2021 Medicare Advantage Plan Comparison Chart for Alameda County

~ Rev 11/05/20 ~

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. In 2021, for the first time, people with ESRD can also enroll in Medicare Advantage plans.

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. The Medicare HMO 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 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 co-pays. In 2021, two Medicare HMO plans in Alameda County do not include the Medicare Part D prescription drug benefit. 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 Advantage Plan.*

A Medicare PPO is another type of Medicare Advantage (MA) plan. A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses will apply.

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. They all must include Part D prescription drug coverage and they have a responsibility to coordinate benefits and care for their members.

In 2021, there are four Special Needs Plans in Alameda County. Three are for people with Medicare and full Medi-Cal (duals, with no share of cost). These are called D-SNPS and they have no premiums or co-payments. The other Special Needs Plan is for people with specific chronic or disabling conditions, such as cardiovascular disorders. It is called a C-SNP and certain cost-sharing applies. In addition, five of the Medicare Advantage Plans *act like* Special Needs plans for duals in that the premiums and cost-sharing are waived for people with Medicare and full Medi-Cal: *Anthem MediBlue Coordination Plus, Health Net Seniority Plus Sapphire Premier, Health Net Seniority Plus Sapphire Premier II, Imperial Traditional Plus, and United Health Care Medicare Complete Assure.* These plans are called "look-alike" D-SNPS. Anyone on Medicare can join them but those without full Medi-Cal will pay significant cost-sharing expenses. These "look-alike" plans do not have a responsibility to coordinate members' Medicare and Medi-Cal benefits.

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.

In the fall of 2020, Medicare beneficiaries can enroll, disenroll or change plans during the **Medicare Annual Enrollment Period, from October 15 through December 7. Changes take effect on January 1, 2021.** In 2021, members have one more opportunity to make a change: they can leave their MA plan and change back to Original Medicare during the **Medicare Advantage Open Enrollment Period, from Jan 1 through March 31.** This right only applies to those who begin the year enrolled in a Medicare Advantage plan. They can leave their MA plan and enroll in a stand-alone Part D plan or they can change to another Medicare Advantage plan. If someone returns to Original Medicare during this period, they will have through March 31 to join a stand-alone Medicare Prescription Drug Plan. There are no corresponding guarantee issue rights to get a Medigap plan without a health screening although people can apply for a Medigap at any time but must answer health screening questions.

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 benefits covered by Medicare, please see the back of this chart. Also, on the last page is an explanation of the Star Ratings provided by Medicare.

The information in this chart applies to the individual plans under Medicare only. Group coverage (i.e. employer-sponsored 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 www.lashicap.org/hicap.

LOCAL HELP FOR PEOPLE WITH MEDICARE

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

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2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Aetna Medicare** **800-335-1407 (Sales & Marketing)** **833-859-6031 (Customer Service)** www.aetnamedicare.com	**Aetna Medicare** **800-335-1407 (Sales & Marketing)** **833-859-6031 (Customer Service)** www.aetnamedicare.com
Plan Name	**Aetna Medicare Plus Plan** **(H4982-005)**	**Aetna Medicare Eagle Plan** **(H4982-013)**
Star Rating	Plan too new to be measured	Plan too new to be measured
Annual OOP Max	**$4,200**	**$4,200**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** copay for Primary Care Physician; **$15** for Specialist	**$0** copay for Primary Care Physician; **$10** for Specialist
Inpatient Hospital	**$250** copay/day for days 1-7; **$0** per day for days 8-90	**$50** co-pay/day for days 1-3; **$0** for days 4-90; **$0** for days 91 and beyond (unlimited)
Outpatient Hospital	**$0** copay per ambulatory surgical center visit; **$150** copay per outpatient hospital facility visit	**$0** copay per ambulatory surgical center visit; **$0** copay per outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$75** per day for days 21-100	**$0** copay/day for days 1-20; **$184** per day for days 21-100
Ambulance	**$175** copay per ground or air ambulance trip	**$175** copay per ground or air ambulance trip
Emergency & Urgent Care	**$90** copay per emergency room visit; **$15** per urgent care visit; **$90** per emergency or urgent care visit worldwide; copays waived if admitted to hospital	**$90** copay per emergency room visit; **$10** copay per urgent care visit; **$90** per emergency or urgent care visit worldwide; copays waived if admitted to hospital
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, diagnostic tests, procedures, and x-rays; **$0** co-pay for diagnostic radiology; **$60** copay for therapeutic radiology	**$0** copay for lab services, diagnostic tests, procedures, and x-rays; **$100** co-pay for diagnostic radiology; **$60** copay for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$25** copay per individual or group therapy session	**$25** copay per individual or group therapy session
Eyewear	**$175** annual reimbursement allowance for eyeglasses or contacts	**$250** annual reimbursement allowance for eyeglasses or contacts
Eye Exams	**$0** copay per Medicare-covered vision services; **$0** copay for one routine exam per year	**$0** copay per Medicare-covered vision services; **$0** copay for one routine exam per year
Hearing Aids	**$1,250** annual hearing aid allowance, per ear	**$2,500** annual hearing aid allowance, per ear
Hearing Exams	**$0** copay for diagnostic hearing exam**;** **$0** copay for one annual routine exam	**$0** copay for diagnostic hearing exam**;** **$0** copay for one annual routine exam
Dental	Up to **$750** annual reimbursement for covered preventive and comprehensive services; Any licensed dentist that is a Medicare provider	Up to **$2,000** annual reimbursement for covered preventive and comprehensive services; Any licensed dentist that is a Medicare provider
Chiropractic	**$0** copay for Medicare covered visits; **$0** copay for routine chiropractic visits (unlimited)	**$0** copay for Medicare covered visits; **$0** copay for routine chiropractic visits (unlimited)
Podiatry	**$15** copay per Medicare-covered visit	**$10** copay per Medicare-covered visit
Prescription Drugs (Outpatient)	*Cost-sharing shown is for network pharmacies* / 30 days / 90 days / 90 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$0** / **$0** / **$0** Preferred Brand: **$42** / **$141** / **$126** Non-Preferred Brand: **$99** / **$300** / **$297** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; **after total yearly drug costs reach $4,130**, you pay $0 for Tier 1 and 2 drugs and no more than **25%** of the plan's cost for brand name drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.	**THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.** **YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.**
Other Benefits/Options	**Acupuncture: $0** copay for unlimited acupuncture treatments within American Specialty Health network **Over the Counter: $75** every 3 months for OTC items in catalog **Transportation:** 12 one-way trips each year to plan approved locations **Wellness: $0** co-pay for Silver Sneakers membership	**Acupuncture: $0** copay for unlimited acupuncture treatments within American Specialty Health network **Over the Counter: $105** quarterly allowance for OTC items in catalog **Transportation:** 12 one-way trips each year to plan approved locations **Wellness: $0** co-pay for Silver Sneaker membership
Medical Groups and Hospitals	**Medical Groups:** Brown and Toland **Hospitals**: Alta Bates/Summit Medical Center (Berkeley/Oakland), St. Rose (Hayward) Stanford Valley Care (Pleasanton and Livermore), and Washington Hospital (Fremont)	**Medical Groups:** Brown and Toland **Hospitals**: Alta Bates/Summit Medical Center (Berkeley/Oakland), St. Rose (Hayward) Stanford Valley Care (Pleasanton and Livermore), and Washington Hospital (Fremont)

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Aetna Medicare** **800-335-1407 (Sales & Marketing)** **833-859-6031 (Customer Service)** www.aetnamedicare.com	**Blue Shield of California** **1-800-260-9607 (Sales & Marketing)** **1-800-776-4466 (Member Services)** www.blueshieldca.com/medicare
Plan Name	**Aetna Medicare Elite Plan (PPO)*** **(H5521-293)**	**Blue Shield Inspire (PPO)*** **(H4937-001)**
Star Rating	★★★★	Plan too new to be measured
Annual OOP Max	**$7,550 / $11,300***	**$6,700 / $10,000***
Monthly Premium	**$0**	**$98**
Doctor Visits	**$0** copay for PCP; **$40** for Specialist (in network) **45%** co-insurance (out of network)	**$10** copay for PCP; **$35** for Specialist (in network) **40%** co-insurance (out of network)
Inpatient Hospital	**$325** copay per day for days 1-4; **$0** per day for days 5 and beyond (unlimited) in network; **45%** co-insurance out of network	**$175** copay per day for days 1-7; **$0** for days 8 and over; **40%** co-insurance out of network
Outpatient Hospital	**$295** copay for ambulatory surgical center visit; **$40-$295** for outpatient hospital facility visits **45%** co-insurance out of network	**$100** copay for ambulatory surgical center visit; **$250** for outpatient hospital facility visit **40%** co-insurance out of network
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$184** per day for days 21-100 **45%** co-insurance out of network	**$0** copay/day for days 1-20; **$178** per day for days 21-100 **40%** co-insurance out of network
Ambulance	**$285** copay per ground or air ambulance trip	**$225** copay per ground or air ambulance trip
Emergency & Urgent Care	**$90** copay/emergency room visit; **$40** per urgent care visit; **$90** per emergency or urgent care visit worldwide; co-pays waived if admitted to hospital	**$90** copay/emergency room visit; **$30** per urgent care visit; **$90** per emergency or urgent care visit worldwide; Waived if admitted to hospital in 24 hours
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, diagnostic tests, procedures, and x-rays; **$250** co-pay for diagnostic radiology; **$60** co-pay for therapeutic radiology **45%** co-insurance out of network	**$40** copay for lab services, diagnostic tests, procedures, and x-rays; **$100** for diagnostic radiology; **20%** co-insurance for therapeutic radiology; **40%** co-insurance out of network
Renal Dialysis	**20%** co-insurance per treatment (in network) **50%** co-insurance per treatment (out of network)	**0-20%** co-insurance per treatment (in network) **40%** co-insurance per treatment (out of network)
Outpatient Mental Health Visits	**$40** copay per individual or group therapy session in network; **45%** co-insurance out of network	**$20** copay per visit per individual or group therapy session in network; **40%** co-insurance out of network
Eyewear	**$275** annual reimbursement for eyeglasses or contacts	**$20** copay for eyeglass frames every 2 years; **$20** for lenses every year; **$75** reimbursement for frames every 2 years and lenses each year out of network
Eye Exams	**$0** copay for one annual routine exam in network **45%** co-insurance out of network	**$0** co-pay for one annual routine exam in network; **$30** reimbursement out of network
Hearing Aids	**$1,250** annual allowance per ear	Not Covered
Hearing Exams	**$0** copay for one annual routine exam; **45%** co-insurance out of network	**$0** copay for one annual routine exam; **40%** co-insurance out of network
Dental	Up to **$1,000** annual reimbursement for covered preventive and comprehensive services; Any licensed dentist that is a Medicare provider	**Optional Dental Package:** Dental PPO at **$40.50** per month**;** up to **$1,500** for covered preventive and comprehensive services with **$50** deductible
Chiropractic	**$0** copay for Medicare covered visit; Routine chiropractic visits not covered	**$20** co-pay per Medicare-covered visit; **$0** copay/visit for 12 routine visits per year **40%** co-insurance out of network
Podiatry	**$40** copay per Medicare-covered visit; Routine podiatry services not covered	**$35** copay per Medicare-covered visit; **40%** co-insurance out of network

