2023 Included and Optional Dental, Vision, Hearing, and Alternative Care Benefits For Medicare Advantage Plans Available in Multnomah County (Updated 02-16-2023)

	Plan Name, Plan ID, Type	Premium	Premium w/ Full Extra Help	Included Dental	Optional Packages (Additional $/mo)	Vision	Hearing	Alternative Care
1	AARP Medicare Advantage Plan 1 (HMO-POS1) H3805-001-0	$61	$23.40	$0 copay in-network for preventive and comprehensive, up to $1,250/yr max combined.		Exam: $0 copay. Frames or contacts--$250 allowance/yr. Standard lenses covered in full.	Routine exam $0; aids $175 to $1,225.	$0 **fitness**. $10 copay in-network for 12 visits each for routine **A, C**; same for **N** but no visit limit. $25 copay in-network **foot care**--6 visits/yr. $50/qtr **OTC**.
2	AARP Medicare Advantage Plan 2 (HMO-POS1) H3805-036-0	$0	$0	$0 copay in-network for preventive and comprehensive care, up to $1,000/yr max combined.		Exam: $0 copay. Frames or contacts: $150 allowance/yr. Standard lenses covered in full.	Routine exam $0; aids $175 to $1,225.	$0 **fitness**. $35 copay **foot care,** 6 visits. $40/qtr. **OTC**.
3	AARP Medicare Advantage Choice (PPO1) H2228-029-0	$32	$0	$0 copay in-network for preventive and comprehensive care, up to $1,000/yr. max combined.		Exam: In network $0 copay; Out of network $50 copay. Frames or contacts allowance: In & Out Network $200/yr. Standard lenses covered in full.	Routine exam in-network $0, out of network $50; aids $175 - 1,225 per ear.	$0 **fitness**. $10 copay in-network-12 visits each for **A, C**; same for **N** but no visit limit. $50/qtr **OTC**. $30 copay in-network **foot care**-- 6 visits/yr.
4	AARP Medicare Advantage Walgreens (PPO1) H2228-084-0	$0	$0	$0 copay in-network for preventive and comprehensive care, up to $500/yr max combined.	$50/ mo. for preventive and comprehensive dental care; raises annual maximum to $1,500/yr. $0 copay in-network.	Exam: In network $0 copay; Out network: $65 copay. Frames or contacts allowance: In & Out Network $150/yr. Standard lenses covered in full.	Routine exam in-network $0, out of network $65; aids $175 - 1,225 per ear.	$0 copay **fitness**. $45 copay in-network for 6 **foot care** visits.
5	Aetna Medicare Elite Plan (HMO-POS1) H2056-003-0	$0	$0	$0 copay in-network for preventive and comprehensive care. $2,100 max/yr benefit. (Indemnity if out-of-network)		Exam: $0 copay. Frames/lens or contacts allowance: $300/yr.	$0 co-pay for everything, including 2 hearing aids/year. $1,250 max hearing aid benefit per ear per year. Must use their provider.	$0 copay **fitness**. $10 copay in-network for **A** & **Massage**, 24 visits each. $10 copay in-network for **C** & **N**, up to 12 visits each. $45/qtr **OTC**.
6	Aetna Medicare Value Plan (HMO-POS1) H2056-004-0	$0	$0	$0 co-pay in-network for preventive and comprehensive care. $1,400 max/yr benefit. (Indemnity if out-of-network)		Exam: $0 copay. Frames/lens or contacts allowance: $250/yr.	$0 co-pay for everything, including 2 hearing aids/year. $1,250 max hearing aid benefit per ear per year. Must use their provider.	$0 copay **fitness**. $20 copay in-network for **C** and **N**, up to 12 visits each.
