BlueCross BlueShield Minnesota

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.

BlueCross BlueShield Minnesota

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

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

BlueCross BlueShield Minnesota

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 (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.

BlueCross BlueShield Minnesota

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

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/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	$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

BlueCross BlueShield Minnesota

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 (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.

BlueCross BlueShield Minnesota

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

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/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

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

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/all tiers

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 nurseline, $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

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, 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.
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.
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.

MINNESOTA
SENIOR LINKAGE LINE

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)

AARP Medicare Advantage from UnitedHealthcare

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)

AARP Medicare Advantage from UnitedHealthcare

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, Mahnomen, 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

MINNESOTA SENIOR LINKAGE LINE

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

AARP Medicare Advantage from UnitedHealthcare

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

MINNESOTA SENIOR LINKAGE LINE

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

AARP Medicare Advantage from UnitedHealthcare

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

Monthly Premium: $0

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)

AARP Medicare Advantage from UnitedHealthcare

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, Mahnomen, Marshall, Martin, Meeker, 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

MINNESOTA SENIOR LINKAGE LINE

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

AARP Medicare Advantage from UnitedHealthcare

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

MINNESOTA SENIOR LINKAGE LINE

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

AARP Medicare Advantage from UnitedHealthcare

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

MINNESOTA SENIOR LINKAGE LINE

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

AARP Medicare Advantage from UnitedHealthcare

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

Monthly Premium: $42.20

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, Mahnomen, 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% coinsuramce/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

MINNESOTA SENIOR LINKAGE LINE

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

AARP Medicare Advantage from UnitedHealthcare

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

Monthly Premium: $58

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 facilty, 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% coinsurace/ 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

MINNESOTA SENIOR LINKAGE LINE

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

AARP Medicare Advantage from UnitedHealthcare

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

Monthly Premium: $50

Plan Area: Aitkin, Becker, Beltrami, Benton, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomen, 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

MINNESOTA SENIOR LINKAGE LINE

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

AARP Medicare Advantage from UnitedHealthcare

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	
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/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	$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)

AARP Medicare Advantage from UnitedHealthcare

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

Monthly Premium: $90

Plan Area: Aitkin, Becker, Beltrami, Benton, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Grant, Hubbard, Itasca, Kanabec, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomen, 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/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	$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

MINNESOTA SENIOR LINKAGE LINE

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

AARP Medicare Advantage from UnitedHealthcare

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

Monthly Premium: $108

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 In-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

MINNESOTA SENIOR LINKAGE LINE

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

Plan Area: Becker, Beltrami, Big Stone, Clay, Clearwater, Hubbard, Lac qui Parle, Mahnomen, 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.

MINNESOTA SENIOR LINKAGE LINE

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, Mahnomen, Marshall, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Red Lake, Rock, Traverse, Wilkin Counties	
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/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 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.

MINNESOTA SENIOR LINKAGE LINE

Allina Health | Aetna Medicare Eagle (H3219-005)

Advantage PPO Plan

Enrollment: 833-206-8764
Service: 833-570-6671 • TTY: 711
AllinaHealthAetnaMedicare.com

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	
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 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, $500 annual allowance to pay for out-of-pocket dental, vision, and hearing costs, Routine Podiatry Services: $35 copay, 12 visits per year

Allina Health | Aetna Medicare SmartFit (H3219-008)

Advantage PPO Plan
Enrollment: 833-206-8764
Service: 833-570-6671 • TTY: 711
AllinaHealthAetnaMedicare.com

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 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. 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.

Allina Health | Aetna Medicare Plus (H3219-001)

Advantage PPO Plan

Enrollment: 833-206-8764

Service: 833-570-6671 • TTY: 711

AllinaHealthAetnaMedicare.com

Monthly Premium: $0

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:** $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 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, 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.

