

2020 Medicare Advantage Plan Comparison Chart for Monroe County. Prepared by Lifespan. 585-287-6413.

	EXCELLUS BLUE CHOICE PLANS				
BENEFIT	Phone: 888-529-1386 (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	4	4	4	4
Monthly Premium	\$0	\$39	\$79	\$157	\$255.00
Hospitalization - Inpatient	\$380/day days 1-5 >5 days @ \$0 <i>(\$315 days 1-5 Mental Health)</i>	\$360/day days 1-5 >5 days @ \$0 <i>(\$315 days 1-5 Mental Health)</i>	\$360/day days 1-5 >5 days @ \$0 <i>(\$315 days 1-5 Mental Health)</i>	\$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 (May Need Authorization)	Days 1-20 @ \$0 Days 21-100 @ \$178/day	Days 1-20 @ \$0 Days 21-100 @ \$178/day	Days 1-20 @ \$0 Days 21-100 @ \$178/day	Days 1-20 @ \$0 Days 21-100 @ \$178/day	Days 1-20 @ \$0 Days 21-100 @ \$178/day
Primary Care Physician / Specialist	\$15 / \$50	\$15 / \$50	\$10 / \$50	\$10 / \$45	\$10 / \$40
Chiropractic (Spinal Manipulation)	\$15	\$15	\$10	\$10	\$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	\$250	\$225	\$225	\$200	\$150
Emergency / Urgent Care (Worldwide)	\$90 / \$45	\$90 / \$45	\$90 / \$40	\$90 / \$40	\$90 / \$40
Durable Med Equip.; Dialysis; and Part B Drugs (20% (IN) in all Plans)	20%	20%	20%	20%	20%
Diagnostic: Lab / Other Procedures	\$12	\$12	\$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%
Part D Prescription Drug Retail Co-Pays (30 day supply)	\$0/\$15/\$42/\$95/26% (At Preferred Pharmacies) (\$380 Deduct. Tiers 3-5)	\$0/\$15/\$42/\$95/27% (At Preferred Pharmacies) (\$300 Deduct. Tiers 3-5)	\$0/\$15/\$42/\$95/29% (At Preferred Pharmacies) (\$225 Deduct. Tiers 3-5)	\$0/\$15/\$42/\$95/33% (At Preferred Pharmacies) (No Deductible)	\$0/\$12/\$42/\$95/33% (At Preferred Pharmacies) (No Deductible)
Diabetic Monitoring Supplies	\$5 /30 days @ Pref. Suppliers (Insulin 20% via Pump)	\$5 /30 days @ Pref. Suppliers (Insulin 20% via Pump)	\$5 /30 days @ Pref. Suppliers (Insulin 20% via Pump)	\$5 /30 days @ Pref. Suppliers (Insulin 20% via Pump)	\$5 /30 days @ Pref. Suppliers (Insulin 20% via Pump)
Dental Coverage	Optional Rider for \$39/mo. \$100 Deduc/\$1000 Max Benef.	\$0 copay 2 Preventive Visits Optional Rider for \$29/mo. (\$100 Deduc/\$1000 Max Benef)	\$0 copay 2 Preventive Visits Optional Rider for \$29/mo. (\$100 Deduc/\$1000 Max Benef)	\$0 copay 2 Preventive Visits Optional Rider for \$29/mo. (\$100 Deduc/\$1000 Max Benef)	\$0 copay 2 Preventive Visits Optional Rider for \$29/mo. (\$100 Deduc/\$1000 Max Benef)
Routine 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 / \$45 Diagnos. \$699 or \$999 copay for Aid	\$45 Routine / \$40 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./yr	\$45 Exam / \$75 Allow./yr	\$40 Exam / \$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%) <small>Excludes premiums, drugs and uncovered costs</small>	\$6,700 In Network	\$6,700 In Network	\$6,700 In Network	\$6,700 In Network	\$6,700 In Network
Note: Current as of Oct 11, 2019. Please refer to documents provided by each plan for the most detailed, up-to-date information					
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2020 Medicare Advantage Plan Comparison Chart for Monroe County. Prepared by Lifespan. 585-287-6413.

