# 2019 Medicare Advantage Plan Comparison Chart for Alameda County ~ Rev 10/23/18 ~

Medicare Advantage Plans contract with the Centers for Medicare and Medicaid Services (CMS) to provide all the benefits covered by Medicare and some additional benefits. In exchange, CMS (Medicare) pays the plan a fixed fee per member, per month. This amount varies by region and is also adjusted for the individual member's age, gender and health condition. To enroll in a Medicare Advantage plan, a person must have both Medicare Parts A & B. The person must also live within the plan's service area. Medicare Advantage plans must accept anybody on Medicare, including those who are under age 65 on Medicare through disability, regardless of their health condition, *except* for those with end stage renal disease (ESRD). However, if a person develops ESRD *while enrolled* in a Medicare Advantage plan, the plan cannot disenroll that individual.

Medicare Advantage plans can discontinue coverage if a member spends more than twelve consecutive months outside of the service area. The plan is required to send written notice of its intent to disenroll someone for this reason. A Medicare Advantage plan may not be a good option for someone who travels frequently or for extended periods. Members have the right to appeal decisions made by the plan. For denials of care, the physician or the member can request an expedited review or a fast track appeal. Contact the plan's Member Services Department or HICAP for more information.

*Medicare HMOs are one type of Medicare Advantage (MA) plan.* When joining a Medicare HMO, beneficiaries do not give up their Medicare coverage; rather they agree to receive it through the plan's network of providers. A member must choose a Primary Care Physician and receive a referral to see a specialist. Medicare will *not* pay for services received outside the plan's network unless it is urgent or emergency care. In those circumstances, the member should notify the plan as soon as possible.

The cost-sharing for this coverage varies from plan to plan. Premiums, co-payments, and extra benefits can differ. The Annual Out of Pocket Maximum listed for each plan applies to all cost-sharing *except* plan premiums and prescription drug copays. In 2019, ten out of the eleven Medicare HMO plans in Alameda County include a prescription drug benefit (Medicare Part D). When people join an HMO *without* drug coverage, they are opting out of Part D. *Enrolling in a stand-alone Part D plan will automatically trigger disenrollment from the Medicare HMO*.

In the fall of 2018, members can enroll, disenroll or change plans during the **Medicare Annual Enrollment Period**, **from October 15 through December 7. Changes take effect on January 1, 2019.** In 2019, members have one more opportunity to make a change: they can leave their HMO and change back to Original Medicare during the **Medicare Advantage Open Enrollment Period**, **from Jan 1 through March 31.** They can enroll in a stand-alone Part D plan or change to another Medicare Advantage plan. This right only applies to those who begin the year enrolled in a Medicare Advantage plan. If someone returns to Original Medicare during this period, s/he will have through March 31 to join a stand-alone Medicare Prescription Drug Plan. There are no corresponding guarantee issue rights to join a Medigap plan without a health screening although people can apply for a Medigap at any time.

*Medicare Special Needs Plans are another type of Medicare Advantage plan.* They are designed for people on Medicare and Medi-Cal (duals), those with certain chronic conditions, or those who reside in nursing homes.

In 2019, there is one Special Needs plan in Alameda County and it is for people with <u>Medicare and full Medi-Cal</u> (no share of cost): *Kaiser Senior Advantage Medicare Medi-Cal Plan.* There is no premium and co-payments and cost-sharing do not apply. Also, three of the Medicare HMOs act like Special Needs plans for duals in that the premiums and cost-sharing are waived for people with <u>Medicare and full Medi-Cal</u>: *Health Net Seniority Plus Sapphire Premier, Health Net Seniority Plus Sapphire Premier II, and United Health Care Medicare Complete Assure.* California state law prohibits the medical billing of any balances for people with Medicare and full Medi-Cal.

People who have both Medicare and Medi-Cal and those with the Low-Income Subsidy (Extra Help) for Part D can enroll, disenroll or change plans on quarterly basis. The change will become effective the first of the following month, except in the last quarter of the year (October through December), when it becomes effective on January 1.

#### ABOUT THIS CHART

This Comparison Chart is a summary and highlights the areas where the Medicare Advantage plans may differ in benefits. For preventive care information, please see the back of this chart. Also on the last page is an explanation of the Star Ratings provided by Medicare. *For a Summary of Benefits or more specific information about the plan(s), please contact the company directly.* 

The information in this chart applies to the individual plans under Medicare only. Group coverage (i.e. employersponsored plans) may be very different and should be evaluated and compared to the individual plans. Converting an employer group plan from primary to secondary coverage when retiring and going on Medicare may offer different benefits and premiums. This chart is also available at <u>www.lashicap.org/hicap</u>.

Information provided by the Health Insurance Counseling and Advocacy Program (HICAP) of Legal Assistance for Seniors: 510-839-0393 HICAP Statewide: 1-800-434-0222