7	Aetna Medicare Choice Plan (PPO1) H9431-005-0	$24	$7.70	$0 co-pay in-network for preventive and comprehensive care. $1,500 max/yr benefit. (Indemnity if out-of-network)		Exam: In network $0 copay; Out network: 45% coinsurance. Frames/lens or contacts allowance: In & Out Network $125/yr.	Routine exam in-network $0, out of network 45%; aids $0 copay - 2 aids per year; $1,250 max benefit per ear. Must use their provider.	$0 copay **fitness**. $10 copay in-network for **A** and **Massage**, up to 24 visits each. $10 copay in-network for **C** and **N**, up to 12 visits each. $75/qtr **OTC**.
8	Cigna Preferred Medicare (HMO) H7389-002-0	$0	$0	$0 copay for preventive in-network. In-network comprehensive services benefit of $20,000, but have substantial copays ranging from $10 to $600+ on itemized list.		Exam: $0 copay. Frames/lens and contacts allowance: $350/yr.	Routine exam 0; aids $2,500 allowance for both ears combined every three years.	$0 copay **fitness**. $300 max allowance for **A**. $70/qtr **OTC.**
9	Cigna True Choice Savings Medicare (PPO1) H7389-055-0	$0	$0	$2,000 max/yr for preventive and comprehensive services. No copays listed.		Exam: In network $0 copay; Out network: 35% coinsurance. Frames/lens and contacts allowance: In & Out Network $250/yr.	Routine exam and fitting in-network $0, out of network 35%; aids in and out of network $2,000 allowance both ears combined every three yrs.	$0 copay **fitness**. $30 **rebate** on monthly part B premium**.** $300 max allowance for **A**. $65/qtr **OTC.**
10	Devoted CORE Oregon (HMO) H2923-001-0	$0	$0	$3,500 max/yr for preventive and comprehensive dental services; $0 copay.		Exam: $0 copay. Frames/lens and contacts allowance: $350/yr.	Routine exam $0; aids $399-699 per ear.	$0 copay **fitness**. $150 fitness reimbursement. $0 copay for **A**, 12 visits/yr. $20 copay- **foot care**; 6 visits/yr. $10 copay for **N**--12 visit/yr. $10 copay-**Massage**-- 6 visit/yr. $20 copay for **C**--12 visits/yr. $80/qtr **OTC.**
11	Devoted CHOICE Oregon (PPO1) H7199-001-0	$0	$0	$3,000 max/yr. $0 copay for preventive, in or out of network. Comprehensive: $0 copay in-network, 50% out-of-network.		Exam: In network $0 copay; Out network: $0 copay (submit expense for reimbursement). Frames/lens or contacts allowance: In & Out Network $300/yr (Out of network submit expense for reimbursement)	Routine exam 0; aids $99-299 per ear in network only.	$0 copay **fitness**. $150 fitness reimbursement. $0 copay for **A**, 12 visits/yr. $30 copay for **foot care**, 6 visits/yr. $10 copay for in-network **N**, 12 visits/yr. $10 co-pay for **massage** in-network, 6 visits/yr. $20 copay for **C**, 12 visits/yr.$60/qtr**OTC**.
12	Devoted CHOICE PLUS Oregon (PPO1) H7199-002-0	$36.20	$0	$4,000 max/yr. $0 copay for preventive, in or out of network. $0 copay for comprehensive care in-network, 50% out-of-network.		Exam: In network $0 copay; Out network: $20 copay (submit expense for reimbursement). Frames/lens or contacts allowance: In & Out Network $350/yr (Out of network submit expense for reimbursement)	Routine exam in network $0 out of network $20; aids $399-699 per ear in network only.	$0 copay **fitness**. $150 fitness reimbursement. $0 copay for **A**, 12 visits/yr. $10 copay in-network for **N**, 12 visits/yr. $10 copay in-network **massage**, 6 visits/yr. $20 copay for **C**, 12 visits/yr. $20 copay for **foot care**, 6 visits/yr. $50/qtr **OTC**.

A = Acupuncture; C = Chiropractic; N = Naturopathy; OTC= Over the Counter

Note: This sheet should only be considered a comparison tool. Information is from the Medicare Plan Finder and health plan websites. People who wish to enroll should rely on materials provided by the plan or Medicare.

