Medicare.gov

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Overview Star rating

Health deductible

Health premium Drug premium Part B premium

Plan features

Drug plan deductible



Otter Tail, MN

Blue Cross Medicare Advantage Choice MA Only (PPO)

\$0.00

Medicare Advantage (without drug coverage) monthly premium

\$0 \$0.00

\$7,500 In and Out-of-network

t-of-network: 40% coinsurance

-network: 15% coinsurance It-of-network: 40% coinsurance

\$90 copay per visit (always covered)

\$35 copay per visit (always covered)

AARP Medicare Advantage Patriot (PPO)

\$0.00

Medicare Advantage (without drug coverage) monthly premium

Plan too new to be measured

\$0

\$0.00

\$10,000 In and Out-of-network 0 In-network

50

lision

)ental

learing

ransportation

itness benefits

orldwide emergency

over the counter drug benefits

n-home support services

outine chiropractic service

lome and bathroom safety devices

leals for short duration

nnual physical exams

elehealth

ndodontics

Periodontics

xtractions

twork: \$10 copay per visit of-network: \$10 copay per visit

twork: \$45 copay per visit of-network: \$45 copay per visit

twork: \$20 copay of-network: \$20 copay

twork: \$0 copay of-network: \$0 copay

twork: \$0-140 copay Out-of-network: \$0-140 copay

In-network: \$15 copay Out-of-network: \$15 copay

\$90 copay per visit (always covered)

\$30-40 copay per visit (always covered)

or health services	\$5,500 In-network \$7,500 Out-of-network	\$7,500 In and Out-of-network \$4,900 In-network	\$10,00 \$6,700
	\$0.00	\$0.00	\$0.00
	\$0.00	\$0.00	\$0.00
	\$148.50	\$148.50	\$148.5
	Vision	🗸 Vision	🗸 Vis
	🗸 Dental	🗸 Dental	V De
	Hearing	Hearing	V He
	🗙 Transportation	🗙 Transportation	🗙 Tra
	 Fitness benefits 	Fitness benefits	🗸 Fit
	✔ Worldwide emergency	👽 Worldwide emergency	V Wo
	Over the counter drug benefits	Over the counter drug benefits	V 0v
	🗙 In-home support services	X In-home support services	🗙 In-
	X Home and bathroom safety devices	X Home and bathroom safety devices	V Ro
	X Meals for short duration	Meals for short duration	Х Но
	Annual physical exams	Annual physical exams	X Me
	Telehealth	Telehealth	V An
	X Endodontics	X Endodontics	V Te
	Periodontics	Periodontics	V En
	X Extractions	× Extractions	V Pe
			V Ex
sts			
	In-network: \$0 copay	In-network: \$0-20 copay per visit	In-net
	Out-of-network: \$0 copay	Out-of-network: 40% coinsurance per visit	Out-of
	In-network: \$45 copay per visit	In-network: \$20-30 copay per visit	In-net
	Out-of-network: \$45 copay per visit	Out-of-network: 40% coinsurance per visit	Out-of
ocedures	In-network: 20% coinsurance	In-network: 15% coinsurance	In-net
	Out-of-network: 20% coinsurance	Out-of-network: 40% coinsurance	Out-of
	In-network: \$0 copay	In-network: \$0 copay	In-net
	Out-of-network: \$0 copay	Out-of-network: \$0 copay	Out-of
services (like	In-network: 20% coinsurance	In-network: 15% coinsurance	In-net

Urgent care

**** \$0 \$0.00 Maximum you pay for health services \$5,500 In-network

POS)

\$0.00

UCare Value Plus (HMO-

Medicare Advantage (without drug

coverage) monthly premium

Benefits & Cos

Primary doctor visit

		visi
Specialist visit	In-network: \$45 copay per visit	In-r
	Out-of-network: \$45 copay per visit	Out visi
Diagnostic tests & procedures	In-network: 20% coinsurance	In-r
	Out-of-network: 20% coinsurance	Out
Lab services	In-network: \$0 copay	In-r
	Out-of-network: \$0 copay	Out
Diagnostic radiology services (like	In-network: 20% coinsurance	in-r
MRI)	Out-of-network: 20% coinsurance	Out
Outpatient x-rays	In-network: 20% coinsurance	In-r
	Out-of-network: 20% coinsurance	Out
Emergency care	\$90 copay per visit (always covered)	\$90

\$50 copay per visit (always covered)

Inpatient hospital coverage	UCare Value Plus (HMO- POS) \$0.00 Medicare Advantage (without drug coverage) monthly premium In-network: \$150 per day for days 1 through 5 \$0 per day for days 6 through 90 Out-of-network: 20% per stay	Blue Cross Medicare Advantage Choice MA Only (PPO) \$0.00 Medicare Advantage (without drug coverage) monthly premium In-network: \$200 per stay Out-of-network: 40% per stay	AARP Medicare Advantage Patriot (PPO) \$0.00 Medicare Advantage (without drug coverage) monthly premium In-network: \$295 per day for days 1 through 6 \$0 per day for days 7 through 90 \$0 per day for days 91 and beyond Out-of-network: \$295 per day for days 1 through 6 \$0 per day for days 7 and beyond
Outpatient hospital coverage	In-network: \$250 copay per visit Out-of-network: 20% coinsurance per visit	In-network: \$10-150 copay per visit Out-of-network: 40% coinsurance per visit	In-network: \$0-250 copay per visit Out-of-network: \$0-250 copay per visit
Preventive services	In-network: \$0 copay Out-of-network: \$0 copay	In-network: \$0 copay Out-of-network: 40% coinsurance	In-network: \$0 copay Out-of-network: \$0 copay
Extra benefits			
Hearing aids	In-network: \$699-999 copay	In-network: \$599-899 copay Out-of-network: \$599-899 copay	In-network: \$375-2,075 copay Out-of-network: \$375 copay
Preventive dental (like oral exams and cleanings)	In-network: \$0 copay Out-of-network: \$0 copay	In-network: \$0 copay Out-of-network: \$0 copay	In-network: \$0 copay Out-of-network: \$0 copay
Comprehensive dental (like root canal and implants)	Some coverage	Some coverage	Some coverage
Eyeglasses (frames & lenses)	Not covered	In-network: \$0 copay Out-of-network: \$0 copay	In-network: \$0 copay Out-of-network: \$0 copay
Wellness programs (like fitness & nursing hotline)	Covered	Covered	Covered
Transportation	Not covered	Not covered	Not covered
Skilled nursing facility	In-network: \$0 per day for days 1 through 20 \$184 per day for days 21 through 100 Out-of-network: 20% per stay	In-network: \$0 per day for days 1 through 20 \$184 per day for days 21 through 100 Out-of-network: 40% per stay	In-network: \$0 per day for days 1 through 20 \$184 per day for days 21 through 57 \$0 per day for days 58 through 100 Out-of-network: \$150 per day for days 1 through 16 \$250 per day for days 17 through 34 \$0 per day for days 35 through 100
Durable medical equipment (like wheelchairs & oxygen)	In-network: 20% coinsurance per item	In-network: 20% coinsurance per item Out-of-network: 40% coinsurance per item	In-network: 20% coinsurance per item Out-of-network: \$55 copay or 50% coinsurance per item
Diabetes supplies	In-network: 0-20% coinsurance per item Out-of-network: 20% coinsurance per item	In-network: \$0 copay Out-of-network: 40% coinsurance per item	In-network: \$0 copay per item Out-of-network: 20% coinsurance per item