LOCAL HELP FOR PEOPLE WITH MEDICARE

	EDICARE HMO CON	<b>APAR</b>	ISON (	CHART F	OR A	LAMEDA COU	JNTY			
Please contact the	Health Net									
HMO for more information or call	1-800-977-6738 (Sales & Marketing)									
1-800-Medicare		1-		(Member Services)						
DL N	Health Net Senio	rity P			thnet.com Health Net Seniority Plus Sapphire					
Plan Name	Premier (H3561-0	02) (Fe	or Full	Duals)*		nier II (H3561-0				
Star Rating		**					**			
Annual OOP Max		<u>,700</u>					<u>,700</u>			
Monthly Premium Doctor Visit	•	.80 *				•	.80 *			
Co-Payment	<b>\$0</b> for Primary <b>\$0</b> for \$					<b>\$0</b> for Primary <b>\$0</b> for \$	Care Ph Specialis			
Inpatient Hospital Co-Payment	<b>\$1,364</b> deductible for days days 61-90; <b>\$682</b> co-pa					<b>4</b> deductible for days ys 61-90; <b>\$682</b> co-pa				
Inpatient Mental Health Co-payment	<b>\$90</b> per day f <b>\$0</b> per day f					<b>\$90</b> per day f <b>\$0</b> per day f				
Outpatient Surgery Co-payment	20% co-insurance per ambulatory surg				20	% co-insurance per ambulatory surg				
Skilled Nursing	<b>\$0</b> co-pay f					<b>\$0</b> co-pay f				
Care Co-Payment	\$170.50 copay/da		-	) *		\$170.50 copay/da	· ·		) *	
Ambulance	20% co-insur \$0 per emergency room v	1	1	irance (un	\$0 pe	20% co-insut r emergency room v	1	-	irance (up	
Emergency & Urgent Care Co-	to \$65) per urgent care	visit; * (	Co-pays v	vaived if		65) per urgent care	visit; * C	'o-pays v	vaived if	
payments	admitted to hospit \$50,000 annual limit f				¢	admitted to hospin 50,000 annual limit f				
Lab Tests,						co-pay for lab servic				
Procedures, and	diagnostic tests & procedu	<b>\$0</b> co-pay for lab services; <b>20%</b> co-insurance for diagnostic tests & procedures, x-rays, diagnostic and					ures, x-ra	ays, diag	nostic and	
Radiation Therapy	therapeutic radiology *					therapeutic radiology *				
Renal Dialysis	<b>20%</b> of		<b>20%</b> of the cost *							
Outpatient Mental Health Visits	<b>20%</b> co-insuration or group the co-insuration of group the co-insuration o	20% co-insurance per individual or group therapy visit *								
Eyeglasses (or Contact Lenses)	Up to <b>\$550</b> allowar every t	ear,			wo years		ear,			
Eye Exams	<b>\$0</b> co-pay per diagnostic exam; <b>\$0</b> co-pay for 1 routine annual exam					<b>\$0</b> co-pay per of <b>\$0</b> co-pay for 1 ro			m	
Hearing Aids	<b>\$0</b> co-pay for two he		\$0 co-pay for two he							
Hearing Exams	<b>\$0</b> co-pay for one routine annual exam					\$0 co-pay for one	outine a	nnual ex	am	
Dental	<ul> <li>20% co-insurance per Medicare-covered visit; *</li> <li>\$0 co-pay for preventive services (exams, cleanings, fluoride treatments, and x-rays); discounts apply to comprehensive services</li> </ul>					20% co-insurance per Medicare-covered visit; * Routine dental not covered				
Chiropractic	\$0 co-pay per Mec \$0 co-pay for up to 30 combined with a	licare-co ) routine	overed vi visits pe	sit; r year,	<ul> <li>\$0 co-pay per Medicare-covered visit;</li> <li>\$0 co-pay for up to 30 routine visits per year, combined with acupuncture visits</li> </ul>					
Podiatry	<b>\$0</b> co-pay per Mec	licare-co	overed vi	sit;	¢	\$0 co-pay per Med	licare-co	vered vi	sit;	
	<b>\$0</b> co-pay for up to 12	2 routine	90	er year 90 days	\$	0 co-pay for up to 12	2 routine	visits pe	90 days	
		days	days	mail			days	days	mail	
	Preferred Generic Non-Preferred Generic	25% 25%	25% 25%	25% 25%		erred Generic -Preferred Generic	25% 25%	25% 25%	25% 25%	
	Preferred Brand	25%	25%	25%	Pref	erred Brand	25%	25%	25%	
Prescription Drugs	Non-Preferred Brand Specialty co-insurance	25% 25%	25% 25%	25% 25%		-Preferred Brand tialty co-insurance	25% 25%	25% 25%	25% 25%	
(Outpatient)	<b>\$415</b> deductible; after tota					deductible; after tot				
	\$3,820, you pay no more t	han 25%	6 of the p	olan's cost	<b>\$3,820</b> , you pay no more than <b>25%</b> of the plan's cost					
	for brand name drugs and of-pocket drug expenses re					and name drugs and				
	you pay the greater of \$3.4	10 or 5%	6 for gen		out-of-pocket drug expenses reach \$5,100. * After that, you pay the greater of \$3.40 or 5% for generics					
	the greater of <b>\$8.50</b> or <b>5%</b> <b>\$0</b> co-pay for fitness progr		nds.			e greater of <b>\$8.50</b> or pay for fitness prog			rsa Advica	
0.1	24-hour Nurse Advice Lin	e with \$			Line v	with <b>\$0</b> copay; <b>\$55</b> a	llowance	e for OT	C items	
Other Benefits/Options	<b>\$55</b> allowance for Over-th via mail order	e-Count	er items	per quarter	per quarter, via mail order; Transportation: <b>\$0</b> co-pay for up to 40 one-way trips per year to plan-approved locations <b>\$0</b> co-pay for home-delivered meals (up to 2/day for 14 days) following a hospital or skilled					
Denents/Options	Transportation: <b>\$0</b> co-pay per year to plan-approved			way trips						
	4 <b>D</b> • 1	1 •	•	1.0	nursin	g facility stay and o	rdered b	y a docto	or	
	*Premium and cost-st those with Medicare d					mium and cost-s with Medicare	0		•	
Notes	Medical Groups: Affinit	v Brow	n & Tola	nd	Medi	cal Groups. Affinit	v Brow	n & Tola	nd	
				da, Alta	Medical Groups: Affinity, Brown & Toland Physicians Fact Bay, Hespitals: Alamada, Alta					
		Physicians East Bay <b>Hospitals</b> : Alameda, Alta Bates (Berkeley), San Leandro, St. Rose (Hayward),								
	Bates (Berkeley), San Lea Stanford Valley Care (Plea	ndro, St	. Rose (H	layward),	Bates		ndro, St	Rose (H	layward),	