2023 Included and Optional Dental, Vision, Hearing, and Alternative Care Benefits For Medicare Advantage Plans Available in Multnomah County (Updated 02-16-2023)

	Plan Name, Plan ID, Type	Premium	Premium w/ Full Extra Help	Included Dental	Optional Packages (Additional $/mo)	Vision	Hearing	Alternative Care
13	Humana Gold Plus (HMO) H1036-153-0	$0	$0	$2,500 max/yr. In-network copay $0 for preventive or comprehensive.		Exam: In network $0 copay. In network frames/lens or contacts allowance: $200/yr.	Routine exam $0; aids $399-699 per ear; must use their provider.	$0 copay **fitness**. $500 annual **flex card** usable in-network for dental, vision or hearing incl copays. $0 copay--25 visits for **A**. $20 copay --25 visits for **N**. $50/qtr **OTC**.
14	HumanaChoice (PPO1) H5216-247-0	$0	$0	$1,500 max/yr for preventive and comprehensive. $15 copay in-network; 35% out of network.	$37.50 premium, $2,000 max benefit combined--preventive or comprehensive dental.	Exam: In and Out network copay $0 with combined max benefit $75/year. Frames/lens or contacts: In and Out network maximum benefit $200/yr. Pre-auth may apply.	Routine exam $0; aids $599-$899; must use their provider.	$0 copay **fitness**. **C**--max 12 visits, $20 co-pay in-network. $30/qtr **OTC**.
15	Humana Value Plus (PPO1) H5216-294-0	$38	$0	$2,000 max/yr for preventive and comprehensive, with $0 copay in- or out-of-network.		Exam: In and Out network copay $0 with combined max benefit $75/year. Frames/lens or contacts: In and Out network maximum benefit $200/yr. Pre-auth may apply.	Routine exam $0; aids $0 - 299, 1 per ear every 3 years; must use their provider.	$0 copay **fitness**. $150/qtr **OTC**.
16	Kaiser Permanente Senior Advantage Enhanced (HMO-POS1) H9003-001-0	$127	$86		"Advantage Plus" -- $44/mo premium for DVH; Dental---$0 copay preventive. Comprehensive: $50 deductible and 50% coinsure. $1,250 max dental benefit, in/out of network.	Exam: $20 copay. Frames/lens and contacts: Not covered unless enrolled in Advantage Plus $44/m, then $175 allowance/2 yr.	Routine exam $20. "Advantage Plus" includes $500 for hearing aid for each ear, once every 3 yrs, also $0 copay for evaluation/fitting; $10 copay to service.	18 visits/yr total for either **A, C or N**. $10 copay.
17	Kaiser Permanente Senior Advantage Standard (HMO-POS1) H9003-006-0	$42	$0		"Advantage Plus" -- $44/mo premium for DVH; Dental--$0 copay preventive. Comprehensive: $50 deductible and 50% coinsure. $1,250 max dental benefit, in/out of network.	Exam: $35 copay. Frames/lens and contacts: Not covered unless enrolled in Advantage Plus $44/m, then $175 allowance/2 yr.	Routine exam $35. "Advantage Plus" includes $500 for hearing aid for each ear, once every 3 yrs, also $0 copay for hearing aid evaluation/fitting; $10 copay to service.	18 visits/yr total for either **A, C or N**. $15 copay.
18	Kaiser Permanente Senior Advantage Value (HMO-POS1) H9003-009-0	$0	$0		"Advantage Plus" -- $44/mo premium for DVH; Dental--$0 copay preventive. Comprehensive: $50 deductible & 50% coinsure. $1,250 max dental benefit, in/out of network.	Exam: $40 copay. Frames/lens and contacts: Not covered unless enrolled in Advantage Plus $44/m, then $175 allowance/2 yr.	Routine exam $40; "Advantage Plus" includes $500 for hearing aid for each ear, once every 3 years, also $0 copay for evaluation/fitting; $10 copay to service.	18 visits/yr total for either **A, C or N.** $20 copay.