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 HMO-POS	WellSelect PPO	Preferred Gold HMO-POS	(URMC Hospitals Not In Network)
Medicare Star Rating (5 Stars Max.)	4	4.5	4	TBD for 2020
Monthly Premium	\$25.00	\$79.00	\$210.00	\$58/mo.
Hospitalization - Inpatient	Days 1-5 @ \$365/day >5 days @ \$0 Mental Health Hosp. Days 1-3 @ \$495 > 3 Days @ \$0	Days 1-5 @ \$350 >5 days @ \$0 (IN Network) 40% (Out of Network)	Days 1-5 @ \$350/day > 5 Days @ \$0	Days 1-3 @ \$575/ day >3 days @ \$0
Hospital - Observation	\$325 / Stay	\$300 / Stay (IN) - 40% (OUT)	\$300 / Stay	\$90 via ER - 20% Otherwise
Skilled Nursing Facility for Rehab (May Need Authorization)	Days 1-20 @ \$0 Days 21-100 \$178/day	(IN) Days 1-20 @ \$0 Days 21-100 \$178/day (OUT) 40%	Days 1-20 @ \$0 Days 21-100 \$178/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	\$0 / \$50
Chiropractic (Spinal Manipulation)	\$20	\$15 (IN) - \$20 (OUT)	\$20	\$0 for Unlimited Visits
Outpatient - Hospital / Surgical Facil.	\$425 / \$325	\$400/\$300 (IN)- 40% OUT	\$300 / \$200	20% / \$100
Outpatient - Mental Health	\$40 (Need Authorization)	\$40 (In) - \$60 (Out) (Need Authoriz.)	\$40 (Need Authorization)	\$40
Ambulance	\$200	\$200	\$150	\$300
Emergency / Urgent Care (Worldwide)	\$90 / \$65	\$90 / \$55	\$90 / \$50	\$90 / \$25 US - \$90 WW
Durable Med Equip.; Dialysis; and Part B Drugs (20% (IN) in all Plans)	20%	20% (IN) - 40% (OUT) Dialysis: 20% (IN) - 20% (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%	\$50 or 20% if at Hospital
Part D Prescription Drug Retail Co-Pays (30 day supply - Discounts for mailorder)	\$0/\$12/\$47/25%/25% (\$350 Deductible for Tiers 3-5)	\$0/\$12/\$47/25%/25% (\$300 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/ Authorization)	10% or 20% (w/ Authorization) (IN) 40% (OUT)	10% Preferred Supplier 20% Others (w/ Authorization)	20%
Dental Coverage	\$120/ yr. Preventive Allowance Optional \$17.34 rider with \$100 Deduc. & \$1000 Max Benefit	\$240/ yr. Preventive Allowance Optional \$17.34 rider with \$100 Deduc. & \$1000 Max Benefit	\$300/ yr. Comprehensive Allowance Optional \$17.34 rider with \$100 Deduc. & \$1000 Max Benefit	\$0 (IN) - 20% (Out) for 2X/yr Preventive \$500/yr. Max. Comprehensive Benefit
Routine Hearing Exam / Hearing Aid Allow.	Exam: \$20 Routine / \$50 Diagnostic \$699 or \$999 copay for Aid	Exam \$20 or \$50 (IN) - \$60 (OUT) / \$699 or \$999 copay for Aid	Exam: \$20 Routine / \$40 Diagnostic \$499 or \$799 copay for Aid	Routine Exam \$0 / \$50 Diagnostic \$350 Allowance for 1 Aid
Routine Vision Exam / Glasses Allow.	\$20 Exam/ No glasses Allowance	Exam: \$20 (IN) - \$60 (OUT)/ No Glasses Allowance	\$20 Exam/ \$175 Glasses Allowance / yr.	\$0 Exam/ \$100 Glasses Allowance/ yr.