Prescription Drugs (Outpatient)

Aetna Medicare Elite Plan (PPO):

Cost-sharing shown is for network pharmacies	30 days	90 days	90 days mail
Preferred Generic	**$0**	**$0**	**$0**
Generic	**$0**	**$0**	**$0**
Preferred Brand	**$47**	**$141**	**$141**
Non-Preferred Brand	**$100**	**$300**	**$300**
Specialty co-insurance	**33%**	**N/A**	**N/A**

$0 deductible; **after total yearly drug costs reach $4,130**, you pay **$0** for Tier 1 and 2 drugs and no more than **25%** of the plan's cost for brand name drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generic & greater of **$9.20** or **5%** for brand.

Blue Shield Inspire (PPO):

Cost-sharing shown is for network pharmacies	30 days	90 days	90 days mail
Preferred Generic	**$0**	**$0**	**$0**
Generic	**$15**	**$22.50**	**$22.50**
Preferred Brand	**$40**	**$100**	**$100**
Non-Preferred Brand	**$95**	**$237.50**	**$237.50**
Specialty co-insurance	**25%**	**N/A**	**N/A**

$400 deductible (for Tiers 3, 4, and 5); **after total yearly drug costs reach $4,130**, you pay no more than **25%** of the plan's cost for brand name drugs and **25%** for generics until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generic & greater of **$9.20** or **5%** for brand.

	Aetna Medicare Elite Plan (PPO)	Blue Shield Inspire (PPO)
Other Benefits/Options	**Meals:** Up to 14 home-delivered meals after an inpatient hospital stay **Visitor/Travel Benefit:** Can stay in plan for up to 12 months when outside service area **Wellness: $0** for Silver Sneakers gym membership	**Acupuncture: $0** copay/visit for 12 visits per year **Mobility:** Annual AAA Membership for members with chronic illnesses; **Over the Counter: $80** quarterly allowance for covered items; **Wellness: $0** for Silver Sneakers gym membership
Medical Groups and Hospitals	**Medical Groups:** Brown and Toland **Hospitals**: Alta Bates/Summit Medical Center, St. Rose, Stanford Valley Care, Washington Hospital ***$750 annual deductible applies to in and out of network services; Higher cost-sharing applies to out-of-network services.**	**Medical Groups:** Brown & Toland, Hill Physicians **Hospitals**: Alameda, Alta Bates/Summit Medical Center, Eden, San Leandro, Stanford Valley Care, and Washington Hospital ***$750 annual deductible applies to out of network services; Higher cost-sharing applies to out-of-network services.**

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Anthem Blue Cross** **1-888-211-9813 (Sales & Marketing)** **1-888-230-7338 (Member Services)** www.shop.anthem.com/medicare/ca	
Plan Name	**Anthem MediBlue Plus (H0544-097)**	**Anthem MediBlue Select (H0544-098)**
Star Rating	★★★1/2	★★★1/2
Annual OOP Max	**$4,400**	**$7,550**
Monthly Premium	**$49**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$15** for Specialist	**$15** for Primary Care Physician; **$45** for Specialist
Inpatient Hospital	**$265** copay for days 1-7; **$0** copay/day for days 8 and beyond	**$325** copay for days 1-6; **$0** copay/day for days 7 and beyond
Outpatient Hospital	**$200** copay for ambulatory surgical center visit; **$265** for outpatient hospital facility visit	**$275** copay for ambulatory surgical center visit; **$325** for outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$184** per day for days 21-100	**$0** copay/day for days 1-20; **$184** per day for days 21-100
Ambulance	**$250** copay per ground ambulance trip; **20%** coinsurance per air ambulance trip	**$250** copay per ground ambulance trip; **20%** coinsurance pe air ambulance trip
Emergency & Urgent Care	**$90** copay for ER visit; **$35** for urgent care visit; Waived if admitted to hospital within 24 hours; **$100,000** annual limit for ER care outside U.S.	**$90** copay for ER visit; **$35** for urgent care visit; Waived if admitted to hospital within 24 hours; **$100,000** annual limit for ER care outside U.S.
Lab Tests, Procedures, and Radiation Therapy	**$10** copay for lab services; **$0-50** for diagnostic tests & procedures; **$10** for x-rays; **$150** for diagnostic radiology services; **20%** coinsurance for therapeutic radiology	**$10** copay for lab services; **$0-75** for diagnostic tests & procedures; **$10** for x-rays; **$150** for diagnostic radiology services; **20%** coinsurance for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$40** copay per individual or group therapy session	**$40** copay per individual or group therapy session
Eyewear	**$100** allowance toward eyewear each year	**$100** allowance toward eyewear each year
Eye Exams	**$15** copay for diagnostic exam; **$0** copay for one annual routine exam	**$45** copay for diagnostic exam; **$0** copay for one annual routine exam
Hearing Aids	**$3,000** annual maximum with **$0** copay	**$3,000** annual maximum with **$0** copay
Hearing Exams	**$15** copay for Medicare-covered hearing exam; **$0** copay for one annual routine exam	**$45** copay for Medicare-covered hearing exam; **$0** copay for one annual routine exam
Dental	**$15** copay for Medicare covered services; **$0** copay for 1 oral exam and 1 cleaning per year	**$45** copay for Medicare covered services**;** **$0** copay for 1 oral exam and 1 cleaning per year
Chiropractic	**$20** copay per Medicare-covered visit	**$20** copay per Medicare-covered visit
Podiatry	**$0-15** copay for Medicare-covered services; **$0** copay for unlimited routine visits each year	**$0-45** copay for Medicare-covered services**;** **$0** copay for 24 routine visits each year

Prescription Drugs (Outpatient)

Anthem MediBlue Plus:

Cost-sharing shown is for network pharmacies	30 days	90 days	90 days mail
Preferred Generic	**$0**	**$0**	**$0**
Generic	**$8**	**$24**	**$24**
Preferred Brand	**$42**	**$126**	**$126**
Non-Preferred Brand	**$95**	**$285**	**$285**
Specialty co-insurance	**33%**	**33%**	**N/A**

$0 deductible; **after total yearly drug costs reach $4,130**, you pay no more than **25%** of the plan's cost for brand name drugs and **25%** for generics until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.

Anthem MediBlue Select:

Cost-sharing shown is for network pharmacies	30 days	90 days	90 days mail
Preferred Generic	**$0**	**$0**	**$0**
Generic	**$10**	**$20**	**$20**
Preferred Brand	**$42**	**$126**	**$84**
Non-Preferred Brand	**$95**	**$285**	**$190**
Specialty co-insurance	**33%**	**33%**	**N/A**

$0 deductible; **after total yearly drug costs reach $4,130**, you pay no more than **25%** of the plan's cost for brand name drugs and **25%** for generics until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.

	Anthem MediBlue Plus	Anthem MediBlue Select
Other Benefits/Options	**Acupuncture: $0** co-pay for up to 24 visits per year **Medicare Community Resource Support:** Referrals and coordination for community services **Over the Counter: $50** allowance per quarter for covered items **Wellness: $0** for Silver Sneakers gym membership **Optional supplemental packages:** **1: Preventive Dental at $13 per month:** up to **$500**/year **$0** co-pays for basic services **2: Dental & Vision at $32 per month:** up to **$1,000**/year for dental and **$150**/year for eyewear **3: Enhanced Dental & Vision at $53 per month:** up to **$2,000**/year for dental and **$200**/year for eyewear	**Acupuncture: $0** co-pay for up to 12 visits per year **Medicare Community Resource Support:** Referrals and coordination for community services **Over the Counter: $25** allowance per quarter for covered items **Wellness: $0** for Silver Sneakers gym membership **Optional supplemental packages:** **1: Preventive Dental at $13 per month:** up to **$500**/year; **$0** co-pays for basic services **2: Dental & Vision at $32 per month:** up to **$1,000**/year for dental and **$150**/year for eyewear **3: Enhanced Dental & Vision at $53 per month:** up to **$2,000**/year for dental and **$200**/yr for eyewear
Medical Groups and Hospitals	**Medical Groups:** Brown & Toland, Hill Physicians **Hospitals**: Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), St. Rose, (Hayward), Stanford Valley Care (Pleasanton & Livermore), Washington (Fremont)	**Medical Groups:** Brown & Toland, Hill Physicians **Hospitals**: Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), St. Rose, (Hayward), Stanford Valley Care (Pleasanton & Livermore), Washington (Fremont)