19	Moda Health Metro PPORX (PPO1) H3813-013-0	$88	$47	$1,000 total allowance for preventive and comprehensive care. In network: $0 copay for preventive and 20% for comprehensive. Out of network: 50%.		Exam: In network $0 copay; 50% out. Frames/lens or contacts: In Network $0 copay/2 yr Genesis eyewear collection only, otherwise $50 allowance for eyewear; Out Network costs, see EOC.	Routine exam in-network $0, no benefit out of network; aids $599-899 per ear per year. + $50 for rechargeable. Must use their provider.	$0 copay **fitness**. $500 combined total annual benefit for **A, C or N**. 50% coinsurance in or out of network.
20	Moda Health + Fred Meyer PPORX (PPO1) H3813-016-0	$39	$0	$500 total allowance for preventive and comprehensive care, in & out of network. In network: $0 copay for preventive and 20% for comprehensive. Out of network: 50% coinsurance.		Exam: In network $0 copay; 50% out. Frames/lens or contacts: In Network $0 copay/2 yr Genesis eyewear collection only, otherwise $50 allowance for eyewear; for Out Network costs, see EOC.	Routine exam in-network $0, no benefit out of network; aids $699-999 per ear per year. +$50 for rechargeable. Must use their provider.	$0 copay **fitness**. $500 combined total annual benefit for **A, C or N**. 50% coinsurance in or out of network.
21	PacificSource Medicare MyCare Rx40 (HMO) H3864-040-0	$0	$0	$1,750 maximum dental benefit. $0 copay for preventive and 30% coinsurance for restorative & extractions in network.	$57/mo premium for optional dental package including preventive & comprehensive; $2,000 max benefit. 20-50% coinsure for comprehensive only.	Exam: $0 copay. Frames/lens or contacts allowance: $200/2 yr.	Routine exam $0; aids $599-999 per ear; must use their provider.	$0 copay **fitness**. Combined 24 visits for either **A, C or N**, $25 copay per visit. $25/qtr **OTC**.
22	PacificSource Medicare MyCare Choice Rx 34 (HMO-POS1) H3864-034-0	$0	$0	$1,500 maximum dental benefit. $0 copay for preventive services and 30% coinsurance for comprehensive services.	$57/mo premium for optional dental pkg including preventive & comprehensive; $2,000 max benefit. 20-50% coinsurance for comprehensive only.	Exam: In network $0 copay; Out network: $0 copay. Frames/lens or contacts allowance: In & Out Network $200/2 yr.	Routine exam in-network $0, no benefit out of network; aids $599-999 per ear per year. Must use their provider.	$0 copay **fitness**. Combined 12 visits for either **A, C or N**, $25 copay per visit. $25/qtr **OTC**.

A = Acupuncture; C = Chiropractic; N = Naturopathy

2023 Included and Optional Dental, Vision, Hearing, and Alternative Care Benefits For Medicare Advantage Plans Available in Multnomah County (Updated 02-16-2023)

	Plan Name, Plan ID, Type	Premium	Premium w/ Full	Included Dental	Optional Packages (Additional $/mo)	Vision	Hearing	Alternative Care
23	Providence Medicare Extra + Rx (HMO) H9047-064-0	$173	$132	$0 copay for preventive, in-network.	**Providence Basic dental plan** (optional pkg): $32.50/mo. for $1,000 max/yr. benefit. $50 deductible and $0 copay in-network for diagnostic and preventive care. More comprehensive care--50% coinsurance in-network. **Enhanced plan**: $45.10/mo. for $1,500 max/yr. with same in-network cost share.	Exam: $75 allowance. Frames/lens or contacts allowance: $215/yr.	$0 for routine exam. $699 copay per advanced aid or $999 copay per premium aid. In-network.	$0 copay **fitness**. $195/qtr **OTC**.