Health Clubs / Wellness Programs	\$0 for Silver Sneakers Plus \$100 WellBeing Reward	\$0 for Silver Sneakers Plus \$100 WellBeing Reward	\$0 for Silver Sneakers Plus \$100 WellBeing Reward	\$0 at Participating Health Clubs
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%) <small>Excludes premiums, drugs and uncovered costs</small>	\$6700 In Network	\$6,700 (IN) \$10,000 (IN and OUT)	\$6700 In Network	\$6700 In Network

Note: Current as of Oct 11, 2019. Please refer to documents provided by each plan for the most detailed, up-to-date information

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2020 Medicare Advantage Plan Comparison Chart for Monroe County. Prepared by Lifespan. 585-287-6413.

BENEFIT	AETNA PLANS 844-377-1719 (All Rochester Hosp. are In Network)		WELLCARE PLANS: 866-527-0056 (URMC Hospitals not in Network)	
	Premier PPO Plan	Elite PPO Plan	Wellcare Today's Option	Wellcare Today's Option
	(IN) and (OUT) of Ntwrk. Costs	* \$1000 Deduct. for Major & OoN Items	Advantage Plus 550B PPO	Advantage Plus 150A PPO
Medicare Star Rating (5 Stars Max.)	4.5	4.5	3.5	3.5
Monthly Premium	\$58.00	\$0 (* With Deductibles)	\$10.00	\$136.00
Hospitalization - Inpatient	(IN) Days 1-5 @\$390/da. >5 days @ \$0 (OUT) Days 1-5 @\$500/da. >5 da. @ \$0 (IN) Mntl Hlth \$1750 /Stay - (OUT) 20%	* (IN) \$700/ Stay - (OUT) \$500 days 1-5 * (IN) Mntl. Hlth. \$1750/Stay - (OUT) 20%	(IN) Days 1-6 \$325 /day; Then \$0 (URMC Hospitals not in Ntwrk) (OUT) Days 1-7 \$388 /da; Then \$0	(IN) \$600 per STAY (URMC Hospitals. not in Network.) (OUT) Days 1-7 \$350/da.; Then \$0
Hospital - Observation	\$350 (IN) - 20% (OUT)	* \$350 (IN) - 20% (OUT)	\$90 via ER or \$300 (IN) - 30% (OUT)	\$120 via ER or \$200 (IN) - 30% (OUT)
Skilled Nursing Facility for Rehab (May Need Authorization)	(IN) Days 1-20 @ \$0 (IN) Days 21-100 @\$178/day (OUT) @20%	(IN) Days 1-20 @ \$0/day * (IN) Days 21-100 @\$178/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 / \$45 (IN) - \$50 / \$60 (OUT)	\$20 / \$45 (IN) - \$50 / \$60 (OUT)	\$5 / \$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) - 20% (OUT)	* \$350 (IN) - 20% (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	\$270 (IN & OUT)	\$275 (IN & OUT)	\$285 (IN & OUT)	\$300 (IN & OUT)
Emergency / Urgent Care (Worldwide)	\$90 / \$45 in US; \$90 WW	\$90 / \$45 in US; \$90 WW	\$90 / \$35 US - \$90 WW	\$120 / \$35 US - \$120 WW
Durable Med Equip.; Dialysis; and Part B Drugs (20% (IN) in all Plans)	20% (IN) - 20% (OUT)	20% (IN) - (20% (OUT) * Dialysis subject to Deductible	20% (IN) - 30% (OUT)	20% (IN) - 30% (OUT)
Diagnostic: Lab / Other Procedures	\$5 / \$45 (IN) - 20% / 20% (OUT)	\$10 / \$45 (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.)	20% (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)
Part D Prescription Drug Retail Co-Pays (30 day supply - Discounts for mailorder)	\$0/\$5/\$47/\$100/27% At Preferred Pharmacies (\$300 Drug Deductible Tiers 3-5)	\$0/\$10/\$47/\$100/26% At Preferred Pharmacies (\$350 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 - for OneTouch / Lifescan 20% Other Suppliers (w/ Authoriz.)	\$0 - for OneTouch / Lifescan 20% Other Suppliers (w/ Authoriz.)	\$0 (IN) - 30% (OUT)	\$0 (IN) - 30% (OUT)