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www	.hea	lthnet.co	om	

HMO for more information or call 1-800-Medicare	1-800-977-6738 (Sales & Marketing) 1-800-275-4737 (Member Services)									
	www.healthnet.com									
Plan Name	Ruby Selec		62-113)		Ruby Select II (H0562-116)					
Star Rating		$\star \star$								
Annual OOP Max	· · · · · · · · · · · · · · · · · · ·	,200				,900				
Monthly Premium		69 G			•	59				
Doctor Visit Co-Payment	<b>\$5</b> for Primary <b>\$20</b> for	Care Phy Specialis			<b>\$0</b> for Primary <b>\$15</b> for	Care Ph Specialis				
Inpatient Hospital	\$345 per day	•			<b>\$275</b> per da	-				
Co-Payment	<b>\$0</b> per day for d				<b>\$0</b> per day for c					
Inpatient Mental	<b>\$900</b> per Medic	20#2 2012	rad stay		<b>\$900</b> per Medi	20*2 2010	rad stay			
Health Co-payment										
Outpatient Surgery	\$345 per outpati			•,	\$250 per outpat	-				
Co-payment	\$200 per ambulator			SIL	\$200 per ambulator			/1S1t		
Skilled Nursing Care Co-Payment	<b>\$0</b> co-pay f <b>\$75</b> per day f				<b>\$0</b> co-pay f <b>\$75</b> per day f					
Ambulance	\$250 co-j				\$180 co-					
Emergency &	\$90 per emergency room		-	ent care	<b>\$90</b> per emergency roon		*	tent care		
Urgent Care	visit; co-pays waived if ad				visit; co-pays waived if ac					
<b>Co-payments</b>	hours; <b>\$50,000</b> annual lin		1		hours; <b>\$50,000</b> annual lin					
Lab Tests,	<b>\$0</b> co-pay for lab, d	liagnostic	procedure	es,	<b>\$0</b> co-pay for lab, d	liagnostic	c procedu	res,		
Procedures, and	tests, x-rays, and d	liagnostic	radiology	/;	tests, x-rays, and c	liagnosti	c radiolog	,y;		
Radiation Therapy	\$60 co-pay for the	-		1	\$60 co-pay for th	-		У		
Renal Dialysis		f the cost				f the cost				
Outpatient Mental Health Visits	\$25 co-pay for group then	\$25 co-pay fo group the								
Eyeglasses	\$0 co-pay for one pair for	<b>\$0</b> co-pay for one pair following cataract surgery;								
(or Contact Lenses)	\$250 eyewear allo \$25 co-pay per	\$250 eyewear allowance every 2 years \$25 co-pay per diagnostic exam;								
Eye Exams	\$25 co-pay per \$12 co-pay for one \$0 co-pay for	\$25 co-pay per \$12 co-pay for 1 a \$0 co-pay for	annual ro	utine exa	m					
Hearing Aids	\$0-\$1,580 co-pay allowar	<b>\$0-\$1,580</b> allowance	for two a	ids, every	y year					
Hearing Exams	<ul><li>\$0 co-pay per diagnostic exam;</li><li>\$0 co-pay for 1 annual routine exam</li></ul>				<b>\$0</b> co-pay per <b>\$0</b> co-pay for 1 a			n		
Dental	<b>\$0</b> co-pay per Medicare covered visit				<b>\$0</b> co-pay per Me	dicare co	overed vis	sit		
	(See optional benefit package below.) <b>\$10</b> co-pay per Medicare covered visit				(See optional bene \$10 co-pay per Mo					
Chiropractic	(See Optional benefit package below.)				(See Optional ben	efit pack	age belov	v.)		
Podiatry	\$25 co-pay per Me \$25 co-pay/visit for up to				<b>\$25</b> co-pay per Mo <b>\$25</b> co-pay/visit for up t					
		30	30	90 days		30	30	90 days		
		days	days	mail		days	days	mail		
	Preferred Generic	pref \$3	stand \$8	\$6	Preferred Generic	pref \$3	stand \$8	\$6		
	Non-Preferred Generic	\$3 \$10	\$0 \$15	\$0 \$20	Non-Preferred Generic	\$3 \$10	\$15	\$0 \$20		
	Preferred Brand	\$37	\$47	\$101	Preferred Brand	\$37	\$47	\$101		
Prescription Drugs	Non-Preferred Brand	\$90	\$100	\$260	Non-Preferred Brand	\$90	\$100	\$260		
(Outpatient)	Specialty co-insurance	33%	33%	N/A	Specialty co-insurance	33%	33%	N/A		
	<b>\$0</b> deductible; <b>after total \$3,820</b> , you pay no more t				<b>\$0</b> deductible; <b>after total yearly drug costs reach</b> <b>\$3,820</b> , you pay no more than <b>25%</b> of the plan's cost					
	for brand name drugs and i				for brand name drugs and <b>37%</b> for generic drugs until					
	out-of-pocket drug expens				out-of-pocket drug expenses reach \$5,100. After that,					
	you pay the greater of \$3.4 the greater of \$8.50 or 5%			ics and	you pay the greater of \$3.4 the greater of \$8.50 or 5%			rics and		
	24-hour Nurse Advice Lin				24-hour Nurse Advice Lin					
	Optional supplemental p				Optional supplemental packages at:					
	<b>#3</b> at <b>\$14/month:</b> dental b cleanings, exams, and x-ra				<b>#5</b> at <b>\$11/month:</b> dental benefits with <b>\$0</b> co-pay for cleanings, exams, & x-rays; other discounts apply;					
Other	Dental HMO network	ijs, onici	uiscounts	appij,	Dental HMO network	inscounts	appij,			
Benefits/Options	#4 at \$25/month: \$0 denta	#11 at \$21/month: \$0 dental benefits with \$0 co-pay for preventive and diagnostic services; other discounts								
L	for preventive and diagnos apply; <b>\$35</b> annual deductil				apply; <b>\$35</b> annual deducti					
	Dental PPO Network				Dental PPO Network					
	<b>Both Include:</b> acupunctur			with <b>\$10</b>	Both Include: acupuncture and chiropractic with \$10					
	co-pay for 30 combined vi Membership with Silver&				co-pay for 30 combined vi Membership with Silver&			7		
	Medical Groups: Affinity			land	Medical Groups: Brown					
Notos	Physicians East Bay				Bay		-			
Notes	Hospitals: Alameda, Alta (Castro Valley), San Leand				Hospitals: Alameda, Alta Leandro, Summit (Oaklan					
	Stanford Valley Care (Plea				(Pleasanton and Livermor		ora vane	y care		
	Summit (Oakland), Washi									

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### Health Net 1-800-977-6738 (Sales & Marketing)

1-800-275-4737 (Member Services)