24	Providence Medicare Prime + Rx (HMO) H9047-037-0	$0	$0	$0 copay for preventive care, in-network.		Exam: $75 allowance. Frames/lens or contacts allowance: $100/yr.	$0 copay routine exam. $699 copay per advanced aid or $999 copay per premium aid. In-network.	$0 copay **fitness**. $500 combined benefit for **A, C, & N**. Chiro-$20 copay; A & N--$40 copay; in-network.
25	Providence Medicare Bridge + Rx (HMO-POS1) H9047-059-0	$35	$0	$0 copay for preventive care, in-network.		Exam: In and Out network $75 allowance. Frames/lens or contacts allowance: In and Out of network $150/yr.	$0 copay routine exam. $699 copay per advanced aid or $999 copay per premium aid. In-network.	$0 copay **fitness**. $500 combined benefit for **A, C** & **N**. Chiro-$20 copay; A & N--$35 copay; in-network. $70/qtr. **OTC**.
26	Providence Medicare Choice + Rx (HMO-POS1) H9047-065-0	$89	$48	$0 copay for preventive care.		Exam: In and Out network $75 allowance. Frames/lens or contacts allowance: In and Out of network $220/yr.	$0 copay routine exam. $699 copay per advanced aid or $999 copay per premium aid. In-network.	$0 copay **fitness**.
27	Regence BlueAdvantage (HMO) H6237-007-1	$0	$0	$0 copay for $1,000 max/yr. for 2 preventive visits plus diagnostic services.	$24/mo. for $1,000 max/yr benefit for comprehesive dental, with 50% coinsurance.	Exam: $0 copay. Frames/lens or contacts allowance: $100/yr.	$0 copay routine exam. Diagnostic exam-$30 copay. Aids $699-999 copay, up to 2 aids per year.	$0 copay **fitness**. **C** and **A**--$20 copay for a combined 18 visits/max. **N** and **massage**--$20 copay up to 6 visits each. $40/qtr **OTC**.
28	Regence BlueAdvantage HMO Plus (HMO) H6237-008-1	$45	$32.60	$0 copay for 2 preventive visits plus diagnostic services.	$24/mo. for $1,000 max/yr benefit for comprehesive dental, with 50% coinsurance.	Exam: $0 copay. Frames/lens or contacts allowance: $100/yr.	$0 copay routine exam. Diagnostic exam-$30 copay. Aids $699-999 copay, up to 2 aids per year.	$0 copay **fitness**. **C** and **A**--$20 copay for a combined 18 visits/max. **N** and **massage**--$20 copy up to 6 visits each.
29	Regence MedAdvantage + Rx Classic (PPO1) H3817-008-1	$47	$16.40	$0 copay in-network for 2 preventive visits plus diagnostic services, 50% out-of-network.	$24/mo. for $1,000 max/yr benefit for comprehesive dental, with 50% coinsurance.	Exam: In network $0 copay; Out network 30% coinsurance. Frames/lens or contacts allowance: In network $100/yr.	Routine exam in-network $0,out of network $150; aids in-network $699-999 per ear per year.	$0 copay **fitness**. **A** and **C** --18 visits/yr combined, $20 copay in- and 30% out-of-network. **N** and **massage**-6 visits/yr each, $20 in- and 50% out-of-network. $20/qtr **OTC**.
30	Regence MedAdvantage + Rx Enhanced (PPO1) H3817-009-1	$172	$131	$1,000 max/yr. Preventive and diagnostic-- $0 copay in-network and 50% out-of-network. Comprehensive--50% in- or out-of-network.		Exam: In network $0 copay; Out network 30% coinsurance. Frames/lens or contacts allowance: In network $0 copay; Out network 0-50% coinsurance. Allowance In & Out network: $150/yr.	Routine exam in-network $0,out of network $150; aids in-network $599-899 per ear per year.	$0 copay **fitness**. **A** and **C** --18 visits/yr combined, $20 copay in- and 30% out-of-network. **N** and **massage**-6 visits/yr each, $20 in- and 30% out-of-network.
