OUT) \$300 - \$2025 copay on Aid per yr.	\$5 Exam (IN) / \$75 Exam (OUT) \$300 - \$2025 copay on Aid per yr.
Routine Vision Exam / Glasses Allow.	\$0 Exam / No Glasses	\$20 (IN) - \$75 (OUT) / No Glasses	\$20 (IN) - \$75 (OUT) / No Glasses	\$20 (IN) - \$75 (OUT) / No Glasses
Health Clubs / Wellness Programs	\$0 for Renew Active Fitness Program	\$0 (IN) for Renew Active Fitness Program	\$0 (IN) for Renew Active Fitness Program	\$0 (IN) for Renew Active Fitness Program
Travel Benefits - Out of Network	Passport Program	Passport Program or Out of Network Rates	Passport Program or Out of Network Rates	Passport Program or Out of Network Rates
Maximum Out of Pocket Expense (After which Plan pays 100%) Excludes premiums, drugs and uncovered costs	\$6,700	\$6,700 (IN Network) \$10,000 (IN & (OUT) Combined	\$6,700 (IN Network) \$10,000 (IN & (OUT) Combined	\$6,700 (IN Network) \$10,000 (IN & (OUT) Combined

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