1-800-Medicare	www.healthnet.com								
Plan Name	Healthy Hear	rt (H05	62-068	)	Seniority Plus Green (H0562-045)				
Star Rating	**	**			****				
Annual OOP Max	\$3,4	400			\$3,400				
Monthly Premium	\$12	24			\$139				
Doctor Visit	<b>\$5</b> for Primary (	Care Phys	sician;		<b>\$10</b> for Primary Care Physician;				
<b>Co-Payment</b>	<b>\$10</b> for S		,		<b>\$10</b> for Specialist				
Inpatient Hospital	<b>\$275</b> per day	for days	1-7:		<b>\$275</b> per day for days 1-7;				
Co-Payment	<b>\$0</b> per day for				<b>\$0</b> per day for days 8 and beyond				
Inpatient Mental		-							
Health Co-payment	<b>\$900</b> per Medica	re-cover	ed stay		<b>\$900</b> per Medicare-covered stay				
<b>Outpatient Surgery</b>	\$250 per outpatie	ent hospit	al visit.	<b>\$275</b> per outpatient hospital visit;					
Co-payment	\$125 per ambulatory			sit	\$125 per ambulatory surgical center visit				
Skilled Nursing	<b>\$0</b> co-pay fo	r davs 1-'	20.						
Care Co-Payment	\$170 per day fo				<b>\$0</b> co-pay for days 1-100				
Ambulance	<b>\$75</b> co-pa	· ·			\$125 co-pay per trip				
Emergency &	*			ont coro					
Urgent Care	<b>\$120</b> per emergency room visit; co-pays waived if adm				<b>\$120</b> per emergency room visit; <b>\$10</b> per urgent care visit; co-pays waived if admitted to hospital within 24				
Co-payments	hours; <b>\$50,000</b> annual limit				hours; <b>\$50,000</b> annual limit for ER care outside U.S.				
Lab Tests,									
· · · · · · · · · · · · · · · · · · ·	<b>\$0</b> co-pay for lab, dia		procedure	es,	<b>\$0</b> co-pay for lab, diagnostic procedures,				
Procedures, and Radiation Therapy	tests, and <b>\$60</b> co-pay for diagnostic		peutic ra	diology	tests, and x-rays; <b>\$60</b> co-pay for diagnostic and therapeutic radiology				
<b>.</b> .			ipeulle lu	alology					
Renal Dialysis	<b>20%</b> of		1		<b>20%</b> of the cost				
Outpatient Mental Health Visits	\$25 co-pay for group thera				<b>\$25</b> co-pay for individual or group therapy session				
	<b>.</b> .								
Eyeglasses	<b>\$10</b> co-pay for one pair for				<b>\$10</b> co-pay for one pair following cataract surgery;				
(or Contact Lenses)	(See Optional benefit package below.) \$10 co-pay per diagnostic exam;				(See Optional benefit package below.)				
Eye Exams	<b>\$10</b> co-pay for 1 annual routine exam;				<b>\$10</b> co-pay per diagnostic exam; <b>\$10</b> co-pay for 1 annual routine exam				
<b>TT 1</b> 4 1 1	<b>\$0 - \$995</b> co-pay each aid								
Hearing Aids	for maximum of 2 every year				Not Covered				
Hearing Exams	<b>\$0</b> co-pay per diagnostic exam;				<b>\$10</b> co-pay per diagnostic exam;				
Invuring Exuitio	<b>\$0</b> co-pay for 1 annual routine exam <b>\$0</b> co-pay per Medicare covered visit				\$10 co-pay for 1 annual routine exam				
Dental	SU co-pay per Med (See optional benef				<b>\$0</b> co-pay per Medicare covered visit (See optional benefit package below.)				
	\$10 co-pay per Med				\$10 co-pay per Medicare covered visit				
Chiropractic	(See Optional benef				(See Optional benefit package below.)				
Podiatry	\$10 co-pay per Med			it	<b>\$10</b> co-pay per Medicare-covered visit;				
1 outuri y	Routine foot ca				<b>\$10</b> co-pay for up to 12 routine visits per year				
		30 days	30 days	90 days					
		pref	stand	mail					
	Preferred Generic	\$5	\$10	\$10					
	Non-Preferred Generic	\$15	\$20	\$30	THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.				
	Preferred Brand	\$37	\$47	\$101	I NEGONII I ION DRUG COVERAGE.				
Prescription Drugs	Non-Preferred Brand	<b>\$90</b>	\$100 289/	\$260					
(Outpatient)	<ul><li>Specialty co-insurance</li><li>\$250 deductible (does not a</li></ul>	28%	<b>28%</b>	$\mathbf{N}/\mathbf{A}$					
	after total yearly drug cos			YOU CANNOT BELONG TO THIS PLAN AND					
	<b>25%</b> of the plan's cost for t				ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.				
	generics until out-of-pocket	expense	s reach \$	5,100.	ALDIONNE I REDOMI HON DRUG I LAN.				
	After that, you pay the great								
	generics and the greater of \$ 24-hour Nurse Advice Line			rands.	24-hour Nurse Advice Line with <b>\$0</b> copay				
	Optional supplemental pa		1 .		Optional supplemental packages at:				
	#1 at \$20/month: dental be			#1 at \$20/month: dental benefits with \$0 co-pay for					
041	exams, cleanings, x-rays, ar	nd non-ro	utine serv	exams, cleanings, x-rays, and non-routine services;					
Other	other discounts apply; Dent			other discounts apply; Dental HMO network;					
<b>Benefits/Options</b>	#2 at \$30/month: same dem additional discounts; \$35 an			<b>#2 at \$30/month:</b> same dental as above with additional discounts; <b>\$35</b> annual deductible; <b>\$1000</b>					
					annual limit; Dental PPO Network; <b>Both Include:</b>				
	· · · · · · · · · · · · · · · · · · ·	nual limit; Dental HMO Network; <b>Both Include:</b> upuncture and chiropractic with <b>\$10</b> co-pay for 30 acupuncture and chiropractic with <b>\$10</b> co-							
	combined visits per year; \$2	250 visio	n allowar	ice every	combined visits per year; \$250 vision allowance every				
	2 years; free gym membersl				2 years; free gym membership with Silver&Fit				
	Medical Groups: Affinity,				Medical Groups: Affinity, Brown & Toland, Hill Physicians, Pale Alto Med Foundation, Sutter Fact				
	Physicians, Palo Alto Med Bay, Washington Township			East	Physicians, Palo Alto Med Foundation, Sutter East Bay, Washington Township Med Foundation				
Notes	Hospitals: Alameda, Alta E			Eden	<b>Hospitals:</b> Alameda, Alta Bates (Berkeley), Eden				
	(Castro Valley), San Leanda	ro, Stanfo	ord Valle	y Care	(Castro Valley), San Leandro, Stanford Valley Care				
	(Pleasanton and Livermore)				(Pleasanton and Livermore), Summit (Oakland), and				
	Washington (Fremont)				Washington (Fremont)				