31	Regence MedAdvantage + Rx Primary (PPO1) H3817-011-1	$0	$0	$1,000 max/yr. Preventive and diagnostic-- $0 copay in-network and 50% out-of-network.	$24/mo. for $1,000 max/yr benefit for comprehesive dental, with 50% coinsurance.	Exam: In network $0 copay; Out network 30% coinsurance. Frames/lens or contacts allowance: In network $0 copay; Out network 0-50% coinsurance. Allowance In & Out network: $100/yr.	Routine exam in-network $0,out of network $150; aids in-network $699-999 per ear per year.	$0 copay **fitness**. **A** and **C** --18 visits/yr combined, $20 copay in- and 30% out-of-network. **N** and **massage**-6 visits/yr each, $20 in- and 30% out-of-network. $40/qtr **OTC.**
32	Wellcare Assist (HMO) H6815-037-0	$14.90	$0	$1,000 annual benefit, in-network. $0 copay for preventive and comprehensive, in network.		Exam: $0 copay. Frames/lens or contacts allowance: $100/yr.	Routine exam $0; aids $0 copay; $500 benefit per ear per year.	$0 copay **fitness**. 24 combined total visits for **A, C** or **N**, $0 copay. $40/mo **OTC**.
33	Wellcare No Premium (HMO) H6815-038-0	$0	$0	$1,000 annual benefit. $0 copay for preventive. 20% coinsurance for comprehensive. Must be in network.		Exam: $0 copay. Frames/lens or contacts allowance: $200/yr.	Routine exam $0; aids $0 copay; $500 benefit per ear per year.	$0 copay **fitness**. 24 combined total visits for **A, C** or **N**, $0 copay. $100 "**flex card**" can be expended for dental, hearing or vision expenses. $58/qtr **OTC**.
34	Wellcare Giveback Open (PPO1) H5439-015-0	$0	$0	2 exams/cleanings/yr, flouride once/yr, x-rays 1-3 years, plus some limited comprehensive. $0 copay in-network; 50% coinsurance out of network.		Exam: In network $0 copay; Out network: 40% coinsurance. Frames/lens/ contacts allowance: None.	Routine exam in-network $0; 40% out; aids in-network $0 copay; benefit limited to $750 per ear per year; out of network 40% copay for 2 aids/yr.	$0 copay **fitness**. $22 **rebate** on monthly part B premium.
35	Wellcare Low Premium Open (PPO1) H5439-018-0	$30	$11.40	$2,000/yr benefit for preventive, plus limited comprehensive. Preventive co-pay-$0 in network, 70% out. Comprehensive --40% in network, 70% out.		Exam: In network $0 copay; Out network: 40% coinsurance. Frames/lens or contacts allowance: In Network $200/yr; Out Network 40% coinsurance/yr.	Routine exam $0 in-network, 40% out; aids in-network $0 copay; max benefit $750 per ear per year; out of network 40% copay for 2 aids/yr.	$0 copay **fitness**. 24 combined total visits for **A, C or N**, $0 copay. $53/qtr **OTC**.
36	Wellcare Premium Ultra Open (PPO1) H5439-011-0	$119	$97.70	$2,000 annual benefit. Preventive--$0 copay in-network and 70% out of network. Limited comprehensive -- 40% in-network and 70% out.		Exam: In network $0 copay; Out network: 40% coinsurance. Frames/lens or contacts allowance: In Network $200/yr; Out Network 40% coinsurance/yr.	Routine exam $0 in-network $0, 40% out; aids in-network $0 copay; benefit limited to $750 per ear per year; out of network 40% copay for 2 aids/yr.	$0 copay **fitness**. 24 combined total visits for **A, C or N**, $0 copay.

A = Acupuncture; C = Chiropractic; N = Naturopathy

Note: This sheet should nly be considered a comparison tool. Information is from the Medicare Plan Finder and health plan websites. People who wish to enroll should rely on materials provided by the plan or Medicare.