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<table>
<tr><td>Please contact the Plan for more information or call 1-800-Medicare</td><td>Blue Shield of California
1-800-260-9607 (Sales & Marketing)
1-800-776-4466 (Member Services)
www.blueshieldca.com/medicare</td><td>Health Net of California
1-800-977-6738 (Sales & Marketing)
1-800-275-4737 (Member Services)
www.ca.healthnetadvantage.com</td></tr>
<tr><td>Plan Name</td><td>Blue Shield Inspire
(H0504-041)</td><td>Health Net Green
(H0562-045)</td></tr>
<tr><td>Star Rating</td><td>★★★★</td><td>★★★★</td></tr>
<tr><td>Annual OOP Max</td><td>$5,000</td><td>$3,400</td></tr>
<tr><td>Monthly Premium</td><td>$45</td><td>$0</td></tr>
<tr><td>Doctor Visits</td><td>$5 copay for Primary Care Physician;
$15 for Specialist</td><td>$7 copay for Primary Care Physician;
$10 for Specialist</td></tr>
<tr><td>Inpatient Hospital</td><td>$275 copay/day for days 1-5;
$0 per day for days 6 and over</td><td>$200 copay/day for days 1-5;
$0 per day for days 6 and beyond</td></tr>
<tr><td>Outpatient Hospital</td><td>$200 copay per ambulatory surgical center visit;
$350 per outpatient hospital facility visit</td><td>$50 per ambulatory surgical center visit;
$200 copay per outpatient hospital facility visit</td></tr>
<tr><td>Skilled Nursing Facility</td><td>$0 copay/day for days 1-20;
$145 per day for days 21-100</td><td>$0 copay/day for days 1-20;
$75 for days 21-100</td></tr>
<tr><td>Ambulance</td><td>$250 copay per ground or air ambulance trip</td><td>$125 copay per ground ambulance trip;
5% coinsurance per air ambulance trip</td></tr>
<tr><td>Emergency & Urgent Care</td><td>$85 copay per emergency room visit; waived if admitted to hospital within 24 hours; $15 per urgent care visit; $80 copay for visits outside U.S.</td><td>$120 copay per ER visit; waived if admitted to hospital immediately; $10 per urgent care visit; $50,000 annual limit for care outside of U.S.</td></tr>
<tr><td>Lab Tests, Procedures, and Radiation Therapy</td><td>$0 copay for lab, diagnostic procedures, tests, and x-rays; $70 copay for diagnostic radiology; 20% co-insurance for therapeutic radiology services</td><td>$0 copay for lab, diagnostic procedures, tests, and x-rays; $60 co-pay for diagnostic and therapeutic radiology services</td></tr>
<tr><td>Renal Dialysis</td><td>20% co-insurance per treatment</td><td>20% co-insurance per treatment</td></tr>
<tr><td>Outpatient Mental Health Visits</td><td>$30 copay for individual
or group therapy session</td><td>$25 copay for individual or
group therapy session</td></tr>
<tr><td>Eyewear</td><td>$20 co-pay for eyeglass lenses each year; $20 co-pay for frames every 2 years; Contact lenses not covered</td><td>$100 allowance for routine eyewear each year</td></tr>
<tr><td>Eye Exams</td><td>$15 copay per Medicare-covered exam;
$10 copay for one annual routine exam</td><td>$0-$10 copay per Medicare-covered exam;
$10 copay for one annual routine exam</td></tr>
<tr><td>Hearing Aids</td><td>$499 - $699 copay per aid (depending on type);
limited to 2 hearing aids per year</td><td>Not Covered</td></tr>
<tr><td>Hearing Exams</td><td>$5-$15 copay for Medicare-covered exam;
$0-$15 copay for one annual routine exam</td><td>$10 copay for Medicare-covered exam;
$10 copay for one annual routine exam</td></tr>
<tr><td>Dental</td><td>Dental HMO at $11.60/month: $1,000 each year for basic and certain other covered services;
Dental PPO at $40.50/month: $1,500 each year for covered services with $50 deductible for major svcs.</td><td>Optional Dental Package: $35/month;
$1,000/year for covered preventive and comprehensive services; 50% co-insurance for some comprehensive services</td></tr>
<tr><td>Chiropractic</td><td>$15 copay per Medicare-covered visit;
$0 copay/visit for 12 routine visits per year</td><td>$0 copay per Medicare covered visit;
$0 copay for 30 routine visits per year
(combined with acupuncture visits)</td></tr>
<tr><td>Podiatry</td><td>$15 copay per Medicare-covered visit;
$1,000 annual allowance for routine foot care</td><td>$10 copay per Medicare-covered visit;
$10 co-pay/visit, for 12 routine visits per year</td></tr>
<tr><td>Prescription Drugs (Outpatient)</td><td><table>
<tr><td>Cost-sharing shown is for network pharmacies</td><td>30 days</td><td>90 days</td><td>90 days mail</td></tr>
<tr><td>Preferred Generic</td><td>$0</td><td>$0</td><td>$0</td></tr>
<tr><td>Generic</td><td>$12</td><td>$18</td><td>$18</td></tr>
<tr><td>Preferred Brand</td><td>$40</td><td>$100</td><td>$100</td></tr>
<tr><td>Non-Preferred Brand</td><td>$95</td><td>$237.50</td><td>$237.50</td></tr>
<tr><td>Specialty co-insurance</td><td>33%</td><td>N/A</td><td>N/A</td></tr>
</table>
$0 deductible; after total yearly drug costs reach $4,130, you pay no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach $6,550. After that, you pay the greater of $3.70 or 5% for generics and the greater of $9.20 or 5% for brands.</td><td>THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.

YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.</td></tr>
<tr><td>Other Benefits/Options</td><td>Acupuncture: $0 copay/visit for 12 visits/year
Mobility: Annual AAA Membership for members with chronic illnesses
Over the Counter: $90 quarterly allowance for covered items
Wellness: $0 for Silver Sneakers gym membership</td><td>Acupuncture: $0 copay/visit for 30 routine visits per year (combined with chiropractic visits)
Wellness: $0 for Silver&Fit gym membership</td></tr>
<tr><td>Medical Groups and Hospitals</td><td>Medical Groups: Brown & Toland, Hill Physicians
Hospitals: Alameda, Alta Bates/Summit Medical Center (Berkley/Oakland), Eden (Castro Valley), San Leandro, Stanford Valley Care (Pleasanton & Livermore), and Washington Hospital (Fremont)</td><td>Medical Groups: Affinity, Brown & Toland, Hill Physicians, Palo Alto Medical Foundation, Sutter East Bay
Hospitals: Alameda, Alta Bates/Summit (Berkeley/Oakland), Eden (Castro Valley), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleasanton/Livermore), and Washington (Fremont)</td></tr>
</table>