Allina Health | Aetna Medicare Premier (H3219-002)

Advantage PPO Plan

Enrollment: 833-206-8764
Service: 833-570-6671 • TTY: 711
AllinaHealthAetnaMedicare.com

Monthly Premium: $27

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, 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: $25 copay, 12 visits per year.

Allina Health | Aetna Medicare Value (H3219-007)

Advantage PPO Plan

Enrollment: 833-206-8764
Service: 833-570-6671 • TTY: 711
AllinaHealthAetnaMedicare.com

Monthly Premium: $36

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:** $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 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; 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

Allina Health | Aetna Medicare Grand (H3219-003)

Advantage PPO Plan

Enrollment: 833-206-8764
Service: 833-570-6671 • TTY: 711
AllinaHealthAetnaMedicare.com

Monthly Premium: $64

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:** $3,000 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.

Allina Health | Aetna Medicare Elite (H3219-004)

Advantage PPO Plan

Enrollment: 833-206-8764
Service: 833-570-6671 • TTY: 711
AllinaHealthAetnaMedicare.com

Monthly Premium: $137

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 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

BlueCross BlueShield Minnesota

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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, Mahnomen, 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	**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 nusing facility discharge

BlueCross BlueShield Minnesota

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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	
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 nusing facility discharge

BlueCross BlueShield Minnesota

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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

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, Mahnomen, 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 nusing facility discharge

BlueCross BlueShield Minnesota

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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	
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 nusing facility discharge

BlueCross BlueShield Minnesota

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

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	
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-covred 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 nusing facility discharge

BlueCross BlueShield Minnesota

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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

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, Mahnomen, 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 nusing facility discharge

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

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	
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 nusing facility discharge

BlueCross BlueShield Minnesota

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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, Mahnomen, 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**: $3,100 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 nusing facility discharge

BlueCross BlueShield Minnesota

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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	
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 nusing facility discharge

BlueCross BlueShield Minnesota

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

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 nusing facility discharge

BlueCross BlueShield Minnesota

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

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, Mahnomen, 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 nusing facility discharge

BlueCross BlueShield Minnesota

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

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 nusing facility discharge

EssentiaCare
Essentia Health + UCare

EssentiaCare Access (H8783-003)

Advantage PPO Plan

Enrollment: 855-432-7027
Service: 855-432-7025 • TTY: 800-688-2534
UCare.org

Monthly Premium: $0

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
Essentia Health + UCare

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
Essentia Health + UCare

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	
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)

HealthPartners

Advantage PPO Plan
Enrollment: 844-363-8979
Service: 866-233-8734 • TTY: 711
healthpartners.com/medicare

Monthly Premium: $0

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

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, Viruwell 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

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, 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	
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

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, 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

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, Viruwell 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	
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 reline, 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)

Humana.

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; Mahnomen; McLeod; Meeker; Mille Lacs; Norman; Otter Tail; Pennington; Ramsey; Red Lake; Roseau; Scott; St. Louis; Todd; Wadena; Washington; Wright Counties	
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 reline, 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

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)

MINNESOTA
SENIOR LINKAGE LINE

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

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, Mahnomen, 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

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.

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

MINNESOTA
SENIOR LINKAGE LINE

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

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, Mahnomen, 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

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

MINNESOTA
SENIOR LINKAGE LINE

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

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, Mahnomen, 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	
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 copy/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 reline, 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

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

MINNESOTA
SENIOR LINKAGE LINE

800-333-2433

Humana

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, Mahnomen, 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	
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.

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

MINNESOTA
SENIOR LINKAGE LINE

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, Mahnomen, 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	
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, Mahnomen, 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

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, Mahnomen, 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

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.