Please contact the HMO for more information or call 1-800-Medicare Kaiser Permanente 1-800-777-1238 (Sales & Marketing) 1-800-443-0815 (Member Services)

www.medicare.kaiserpermanente.org

		<u></u>	<u>iserpermanente.org</u>				
				Kaiser Medicare Medi-Cal			
Plan Name	Senior Advant	age (]	H0524	-032)	Special Needs Plan		
		8 、		(H0524-030) (For Full Duals) *			
Star Rating	***				****		
0							
Annual OOP Max		700			\$3,400		
Monthly Premium	\$9				\$0		
Doctor Visit	<b>\$30</b> for Primary Care Physician;				<b>\$0</b> for Primary Care Physician;		
Co-Payment	\$ <b>35</b> for \$	Specialis	st		\$0 for Specialist		
Inpatient Hospital	<b>\$285</b> per day				<b>\$0</b> per day;		
Co-Payment	<b>\$0</b> per day for da	ays 8 an	d beyon	d	Unlimited days each benefit period		
Inpatient Mental	<b>\$230</b> per day				<b>\$0</b> per day;		
Health Co-payment	<b>\$0</b> per day for da	ays 8 an	d beyon	d	190 lifetime days		
<b>Outpatient Surgery</b>	\$250 per outpatie	ent hosp	ital visi	t;	<b>\$0</b> per outpatient hospital visit;		
<b>Co-payment</b>	\$250 per ambulatory	v surgica	al center	visit	<b>\$0</b> per ambulatory surgical center visit		
Skilled Nursing Care	<b>\$0</b> per day for	or days	1-20;		<b>\$0</b> per day;		
Co-Payment	<b>\$100</b> per day f				100 days per benefit period		
Ambulance	<b>\$200</b> co-p	av per t	rip				
	<b>\$90</b> per emerge	• •	1				
Emergency & Urgent	waived if admitted within 24 hours				<b>\$0</b> copay per visit; Worldwide coverage		
Care Co-payments	\$30 per urgent care visi	it; Worl	dwide c	overage			
Lab Tests,	\$30 co-pay for lab, diagn	ostic te	sts & pr	ocedures;			
Procedures, and	\$35 co-pay for x-ra	ay; <b>\$215</b>	co-pay	for	<b>\$0</b> copay per service		
<b>Radiation Therapy</b>	diagnostic radiology; <b>\$0</b>	for ther	apeutic	radiology			
Renal Dialysis	<b>0%</b> co-pay	per serv	vice		<b>\$0</b> co-pay per service		
Outpatient Mental	<b>\$30</b> co-pay per	individu	ial visit:				
Health Visits	\$15 per group				<b>\$0</b> copay per individual or group therapy session		
	<b>\$0</b> co-pay for eyeglasse	s or con	tact len	ses after			
Eyeglasses					<b>\$0</b> co-pay for eyeglasses or contact lenses after		
(or Contact Lenses)	<b>\$40</b> allowance for ey	vewear e	every 2 y	cataract surgery; <b>\$300</b> allowance for eyewear every year			
	(See optional bene						
Eye Exams	<b>\$30</b> co-pay per optometrist visit; <b>\$35</b> co-pay per ophthalmologist visit				<b>\$0</b> copay per diagnostic exam;		
Hearing Aids					\$0 copay for 1 annual routine exam Not Covered		
nearing Alus	Not Covered; (See option		<u> </u>	<u> </u>	\$0 co-pay per diagnostic exam		
Hearing Exams	<b>\$30</b> co-pay per diagnostic exam <b>\$35</b> for 1 routine annual exam				<b>\$0</b> for 1 routine annual exam		
	Not Co				φυ for 1 routile unitur enum		
Dental	(See optional benef	fit pack	age belo	w.)			
Chiropractic	\$35 co-pay per Mec			visit;	<b>\$0</b> co-pay per Medicare covered visit;		
emopraette	Routine care			••.	Routine care not covered		
Podiatry	\$35 co-pay per Mec Routine foot ca			1sit;	<b>\$0</b> co-pay per Medicare covered visit; Routine foot care not covered		
-	Koutille 100t Ca		100	100 days	Routine foot care not covered		
		days	days	mail			
	Preferred Generic	\$6	<b>\$18</b>	\$12	-		
	Non-Preferred Generic	\$18	\$54	\$36	Depending on your income, you pay the following:		
	Preferred Brand	\$47	\$141	\$94	Generic: \$0, \$1.20, or \$3.40		
Prescription Drugs	Non-Preferred Brand	\$100	\$300	\$200	All Other Drugs: \$0, \$3.70, or \$8.50		
(Outpatient)	Specialty co-insurance	33%	33%	33%			
(outputient)	\$0 deductible; after total				After annual drug costs (paid by you, the plan, and by Extra Help from Medicare) reach <b>\$5,100</b> , you		
	\$3,820, you pay \$6 copay				pay <b>\$0</b> copay.		
	for generic and <b>25%</b> for budrugs until out-of-pocket d						
	<b>\$5,100.</b> After that, you pay						
	for generics & the greater o						
	24-hour Nurse Advice Lin				24-hour Nurse Advice Line with <b>\$0</b> copay		
	Acupuncture: \$35 co-pay p	per visit	(limited				
	Optional benefit package	e: Adva	ntage P	<b>Plus</b> at			
Other	\$20/month						
	-Dental: Copays vary depe Delta Care USA network	ending i	ipon the	service;			
<b>Benefits/Options</b>	Dena Care USA network		ids even	v 3 vears	*For People with Medicare and Full		
Benefits/Options	-Hearing \$350 allowance	tor 2 a		-			
Benefits/Options	-Hearing: \$350 allowance -Vision: \$0 co-pay for eye			-Vision: \$0 co-pay for eyewear with \$240 limit (in			
Benefits/Options		wear wi	ith <b>\$240</b>		Medi-Cal)		
Benefits/Options	-Vision: \$0 co-pay for eye addition to \$40 limit above -Gym Membership: \$0 ar	wear wi e) every nnual fe	ith <b>\$240</b> two yea e with S	irs			
-	<ul> <li>-Vision: \$0 co-pay for eye addition to \$40 limit above -Gym Membership: \$0 an Medical Groups: Kaiser I</li> </ul>	wear wi e) every nnual fe Permane	ith <b>\$240</b> two yea e with S ente	ilver&Fit	Medical Groups: Kaiser Permanente		
Benefits/Options Notes	-Vision: \$0 co-pay for eye addition to \$40 limit above -Gym Membership: \$0 ar	wear wi e) every nnual fe Permane	ith <b>\$240</b> two yea e with S ente	ilver&Fit			