<table>
<tr><td>Please contact the Plan for more information or call 1-800-Medicare</td><td colspan="2">Health Net of California
1-800-977-6738 (Sales & Marketing)
1-800-275-4737 (Member Services)
www.ca.healthnetadvantage.com</td></tr>
<tr><td>Plan Name</td><td>Health Net Healthy Heart
(H0562-068)</td><td>Health Net Ruby Select
(H0562-113)</td></tr>
<tr><td>Star Rating</td><td>★★★★</td><td>★★★★</td></tr>
<tr><td>Annual OOP Max</td><td>$3,400</td><td>$6,700</td></tr>
<tr><td>Monthly Premium</td><td>$125</td><td>$0</td></tr>
<tr><td>Doctor Visits</td><td>$5 copay for Primary Care Physician;
$10 for Specialist</td><td>$0 copay for Primary Care Physician;
$15 for Specialist</td></tr>
<tr><td>Inpatient Hospital</td><td>$275 copay/day for days 1-7;
$0 per day for days 8 and beyond</td><td>$275 copay/day for days 1-7;
$0 per day for days 8 and beyond</td></tr>
<tr><td>Outpatient Hospital</td><td>$125 per ambulatory surgical center visit;
$250 copay per outpatient hospital facility visit;</td><td>$200 per ambulatory surgical center visit;
$250 copay per outpatient hospital facility visit</td></tr>
<tr><td>Skilled Nursing Facility</td><td>$0 copay for days 1-20;
$170 per day for days 21-100</td><td>$0 copay for days 1-20;
$140 per day for days 21-100</td></tr>
<tr><td>Ambulance</td><td>$75 copay per ground ambulance trip;
5% coinsurance per air ambulance trip</td><td>$250 copay per ground ambulance trip;
5% coinsurance per air ambulance trip</td></tr>
<tr><td>Emergency & Urgent Care</td><td>$120 copay per ER visit; waived if admitted to hospital immediately; $10 per urgent care visit; $50,000 annual limit for care outside U.S.</td><td>$90 copay per emergency room visit; waived if admitted to hospital immediately; $20 per urgent care visit; $50,000 annual limit for care outside U.S.</td></tr>
<tr><td>Lab Tests, Procedures, and Radiation Therapy</td><td>$0 copay for lab, diagnostic procedures, tests, and x-rays; $60 copay per diagnostic and therapeutic radiology service</td><td>$0 copay for lab, diagnostic procedures, tests, and x-rays; $60 copay per diagnostic and therapeutic radiology service</td></tr>
<tr><td>Renal Dialysis</td><td>20% co-insurance per treatment</td><td>20% co-insurance per treatment</td></tr>
<tr><td>Outpatient Mental Health Visits</td><td>$15 copay for individual or
group therapy session</td><td>$10 copay for individual or
group therapy session</td></tr>
<tr><td>Eyewear</td><td>Routine eyewear available for additional premium;
See Optional Benefit Plans below</td><td>$250 allowance for eyeglasses or contact lenses every two years; $120 allowance for progressive lenses or progressive lens upgrades every two years</td></tr>
<tr><td>Eye Exams</td><td>$0-$10 copay per Medicare-covered exam;
$10 copay for one annual routine exam</td><td>$0-$25 copay per Medicare-covered exam;
$12 copay for one annual routine exam</td></tr>
<tr><td>Hearing Aids</td><td>$0 - $1,350 copay per aid for up to
two hearing aids each year</td><td>$0 - $1,350 co-pay per aid for up to
two hearing aids each year</td></tr>
<tr><td>Hearing Exams</td><td>$0 copay for Medicare-covered exam;
$0 copay for one annual routine exam</td><td>$0-$25 copay for Medicare-covered exam;
$0 copay for one annual routine exam</td></tr>
<tr><td>Dental</td><td>$0 copay for Medicare covered visit;
See Optional Benefit Plans below</td><td>$0 copay for Medicare covered visit;
$0 copays for certain preventive services; varying copays for comprehensive services</td></tr>
<tr><td>Chiropractic</td><td>$10 copay per Medicare covered visit
See Optional Benefit Plans below</td><td>$0 copay per Medicare covered visit;
$0 copay for 24 routine visits per year
(combined with acupuncture visits)</td></tr>
<tr><td>Podiatry</td><td>$10 copay per Medicare-covered visit;
Routine care not covered</td><td>$25 copay per Medicare-covered visit
$25 co-pay per visit, up to 12 routine visits per year</td></tr>
<tr><td>Prescription Drugs (Outpatient)</td><td><table>
<tr><td>Cost-sharing shown is for network pharmacies</td><td>30 days</td><td>90 days</td><td>90 days mail</td></tr>
<tr><td>Preferred Generic</td><td>$5</td><td>$10</td><td>$10</td></tr>
<tr><td>Generic</td><td>$13</td><td>$20</td><td>$26</td></tr>
<tr><td>Preferred Brand</td><td>$42</td><td>$47</td><td>$116</td></tr>
<tr><td>Non-Preferred Brand</td><td>$95</td><td>$100</td><td>$275</td></tr>
<tr><td>Specialty co-insurance</td><td>28%</td><td>28%</td><td>N/A</td></tr>
</table>
$0 deductible for Tiers 1&2; $250 deductible for Tiers 3, 4, & 5; after total yearly drug costs reach $4,130, you pay no more than 25% of the plan’s cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach $6,550. After that, you pay the greater of $3.70 or 5% for generics and the greater of $9.20 or 5% for brands.</td><td><table>
<tr><td>Cost-sharing shown is for network pharmacies</td><td>30 days</td><td>90 days</td><td>90 days mail</td></tr>
<tr><td>Preferred Generic</td><td>$0</td><td>$8</td><td>$0</td></tr>
<tr><td>Generic</td><td>$5</td><td>$15</td><td>$10</td></tr>
<tr><td>Preferred Brand</td><td>$42</td><td>$47</td><td>$116</td></tr>
<tr><td>Non-Preferred Brand</td><td>$95</td><td>$100</td><td>$275</td></tr>
<tr><td>Specialty co-insurance</td><td>33%</td><td>33%</td><td>N/A</td></tr>
</table>
$0 deductible; after total yearly drug costs reach $4,130, you pay no more than 25% of the plan’s cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach $6,550. After that, you pay the greater of $3.70 or 5% for generics and the greater of $9.20 or 5% for brands.</td></tr>
<tr><td>Other Benefits/Options</td><td>-Health Net Total Fit Plus at $20 per month: $0 co-pay for some preventive dental and varying copays for other services; Dental HMO network applies
-Health Net Total Fitness FLEX at $35 per month: $0 co-pay for some preventive dental and 20-50% co-insurance for other services; $1,000 annual benefit; Dental HMO network applies
-Both Plans Include: Acupuncture and Chiropractic at $10 co-pay per visit, up to 30 combined visits per year; $250 annual allowance for eyewear
Wellness: $0 co-pay for tobacco cessation counseling</td><td>Acupuncture: $0 copay for up to 24 routine visits per year (combined with chiropractic visits)
Over the Counter: $50 allowance per quarter for covered items available via mail order
Transportation: $0 copay per trip for up to 20 trips per year to plan-approved locations
Wellness: $0 for Silver&Fit gym membership; $0 copay for tobacco cessation counseling</td></tr>
<tr><td>Medical Groups and Hospitals</td><td>Medical Groups: Affinity, Brown & Toland, Hill Physicians, Palo Alto Med Foundation, Sutter East Bay; Hospitals: Alameda, Alta Bates/Summit, Eden, San Leandro, St. Rose, Stanford Valley Care, and Washington</td><td>Medical Groups: Affinity; Brown and Toland
Hospitals: Alameda, Alta Bates/Summit, Eden, San Leandro, St. Rose, Stanford Valley Care, and Washington</td></tr>
</table>

Please contact the Plan for more information or call 1-800-Medicare	**Imperial Health Plan of California** **800-838-5197 (Sales & Marketing)** **800-838-8271 (Member Services)** **www.imperialhealthplan.com**
Plan Name	**Imperial Traditional** **(H5496-007)**
Star Rating	Plan too new to be measured
Annual OOP Max	**$2,999**
Monthly Premium	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$100** co-pay for days 1-5; **$0** co-pay/day for days 6-90; **$670** per day for days 91-150
Outpatient Hospital	**$0** co-pay per outpatient hospital facility; **$0** per ambulatory surgical center visit
Skilled Nursing Facility	**$0** copay per day for days 1-20; **$164.50**/day for days 21-100
Emergency & Urgent Care	**$125** co-pay per one-way ground trip; **20%** co-insurance per air ambulance trip
Ambulance	**$90** per emergency room visit; waived if admitted to hospital within 48 hours; **$0** copay for urgent care; up to **$50,000** worldwide
Lab Tests, Procedures, and Radiation Therapy	**$0** co-pay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**20%** co-insurance per individual or group therapy session
Eyewear	**$10** co-pay for contact lenses; **$10** co-pay for eyeglasses; **$175** annual allowance
Eye Exams	**$0** co-pay per Medicare-covered vision services; **$15** co-pay for routine annual exam
Hearing Aids	**20%** co-insurance for hearing aids; **$1,000** annual allowance
Hearing Exams	**20%** coinsurance for Medicare-covered diagnostic exams; **20%** co-insurance for routine exam; plan covers up to **$250**/year
Dental	**$0** co-pay per Medicare-covered visit; **$0** co-pay for preventive services; plan covers up to **$500**/year; **$0** co-pay for certain restorative service; plan covers up to **$500** every 3 months; Liberty Dental Plan
Chiropractic	**$0** co-pay per Medicare-covered visit; Routine visits not covered
Podiatry	**$0** co-pay per Medicare-covered visit; **$0** co-pay for up to 6 routine visits per year

Prescription Drugs (Outpatient)

Cost-sharing shown is for network pharmacies	30 days	90 days	90 days mail
Preferred Generic	**$0**	**$0**	**$0**
Generic	**$5**	**$10**	**$10**
Preferred Brand	**$45**	**$90**	**$90**
Non-Preferred Brand	**$90**	**$180**	**$180**
Specialty co-insurance	**33%**	**33%**	**N/A**

$0 deductible; **after total yearly drug costs reach $4,130**, you pay **$0** for generics and no more than **25%** of the plan's cost for brand name drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.

Other Benefits/Options	**Over the Counter: $35** quarterly allowance for OTC items via mail order catalogue **Transportation: $0** co-pay for unlimited round trips to plan approved locations **Wellness: $0** for Silver&Fit gym membership
Medical Groups and Hospitals	**Medical Groups:** Imperial Health Holdings, Nivano Physicians, Physician Partners IPA **Hospitals**: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), and Washington Hospital (Fremont)

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan 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	
Plan Name	**Kaiser Permanente Senior Advantage Basic Alameda (H0524-059)**	**Kaiser Permanente Senior Advantage (H0524-032)**
Star Rating	★★★★★	★★★★★
Annual OOP Max	**$6,700**	**$4,900**
Monthly Premium	**$24**	**$84**
Doctor Visits	**$20** copay for Primary Care Physician; **$30** for Specialist	**$10** copay for Primary Care Physician; **$20** for Specialist
Inpatient Hospital	**$310** copay/day for days 1-7; **$0** per day for days 8 and beyond	**$240** copay/day for days 1-7; **$0** per day for days 8 and beyond
Outpatient Hospital	**$300** per ambulatory surgical center visit**;** **$0-$300** copay per outpatient hospital facility visit;	**$200** per ambulatory surgical center visit**;** **$0-$200** copay per outpatient hospital facility visit;
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$100** per day for days 21-100	**$0** copay/day for days 1-20; **$100** per day for days 21-100
Ambulance	**$200** copay per air or ground ambulance trip	**$200** copay per air or ground ambulance trip
Emergency & Urgent Care	**$90** for emergency room visit; **$20** for urgent care visit; Worldwide coverage	**$90** for emergency room visit; **$10** for urgent care visit; Worldwide coverage
Lab Tests, Procedures, and Radiation Therapy	**$0-$20** copay for lab, diagnostic tests & procedures; **$30** copay for x-ray; **$215** copay for diagnostic radiology; **$0** for therapeutic radiology	**$0-$10** copay for lab, diagnostic tests & procedures; **$20** copay for x-ray; **$200** copay for diagnostic radiology; **$0** for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$20** copay per individual session; **$10** per group therapy session	**$10** copay per individual session; **$5** per group therapy session
Eyewear	**$40** allowance for eyewear every 2 years; See Optional Benefits Plan below	**$40** allowance for eyewear every 2 years; See Optional Benefits Plan below
Eye Exams	**$10-$20** copay per Medicare-covered exam; **$20** per routine exam	**$10-$20** copay per Medicare-covered exam; **$10** per routine exam
Hearing Aids	Not Covered See Optional Benefits Plan below	Not Covered See Optional Benefit Plan below
Hearing Exams	**$20-$30** copay per Medicare-covered exam; Routine exams not covered	**$10-$20** copay per Medicare-covered exam; Routine exams not covered
Dental	Not Covered; See Optional Benefits Plan below	Not Covered; See Optional Benefits Plan below
Chiropractic	**$20** copay per Medicare covered visit; Routine care not covered	**$10** copay per Medicare covered visit; Routine care not covered
Podiatry	**$20** copay per Medicare covered visit; Routine foot care not covered	**$10** copay per Medicare covered visit; Routine foot care not covered
Prescription Drugs (Outpatient)	**$0** deductible; **after total yearly drug costs reach $4,130**, you pay **$6** copay for preferred generic, **$18** for generic and **25%** for brand name and specialty drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay **$3** for generics and **$12** for brands.	**$0** deductible; **after total yearly drug costs reach $4,130**, you pay **$3** copay for preferred generic, **$12** for generic and **25%** for brand name and specialty drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay **$3** for generics and **$12** for brands.
Other Benefits/Options	**Optional Benefit Plan: Advantage Plus** at **$16/month:** **-Dental:** Copays vary depending upon the service; Delta Care USA HMO network **-Hearing: $350** allowance for 1 aid every 3 years **-Vision: $0** copay for eyewear with **$280** limit (in addition to **$40** limit above) every two years **Meals: $0** copay for home-delivered meals after hospitalization due to congestive heart failure, two per day for four weeks, once per year **Wellness: $0** for Silver&Fit gym membership	**Optional Benefit Plan: Advantage Plus** at **$16/month:** **-Dental:** Copays vary depending upon the service; Delta Care USA HMO network **-Hearing: $350** allowance for 1 aid every 3 years **-Vision: $0** copay for eyewear with **$280** limit (in addition to **$40** limit above) every two years **Meals: $0** copay for home-delivered meals after hospitalization due to congestive heart failure, two per day for four weeks, once per year **Wellness: $0** for Silver&Fit gym membership
Medical Groups and Hospitals	**Medical Groups:** Kaiser Permanente **Hospitals:** Kaiser Oakland, San Leandro, Fremont	**Medical Groups:** Kaiser Permanente **Hospitals:** Kaiser Oakland, San Leandro, Fremont