Dental Coverage	Optional Dental Rider for \$30/mo. \$2000/yr. Max. Benef.-\$50 Deduct.	Optional Dental Rider for \$30/mo. \$2000/yr. Max. Benef.-\$50 Deduct.	\$0 (IN) - 20% (Out) for 2X/yr Preventive \$500/yr. Max. Comprehensive Benefit	\$0 (IN) - 20% (Out) for 2X/yr Preventive \$500/yr. Max. Comprehensive Benefit
Routine Hearing Exam / Hearing Aid Allow.	Routine Exam \$0 (IN) - \$60 (OUT) \$1000 Aid Allow. w/ Optional Rider	Routine Exam \$0 (IN) - \$60 (OUT) \$1000 Aid Allow. w/ Optional Rider	Exam \$0 (IN) - 50% (OUT) \$1500 Aid Value for 2 Ears	Exam \$0 (IN) - 50% (OUT) \$1500 Aid Value for 2 Ears
Routine Vision Exam / Glasses Allow.	Exam: \$0 (IN) - 20% (OUT) \$200 Allow./yr. w/ Optional Rider	Exam: \$0 (IN) - 20% (OUT) \$200 Allow./yr. w/ Optional Rider	Exam: \$0 (IN) - 30% (OUT) / \$100 Glasses Allowance	Exam: \$0 (IN) - 30% (OUT) / \$100 Glasses Allowance
Health Clubs / Wellness Programs	\$0 Silver Sneakrs @ Participating Health Clubs	\$0 Silver Sneakrs @ Participating Health Clubs	\$0 at Particip. Health Clubs \$25/ mo. OTC Allowance \$0 Medical Alert Sys.	\$0 at Particip. Health Clubs \$25/ mo. OTC Allowance \$0 Medical Alert Sys.
Travel Benefits - Out of Network	Use Aetna Network in US or the Plan's Out of Network Rates	Use Aetna Network in US 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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2020 Medicare Advantage Plan Comparison Chart for Monroe County. Prepared by Lifespan. 585-287-6413.

	UNITED HEALTH CARE PLANS (Accepted at all Local Hospitals) Phone: 800-555-5757			
BENEFIT	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.)	4	4	4	4
Monthly Premium	\$0	\$16 / mo.	\$46 / mo.	\$79/ mo.
Hospitalization - Inpatient	\$390/day, days 1-5 >5 days @ \$0	(IN) Days 1-5 @ \$375 / Day; > 5 days @ \$0 (IN) Mental Health Days 1-4 @ \$375/ day (OUT) Days 1-20 @ \$500 / day; >20 days @ \$0	(IN) Days 1-5 @ \$360 / Day; > 5 days @ \$0 (IN) Mental Health Days 1-4 @ \$360/ day (OUT) Days 1-20 @ \$500/ day; >20 days @ \$0	(IN) Days 1-4 @ \$315 / Day; > 5 days @ \$0 (OUT) Days 1-20 @ \$500/ day; >20 days @ \$0
Hospital - Observation	\$390 / Day	\$325 /Day (IN) - 40% (OUT)	\$295 /day (IN) - 40% (OUT)	\$295 /day (IN) - 40% (OUT)
Skilled Nursing Facility for Rehab (May Need Authorization)	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	\$0 / \$45 (IN) - \$50 / \$75 (OUT)	\$0 / \$40 (IN) - \$50 / \$75 (OUT)	\$0 / \$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.	\$390	\$325 (IN) - 40% (OUT)	\$295 (IN) - 40% (OUT)	\$295 (IN) - 40% (OUT)
Outpatient - Mental Health	\$40 or \$30 (Group)	\$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 / Urgent Care (Worldwide)	\$90 / \$30 (IN) \$40-\$90 (OUT)	\$90 / \$30 (IN) - \$90 / \$40 US - \$90 WW (OUT)	\$90 / \$30 (IN) - \$90 / \$40 US - \$90 WW (OUT)	\$90 / \$30 (IN) - \$90 / \$40 US - \$90 WW (OUT)