2023 Included and Optional Dental, Vision, Hearing, and Alternative Care Benefits For Medicare Advantage Plans Available in Multnomah County (Updated 02-16-2023)

	Plans Without Drug Coverage Plan Name, Plan ID, Type	Premium	Premium w/ Full Extra Help	Included Dental	Optional Packages (Additional $/mo)	Vision	Hearing	Alternative Care
1	AARP Medicare Advantage Patriot (PPO1) H2228-088-000	$0	n/a	$1,500 annual benefit. $0 copay in or out of network. Preventive and some comprehensive services.		Exam: In network copay $0. Out network copay: $65. Frames or contacts allowance: In & Out Network $300/yr. Standard lenses covered in full.	Routine exam in-network $0, out of network $65; aids in network $175 - 1,225 per ear.	$0 copay **fitness**. $45 copay in-network for up to 6 **foot care** visits. $85/qtr **OTC**. Up to $75 Part B premium **rebate**.
2	Aetna Medicare Eagle Plan (PPO1) H9431-015-0	$0	n/a	$1,250 annual benefit. $0 copay in-network for preventive or comprehensive, 20% out of network.		Exam: In network copay $0. Out network copay: 50% coinsurance. Frames/lens or contacts: In & Out Network $225/yr.	Routine exam in-network $0, out of network 50%; aids $0 copay - 2 aids per year; $1,250 max benefit per ear. Must use their provider.	$0 copay **fitness**. $50 **rebate** on monthly Part B premium. 24 **massage** visits covered--$10 copay in-network. $120/qtr **OTC**.
3	Humana Honor (PPO1) H5216-301-1	$0	n/a	$2,000 max/yr. for preventive or comprehensive care. $35 copay in network, 50% out of network.		Exam: In and Out network copay $0 with combined max benefit $75/yr. Frames/lens/contacts: In & Out network max benefit $200/yr. Pre-auth may apply.	In or out of network: Routine exam $0; aids $399-699 per ear; must use their provider.	$0 copay **fitness.** $50 **rebate** on monthly Part B premium. $0 copay for **A** up to 25 visits. $75/qtr **OTC**.
4	Humana Honor (PPO1) H5216-315-0	$0	n/a	$500 max/yr. for preventive and comprehensive. $50 copay in network; 50% out of network.	Supplemental Dental, $45.70 premium, $2000 maximum benefit.	Exam: In & Out network copay $0 w/combined max benefit $75/year. Frames/lens /contacts: In & Out network max benefit $100/yr. Pre-auth may apply.	In or out of network: Routine exam $0; aids $699-999 per ear; must use their provider.	$0 copay **fitness**. $100 **rebate** on monthly part B premium. Copay $20 for **A**--25 visit max. $25/qtr **OTC**.
5	Lasso Healthcare Growth (MSA) H1924-001-0	$0	n/a	no coverage	no coverage	N/A	no coverage	no coverage
6	Lasso Healthcare Growth Plus (MSA) H1924-004-0	$0	n/a	no coverage	no coverage	N/A	no coverage	no coverage
7	Moda Health (PPO1) H3813-001-0	$0	n/a	$750 max/yr. In-network--0% coinsurance for preventive/20% for comprehensive. Out-of-network--50%.		Exam: In network--$0 copay; 50% out. Frames/lens or contacts: In Network $0 copay/2 yr for Genesis eyewear collection only, otherwise $50 allowance for eyewear; Out Network costs, see EOC.	Routine exam in-network $0, no benefit out of network; aids $699-999 per ear per year. +$50 for rechargeable. Must use their provider.	$0 copay **fitness**. $500/yr combined allowance for **A, C, N** with 50% coinsure in or out of network.