Prescription Drugs — Kaiser Permanente Senior Advantage Basic Alameda (H0524-059):

Cost-sharing shown is for network pharmacies	30 days	100 days	100 days Mail
Preferred Generic	**$6**	**$18**	**$0**
Generic	**$18**	**$102**	**$36**
Preferred Brand	**$47**	**$141**	**$94**
Non-Preferred Brand	**$100**	**$300**	**$200**
Specialty co-insurance	**33%**	**33%**	**33%**

Prescription Drugs — Kaiser Permanente Senior Advantage (H0524-032):

Cost-sharing shown is for network pharmacies	30 days	100 days	100 days Mail
Preferred Generic	**$3**	**$9**	**$0**
Generic	**$12**	**$36**	**$24**
Preferred Brand	**$47**	**$141**	**$94**
Non-Preferred Brand	**$100**	**$300**	**$200**
Specialty co-insurance	**33%**	**33%**	**33%**

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Stanford Health Care Advantage** **1-855-921-3777 (Sales & Marketing)** **1-855-996-8422 (Member Services)** www.stanfordhealthcareadvantage.org	
Plan Name	**Gold (H2986-007)**	**Platinum (H2986-004)**
Star Rating	★★★1/2	★★★1/2
Annual OOP Max	**$6,500**	**$5,250**
Monthly Premium	**$69**	**$99**
Doctor Visits	**$10** copay for Primary Care Physician; **$30** for Specialist	**$10** copay for Primary Care Physician; **$20** for Specialist
Inpatient Hospital	**$275** copay/day for days 1-7; **$0** for days 8 and beyond	**$275** copay/day for days 1-7; **$0** for days 8 and beyond
Outpatient Hospital	**20%** co-insurance per ambulatory surgical center and outpatient hospital visit	**$240** copay per ambulatory surgical center and outpatient hospital visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$150** per day for days 21-100	**$0** copay/day for days 1-20; **$100** per day for days 21-100
Ambulance	**$210** copay per ground or air ambulance trip	**$200** copay per ground or air ambulance trip
Emergency & Urgent Care	**$80** copay for emergency room visit; waived if admitted to hospital within 24 hours; **$35** for urgent care visit; coverage in US & territories only	**$80** per emergency room visit; waived if admitted to hospital within 24 hours; **$35** per urgent care visit; Worldwide coverage with **$80** and **$35** copays, up to **$50,000** lifetime max
Lab Tests, Procedures, and Radiation Therapy	**$10** copay for lab services; **$45** for diagnostic procedures, tests, and x-rays; **$210** copay for diagnostic radiology; **20%** of cost for therapeutic radiology	**$10** copay for lab services; **$25** for diagnostic procedures, tests, and x-rays; **$210** copay for diagnostic radiology; **20%** of cost for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$20** copay per individual session; **$30** per group therapy session	**$10** copay per individual session; **$20** per group therapy session
Eyewear	See Optional Benefit Package below	See Optional Benefit Package below
Eye Exams	**$10-$20** copay per Medicare-covered exam; Routine exams not covered; See Optional Benefit Package below	**$10-$20** copay per Medicare-covered exam**;** Routine exams not covered; See Optional Benefit Package below
Hearing Aids	Not Covered	Not Covered
Hearing Exams	**$0** copay per Medicare-covered exam; **$0** copay for 1 annual routine exam	**$0** copay per Medicare-covered exam **$0** for one annual routine exam
Dental	**$30** copay per Medicare covered visit See Optional Benefit Package below	**$20** copay per Medicare covered visit See Optional Benefit Package below
Chiropractic	**$20** copay per Medicare covered visit; Routine care not covered	**$20** copay per Medicare covered visit; Routine care not covered
Podiatry	**$30** copay per Medicare-covered visit; Routine foot care not covered	**$20** copay per Medicare covered visit; Routine foot care not covered

Prescription Drugs (Outpatient)

Gold (H2986-007):

Cost-sharing shown is for network pharmacies	30 days	90 days	100 days mail
Preferred Generic	**$5**	**$15**	**$10**
Generic	**$15**	**$45**	**$30**
Preferred Brand	**$47**	**$141**	**$94**
Non-Preferred Brand	**$100**	**$300**	**$200**
Specialty co-insurance	**28%**	**N/A**	**N/A**

$0 deductible for tiers 1&2; **$250** deductible for tiers 3,4,&5; after total yearly drug costs reach **$4,130**, you pay no more than **25%** of the plan's cost for brand name drugs and **25%** for generics until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics & the greater of **$9.20** or **5%** for brands.

Platinum (H2986-004):

Cost-sharing shown is for network pharmacies	30 days	90 days	100 days mail
Preferred Generic	**$5**	**$15**	**$10**
Generic	**$15**	**$45**	**$30**
Preferred Brand	**$47**	**$141**	**$94**
Non-Preferred Brand	**$100**	**$300**	**$200**
Specialty co-insurance	**33%**	**33%**	**33%**

$0 deductible; after total yearly drug costs reach **$4,130**, you pay no more than **25%** of the plan's cost for brand name drugs and **25%** for generics until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.

	Gold (H2986-007)	Platinum (H2986-004)
Other Benefits/Options	**Optional benefit package** at **$20/month:** -**$25** co-pay for one routine annual vision exam -**$150** allowance for eyewear every two years w/VSP -**$0** co-pay for preventive dental services; **$0-$125** co-pay for general services; **$5-$445** co-pay for major services; Dental HMO with Delta Care USA **Meals:** **$0** copay for up to 2 meals/day for 28 days (max 56/year), following surgery or inpatient hospital stay; **$0** copay for up to 2 meals/day for 14 days (max 28/year) for chronic condition **Transportation: $0** co-pay for 24 trips per year to plan approved locations	**Optional benefit package** at **$20/month:** -**$25** co-pay for one routine annual vision exam -**$150** allowance for eyewear every two years w/VSP -**$0** co-pay for preventive dental services; **$0-$125** co-pay for general services; **$5-$445** co-pay for major services; Dental HMO with Delta Care USA **Acupuncture: $10** co-pay per visit up to 15/year **Meals: $0** copay for up to 2 meals/day for 28 days (max 56/year), following surgery or inpatient hospital stay; **$0** copay for up to 2 meals/day for 14 days (max 28/year) for chronic condition **Transportation: $0** co-pay for 24 trips per year to plan approved locations **Wellness: $0** for Silver&Fit gym membership
Medical Groups and Hospitals	**Medical Groups:** Sutter East Bay Medical Foundation, Stanford Affiliates **Hospitals:** Alameda, Alta Bates/Summit, Eden, Highland, San Leandro, St. Rose, Stanford Palo Alto, and Stanford Valley Care	**Medical Groups:** Sutter East Bay Medical Foundation, Stanford Affiliates **Hospitals:** Alameda, Alta Bates/Summit, Eden, Highland, San Leandro, St. Rose, Stanford Palo Alto, and Stanford Valley Care