Please contact the HMO for more information or call 1-800-Medicare

### Stanford Health Care Advantage 1- 844-205-8422 (Sales & Marketing)

1-855-996-8422 (Member Services)

www.stanfordhealthcareadyantage.org

1-800-Medicare	www.stanfordhealthcareadvantage.org											
Plan Name	Gold (H2	2986-(	<b>)05</b> )		Platinum (	H298	6-004	)				
Star Rating	**	★★			*:	***						
Annual OOP Max	\$5,	900			\$4,	900						
Monthly Premium	\$(	69			\$	99						
Doctor Visit	\$10 for Primary	Care Pl	nysician	;	\$10 for Primary	Care Pl	hysician	;				
<b>Co-Payment</b>	<b>\$30</b> for \$	Specialis	st		<b>\$20</b> for	Specialis	st					
Inpatient Hospital	<b>\$275</b> per day				<b>\$275</b> per day							
Co-Payment	<b>\$0</b> per day for days 8 a	and beyo	ond (unl	imited)	<b>\$0</b> per day for days 8	and beyo	ond (unl	imited)				
Inpatient Mental	<b>\$270</b> per day				\$270 per day							
Health Co-payment	\$0 per day for da	ays 7 an	d beyon	d	<b>\$0</b> per day for d	•	-					
Outpatient Surgery	<b>20%</b> co-i	insuranc	ce		<b>\$240</b> per outpatien ambulatory sur							
Co-payment Skilled Nursing Care	<b>\$0</b> per day fo		1.20.		-	-						
Co-Payment	<b>\$0</b> per day for \$150 per day for				<b>\$0</b> per day f <b>\$100</b> per day f							
Ambulance	<b>\$210</b> co-p				\$200 co-r							
	<b>\$80</b> per emergency room	• 1	1	rgent care		<b>V</b> I	1					
<b>Emergency &amp; Urgent</b>	visit; co-pays waived if a	dmitted	to hospi	ital within	<b>\$80</b> per emergency room visit; Co-pays waived if ac							
Care Co-payments	24 hours; emergency cove		US and	territories	Worldwide coverage,							
		lly. rvices: \$	345 co-n	ay for	\$10 co-pay for lab se	-	-					
Lab Tests,		<b>\$10</b> co-pay for lab services; <b>\$45</b> co-pay for diagnostic procedures, tests, and x-rays;					, and $x-1$					
Procedures, and Padiation Thorany	\$210 co-pay for diag	gnostic r	adiolog	y and	\$210 co-pay for diag	gnostic r	adiolog	y and				
Radiation Therapy	20% of cost for the			ogy	20% of cost for th			ogy				
Renal Dialysis	<b>20%</b> of					the cos						
Outpatient Mental	<b>\$20</b> co-pay per			,	<b>\$20</b> co-pay per							
Health Visits	\$30 per group		\$20 per group									
Eyeglasses	<b>\$0</b> copay for one pair fo (See optional benef		<b>\$0</b> copay for one pair following cataract surgery (See optional benefit packages below.)									
(or Contact Lenses)	<b>\$10-\$20</b> co-pay pe		<b>\$10-\$20</b> co-pay per diagnostic exam;									
Eve Exams	Routine exam	alli,	Routine exams not covered;									
v		(See optional benefit packages below.)					ages belo	ow.)				
Hearing Aids		overed			Not C	overed						
Hearing Exams	<b>\$0</b> co-pay per d				\$0 co-pay per							
0	\$0 co-pay for 1 annual routine exam \$30 co-pay per Medicare covered visit				<b>\$0</b> for 1 routin <b>\$20</b> co-pay per Me			ricit				
Dental	(See optional benefit packages below.)				(See optional benefit							
Chiropractic	\$20 co-pay per Med			visit;	\$20 co-pay per Me			visit;				
omoptuette	Routine care			vicit.	Routine car			isit.				
Podiatry	\$30 co-pay per Mec Routine foot ca			/1811;	\$20 co-pay per Me Routine foot c			1811;				
		30	90	100 days			T	100 dama				
		days	days	mail		30 days	90 days	100 days mail				
	Preferred Generic	\$5	\$15	\$10	Preferred Generic	\$5	\$15	\$10				
	Non-Preferred Generic	\$15	\$45	\$30	Non-Preferred Generic	\$15	\$45	\$30				
	Preferred Brand	\$47	\$141	<b>\$94</b>	Preferred Brand	\$47	\$141	\$94				
Prescription Drugs	Non-Preferred Brand	\$100 28%	\$300 N/A	\$200 N/A	Non-Preferred Brand	\$100	\$300	\$200				
(Outpatient)	Specialty co-insurance <b>\$0</b> deductible for Tiers 1 &				Specialty co-insurance	33%	33%	33%				
(•••••••••••••••••	Tiers 3, 4, & 5; after total				<b>\$0</b> deductible; after total yearly drug costs reach							
	\$3,820, you pay no more the	han 25%	6 of the	plan's cost	\$3,820, you pay no more t							
	for brand name drugs and .				for brand name drugs and <b>37%</b> for generic drugs until out-of-pocket drug expenses reach <b>\$5,100</b> .							
	until out-of-pocket drug ex After that, you pay the grea				After that, you pay the gre							
	generics & the greater of \$8				generics & the greater of \$	8.50 or 5	5% for b	orands.				
	Optional benefit package	e at <b>\$20</b> /	month:		Optional benefit package							
	-\$25 co-pay for one routing				-\$25 co-pay for one routin							
	- <b>\$150</b> allowance for eyewe				-\$150 allowance for eyewear every two years w/VSI							
		-\$0 co-pay for preventive dental services; \$0-\$250					-\$0 co-pay for preventive dental services; \$0-\$250 co-pay for general services; \$5-\$445 co-pay for					
Other Benefits/Options	-\$0 co-pay for preventive of		- co-pay for general services; <b>55-5445</b> co-pay for					major services; Dental HMO with Delta Care USA				
	-\$0 co-pay for preventive of	s; <b>\$5-\$4</b>						are USA				
	- <b>\$0</b> co-pay for preventive of co-pay for general services	s; <b>\$5-\$4</b>			major services; Dental HN Acupuncture: \$10 co-pay	10 with per visi	Delta C it up to 1	15/year				
	- <b>\$0</b> co-pay for preventive of co-pay for general services major services; Dental HM	s; <b>\$5-\$4</b> IO with	Delta C	Care USA	major services; Dental HM Acupuncture: \$10 co-pay Gym Membership: \$0 an	IO with per vision per vision p nual fee	Delta C it up to 1 for Silv	<b>15/year</b> ver&Fit				
	-\$0 co-pay for preventive of co-pay for general services major services; Dental HM	s; <b>\$5-\$4</b> IO with to and S	Delta C	Care USA	major services; Dental HN Acupuncture: \$10 co-pay Gym Membership: \$0 an Medical Groups: Palo Al	IO with per vision nual fee to and S	Delta C it up to 1 for Silv outter Ea	<b>15/year</b> ver&Fit				
Benefits/Options	- <b>\$0</b> co-pay for preventive of co-pay for general services major services; Dental HM	s; <b>\$5-\$4</b> IO with to and S	Delta C	Care USA	major services; Dental HM Acupuncture: \$10 co-pay Gym Membership: \$0 an	IO with per vision nual fee to and S	Delta C it up to 1 for Silv outter Ea	<b>15/year</b> ver&Fit				
	-\$0 co-pay for preventive of co-pay for general services major services; Dental HM	s; <b>\$5-\$4</b> IO with to and S aford Af	Delta C utter Ea filiates	are USA Ist Bay	major services; Dental HN Acupuncture: \$10 co-pay Gym Membership: \$0 an Medical Groups: Palo Al	IO with y per vision per vision per vision in the second s	Delta C it up to 1 for Silv sutter Ea filiates	<b>15/year</b> ver&Fit st Bay				
Benefits/Options	-\$0 co-pay for preventive of co-pay for general services major services; Dental HM Medical Groups: Palo Alt Medical Foundations, Stan Hospitals: Alameda, Alta (Castro Valley), San Leand	s; <b>\$5-\$4</b> 10 with to and S aford Af Bates (I dro, Star	Delta C utter Ea filiates Berkeley nford (P	Yare USA Ist Bay y), Eden Yalo Alto)	major services; Dental HM Acupuncture: \$10 co-pay Gym Membership: \$0 an Medical Groups: Palo Al Medical Foundations, Star Hospitals: Alameda, Alta (Castro Valley), San Lean	IO with y per visi nual fee to and S nford Af Bates (I dro, Star	Delta C it up to 1 for Silv utter Ea filiates Berkeley nford (P	15/year ver&Fit st Bay v), Eden alo Alto)				
Benefits/Options	-\$0 co-pay for preventive of co-pay for general services major services; Dental HM Medical Groups: Palo Alt Medical Foundations, Stan Hospitals: Alameda, Alta	to and S ford Af Bates (I dro, Star nit (Oak	Delta C utter Ea filiates Berkeley nford (P land) St	Yare USA Ist Bay y), Eden Yalo Alto)	major services; Dental HM Acupuncture: \$10 co-pay Gym Membership: \$0 an Medical Groups: Palo Al Medical Foundations, Star Hospitals: Alameda, Alta	10 with per visition to and S ford Af Bates (I dro, Stan nit (Oak	Delta C it up to 1 for Silv tutter Ea filiates Berkeley nford (P dand) St	15/year ver&Fit st Bay v), Eden alo Alto)				