8	PacificSource Medicare MyCare Choice 30 (HMO-POS1) H3864-030-0	$0	$0	$2,000 maximum benefit. $0 copay for preventive/30% coinsurance for comprehensive, in or out of network.	$57/mo. for optional dental pkg including preventive & comprehensive; $2,000 max benefit. $0 preventive, 50% coinsure for comprehensive only.	Exam: $0 copay. Frames/lens and/or contacts allowance: In and Out of Network $250/yr.	Routine exam in-network $0, out of network not covered; aids $599-999, 1 aid per ear per year. Must use their provider.	$0 copay **fitness**. Combined 24 visits for either **A, C or N**, $0 copay per visit, in or out of network. $200/qtr **OTC**.
9	Providence Medicare Focus Medical (HMO) H9047-033-0	$128	n/a	$0 copay for preventive care.	**Providence Basic dental plan**: $32.50/mo. for $1,000 max/yr. benefit. $50 deductible and $0 copay in-network for diagnostic & preventive. More comprehensive care--50% coinsure in-network. **Providence Enhanced plan**: $45.10/mo. for $1,500 max/yr. with same in-network cost share.	Exam: $75 allowance. Frames/lens or contacts allowance: $250/yr.	$0 for routine exam. $399 copay per advanced aid or $699 copay per premium aid. In-network.	$0 copay **fitness**. $500 combined benefit for **A, C & N**, with $20 copay per visit, in network. $75/qtr **OTC**.
10	Providence Medicare Reverence (HMO-POS1) H9047-035-0	$51	n/a	$0 copay for preventive care.	**Providence Basic dental plan**: $32.50/mo. for $1,000 max/yr. benefit. $50 deductible and $0 copay in-network for diagnostic & preventive. More comprehensive care--50% coinsure in-network. **Providence Enhanced plan**: $45.10/mo. for $1,500 max/yr. with same in-network cost share.	Exam: In and Out network $75 allowance. Frames/lens or contacts allowance: In and Out of network $250/yr.	$0 for routine exam. $399 copay per advanced aid or $699 copay per premium aid. In-network.	$0 copay **fitness**. $500 combined benefit for **A, C** & **N**, with $20 copay for C; $30 copay for A, N, in network. $75/qtr **OTC**.
11	Regence Valiance (HMO) H6237-006-0	$0	n/a	$0 copay for 2 preventive visits plus diagnostic services.	$24/mo. for $1,000 max/yr benefit for comprehesive dental, with 50% coinsurance.	Exam: $0 copay. Frames/lens or contacts allowance: $100/yr.	Routine exam $0; aids $699-999 per ear per year. Must use their provider.	$0 copay **fitness**. $15 **rebate**. **A** and **C** --18 visits/yr combined, $20 copay. **N** and massage-6 visits/yr each, $20 copay. $40/qtr **OTC**.
12	Regence Valiance (PPO1) H3817-010-0	$0	n/a	$1,000 max/yr. Preventive and diagnostic-- $0 copay in-network and 50% out-of-network. Comprehensive--50% in- or ot-of-network.		Exam: In network $0 copay; Out network 30% coinsurance. Frames/lens or contacts allowance: In network $0 copay; Out network 0-50% coinsurance. Allowance In & Out network: $100/yr.	Routine exam in-network $0, out of network $150; aids $699-999, 1 aid per ear per year. Must use their provider.	$0 copay fitness. $35 **rebate.** A and C --18 visits/yr combined, $20 copay. N and massage-6 visits/yr each, $20 copay. $40/qtr OTC.
13	Wellcare Patriot No Premium Open (PPO1) H5439-010-0	$0	n/a	$2,000 annual benefit. Preventive--$0 copay in-network and 70% out. Limited comprehensive --40% in-network; 70% out.		Exam: In network $0 copay; Out network: 40% coinsurance. Frames/lens or contacts allowance: In Network $200/yr; Out Network 40% coinsurance/yr.	Routine exam in-network $0, out of network 40%; aids in-network $0 copay; benefit limited to $1,000 per ear/yr; out of network 40% copay for 2 aids/yr.	$0 copay **fitness**. 24 combined total visits for **A, C or N**, $0 copay.

A = Acupuncture; C = Chiropractic; N = Naturopathy