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<table>
<tr><td>Please contact the Plan for outline of coverage & provider information or call 1-800-Medicare</td><td colspan="2">United Health Care
1-844-723-6473 (Sales and Marketing)
1-877-596-3258 (Member Services)
www.aarpmedicareplans.com</td></tr>
<tr><td>Plan Name</td><td>AARP SecureHorizons Plan 1
(H0543-070)</td><td>UnitedHealthcare Canopy Health
(H0543-188)</td></tr>
<tr><td>Star Rating</td><td>★★★★</td><td>★★★★</td></tr>
<tr><td>Annual OOP Max</td><td>$6,700</td><td>$4,900</td></tr>
<tr><td>Monthly Premium</td><td>$110</td><td>$69</td></tr>
<tr><td>Doctor Visits</td><td>$10 copay for Primary Care Physician;
$10 for Specialist</td><td>$0 copay for Primary Care Physician;
$15 for Specialist</td></tr>
<tr><td>Inpatient Hospital</td><td>$390 copay/day for days 1-5;
$0 for days 6 and beyond (unlimited)</td><td>$250 copay/day for days 1-7;
$0 for days 8 and beyond (unlimited)</td></tr>
<tr><td>Outpatient Hospital</td><td>$370 copay for ambulatory surgical center visit;
$370 copay for outpatient hospital visit</td><td>$150 copay for ambulatory surgical center visit;
$210 copay for outpatient hospital visit</td></tr>
<tr><td>Skilled Nursing Facility</td><td>$0 copay/day for days 1-20;
$184 per day for days 21-57; $0 for 58-100</td><td>$0 copay/day for days 1-20;
$184 per day for days 21-47; $0 for 48-100</td></tr>
<tr><td>Emergency & Urgent Care</td><td>$90 copay for emergency room visit; waived if admitted to hospital within 24 hours;
$40 per urgent care visit;
$0 copay for worldwide coverage</td><td>$90 copay per emergency room visit; waived if admitted to hospital within 24 hours;
$40 per urgent care visit;
$0 copay for worldwide coverage</td></tr>
<tr><td>Ambulance</td><td>$250 copay per ground or air ambulance trip</td><td>$250 copay per ground or air ambulance trip</td></tr>
<tr><td>Lab Tests, Procedures, and Radiation Therapy</td><td>$0 copay for lab, diagnostic tests and procedures; $15 copay per x-ray; $105 copay for diagnostic radiology; $60 copay for therapeutic radiology</td><td>$0 copay for lab, diagnostic tests and procedures; $15 copay per x-ray; $105 copay for diagnostic radiology; $60 copay for therapeutic radiology</td></tr>
<tr><td>Renal Dialysis</td><td>20% co-insurance per treatment</td><td>20% co-insurance per treatment</td></tr>
<tr><td>Outpatient Mental Health Visits</td><td>$25 copay for individual therapy session;
$15 copay for group therapy session</td><td>$25 copay for individual therapy session;
$15 copay for group therapy session</td></tr>
<tr><td>Eyewear</td><td>$0 copay for standard lenses
with $100 allowance toward frames or additional contact lenses every two years</td><td>$0 copay for standard lenses
with $100 allowance toward frames or additional contact lenses every two years</td></tr>
<tr><td>Eye Exams</td><td>$0 copay for Medicare-covered exam;
$0 copay for one annual routine exam</td><td>$0 copay for Medicare-covered exam;
$0 copay for one annual routine exam</td></tr>
<tr><td>Hearing Aids</td><td>$375 - $2,075 copay per aid, through United Healthcare Hearing; 2 aids every two years</td><td>$375 - $2,075 copay per aid, through United Healthcare Hearing; 2 aids every two years</td></tr>
<tr><td>Hearing Exams</td><td>$0 copay for Medicare-covered exam;
$0 copay for one annual routine exam</td><td>$0 copay for Medicare-covered exam;
$0 copay for one annual routine exam</td></tr>
<tr><td>Dental</td><td>$0 copay for Medicare-covered visit
See Optional Benefits Plan below</td><td>$0 copay for Medicare-covered visit
See Optional Benefit Plan below</td></tr>
<tr><td>Chiropractic</td><td>$10 copay for Medicare-covered visit;
Routine care not covered</td><td>$15 copay for Medicare-covered visit;
Routine care not covered</td></tr>
<tr><td>Podiatry</td><td>$10 co-pay per Medicare-covered visit;
$10 co-pay per routine visit, up to 6 per year</td><td>$15 co-pay per Medicare-covered visit;
$15 co-pay per routine visit, up to 6 visits per year</td></tr>
<tr><td>Prescription Drugs (Outpatient)</td><td><table><tr><td>Cost-sharing shown is for network pharmacies</td><td>30 days</td><td>90 days</td><td>90 days mail</td></tr><tr><td>Preferred Generic</td><td>$3</td><td>$9</td><td>$9</td></tr><tr><td>Generic</td><td>$12</td><td>$36</td><td>$36</td></tr><tr><td>Preferred Brand</td><td>$47</td><td>$141</td><td>$141</td></tr><tr><td>Non-Preferred Brand</td><td>$100</td><td>$300</td><td>$300</td></tr><tr><td>Specialty co-insurance</td><td>26%</td><td>26%</td><td>26%</td></tr></table>$0 deductible for Tiers 1-2; $350 for Tiers 3-5; after total yearly drug costs reach $4,130, you pay no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach $6,550. After that, you pay the greater of $3.70 or 5% for generics and the greater of $9.20 or 5% for brands.</td><td><table><tr><td>Cost-sharing shown is for network pharmacies</td><td>30 days</td><td>90 days</td><td>90 days mail</td></tr><tr><td>Preferred Generic</td><td>$2</td><td>$6</td><td>$6</td></tr><tr><td>Generic</td><td>$12</td><td>$36</td><td>$36</td></tr><tr><td>Preferred Brand</td><td>$47</td><td>$141</td><td>$141</td></tr><tr><td>Non-Preferred Brand</td><td>$100</td><td>$300</td><td>$300</td></tr><tr><td>Specialty co-insurance</td><td>33%</td><td>N/A</td><td>N/A</td></tr></table>$0 deductible; after total yearly drug costs reach $4,130, you pay no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach $6,550. After that, you pay the greater of $3.70 or 5% for generics and the greater of $9.20 or 5% for brands.</td></tr>
<tr><td>Other Benefits/Options</td><td>Optional Dental Platinum Rider at:
$45/month: includes certain preventive and comprehensive benefits with varied cost-sharing</td><td>Over the Counter: $40 allowance per quarter for items from Health and Wellness Products catalog
Wellness: $0 for Renew Active Fitness gym membership
Optional Dental Platinum Rider at:
$45/month: includes certain preventive and comprehensive benefits with varied cost-sharing</td></tr>
<tr><td>Medical Groups and Hospitals</td><td>Medical Groups: Brown & Toland, Hill Physicians East Bay, and Sutter East Bay Medical Foundation
Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), and Washington (Fremont)</td><td>Medical Groups: Canopy Health Hill Physicians East Bay, Canopy Health John Muir Physicians, and Canopy Health Meritage Medical Network
Hospitals: Alameda, Alta Bates/Summit, Eden, Highland, San Leandro, St. Rose, UCSF, and Washington</td></tr>
</table>

Please contact the Plan for more information or call 1-800-Medicare	**Health Net of California** **1-800-977-6738** (Sales & Marketing) **1-800-275-4737** (Member Services) www.ca.healthnetadvantage.com	
Plan Name	**Sapphire Premier (H3561-002) (PREMIUMS and COPAYS WAIVED for FULL DUALS)**	**Sapphire Premier II (H3561-005) (PREMIUMS and COPAYS WAIVED for FULL DUALS)**
Star Rating	★★★1/2	★★★1/2
Annual OOP Max	**$3,450**	**$3,450**
Monthly Premium	**$25.40**	**$26.70**
Doctor Visits	**$0** copay for Primary Care Physician; **$0** for Specialist	**$0** copay for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$800** copay/day for days 1-3; **$0** for days 4-90	**$800** copay/day for days 1-3; **$0** for days 4-90
Outpatient Hospital	**20%** co-insurance for ambulatory surgical center or outpatient hospital facility visit	**20%** co-insurance for ambulatory surgical center or outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay for days 1-20; **$176** per day for days 21-100	**$0** copay for days 1-20; **$176** per day for days 21-100
Emergency & Urgent Care	**$120** per emergency room visit; waived if admitted to the hospital immediately; **20%** co-insurance (up to **$65**) per urgent care visit	**$120** per emergency room visit; waived if admitted to the hospital immediately; **20%** co-insurance (up to **$65**) per urgent care visit
Ambulance	**20%** co-insurance for ground or air ambulance trip	**20%** co-insurance for ground or air trip
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services; **20%** co-insurance for diagnostic tests and procedures, x-rays, diagnostic and therapeutic radiology	**$0** copay for lab services; **20%** co-insurance for diagnostic tests and procedures, x-rays, diagnostic and therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**20%** co-insurance per individual or group therapy session	**20%** co-insurance per individual or group therapy session
Eyewear	**$550** allowance for eyewear each year	**$550** allowance for eyewear each year
Eye Exams	**$0** copay for Medicare-covered exam; **$0** copay for one annual routine exam	**$0** copay for Medicare-covered exam; **$0** copay for one annual routine exam
Hearing Aids	**$0 - $1,350** copay each aid for two hearing aids per year	**$0 - $1,350** co-pay each aid for two hearing aids per year
Hearing Exams	**20%** co-insurance for Medicare-covered exam; **$0** for one routine annual exam	**20%** co-insurance for Medicare-covered exam; **$0** for one routine annual exam
Dental	**20%** co-insurance for Medicare covered visit; **$0** co-pay for certain preventive services; **$1,000** allowance per year for comprehensive services	**$0** copay for Medicare covered visit; **$1,000** allowance per year for comprehensive services
Chiropractic	**$0** co-pay for Medicare-covered visit; **$0** copay/visit for 30 routine visits per year; combined with acupuncture visits	**$0** copay for Medicare-covered visit; **$0** copay/visit for 30 routine visits per year; combined with acupuncture visits
Podiatry	**$0** co-pay for Medicare-covered visit; **$0** co-pay/visit for 12 routine visits per year	**$0** co-pay for Medicare-covered visit; **$0** co-pay/visit for 12 routine visits per year

Prescription Drugs (Outpatient)

Sapphire Premier (H3561-002):

Cost-sharing shown is for network pharmacies	30 days	90 days	90 days mail
Preferred Generic	**$0**	**$0**	**$0**
Generic	**$20**	**$60**	**$60**
Preferred Brand	**$47**	**$141**	**$141**
Non-Preferred Brand	**45%**	**$300**	**45%**
Specialty co-insurance	**25%**	**N/A**	**N/A**

$0 deductible for Tier 1; **$445** deductible for Tiers 2, 3, 4, & 5; after total yearly drug costs reach **$4,130**, you pay no more than **25%** of the plan's cost for brand name drugs and **25%** for generic drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics & the greater of **$9.20** or **5%** for brands.