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

MINNESOTA
SENIOR LINKAGE LINE

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

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 nurseline, $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

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, Mahnomen, 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, Mahnomen, Marshall, Morrison, Norman, Otter Tail, Pennington, Polk, Pope, Ramsey, Red Lake, Renville, Roseau, Scott, Sherburne, Stearns, Swift, Todd, Wadena, Washington, Wilkin, and Wright Counties	
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 virtuwell, 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

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 virtuwell, 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 virtuwell , 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

Plan Area: Becker, Beltrami, Benton, Cass, Chippewa, Chisago, Clay, Clearwater, Crow Wing, Douglas, Grant, Hubbard, Isanti, Kandiyohi, Kittson, Lake of the Woods, Mahnomen, 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 virtuwell, 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	
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 virtuwell, 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/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.

MINNESOTA SENIOR LINKAGE LINE

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

MINNESOTA SENIOR LINKAGE LINE

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, Mahnomen, 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

MINNESOTA SENIOR LINKAGE LINE

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.

MINNESOTA SENIOR LINKAGE LINE

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, Mahnomen, 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, Mahnomen, 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

MINNESOTA SENIOR LINKAGE LINE

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, Mahnomen, 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

MINNESOTA
SENIOR LINKAGE LINE

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

MINNESOTA
SENIOR LINKAGE LINE

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

MINNESOTA SENIOR LINKAGE LINE

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

MINNESOTA SENIOR LINKAGE LINE

800-333-2433

BlueCross BlueShield Minnesota

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

SecureBlue (H2425-001)

Advantage HMO-Special Needs Plan 65+

Enrollment: 866-477-1584
Service: 888-740-6013 • TTY: 711
bluecrossmn.com/secureblue

Monthly Premium: $0

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 lense 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℠ 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

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

MINNESOTA SENIOR LINKAGE LINE

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

Plan Area: Aitkin, Anoka, Becker, Carlton, Carver, Chisago, Cook, Crow Wing, Dakota, Fillmore, Freeborn, Hennepin, Isanti, Kandiyohi, Kanabec, Kittson, Koochiching, Lake, Le Sueur, Mahnomen, 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

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.

MINNESOTA
SENIOR LINKAGE LINE

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, Mahnomen, 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.

MINNESOTA
SENIOR LINKAGE LINE

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.

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.

MINNESOTA
SENIOR LINKAGE LINE

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	
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.

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.

MINNESOTA
SENIOR LINKAGE LINE

800-333-2433

AbilityCare SNBC (H5703-001)

Advantage HMO-Special Needs Plan <65

Enrollment: 866-567-7242
Service: 866-567-7242 • TTY: 800-627-3529
mnscha.org

Monthly Premium: $0

Plan Area: Brown, Dodge, Goodhue, Kanabec, Sibley, Steele, Wabasha, Waseca Counties	
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

SeniorCare Complete MSHO (H2419-001)

Advantage HMO-Special Needs Plan 65+

Enrollment: 866-567-7242
Service: 866-567-7242 • TTY: 800-627-3529
mnscha.org

Monthly Premium: $0

Plan Area: Brown, Dodge, Goodhue, Kanabec, Sibley, Steele, Wabasha, Waseca 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/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, Mahnomen, 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

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 of 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 musculorskeletal 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.

Medicare Part D Deductible	$0
Discounts & Programs	**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

MINNESOTA
SENIOR LINKAGE LINE

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, Mahnomen, 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

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.

MINNESOTA
SENIOR LINKAGE LINE

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

MINNESOTA SENIOR LINKAGE LINE

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)

MINNESOTA SENIOR LINKAGE LINE

800-333-2433

UHC Dual Complete MN-Y001 (H7778-001)

Advantage HMO-Special Needs Plan <65

UnitedHealthcare®

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

MINNESOTA SENIOR LINKAGE LINE

800-333-2433

UHC Dual Complete MN-Y002 (H0845-001)

Advantage HMO-Special Needs Plan 65+

UnitedHealthcare®

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

MINNESOTA SENIOR LINKAGE LINE

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

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

UnitedHealthcare®

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

MINNESOTA SENIOR LINKAGE LINE

800-333-2433