Please contact the HMO for outline of coverage & provider information or call 1-800-Medicare	United Health Care 1-877-555-5757 (Sales & Marketing) 1-800-950-9355 (Member Services) www.aarpmedicareplans.com								
Plan Name	AARP Media (H054	lete	AARP Medicare Complete Assure (H0543-070) (For Full Duals) *						
Star Rating	````	**	,		**		,		
Annual OOP Max	\$5,	,900			\$6,7	700			
Monthly Premium	\$1	104			\$18.	70 *			
Doctor Visit Co-Payment	\$10 for Primary Care Physician; \$15 for Specialist				\$20% co-insurance for P 20% co-insurance			sician; *	
Inpatient Hospital Co-Payment	<b>\$395</b> per day <b>\$0</b> per day for days 5			limited)	<b>\$1,364</b> deductible for days days 61-90; <b>\$682</b> co-pa				
Inpatient Mental Health Co-payment	<b>\$395</b> per day <b>\$0</b> per day				<b>\$1,364</b> deductible for days days 61-90; <b>\$682</b> co-pa				
Outpatient Surgery Co-payment	\$370 copay per outpa ambulatory sur				20% co-insura	ince per	visit *		
Skilled Nursing Care Co-Payment	<b>\$0</b> co-pay f <b>\$160</b> for days 21			00	<b>\$0</b> co-pay fo <b>\$170.50</b> copay/day			*	
Emergency & Urgent Care Co-payments	<b>\$90</b> per emergency room care visit; Co-pays waiv within 24 hours; No limi	ved if ad	lmitted to	o hospital	<b>\$90</b> per emergen <b>\$65</b> per urgen Worldwide	t care vi	sit; *		
Ambulance	\$250 co-I				<b>20%</b> co-insura		<u> </u>		
Lab Tests, Procedures, and Radiation Therapy	<b>\$0</b> co-pay for lab, diagne <b>\$14</b> co-pay per x-ray; <b>\$</b> radiology; <b>\$60</b> co-pay	iagnostic	<ul> <li>\$0 co-pay for lab, diagnostic tests &amp; procedures;</li> <li>20% co-insurance for x-rays, diagnostic and therapeutic radiology *</li> </ul>						
Renal Dialysis	<b>20%</b> of cost				<b>20%</b> of cost *				
Outpatient Mental Health Visits	<ul><li>\$40 co-pay for individual therapy session;</li><li>\$30 co-pay for group therapy session</li></ul>				20% co-insurance for individual or group therapy session *				
Eyeglasses (or Contact Lenses)	<b>\$0</b> co-pay for one pair following cataract surgery				<b>\$0</b> co-pay for one pair fo				
Eye Exams	<pre>\$15 co-pay per diagnostic exam; \$15 co-pay for 1 routine annual exam</pre>				20% co-insurance pe \$0 co-pay for 1 an				
Hearing Aids	<b>\$330 - \$380</b> co-pay per aid, up to 2 per year				<b>\$0</b> co-pay for up	to 2 aids	per year		
Hearing Exams	<ul><li>\$10 co-pay per diagnostic exam;</li><li>\$10 co-pay for 1 annual routine exam</li></ul>				20% co-insurance per diagnostic exam; * \$0 co-pay for 1 annual routine exam				
Dental	<b>\$0</b> co-pay per Me (See optional bene				20% co-insurance per Medicare-covered visit; * Routine dental not covered				
Chiropractic	\$15 co-pay per Me Routine car	dicare c e not co	covered v	visit;	20% co-insurance per M Routine care	not cov	ered		
Podiatry	\$15 co-pay per Me \$15 co-pay/visit for up t				20% co-insurance per Medicare covered visit; * \$0 co-pay/visit for up to 4 routine visits per year				
	Preferred Generic Non-Preferred Generic Preferred Brand	30 days \$3 \$12 \$47	90 days <b>\$9</b> <b>\$36</b> <b>\$141</b>	90 days mail \$9 \$36 \$141	Preferred Generic Non-Preferred Generic Preferred Brand	30 days 25% 25% 25%	90 days 25% 25% 25%	90 days mail 25% 25% 25%	
Prescription Drugs (Outpatient)	Preferred Brand\$47\$141\$141Non-Preferred Brand\$100\$300\$300Specialty co-insurance26%26%26%\$0 deductible for Tiers 1-2;\$350 for Tiers 3-5; aftertotal yearly drug costs reach\$3,820, you pay nomore than 25% of the plan's cost for brand namedrugs and 37% for generics until out-of-pocket drugexpenses reach\$5,100. After that, you pay thegreater of\$3.40 or 5% for generics and the greaterof \$8.50 or 5% for brands.				Non-Preferred Brand25%25%Specialty co-insurance25%25%\$415 deductible; after total yearly drug costs reach\$3,820, you pay no more than 25% of the plan's costfor brand name drugs and 37% for generics until				
Other Benefits/Options	24-hour Nurse Advice Lir 24-hour Care Manager Ac <b>Optional Dental Riders a</b> <b>\$2.50/month:</b> fixed co-pa diagnostic services <b>\$12.50/month:</b> fixed co-pa diagnostic services	<b>\$0</b> co-pay ve and	24-hour Nurse Advice Line 24-hour Care Manager Adv <b>\$20</b> credit per quarter for a products <b>*Premium and cost-s</b> <b>those with Medicare</b>	vice Line pproved <b>haring</b>	e with \$0 Over-the	e-Counter ved for			
Notes	Medical Groups: Affinity Physicians East Bay, Hill Sutter East Bay; Hospit Eden (Castro Valley), Joh San Leandro, St. Rose (Ha Care (Pleasanton and Live (Oakland), and Washingto	Physicia als: Alta n Muir ayward) ermore),	ans, Palo a Bates ( (Walnut , Stanfor , Summi	o Alto, (Berkeley), Creek), rd Valley	Medical Groups: Affinity Physicians East Bay, Hill F Sutter East Bay; Hospita Eden (Castro Valley), San (Hayward), Stanford Valle Livermore), Summit (Oakl (Fremont)	, Brown Physician als: Alta Leandro y Care (	& Tolan 1s, Palo A Bates (E 9, St. Rose Pleasanto	d Alto, Berkeley), e on and	

## **Medicare Coverage for Preventive Care Benefits**

To help people with Medicare stay healthy, Medicare covers certain screening tests, supplies, and teaching services. People with Original Medicare can receive most of these preventive benefits without having to pay coinsurance or the Part B deductible (\$185 in 2019). Medicare Advantage plans also cannot charge cost sharing (meaning no deductible, no copayment or coinsurance) for most innetwork preventive benefits. These preventive benefits available at no cost include:

- Abdominal Aortic Aneurysm Screening: one per lifetime
- Alcohol Misuse Screening and Counseling: one screening per year and up to 4 counseling sessions per year
- Annual Wellness Visit: one per year
- Bone Mass Measurement: one every 2 years
- Breast Cancer Screening: one per year
- Cardiovascular (Heart Disease) Screening and Therapy: one screening every 5 years and one counseling session (with primary care physician) per year
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam): one every 2 years or one a year if at high risk
- Colorectal Cancer Screening: frequency varies by type of test
- Depression Screening: one per year
- Diabetes Screening: 2 per year if at risk
- Flu Shot: one per year
- Hepatitis B Shots: as needed depending on health status
- HIV Screening: one per year
- Medical Nutrition Therapy: as needed depending on health status
- Obesity Screening and Counseling: one screening per year and up to 22 counseling sessions per year
- Pneumococcal Shots: one per lifetime
- Prostate Cancer Screening: one per year for age 50 and over
- Sexually Transmitted infections (STI) Screening & Counseling: one screening per year and 2 counseling sessions (with primary care physician) per year
- Tobacco-use Cessation Counseling (if not diagnosed with related illness): up to 8 sessions per year
- "Welcome to Medicare" Exam: one in the year following enrollment into Part B

The following preventive benefits are subject to cost-sharing under Original Medicare (the Part B deductible and 20% co-insurance). Medicare Advantage plans may charge for these services:

- Barium Enema Screening: one every 4 years for age 50 and over
- Diabetes Self-Management Training Services: as ordered by doctor
- Glaucoma Screening: one per year if at high risk
- Prostate Cancer Screening (digital rectal exam): one per year for age 50 and over
- Tobacco-use Cessation Counseling (if diagnosed with related illness): up to 8 sessions per year

For more information on Medicare coverage of preventive care, you can refer to the Medicare and You 2019 Handbook. Call 1-800-Medicare to request a copy or visit: <u>https://www.medicare.gov/medicare-and-you</u>

#### **Star Ratings:**

This summary rating gives an overall score of the Medicare Advantage plan's quality and performance on up to 46 unique quality and performance factors that fall into 5 categories:

- Staying healthy: screenings, tests, and vaccines. Includes whether members got various screening tests, vaccines, and other check-ups that help them stay healthy.
- Managing chronic (long-term) conditions. Includes how often members with different conditions got certain tests and treatments that help manage their condition.
- Member experience with the health plan. Includes ratings of member satisfaction with the plan.
- Member complaints and changes in the health plan's performance: Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- Health plan customer service. Includes how well the plan handles member appeals.

This information is gathered from several different sources. In some cases it is based on member surveys, information from clinicians, or information from plans. In other cases, it is based on results from Medicare's regular monitoring activities. (Explanation is from <a href="https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx">https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx</a>)