<table>
<thead>
<tr>
<th>TYPE OF PLAN</th>
<th>MEDICARE SUPPLEMENT</th>
<th>MEDICARE HMO</th>
<th>MEDICARE ESA/PPO</th>
<th>MEDICARE ESA/PPO</th>
<th>MEDICARE SUPPLEMENT</th>
<th>MEDICARE RELATED</th>
<th>MEDICARE HMO</th>
<th>MEDICARE Advantage HMO</th>
</tr>
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<tbody>
<tr>
<td>UHN/RC SeniorCare</td>
<td>Hip-Yip Premier Medicare Plan</td>
<td>Aetna Medicare PPO/ESA NY/NJ/PA</td>
<td>Aetna Medicare PPO/ESA (all other areas)</td>
<td>GHI-HMO Medicare Senior Supplement</td>
<td>Empire Blue Cross &amp; Blue Shield Medicare Related Coverage</td>
<td>Medicare HMO Plus</td>
<td>UnitedHealthcare Medicare Advantage HMO</td>
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<tr>
<td><strong>MONTHLY COST PER-PERSON RATES EFFECTIVE 7/1/19</strong></td>
<td><strong>BASIC COVERAGE: $0 RETIREE OPTION: $134.00</strong></td>
<td><strong>BASIC COVERAGE: $146.31 RETIREE OPTION: $307.18</strong></td>
<td><strong>BASIC COVERAGE: $179.24 RETIREE OPTION: $587.66</strong></td>
<td><strong>BASIC COVERAGE: $449.66 RETIREE OPTION: $597.29</strong></td>
<td><strong>5 BOROUGHS OF NY: AUTOMATIC OPTION: $254.97</strong></td>
<td><strong>NY COUNTIES: AUTOMATIC OPTION: $240.45</strong></td>
<td><strong>OUT OF AREA: CALL FOR COST AND COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>(SUBJECT TO CHANGE)</strong></td>
<td><strong>AUTOMATIC OPTION: $169.54</strong></td>
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</tbody>
</table>

**COVERAGE AREA**
- Nationwide
- 5 boroughs of NYC & Nassau, Suffolk and Westchester Counties
- New: FL AZ VA DC Only city of New York Medicare beneficiaries residing in Connecticut, Delaware, Georgia, Massachusetts, Maryland, North Carolina and Texas are eligible to enroll in this plan.
- NY: 5 boroughs of NYC, Cuyahoga, Cleveland, Tuscarawas, Marion, Stark, Mahoning, Muskingum, and Coshocton counties.
- NY: 5 boroughs of NYC, Nassau, Suffolk, Rockland, Sullivan, Ulster and Westchester Counties
- NY: Bronx, Dutchess, Kings, Nassau, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester

**OFFICE VISIT CO-PAYMENT**
- $50 co-pay
- $30 Specialist
- $100 Office visit co-pay (Specialist visit)
- $0 Office visit co-pay (Specialist visit)
- $15 co-pay
- Lab: Covered in full. X-ray: $15 co-pay
- Lab tests covered in full. X-ray: $55 co-pay
- Covered in full

**OUTPATIENT LAB & X-RAY CO-PAYMENT**
- $50 co-pay
- $30 Specialist
- $100 Office visit co-pay (Specialist visit)
- $0 Office visit co-pay (Specialist visit)
- $15 co-pay
- Lab: Covered in full. X-ray: $15 co-pay
- Lab tests covered in full. X-ray: $55 co-pay
- Covered in full

**PARTICIPATING OR OUT-OF-NETWORK PROVIDER**
- Choice of any provider
- In-network providers only
- Choice of any provider
- Participating providers only
- Participating providers only

**HOSPITALIZATION DEDUCTIBLE OR CO-PAY (INPATIENT)**
- You pay $250 per day for days 1 through 7. No co-pay for days 8 and beyond.
- Reimburses Part A hospital deductible, 365 days
- $275 per day for days 1-6
- No hospitalization deductible or co-pay

**PRIVATE DUTY NURSING**
- 80% subject to $25 deductible.
- $250 maximum combined with ambulance and medical equipment
- Not covered unless medically necessary and in a skilled nursing facility
- Not covered unless medically necessary and in a skilled nursing facility
- 80% after first 72 hours when authorized by a physician. $100 deductible
- Not covered
- Not covered

**INPATIENT MENTAL HEALTH**
- You pay $250 per day for days 1 through 7. You pay $50 per day for days 8 through 90.
- Covered in full combined with inpatient substance abuse.
- Covered in full.
- No maximum.
- $275 co-pay per day for days 1-5
- 190 days lifetime maximum. Contact plan for specifics.

**OUTPATIENT MENTAL HEALTH**
- After satisfying Medicare Part B deductible and Medicare paying 50% Reimburses 20% of amount approved by Medicare
- $55 co-pay
- $15 co-pay
- $15 co-pay
- Reimburses 20% of amount approved by Medicare (after Medicare pays 80%)
- $40 co-pay
- $15 co-pay

**OUT-OF-AREA COVERAGE**
- Anywhere in USA
- Emergency care only
- Yes
- Yes
- Urgent and emergency care only
- Emergency and urgent care worldwide
- $55 co-pay/urgent care

**RETAIL PRESCRIPTION DRUG COVERAGE 30-DAY SUPPLY**
- Up to $3,820 member pays 25% of drug cost.
- After $3,820 member pays 25% of Brand cost.
- 25% of Generic cost.
- After $5,100 in member out-of-pocket costs, unlimited drugs with co-payment of 5%.
- Prescription drug rider automatically included.
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- Prescription drug rider automatically included.
- Deductible $451.
- Member pays 25% of drug cost.
- After $3,820, member pays 37% of Generic, 25% of Brand.
- After $5,100 in out-of-pocket costs, member pays 5% of drug cost.
- Must purchase Optional Rider.
- Must purchase Optional Rider. Prescription drug costs up to $3,310.
- $10 Generic, $25 Brand.
- $50 Non-Farmulary, 25% Biologicals. Coverage gap member pays 50%.
- $5 of cost after $4,850 out-of-pocket cost.
- Prescription drug rider automatically included.

**ADDITIONAL OUT-OF-AREA PLANS ARE:**
- AvMed Medicare Plan (Florida only) 800-782-8633; Blue Cross Blue Shield of Florida Health Options (Florida only) 800-999-6758; Cape Healthcare for Seniors (Arizona) 800-627-7334; Humana Gold Plus (Florida only) 866-205-0000.

*Please note that July 1, 2019 rates have not yet been finalized. These rates will be modified at a later date retroactive to July 1, 2019.*