Sapphire Premier II (H3561-005):

Cost-sharing shown is for network pharmacies	30 days	90 days	90 days mail
Preferred Generic	**$0**	**$15**	**$0**
Generic	**$20**	**$45**	**$60**
Preferred Brand	**$47**	**$141**	**$141**
Non-Preferred Brand	**47%**	**$300**	**47%**
Specialty co-insurance	**25%**	**N/A**	**N/A**

$0 deductible for Tier 1; **$445** deductible for Tiers 2, 3, 4, & 5; after total yearly drug costs reach **$4,130**, you pay no more than **25%** of the plan's cost for brand name drugs and **25%** for generic drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics & the greater of **$9.20** or **5%** for brands.

	Sapphire Premier (H3561-002)	Sapphire Premier II (H3561-005)
Other Benefits/Options	**Acupuncture:** **$0** copay/visit for 30 visits per year; combined with chiropractic visits **Over the Counter:** **$125** allowance per quarter for mail order items from catalogue **Transportation:** **$0** co-pay for up to 40 one-way trips to plan-approved locations each year **Wellness:** **$0** for Silver&Fit gym membership; **$0** copay for tobacco cessation counseling	**Acupuncture:** **$0** copay/visit for 30 visits per year; combined with chiropractic visits **Meals:** **$0** copay for home-delivered meals (up to 2/day for 14 days) following hospital or skilled nursing facility stay and medically necessary **Over the Counter:** **$125** allowance per quarter for mail order items from catalog **Transportation:** **$0** co-pay for up to 40 one-way trips to plan-approved locations each year **Wellness:** **$0** for Silver&Fit gym membership; **$0** copay for tobacco cessation counseling
Medical Groups and Hospitals	**Medical Groups:** Affinity; Brown and Toland **Hospitals:** Alameda, Alta Bates/Summit (Berkeley/Oakland), Eden (Castro Valley), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleasanton/Livermore), and Washington (Fremont)	**Medical Groups:** Affinity; Brown and Toland **Hospitals:** Alameda, Alta Bates/Summit (Berkeley/Oakland), Eden (Castro Valley), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleasanton/Livermore), and Washington (Fremont)

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Imperial Health Plan of California** **1-800-838-5197 (Sales & Marketing)** **1-800-838-8271 (Member Services)** www.imperialhealthplan.com	
Plan Name	**Imperial Traditional Plus** **(H5496-009)** **(PREMIUMS and COST-SHARING WAIVED for FULL DUALS)**	**Imperial Senior Value (H5496-005)** **(C-SNP: SPECIAL NEEDS PLAN for People with Cardiovascular Disorders, Chronic Heart Failure, Diabetes)**
Star Rating	Plan too new to be measured	Plan too new to be measured
Annual OOP Max	**$2,999**	**$2,999**
Monthly Premium	**$31.50**	**$0**
Doctor Visits	**20%** co-insurance for Primary Care Physician; **20%** co-insurance for Specialist	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$0** copay/day for days 1-60; **$352** co-pay/day for days 61-90; **$704** co-pay/day for days 91-150	**$0** per day for days 1-5; **$0** per day for days 6 through 90; **$670** per day for days 91-150
Outpatient Hospital	**20%** co-insurance per outpatient hospital facility or ambulatory surgical center visit	**$0** per ambulatory surgical center or outpatient hospital facility visit
Skilled Nursing Facility	**$0** co-pay for days 1-20; **$176**/day for days 21-100	**$0** co-pay for days 1-20; **$164.50**/day for days 21-100
Ambulance	**20%** co-insurance per ground or air ambulance trip	**$125** copay per ground ambulance trip **20%** co-insurance per air ambulance trip
Emergency & Urgent Care	**20%** co-insurance (up to **$90)** per ER visit; **20%** co-insurance (up to **$65)** per urgent care visit; waived if admitted to hospital within 3 days	**$0** copay per emergency room visit; **$0** copay per urgent care visit
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services; **20%** co-insurance for diagnostic tests and procedures, x-rays, diagnostic and therapeutic radiology	**$0** copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; **20%** co-insurance for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**20%** co-insurance per individual or group therapy session	**20%** co-insurance per individual or group therapy session
Eyewear	**20%** of cost for eyeglasses every 2 years or 1 pair contact lenses every 6 months; **$250** plan allowance per year	**$15** copay for one pair eyeglasses or contacts every 2 years; **$175** plan allowance per year
Eye Exams	**20%** co-insurance copay per Medicare-covered exam; **20%** co-insurance for one annual routine exam	**$0** copay per Medicare-covered exam; **$15** copay for one routine annual exam
Hearing Aids	**20%** co-insurance; **$1,250** plan allowance per year	**20%** co-insurance; **$1,000** plan allowance per year
Hearing Exams	**20%** co-insurance for diagnostic and routine exams	**20%** co-insurance for Medicare-covered exam; **20%** co-insurance for routine exam; **$250** plan allowance per year
Dental	**$0** co-pay per Medicare-covered visit; **$0** co-pay for preventive services up to **$500** annual allowance; **$0** co-pay for restorative services, up to **$500** quarterly allowance	**$0** co-pay per Medicare-covered visit; **$0** co-pay for preventive services up to **$500** annual allowance; **$0** co-pay for restorative services, up to **$500** quarterly allowance
Chiropractic	**20%** co-insurance per Medicare-covered visit; Routine visits not covered	**$0** co-pay per Medicare-covered visit; Routine visits not covered
Podiatry	**20%** co-insurance per Medicare-covered visit; **$0** co-pay/visit for 6 routine visits per year	**$0** copay per Medicare-covered visit; **$0** copay for up to 6 routine visits per year

Prescription Drugs (Outpatient)

Imperial Traditional Plus:

Cost-sharing shown is for network pharmacies	30 days	90 days	90 days mail
Preferred Generic	**$0**	**$0**	**$0**
Generic	**25%**	**25%**	**25%**
Preferred Brand	**25%**	**25%**	**25%**
Non-Preferred Brand	**25%**	**25%**	**25%**
Specialty co-insurance	**25%**	**N/A**	**N/A**

$0 deductible for Tier 1; **$445** deductible for Tiers 2-5; **after total yearly drug costs reach $4,130**, you pay **$0** for generics and no more than **25%** of the plan's cost for brand name drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.

Imperial Senior Value:

Cost-sharing shown is for network pharmacies	30 days	90 days	90 days mail
Preferred Generic	**$0**	**$0**	**$0**
Generic	**$5**	**$10**	**$10**
Preferred Brand	**$45**	**$90**	**$90**
Non-Preferred Brand	**$90**	**$180**	**$180**
Specialty co-insurance	**33%**	**N/A**	**N/A**

$0 deductible; **after total yearly drug costs reach $4,130**, you pay **$0** for generics and no more than **25%** of the plan's cost for brand name drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.

	Imperial Traditional Plus	Imperial Senior Value
Other Benefits/Options	**Over the Counter: $75** quarterly allowance for OTC items via mail order catalog **Transportation: $0** co-pay for unlimited round trips to plan approved locations **Wellness: $0** for Silver&Fit gym membership	**Over the Counter: $75** quarterly allowance for OTC items via mail order catalog **Transportation: $0** co-pay for up to unlimited round trips to plan approved locations **Wellness: $0** for Silver&Fit gym membership
Medical Groups and Hospitals	**Medical Groups:** Imperial Health Holdings, Nivano Physicians, Physician Partners IPA **Hospitals**: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), and Washington Hospital (Fremont)	**Medical Groups:** Imperial Health Holdings, Nivano Physicians, Physician Partners IPA **Hospitals**: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), and Washington Hospital (Fremont)