Durable Med Equip.; Dialysis; and Part B Drugs (20% (IN) in all Plans)	20%	Medical Equip: 20% (IN) - 50% & 40% (OUT) Dialysis: 20% (IN) - 20% (OUT) Part B Drugs 20% (IN)-40% (OUT)	Medical Equip: 20% (IN) - 50% & 40% (OUT) Dialysis: 20% (IN) - 20% (OUT) Part B Drugs 20% (IN)-40% (OUT)	Medical Equip: 20% (IN) - 50% & 40% (OUT) Dialysis: 20% (IN) - 20% (OUT) Part B Drugs 20% (IN)-40% (OUT)
Diagnostic: Lab / Other Procedures	\$7/ \$30	\$10 / \$30 (IN) - \$10 / 40% (OUT)	\$10 / \$30 (IN) - \$10 / 40% (OUT)	\$10 / \$30 (IN) - \$10 / 40% (OUT)
X - Rays (Standard)	\$50	\$50 (IN) - \$50(OUT)	\$40 (IN) - \$40 (OUT)	\$30 (IN) - \$30 (OUT)
Diag. Radiology (MRI, CT, PET, etc.)	\$160	\$160 (IN) - 40% (OUT)	\$160 (IN) - 40% (OUT)	\$160 (IN) - 40% (OUT)
Radiation Therapy (co-pay may apply)	\$60	\$60 (IN) - 40% (OUT)	\$50 (IN) - 40% (OUT)	\$40 (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, Cvrg.	\$3/\$12/\$47/\$100/27% (\$300 Deductible Tiers 3-5) Limited Out of Network Pharm. Coverage	\$3/\$12/\$47/\$100/28% (\$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 Covered Brands	\$0 for Covered Brands (IN) 40%(OUT)	\$0 for Covered Brands (IN) 40%(OUT)	\$0 for Covered Brands (IN) 40%(OUT)
Dental Coverage	\$43 /mo for Optional Rider \$1000 Max Benefit	Preventive Allowance Included Optional \$38 / mo. for a Dental Rider and \$1000 Max Benefit	Preventive Allowance Included Optional \$38 / mo. for a Dental Rider and \$1000 Max Benefit	Preventive Allowance Included Optional \$38 / mo. for a Dental Rider and \$1000 Max Benefit
Routine Hearing Exam / Hearing Aid Allow.	\$0 Exam \$375-\$2075 copay for Aid	\$0 Exam (IN) / \$75 Exam (OUT) \$375 - \$2075 copay for Aid per yr.	\$0 Exam (IN) / \$75 Exam (OUT) \$375 - \$2075 copay for Aid per yr.	\$0 Exam (IN) / \$75 Exam (OUT) \$375 - \$2075 copay for Aid per yr.
Routine Vision Exam / Glasses Allow.	\$0 Exam / No Glasses	Exam: \$0 (IN) - \$75 (OUT) / (IN) \$0 for Std Lens \$100 Frame Allow	Exam: \$0 (IN) - \$75 (OUT) / \$0 for Std.Lenses, \$200 Frame Allow	Exam: \$0 (IN) - \$75 (OUT) / \$0 for Std.Lenses, \$300 Frame Allow
Health Clubs / Wellness Programs	\$0 for "Renew Active" Fitness Program at Participating Facilities	\$0 for "Renew Active" Fitness Program at Participating Facilities	\$0 for "Renew Active" Fitness Program at Participating Facilities	\$0 for "Renew Active" Fitness Program at Participating Facilities
Travel Benefits - Out of Network	UHC Passport Program	Use UHC In Network Providers or UNC Out of Network Rates	Use UHC In Network Providers or UNC Out of Network Rates	Use UHC In Network Providers or UNC Out of Network Rates
Maximum Out of Pocket Expense (After which Plan pays 100%) Excludes premiums, drugs and uncovered costs	\$6700 In Network	\$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
Note:Current as of Oct 11, 2019. Please refer to documents provided by each plan for the most detailed, up-to-date information				
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