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Anthem Blue Cross** **1-888-211-9813 (Sales & Marketing)** **1-888-230-7338 (Member Services)** www.shop.anthem.com/medicare/ca	**United Health Care** **1-844-723-6473 (Sales and Marketing)** **1-877-596-3258 (Member Services)** www.aarpmedicareplans.com
Plan Name	**MediBlue Coordination Plus** **(H0544-099) (PREMIUMS and COST-SHARING WAIVED for FULL DUALS)**	**Medicare Advantage Assure** **(H0543-183) (PREMIUMS and COST-SHARING WAIVED for FULL DUALS)**
Star Rating	★★★1/2	★★★★
Annual OOP Max	**$7,550**	**$7,550**
Monthly Premium	**$4.20**	**$26.60**
Doctor Visits	**$20%** co-insurance for Primary Care Physician; **20%** co-insurance for Specialist	**20%** co-insurance for Primary Care Physician; **20%** co-insurance for Specialist
Inpatient Hospital	**$1,408** deductible for days 1-60; **$352** co-pay/day for days 61-90; **$704** co-pay/day for days 91-150	**$1,400** copay per stay for unlimited days
Outpatient Hospital	**20%** co-insurance per ambulatory surgical center visit or outpatient hospital facility visit	**20%** co-insurance per ambulatory surgical center visit or outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay for days 1-20; **$176**/day for days 21-100	**$0** co-pay for days 1-20; **$176**/day for days 21-100
Emergency & Urgent Care	**$90** copay per emergency room visit; waived if admitted to hospital within 24 hours; **$65** per urgent care visit; Worldwide coverage up to **$100,000** per year	**$90** per emergency room visit; ; waived if admitted to hospital within 24 hours **$65** per urgent care visit; Worldwide coverage
Ambulance	**20%** co-insurance per ground or air ambulance trip	**20%** co-insurance per ground or air ambulance trip
Lab Tests, Procedures, and Radiation Therapy	**20%** co-insurance for lab services and diagnostic tests, procedures, x-rays and diagnostic and therapeutic radiology	**$0** copay for lab services and diagnostic tests and procedures; **20%** co-insurance for x-rays, diagnostic and therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**20%** co-insurance per individual or group therapy session	**$0** copay per individual or group therapy session
Eyewear	**$300** annual allowance for eyeglasses or contact lenses	**$100** allowance for eyeglasses or contact lenses every 2 years; eyeglass lenses covered in full
Eye Exams	**20%** co-insurance per Medicare-covered exam; **$0** copay for 1 annual routine exam	**20%** co-insurance per Medicare-covered exam; **$0** copay for 1 annual routine exam
Hearing Aids	**$3,000** annual allowance for hearing aids	**$2,500** allowance for up to 2 aids every 2 years
Hearing Exams	**$0** co-pay per Medicare-covered exam **$0** for 1 annual routine exam	**$0** co-pay per Medicare-covered exam **$0** for 1 annual routine exam
Dental	**$0** co-pay for certain routine dental services; **$225** quarterly allowance for some comprehensive dental	**20%** co-insurance per Medicare-covered visit; routine dental not covered
Chiropractic	**20%** co-insurance per Medicare covered visit; **$0** co-pay for 12 visits per year	**20%** co-insurance per Medicare covered visit; Routine care not covered
Podiatry	**$0** co-pay per Medicare covered visit; **$0** co-pay for unlimited routine visits each year	**20%** co-insurance per Medicare covered visit; **$0** copay for 4 routine visits per year
Prescription Drugs (Outpatient)	*Cost-sharing shown is for network pharmacies* — 30 days / 90 days / 90 days mail: Preferred Generic: **$0** / **$0** / **$0** Generic: **$13** / **$39** / **$39** Preferred Brand: **$47** / **$141** / **$141** Non-Preferred Brand: **$95** / **$285** / **$285** Specialty co-insurance: **25%** / **N/A** / **N/A** **$0** deductible for Tier 1; **$445** deductible for Tiers 2-5; **after total yearly drug costs reach $4,130**, you pay $0 for generics and no more than **25%** of the plan's cost for brand name drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.	*Cost-sharing shown is for network pharmacies* — 30 days / 90 days / 90 days mail: Preferred Generic: **$0** / **$0** / **$0** Generic: **25%** / **25%** / **25%** Preferred Brand: **25%** / **25%** / **25%** Non-Preferred Brand: **25%** / **25%** / **25%** Specialty co-insurance: **33%** / **N/A** / **N/A** **$445** deductible; **after total yearly drug costs reach $4,130**, you pay $0 for generics and no more than **25%** of the plan's cost for brand name drugs until out-of-pocket drug expenses reach **$6,550.** After that, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.
Other Benefits/Options	**Acupuncture:** **$0** co-pay for unlimited visits/year **Meals: $0** co-pay for up to 2 meals per day for 5 days following hospital discharge **Medicare Community Resource Support:** Referrals and coordination for community services **Over the Counter: $100** quarterly allowance for plan approved items **Personal Emergency Response System (PERS): $0** co-pay for monitoring device and services. **Transportation**: **$0** copay for 48 one-way trips/year **Wellness: $0** for Silver Sneakers gym membership	**Over the Counter: $100** quarterly allowance for plan-approved items from catalog **Personal Emergency Response System (PERS): $0** co-pay for monitoring device and services. **Wellness**: **$0** for Renew Active gym membership
Medical Groups and Hospitals	**Medical Groups:** Brown & Toland **Hospitals**: Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), St. Rose, (Hayward), Stanford Valley Care (Pleasanton & Livermore), and Washington (Fremont)	**Medical Groups:** Brown & Toland and Hill Physicians East Bay **Hospitals:** Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), and Washington (Fremont)

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Aetna Medicare** **800-335-1407 (Sales & Marketing)** **833-859-6031 (Customer Service)** **www.aetnamedicare.com**	**Kaiser Permanente** **1-800-777-1238 (Sales & Marketing)** **1-800-443-0815 (Member Services)** **www.medicare.kaiserpermanente.org**
Plan Name	**Aetna Medicare Preferred Plan** **(H4982-008)** **(D-SNP: SPECIAL NEEDS PLAN for FULL DUALS)**	**Kaiser Medicare Medi-Cal North** **(H0524-030)** **(D-SNP: SPECIAL NEEDS PLAN for FULL DUALS)**
Star Rating	Plan too new to be measured	★★★★★
Annual OOP Max	**$7,550**	**$3,400**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$0** per day; Unlimited days each benefit period	**$0** per day; Unlimited days each benefit period
Outpatient Hospital	**$0** per outpatient hospital visit; **$0** per ambulatory surgical center visit	**$0** per outpatient hospital visit; **$0** per ambulatory surgical center visit
Skilled Nursing Facility	**$0** per day; 100 days per benefit period	**$0** per day; 100 days per benefit period
Emergency & Urgent Care	**$0** copay per emergency room or urgent care visit; Worldwide coverage	**$0** copay per emergency room or urgent care visit; Worldwide coverage
Ambulance	**$0** copay per air or ground ambulance trip	**$0** copay per air or ground ambulance trip
Lab Tests, Procedures, and Radiation Therapy	**$0** copay per service	**$0** copay per service
Renal Dialysis	**$0** co-insurance per service	**$0** co-insurance per service
Outpatient Mental Health Visits	**$0** copay per individual or group therapy session	**$0** copay per individual or group therapy session
Eyewear	**$400** annual allowance for eyeglasses or contact lenses	**$300** annual allowance for eyeglasses or contact lenses
Eye Exams	**$0** copay per Medicare-covered exam; **$0** copay for 1 annual routine exam	**$0** copay per Medicare-covered exam; **$0** copay for 1 annual routine exam
Hearing Aids	**$2,500** allowance per aid each year	Not Covered
Hearing Exams	**$0** co-pay per diagnostic exam; **$0** copay for one annual routine exam	**$0** co-pay per diagnostic exam; Routine exams not covered
Dental	**$0** copay for certain preventive and comprehensive services; through Liberty Dental network	**$0** co-pay for certain preventive and comprehensive services
Chiropractic	**$0** co-pay per Medicare covered visit; **$0** copay for unlimited routine visits per year	**$0** co-pay per Medicare covered visit; Routine care not covered
Podiatry	**$0** co-pay per Medicare covered visit; **$0** copay for up to 12 routine visits per year	**$0** co-pay per Medicare covered visit; Routine foot care not covered
Prescription Drugs (Outpatient)	**$0** deductible: Depending on your income, you pay the following: **Generic: $0, $1.30, or $3.70** **All Other Drugs: $0, $4.00, or $9.20** After annual drug costs (paid by you, the plan, and by Extra Help from Medicare) reach **$6,550**, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.	**$0** deductible: Depending on your income, you pay the following: **Generic: $0, $1.30, or $3.70** **All Other Drugs: $0, $3.70, or $9.20** After annual drug costs (paid by you, the plan, and by Extra Help from Medicare) reach **$6,550**, you pay the greater of **$3.70** or **5%** for generics and the greater of **$9.20** or **5%** for brands.
Other Benefits/Options	**Acupuncture: $0** copay for unlimited routine visits per year **Fall Prevention: $150** annual allowance for approved home and bathroom safety devices **Meals: $25** monthly allowance for Health Foods benefit card at approved locations; up to 42 home-delivered meals over a 21-day period following inpatient hospital stay **Over the Counter: $150** quarterly allowance for items from catalog **Personal Emergency Response System (PERS): $0** co-pay for monitoring device and services **Transportation:** 40 one-way trips each year to plan-approved locations **Wellness: $0** for Silver Sneakers gym membership	**Meals:** Up to two home-delivered meals per day for four weeks, following inpatient hospital stay due to congestive heart failure
Medical Groups and Hospitals	**Medical Groups:** Brown and Toland **Hospitals:** Alta Bates/Summit Medical Center (Berkeley/Oakland), St. Rose (Hayward), Stanford Valley Care (Pleasanton and Livermore), Washington Hospital (Fremont)	**Medical Groups:** Kaiser Permanente **Hospitals:** Kaiser Oakland, San Leandro, Fremont

2021 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**United Health Care** **1-844-560-4944** **(Sales and Marketing)** **1-877-596-3258** **(Member Services)** www.aarpmedicareplans.com
Plan Name	**UHC Dual Complete** **(H1375-001)** **(D-SNP: SPECIAL NEEDS PLAN for FULL DUALS)**
Star Rating	Plan too new to be measured
Annual OOP Max	**$0**
Monthly Premium	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$0** per day; Unlimited days each benefit period
Outpatient Hospital	**$0** per outpatient hospital visit; **$0** per ambulatory surgical center visit
Skilled Nursing Facility	**$0** per day; 100 days per benefit period
Emergency & Urgent Care	**$0** copay per emergency room or urgent care visit; Worldwide coverage
Ambulance	**$0** copay per air or ground ambulance trip
Lab Tests, Procedures, and Radiation Therapy	**$0** copay per service
Renal Dialysis	**$0** co-insurance per service
Outpatient Mental Health Visits	**$0** copay per individual or group therapy session
Eyewear	**$0** co-pay for eyeglasses or contact lenses after cataract surgery
Eye Exams	**$0** copay per Medicare-covered exam
Hearing Aids	Not Covered
Hearing Exams	**$0** co-pay per Medicare-covered exam
Dental	**$0** co-pay for certain preventive and comprehensive services, up to **$500** annual limit
Chiropractic	**$0** co-pay per Medicare-covered visit; Routine care not covered
Podiatry	**$0** co-pay per Medicare-covered visit; Routine foot care not covered
Prescription Drugs (Outpatient)	**$0** deductible: **$0** copay for all covered drugs
Other Benefits/Options	**Over the Counter: $50** quarterly credit for items in Health and Wellness catalog
Medical Groups and Hospitals	**Medical Groups:** Brown & Toland, Hill Physicians East Bay, and Sutter East Bay Medical Foundation **Hospitals:** Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), and Washington (Fremont)

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 ($198 in 2020). Medicare Advantage plans also cannot charge cost sharing (meaning no deductible, no copayment or coinsurance) for most in-network 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 preventive care coverage, you can refer to the Medicare and You 2021 Handbook. Call 1-800-Medicare to request a copy or visit: www.medicare.gov/medicare-and-you.

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 https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx)