2023 Medicare Advantage Plan HMO Comparison Chart for Alameda County

~Rev. 12/02/22 ~

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.

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 referrals to see specialists. The HMO will not pay for services received outside the plan's network unless it is urgent or emergency care. In those circumstances, members should notify their plans as soon as possible. The cost-sharing varies from plan to plan. Premiums, copayments, 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 2023, there are 30 Medicare HMOs in Alameda County, and they are listed in this chart. Three of these 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 standalone 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 such as deductibles and coinsurance will apply. In 2023, there are five Medicare PPOs in Alameda County. See our 2023 PPO Comparison Cart for more information and details: www.lashicap.org/hicap.

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 2023, there are 20 Special Needs Plans in Alameda County. See our 2023 Special Needs Plan Comparison Chart for more information and details: www.lashicap.org/hicap.

Enrollment:

In the fall of 2022, 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, 2023. In 2023, 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.

People who have both Medicare and Medi-Cal and those with the Low-Income Subsidy (Extra Help) for Part D can enroll, disensoll 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.

IMPORTANT NOTE: Beginning in 2023, no Medicare Advantage or Prescription Drug Plan can charge more than a \$35 copay per month for insulin and any drug deductibles do not apply.

ABOUT THIS CHART

This Comparison Chart is a summary only and highlights the areas where the Medicare Advantage plans may differ in benefits. For more detailed information about coverage and cost-sharing, contact the plans directly. 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.

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



Navigating Medicare

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Please contact the Plan for more information or call 1-800-Medicare	Aetna M 855-859-6031 (S 833-570-6670 (I www.aetnam	ales & Membe	Market r Servi	<u> </u>	Aetna Medicare 855-859-6031 (Sales & Marketing) 833-570-6670 (Member Services) www.aetnamedicare.com
Plan Name/Type	Aetna Medic (HMO) (I	are Pl	us Pla	n	Aetna Medicare Eagle Plan (HMO) (H4982-013)
Star Rating	**	∀			***
Annual OOP Max	\$3,	900			\$4,200
Monthly Premium	\$				\$0
Doctor Visits	\$0 copay for Prima \$15 for S	specialist		;	\$0 copay for Primary Care Physician; \$10 for Specialist
Inpatient Hospital	\$250 copay/da \$0 per day for da	ys 8 and	beyond		\$50 co-pay/day for days 1-3; \$0 for days 4-90; \$0 for days 91 and beyond (unlimited)
Outpatient Hospital	\$0 copay for ambulato \$150 copay for outpatie				\$0 copay for ambulatory surgical center visit; \$50 copay for outpatient hospital facility visit
Skilled Nursing Facility	\$0 copay/day \$75 per day fo				\$0 copay/day for days 1-20; \$196 per day for days 21-100
Ambulance	\$225 copay per ground			\$275 copay per ground or air ambulance trip	
Emergency & Urgent Care	\$110 copay per em \$15 per urge Copays apply copays waived for ER ca	nt care v worldw	isit; ride;		\$110 copay per emergency room visit; \$10 copay per urgent care visit in U.S.; \$110 per emergency or urgent care visit worldwide; copays waived for ER care if admitted to hospital
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, d and x-rays; \$0 copay fo \$60 copay for the	or diagno	stic radio	logy;	\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$100 copay for diagnostic radiology; \$60 copay for therapeutic radiology
Renal Dialysis	20% co-insuran	ce per tre	eatment		20% co-insurance per treatment
Outpatient Mental Health Visits	\$25 copay per individual				\$25 copay per individual or group therapy session
Eyewear	\$200 annual reimbu for eyeglasse	s or cont	acts	e	\$250 annual reimbursement allowance for eyeglasses or contacts
Eye Exams	\$0 copay for dia \$0 copay for one a			n	\$0 copay per Medicare-covered vision services; \$0 copay for one annual routine exam
Hearing Aids	\$1,250 annual hearing purchased throug	aid allov	vance per		\$2,500 annual hearing aid allowance per ear; purchased through NationsHearing
Hearing Exams	\$0 copay for diagno \$0 copay for one as				\$0 copay for diagnostic hearing exam; \$0 copay for one annual routine exam
Dental	Up to \$1,000 annual rein preventive and com any licensed d	prehensiv ental pro	ve service vider	es;	Up to \$1,500 annual reimbursement for covered preventive and comprehensive services; any licensed dental provider
Chiropractic	\$0 copay for Medic \$0 copay for unlin Must use American Sp	nited rout	ine visits	;	\$0 copay for Medicare covered visits; \$0 copay for unlimited routine chiropractic visits; Must use American Specialty Health provider
Podiatry	\$15 copay per Med	licare-co	vered visi	t	\$10 copay per Medicare-covered visit
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Other Benefits/Options Modical Crowns	Acupuncture: \$0 copay for treatments within American Over the Counter: \$105 q plan-approved items at CV. Transportation: \$0 copay year to plan approved locat Wellness: \$0 copay for bas membership; at-home fitne Medical Groups: Brown a Hospitals: Alta Bates/Sum	n Specials uarterly a S retail of for 12 or ions, via ic Silver ss kit	ty Health allowance r by mail ne-way tr SafeRide Sneakers	network e for order ips each	Acupuncture: \$0 copay for unlimited acupuncture treatments with American Specialty Health network Over the Counter: \$105 quarterly allowance for plan-approved items at CVS retail or by mail order Transportation: \$0 copay for 12 one-way trips each year to plan approved locations, via SafeRide Wellness: \$0 copay for basic Silver Sneakers membership; at-home fitness kit Medical Groups: Brown and Toland Hospitals: Alta Bates/Summit Medical Center
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information or call 1-800-Medicare Medicare Select Plan (IHM) (H0523-068) Star Rating Annual OOP Max Star Rating Star Rating Annual OOP Max Star Rating Star Rating Star Rating Annual OOP Max Star Rating S	2023 N	IEDICARE HMO COM	<u> IPARI</u>	ISON C	HART	FOR ALAMEDA CO	UNTY				
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Plan Name/Type	Plan for more	855-859-6031 (Sa	les & l	Marketi	ing)	800-488-8000 (Sales &	k Marke	ting)		
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Hospitals Valley Care (Pleasanton and Livermore), and Center (Berk/Oak), Eden (Castro Valley), San	Hospitals				oru						
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Washington Hospital (Fremont) Leandro, and Washington (Fremont)	1105pitais	,				Leandro, and Washington (Fremont)					

Alignment Health Plan 888-979-2247 (Member Services) 1-909-Medical Core 888-979-2247 (Member Services) Alignment Health CalPlus + Veteras (IIMO) (IESI5-036) Star Rating ***** Annual OOP Max *** Annual OOP Max \$5.900 Doctor Visits \$1.600 deductible; \$9 copps for days 1-60; \$1.600 deductible; \$9 copps for days 1-60; \$800 copps/day for days 1-10; \$1.600 deductible; \$9 copps for days 1-60; \$1.600 deductible; \$9 copps for days 1-60; \$1.600 deductible; \$9 copps for days 1-60; \$1.600 deductible; \$9 copps/day for days 1-10; \$1.600 deductible; \$1 copps/days 1-10	2023 N	IEDICARE HMO COM	PAKI				COUN	TY		
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\$505 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands. Acupuncture: \$0 co-pay for unlimited routine visits covered with Flex Allowance Caregiver Support: \$600 annual allowance for dental, vision, hearing, acupuncture, and chiropractic needs Groceries: \$150 monthly allowance for those with qualifying chronic conditions Meals: \$0 copay for up to 2 meals/day for 14 days for those with qualifying chronic conditions Over the Counter: \$10 quarterly allowance for covered items from OTC catalogue Transportation: \$0 copay for 20 one-way trips per year to plan approved locations within 50 miles Wellness: \$0 copay for basic gym membership Medical Groups and 25% for generics until out-of-pocket drug expenses reach \$7,400. After that, you pay the greater of \$4.15 or 5% for brands. Acupuncture: \$0 co-pay for for 5% for brands. Acupuncture: \$0 co-pay/visit with Flex Allowance Flex Allowance: \$500 annual allowance for dental, vision, hearing, acupuncture, and chiropractic needs Groceries: \$50 monthly allowance for those with qualifying chronic conditions Over the Counter: \$10 quarterly allowance for covered items from OTC catalogue Transportation: \$0 copay for 20 one-way trips per year to plan approved locations within 50 miles			25%	25%				•		
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Wellness: \$0 copay for basic gym membershipservices, with 0-70% co-insurance, up to \$1,500/yearMedical Groups and HospitalsMedical Groups: Alignment Health Plan Network; Brown & Toland, Nivano IPA Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv)Medical Groups: Alignment Health Plan Network; Brown & Toland Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv)		Transportation: \$0 copay for	or 20 on			Optional supplementa	l packa	ge: Enl	nanced D	Dental
Medical Groups and Hospitals Medical Groups: Alignment Health Plan Network; Brown & Toland, Nivano IPA Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv) Medical Groups: Alignment Health Plan Network; Brown & Toland Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv) Medical Groups: Alignment Health Plan Network; Brown & Toland Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv)										
and HospitalsHospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv)Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv)	16.11	Medical Groups: Alignmen	t Health			Medical Groups: Alig				
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San Leandro, Stanford Valley Care (Pleas/Liv) Leandro, Stanford Valley Care (Pleas/Liv)	anu mospitais									
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Please contact the Plan for more information or call 1-800-Medicare	IEDICARE HMO COM	888 860	Alig: -979- 6-634	nment 2247 (8 -2247 (Health Plan Sales & Marketing) Member Services) thealthplan.com	212.2			
Plan Name/Type	Alignment Healt CalPlus (HMO	th My	Cho	ice	Alignment Hea (HMO) (H			n	
Star Rating	***	*			***	k ★			
Annual OOP Max	\$3,00	0			\$4,9				
Monthly Premium	\$0				\$69				
Doctor Visits	\$0 for Primary Care Physi \$0 copay for days 1-4; \$10		-		\$5 for Primary Care Physi \$225 copay for		_	cialist	
Inpatient Hospital	5-10; \$0 copay for days 11	and bey	ond; un	limited	\$0 copay/day for days 6	and bey	ond; unlir		
Outpatient Hospital	\$100 copay for ambulat \$200 copay for outpatie				\$0 copay for ambulatory \$325 for outpatient he				
Skilled Nursing Facility	\$0 copay/day for \$50 copay/day for				\$0 copay/day for days 1-20; \$160 per day for days 21-57; \$0 for days 58-100				
Ambulance	\$175 copay per trip b	y groun		;	\$250 copay per trip	by grou	nd or air;		
Emergency & Urgent Care	waived if ac \$85 copay for ER visit; \$0 f copay waived if admitted to 1 \$12,000 annual limit for ER	or urger nospital	within 4	48 hours;	waived if a \$90 copay for ER visit; \$ copays not waive \$7,500 annual limit for ER	of for urged if adn	gent care nitted;		
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services procedures, x-rays, and d 20% coinsurance for th	iagnost	ic radiol	ogy;	\$0 copay for lab service procedures; \$15 for x-ray radiology; 20% coinsurance	/s; \$150	for diagn	ostic	
Renal Dialysis	20% co-insurance	per trea	tment		20% co-insurance	e per tre	atment		
Outpatient Mental Health Visits	\$0 copay per i or group thera				\$40 copay per or group thera				
Eyewear	\$100 annual allowance for			ontacts	\$150 allowance for eyeglass			ery 2 yrs	
Eye Exams	\$0 copay for diag \$0 copay for one ann			n	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam				
Hearing Aids	\$1,000 allowance with \$0						ине слан		
Hearing Exams	\$0 copay for diag \$0 copay for one ann			n				1	
Dental	\$0 copay for basic pre \$20-\$425 copays for certain	ventive	service	s;	\$0 copay for one annual routine exam \$0 copay for basic preventive services;				
Chiropractic	\$0 copay for 40 routine vis with acupuncture; \$10 co	re-cover its per y	red visit ear, con	; nbined					
Podiatry	\$5 copay for Medicare \$5 copay for unlimited ro				\$0 copay for Medicar	e-cover	ed service	es	
	Cost-sharing shown is for preferred pharmacies Preferred Generic Generic		100 days retail \$0	100 days mail \$0	Cost-sharing shown is for preferred pharmacies Preferred Generic	30 days	100 days retail	100 days mail \$0	
	Preferred Brand	\$40	\$9 \$120	\$9 \$120				\$0 \$120	
Prescription Drugs (Part D)	Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$4,660, you pay no more that								
	for brand name drugs and 25 out-of-pocket drug expenses that, you pay the greater of \$ and the greater of \$10.35 or \$ annual out of pocket max	% for go reach \$7 4.15 or \$	enerics (7,400. A 5% for (until After generics	for brand name drugs and 25 of-pocket drug expenses read pay the greater of \$4.15 or 5	% for g ch \$7,40 % for go	enerics un 0. After an enerics ar	ntil out- that, you nd the	
Other Benefits/Options	Acupuncture: \$0 co-pay for combined with chiropractic; Caregiver Support: \$600 ar Groceries: \$20 monthly allo qualifying chronic conditions Meals: \$0 copay for up to 2 of for those with qualifying chrover the Counter: \$60 quar Pet Services: \$0 copay for 7 walks per year with qualifyin Transportation: \$0 copay for year to plan approved locatio Wellness: \$0 copay for basic	\$10 cov mual all wance f meals/da onic con terly all boardin g chron or 12 on ns withi	erage lir owance or those ay for 14 ditions owance g days (iiic condi e-way tr in 20 mi	with 4 days or 14 tion tips per les nip	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam: Not covered \$0 copay for diagnostic exam; \$0 copay for diagnostic exam; \$0 copay for diagnostic exam; \$0 copay for basic preventive services \$20-\$425 copays for certain comprehensive s \$0 copay per Medicare-covered visit \$0 copay per Medicare-covered services \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered services \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered services \$0 copay for Medicare-covered services \$0 copay for Medicare-covered services \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered services \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered services \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered services \$0 copay for Medicare-covered services \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered visit \$0 copay for Medicare-covered services \$0 copay for Medicare-covered services \$0 copay for Medicare-covered services \$0 copay for Medicare-covered visit				
Medical Groups and Hospitals	Medical Groups: Alignmen Brown & Toland, Nivano IP, Hospitals: Alameda; Alta Ba Eden (C. Valley), Highland (San Leandro, Stanford Valley	A tes/Sum Oak), St	nmit (Be t. Rose,	erk/Oak); (Hay),	Medical Groups: Alignmer Brown & Toland, Nivano IP Hospitals: Alameda; Alta Ba Eden (C. Valley), Highland (San Leandro, Stanford Valle	A ates/Sun (Oak), S	nmit (Ber t. Rose, (k/Oak); Hay),	

2023 N	MEDICARE HMO COMI	ANI					1111		
Please contact the			An	them I	B	lue Cross			
Plan for more		800	-619-0	6164 (S	Sa	lles & Marketing)			
information or call		888	3-230-	7338 (N	Iember Services)			
1-800-Medicare						nem.com			
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Plan Name/Type				uon					,
	Plus (HMO) (I	H0544	-099)		L	(HMO) (H	0544-(198)	
Star Rating	***					**	*		
Annual OOP Max	\$7,550)				\$7,5	50		
Monthly Premium	\$19.70)				\$0			
Doctor Visits	20% co-insurance for Prim			cian;		\$15 for Primary C			
	20% co-insurance f \$1,600 deductible for days 1-6			/doxy for	-	\$45 for Sp \$325 copay fo			
Inpatient Hospital	days 61-90; \$800 copay/d					\$0 copay/day for da			
Outpatient	20% co-insurance for ambul				T	\$275 copay for ambulator	-		
Hospital	20% co-insurance for outpa					\$325 for outpatient ho			
Skilled Nursing	\$0 copay/day for	days 1-	20;			\$0 copay/day fo	or days	1-20;	
Facility	\$200/day for day					\$196 per day for			
Ambulance	20% co-insurance per grou				Ī	\$250 copay per groun			
Ambulance	20% coinsurance per ai				L	20% coinsurance per			
Emergency &	\$90 copay for ER visit; \$60 for copay waived if admitted to he					\$90 copay for ER visit; \$35 copay waived if admitted to			
Urgent Care	\$100,000 annual limit for ER					\$100,000 annual limit for E			
Lab Tests,	20% co-insurance for lab serv				T	\$10 copay for lab services; \$			
Procedures, and	procedures, x-rays, and di					& procedures; \$10 for x-ra			
Radiation Therapy	20% coinsurance for the	rapeutic	radiolo	ogy		radiology; 20% coinsurance	for the	rapeutic 1	adiology
Renal Dialysis	20% co-insurance p	er treat	ment			20% co-insurance	e per tre	atment	
Outpatient Mental	20% co-insurance p	er indiv	idual			\$40 copay per	individ	lual	
Health Visits	or group therap	y sessio	n			or group thera	ıpy sess	ion	
Eyewear	\$300 annual allowance for e	yeglass	es or co	ntacts		\$100 annual allowance for	eyegla	sses or co	ontacts
E E	20% co-insurance for o	diagnost	ic exam	1;	t	\$45 copay for dia	gnostic	exam;	
Eye Exams	\$0 copay for one annu					\$0 copay for one and			a
Hearing Aids	\$3,000 annual allowand			_		\$3,000 annual allowa			ıy
Hearing Exams	20% co-insurance for o					\$45 copay for dia			
	\$0 copay for one annu 20% co-insurance for Medic				\$0 copay for one annual routine examples:				
Dental	\$0 copay for basic prevent					\$45 copay for Medicar			
	annual allowance for covered					\$0 copay for 1 oral exam	ina i ci	eaning po	er year
Chiropractic	\$20 copay per Medicar					\$20 copay per Medic	care-cov	ered visi	it
-	\$0 copay for 12 routing 20% coinsurance for Medic				\$0-45 copay for Medicare-covered services;				
Podiatry	\$0 copay for unlimited rou					\$0 copay for 24 routi			
	Cost-sharing shown is for	30	90	90		Cost-sharing shown is for	30	90	90
	preferred pharmacies	days	days	days	Ш	preferred pharmacies	days	days	days
	Preferred Generic	\$0	retail \$0	mail \$0	11	Preferred Generic	\$0	retail \$0	mail \$0
	Generic Generic	\$13	\$39	\$0	11	Generic	\$10	\$30	\$0
	Preferred Brand	\$47	\$141	\$141	1	Preferred Brand	\$42	\$126	\$84
Prescription Drugs	Non-Preferred Brand	\$95	\$285	\$285	Ш	Non-Preferred Brand	\$95	\$285	\$190
(Part D)	Specialty co-insurance	33%	N/A	N/A	41	Specialty co-insurance	33%	N/A	N/A
	\$505 deductible; after total ye \$4,660, you pay no more than					\$0 deductible; after total yes \$4,660, you pay no more tha			
	for brand name drugs and 25%					for brand name drugs and 25			
	out-of-pocket drug expenses re					of-pocket drug expenses read			
	that, you pay the greater of \$4 and the greater of \$10.35 or 5°			generics		pay the greater of \$4.15 or 5° greater of \$10.35 or 5% for 1		enerics a	nd the
	Acupuncture: \$0 co-pay/visit			visits	۲	greater of \$10.35 or 5% for t	ranus.		
	Cost-Sharing Waived: most					A	:4 C 1/		
	copays are waived for those w			LIS		Acupuncture: \$0 co-pay/vis Over the Counter: \$25 allo			
	Flex Accounts: \$50 monthly a groceries and utilities if diagno			,ia		covered items	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Other	condition; \$500 annual allowa					Wellness: \$0 for basic Silver		ers memb	ership
Benefits/Options	devices and dental/vision/hear	ing nee	ds			Optional supplemental pac 1: Preventive Dental at \$12		onth: un	to
Deficites/Options	Meals: \$0 copay for up to 2 m			days		\$500/year; \$0 co-pays for ba			
	following discharge from hosp Over the Counter: \$100 allow			ter for		2: Dental & Vision at \$31 p	er mon	th: up to	•
	covered items	wance p	or quar	CI 101		\$1,000/year for dental and \$1			
	Transportation: \$0 copay for		-way tri	ips per		3: Enhanced Dental & Visito \$2,000/year for dental and			
	year to plan approved location		10 man 1	orobi.		,=,000, jeur for demar and	42001 y	- 101 O	, J Cui
	Wellness: \$0 for basic Silver			•	+	Modical Correct Inc. 111	Harld 1	Tal.P.	
Medical Groups	Medical Groups: Imperial H Hospitals: Eden (Castro Valle					Medical Groups: Imperial I Hospitals: Eden (Castro Val			
and Hospitals	(Hayward), Stanford Valley C			ı &		(Hayward), Stanford Valley			ı &
	Livermore), Washington (Fren	,				Livermore), Washington (Fro			

2023 N	IEDICARE HMO COM	<u>IPARI</u>	SON C	HART	FOR ALAMEDA COU	INIY			
Please contact the	Brand No	ew Da	y		Brand N	ew Da	ıy		
Plan for more	866-255-4795 (Sal	les & N	Aarket	ing)	866-255-4795 (Sa	les & I	Marketi	ing)	
information or call	866-255-4795 (M	ember	Servic	es)	866-255-4795 (M	Iember	Servic	es)	
1-800-Medicare	www.bndh	mo.cor	<u>n</u>		www.bndl	mo.co	<u>m</u>		
	Classic (Care 1	[Classic	Care I	I		
Plan Name/Type	(HMO) (H				(HMO) (H				
Star Rating	**				**				
Annual OOP Max	\$3,65				\$1,5				
Monthly Premium	\$38.9				\$0				
Doctor Visits	\$0 for Primary Care Phys.		for Spec	cialist	\$0 for Primary Care Physician; \$10 for Specialist				
Inpatient Hospital	\$1,600 for days 1-60; \$40 \$800/day for d	00/day fo	or days 6		\$150 copay/day \$0 per day for day	for days	1-6;		
Outpatient	20% coinsurance per ambul	atory su	rgical ce	nter and					
Hospital Skilled Nursing	outpatient hospita \$0 copay for	days 1-2	0;		\$0 copay for	days 1-2	0;	y visit	
Facility	\$200 per day for	days 21	-100		\$200 per day fo	r days 21	-100		
Ambulance	20% coinsurance per t	rip by gr	ound or	air	\$200 copay per trip	by grou	nd or air		
Emergency &	\$100 copay per emergency				\$0-\$100 copay per emerge				
Urgent Care	admitted within 3 days; \$6 \$50,000 max worldwide				admitted within 3 days; \$ \$50,000 max worldwide				
Lab Tests,	\$0 copay for lab services,	20% cc	oinsuranc	e for	\$0 copay for lab, dia	gnostic p			
Procedures, and	diagnostic procedures				tests, and		11. 1		
Radiation Therapy	20% co-insurance for diagradiological	_	nd thera	oeutic .	\$0-\$50 copay for dia 20% co-insurance for				
Renal Dialysis	20% co-insurance		atment		20% co-insuranc			8,	
Outpatient Mental Health Visits	\$0 copay for individual or	group tl	herapy se	ession	\$10 copay for individual of	or group	therapy se	ession	
Eyewear	\$300 annual eyew	ear allo	wance		\$300 annual eye	wear allo	wance		
Eye Exams	\$0 copay per Medica \$0 copay for one and				\$0 copay per Medic \$0 copay for one an				
Hearing Aids	\$149 copay per aid limited to 2 hearing a	for basic	model;		\$699 copay per aid for bas model; limited to 2 hear	ic model	; \$999 for	prime	
Hearing Exams	\$0 copay for Medica \$0 copay for one ann				\$0 copay for Medica \$0 copay for one an				
Dental	\$0 copay for certain p \$0 - \$350 copay for certain				\$0 copay for preventive a \$0 - \$1,110 copay for certain				
	\$0 copay per Medica				\$0 copay per Medic				
Chiropractic	\$0 copay/visit for 30 ro combined with rout			ear,	\$0 copay/visit for up to 12 combined with rou			year,	
Podiatry	20% coinsurance per M			visit	\$0 copay per Medicare-covered visit				
	Cost-sharing shown is for	30	90	90	Cost-sharing shown is for	30	90	100	
	preferred pharmacies	days	days	days	preferred pharmacies	days	days	days	
	Preferred Generic	\$0	retail \$0	mail \$0	Preferred Generic	\$0	retail \$0	mail \$0	
	Generic	\$0	\$0	\$0	Generic	\$12	\$36	\$24	
D D	Preferred Brand	\$47	\$141	\$94	Preferred Brand	\$47	\$141	\$94	
Prescription Drugs	Non-Preferred Brand	\$100	\$300	\$200	Non-Preferred Brand	\$100 32%	\$300 N/A	\$200	
(Part D)	Specialty co-insurance \$0 deductible; after total ye	33% arly dri	N/A	N/A reach	Specialty co-insurance \$50 deductible; after total y			N/A reach	
	\$4,660, you pay no more that	-	_		\$4,660 , you pay no more that	n 25% c	of the plan	ı's cost	
	for brand name drugs and 25				for brand name and 25% for				
	out-of-pocket drug expenses that, you pay the greater of \$				pocket drug expenses reach pay the greater of \$4.15 or 5				
	and the greater of \$10.35 or			,01101103	\$10.35 or 5% for brands.				
	and the greater of \$10.00 of								
	Acupuncture: \$0 copay/vis	sit for 30	-	ear,					
	Acupuncture: \$0 copay/vis combined with routine chiro	sit for 30 practic v	isits		Acupuncture: \$0 copay/vis	•		its/year,	
	Acupuncture: \$0 copay/vis	sit for 30 practic v t co-insu	risits rance an	d	combined with routine chiro	practic v	isits		
Othor	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: mos copays are waived for those Groceries: \$50 monthly allo	sit for 30 practic v t co-insu w/full M owance a	visits irance an Iedi-Cal/ it plan-ap	d LIS pproved	combined with routine chiro Meals: \$0 copay for up to 1	practic v 5 meals/v	isits week for 6	5 weeks	
Other Renefits/Ontions	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: mos copays are waived for those Groceries: \$50 monthly allo stores, for those with qualify	sit for 30 practic v et co-insu w/full M owance a ring chro	risits rance an Iedi-Cal/ at plan-ap onic cond	d LIS pproved itions	combined with routine chiro Meals: \$0 copay for up to 1 for those with qualifying chi for up to 30 additional meals	practic v 5 meals/v onic con	isits week for t ditions; \$	6 weeks 5 copay	
Other Benefits/Options	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: mos copays are waived for those Groceries: \$50 monthly allostores, for those with qualify Meals: \$0 copay/meal for 14 12 months, for those with qu	sit for 30 practic vot co-insu w/full Mowance aring chround the meals of allifying	visits Irance an Iedi-Cal/ It plan-ap Inic cond Ieach mor Irance and Irance a	d LIS oproved itions of the for cond.	combined with routine chiro Meals: \$0 copay for up to 1 for those with qualifying chi for up to 30 additional meals Over the Counter: \$40 qua	practic v 5 meals/v onic con arterly al	isits week for 6 ditions; \$	6 weeks 5 copay	
	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: mos copays are waived for those Groceries: \$50 monthly allot stores, for those with qualify Meals: \$0 copay/meal for 14 12 months, for those with qu Over the Counter: \$210 qu	sit for 30 practic vote co-insu w/full Mowance a ring chroat meals of alifying parterly a	visits arance and fedi-Cal/ at plan-ap anic cond each mor chronic allowanc	d LIS proved itions th for cond. e for	combined with routine chiro Meals: \$0 copay for up to 1 for those with qualifying chi for up to 30 additional meals	practic v 5 meals/v conic con s arterly al e, retail,	isits week for 6 ditions; \$ lowance f or online	6 weeks 65 copay For plan	
	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: mos copays are waived for those Groceries: \$50 monthly allostores, for those with qualify Meals: \$0 copay/meal for 14 12 months, for those with qu	sit for 30 practic votic co-insum w/full Mowance aring chrous the meals of alifying parterly a alogue, r	visits arance and fedi-Cal/ at plan-aponic cond each more chronic allowance etail, or	d LIS pproved itions ath for cond. e for online	combined with routine chiro Meals: \$0 copay for up to 1 for those with qualifying chi for up to 30 additional meals Over the Counter: \$40 qua approved items via catalogu Transportation: \$0 copay f year to plan approved location	practic v 5 meals/v onic con arterly al e, retail, or 24 on ons withi	isits week for oditions; \$ lowance for online e-way trip n 50 mile	5 weeks 5 copay For plan 5 per	
	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: most copays are waived for those Groceries: \$50 monthly allot stores, for those with qualify Meals: \$0 copay/meal for 14 12 months, for those with qu Over the Counter: \$210 qu plan approved items, via catter Transportation: \$0 copay fyear to plan approved location.	sit for 30 practic v tro-insu w/full M www.full M ware a ring chrod 4 meals of allifying narterly a alogue, r or 48 on ons with	visits arance an Iedi-Cal/ at plan-ap pric cond each mor chronic allowanc etail, or e-way tri in 50 mil	d LIS pproved itions ath for cond. e for online ps per es	combined with routine chiro Meals: \$0 copay for up to 1 for those with qualifying chi for up to 30 additional meals Over the Counter: \$40 qua approved items via catalogu Transportation: \$0 copay for	practic v 5 meals/v onic con arterly al e, retail, or 24 on ons withi	isits week for oditions; \$ lowance for online e-way trip n 50 mile	5 weeks 5 copay For plan 5 per	
Benefits/Options	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: most copays are waived for those Groceries: \$50 monthly allot stores, for those with qualify Meals: \$0 copay/meal for 14 12 months, for those with qu Over the Counter: \$210 qu plan approved items, via catt Transportation: \$0 copay from the counter of the counte	sit for 30 practic varieties to co-insu w/full Mowance a ring chroat meals chalifying narterly a lalogue, roor 48 on ons with r Sneaker	risits prance an Iedi-Cal/ tt plan-ap nic cond each mor chronic allowanc etail, or e-way tri in 50 mill ers memb	d LIS proved itions ath for cond. e for online ps per es pership	combined with routine chiro Meals: \$0 copay for up to 1 for those with qualifying chi for up to 30 additional meals Over the Counter: \$40 qua approved items via catalogu Transportation: \$0 copay f year to plan approved location	practic v 5 meals/v conic con arterly al e, retail, for 24 one ons withing	isits week for of ditions; \$ lowance f or online e-way trip n 50 mile rs membe	6 weeks 5 copay 6 or plan 6 ps per 6 ps 6 ership	
Benefits/Options Medical Groups	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: most copays are waived for those Groceries: \$50 monthly allot stores, for those with quality Meals: \$0 copay/meal for 14 12 months, for those with qu Over the Counter: \$210 qu plan approved items, via catter Transportation: \$0 copay find year to plan approved location Wellness: \$0 for basic Silve Medical Groups: Alameda Physician East Bay, John Months of Control of the Counter o	sit for 30 practic varieties of the co-instance action of the co-instance action of the co-instance action of the co-instance o	risits arance an dedi-Cal/ at plan-ap onic condeach more chronic allowanc retail, or e-way tri in 50 mil ers memb System, l cicians Al	d LIS pproved itions th for cond. e for online ps per es eership Hill ameda	combined with routine chiro Meals: \$0 copay for up to 1 for those with qualifying chi for up to 30 additional meals Over the Counter: \$40 qua approved items via catalogu Transportation: \$0 copay f year to plan approved locativ Wellness: \$0 for basic Silve Medical Groups: Alameda Physicians East Bay; John M	practic v 5 meals/v conic con s arterly al e, retail, or 24 on ons within r Sneake Health S fuir Phys	isits week for o ditions; \$ lowance f or online e-way trip n 50 mile rs member ystem, H sicians Al	6 weeks 5 copay for plan os per es ership ill ameda	
Benefits/Options	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: most copays are waived for those Groceries: \$50 monthly allot stores, for those with quality Meals: \$0 copay/meal for 14 12 months, for those with quality Meals: \$0 copay/meal for 14 12 months, for those with qu plan approved items, via cata Transportation: \$0 copay f year to plan approved locatic Wellness: \$0 for basic Silve Medical Groups: Alameda Physician East Bay, John Mi Hospitals: Alameda, Alta E	sit for 30 practic vortex too-inst w/full Mowance a ring chrod 4 meals of tallifying narrenly a falogue, ror 48 on for swith r Sneaker Health Suir Physis ates/Suir Moractic vortex for 48 on for swith respectively.	risits rance an Iedi-Cal/ It plan-ap ric cond each mor chronic allowanc retail, or e-way tri in 50 mil ers memb System, 1 icians Al mmit Me	d LIS pproved itions th for cond. e for ps per es pership Hill ameda dical	combined with routine chiro Meals: \$0 copay for up to 1 for those with qualifying chi for up to 30 additional meals Over the Counter: \$40 qua approved items via catalogu Transportation: \$0 copay f year to plan approved locativ Wellness: \$0 for basic Silve Medical Groups: Alameda Physicians East Bay; John M Hospitals: Alameda, Alta H	practic v 5 meals/v conic con s arrearly al e, retail, or 24 on cons within r Sneake Health S fuir Phys Bates/Sur	isits week for 0 ditions; \$ lowance f or online e-way trip n 50 mile rs membe ystem, H sicians Al nmit Med	6 weeks 5 copay for plan ps per es ership ill ameda lical	
Benefits/Options Medical Groups	Acupuncture: \$0 copay/vis combined with routine chiro Cost-Sharing Waived: most copays are waived for those Groceries: \$50 monthly allot stores, for those with quality Meals: \$0 copay/meal for 14 12 months, for those with qu Over the Counter: \$210 qu plan approved items, via catter Transportation: \$0 copay find year to plan approved location Wellness: \$0 for basic Silve Medical Groups: Alameda Physician East Bay, John Months of Control of the Counter o	sit for 30 practic vortex co-inst w/full Mowance a ring chrod 4 meals of alalifying narterly a falogue, r for 48 on ons with r Sneaker Health Sair Physis ates/Sunden (Ca	risits rance an Iedi-Cal/ It plan-ap ric cond each mor chronic allowanc retail, or e-way tri in 50 mil ers memb System, l cians Al mmit Me stro Vall	d LIS pproved itions th for cond. e for ps per es pership Hill ameda dical	combined with routine chiro Meals: \$0 copay for up to 1 for those with qualifying chi for up to 30 additional meals Over the Counter: \$40 qua approved items via catalogu Transportation: \$0 copay f year to plan approved locativ Wellness: \$0 for basic Silve Medical Groups: Alameda Physicians East Bay; John M	practic v 5 meals/v conic con s arterly al e, retail, or 24 on cons within r Sneake Health S duir Phys Bates/Sur Eden (Castella Castella C	isits week for 0 ditions; \$ lowance f or online e-way trip n 50 mile rs membe ystem, H sicians Al nmit Med	6 weeks 5 copay for plan ps per es ership ill ameda lical	

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Please contact the	Central Health N				Central Health N			
Plan for more	866-314-2427 (Sal	es & N	Market	ting)	866-314-2427 (Sal	les & N	Marketi	ing)
information or call	866-314-2427 (M	ember	Servi	ces)	866-314-2427 (M	ember	Servic	es)
1-800-Medicare	www.centralhea	lthplai	n.com	ĺ	www.centralhea	althplai	n.com	ĺ
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Plan Name/Type	(HMO) (H5				(HMO) (H			
C4 D-4:	ì		20)				21)	
Star Rating	***	1/2			***	1/2		
Annual OOP Max	\$899)			\$6,70)0		
Monthly Premium	\$0				\$34.5	50		
Doctor Visits	\$0 for Primary Care Physi	cian: \$0	for Spa	oialist	\$0 for Primary Care Physician; \$0 for Specialist			
Doctor visits	50 for Finnary Care Fifysi	Cian, 50	Tor Spe	Claffst				
Inpatient Hospital	\$0 per stay; unl	imited d	lays		\$1,600 for days 1-60; \$400 /day for days 60-90; \$800 /day for days 91-150			
Outpatient Hospital	\$0 per ambulatory sur \$0 copay per outpatient l				\$0 per ambulatory sur 20% coinsurance per outpat			
Skilled Nursing	\$0 copay for c				\$0 copay for o			
Facility	\$200/day for da	•		•	\$200/day for d			•
Ambulance	\$0-\$40 copay per one-v 20% coinsurance	per trip	by air		20% coinsurance per e 20% coinsurance	per trip	by air	
Emergency &	\$0-\$50 copay per emer				20% of cost per emer			t;
Urgent Care	\$0 for urgent care; ER copa hospital within 72 hours; \$1				20% of cost per un ER copay waived if admitte			thin 72
Orgent Care	with \$0 copay/ER and				hours; \$100,000 max wor			
Lab Tests,	\$0 copay for lab service				20% coinsurance for lab ser	vices, d	iagnostic	tests &
Procedures, and	procedures, x-rays, and c	liagnost	ic radiol	ogy;	procedures, x-rays, diagr	nostic ra	diology,	
Radiation Therapy	20% co-insurance for the	erapeut	ic radiol	logy	therapeutic r	adiology	y	
Renal Dialysis	20% co-insurance	per trea	atment		20% co-insurance	per trea	atment	
Outpatient Mental Health Visits	\$0 copay per individual or	group t	herapy s	ession	20% coinsurance or group thera			
Eyewear	\$0 copay for eyeglasses			es;	\$0 copay for eyeglasses or contact lenses; \$300 annual allowance			
Eye Exams	\$0 copay per Medicar	re-cover	ed exan		\$0 copay per Medica	re-cover	ed exam	
Hearing Aids	\$0 copay for one ann \$2,000 annual allowance the				20% coinsurance for one \$3,000 annual allowance t			
	\$0 copay for Medicar				\$0 copay for Medica			
Hearing Exams	\$0 copay for one ann				\$0 copay for one ann			
Dental	\$0 copay for certain pr \$0 - \$295 copay for certain				\$0 copay for certain p. \$0 - \$295 copay for certain			
Chiropractic	\$0 copay per Medica Routine visits r			;	\$0 copay per Medica Routine visits			
Podiatry	\$0 co-pay per Medica Routine visits r			t;	\$0 co-pay per Medic Routine visits			;
	Cost-sharing shown is for	30	90	90	Cost-sharing shown is for	30	90	90
	preferred pharmacies	days	days	days	preferred pharmacies	days	days	days
				mail			-	mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
D D	Generic Preferred Brand	\$0 \$35	\$0 \$105	\$0 \$70	Generic Preferred Brand	\$0 15%	\$0 15%	\$0 15%
Prescription Drugs	Non-Preferred Brand	\$75	\$225	\$150	Non-Preferred Brand	15%	15%	15%
(Part D)	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A
	\$0 deductible; after total year				\$104 deductible; after total			
	\$4,660, you pay \$0 for gener				\$4,660, you pay \$0 for generation 25% of the plan's cost for be			
	25% of the plan's cost for br out-of-pocket drug expenses				out-of-pocket drug expenses			
	that, you pay the greater of \$				that, you pay the greater of \$			
	and the greater of \$10.35 or \$				and the greater of \$10.35 or			
					Acupuncture: \$0 co-pay for			
	Acupuncture: \$0 co-pay for				Cost-Sharing Waived: mos			
	Flex Allowance: \$325 quart items, Herbal Catalogue item	•			copays are waived for those Flex Allowance: \$325 quar			
Other	Groceries: \$25 monthly allo				items, Herbal Catalogue item	_		
Benefits/Options	qualifying chronic conditions	8			Groceries: \$25 monthly allo	wance f		
Deficites/Options	Meals: \$0 copay/meal for 2 i			l days	qualifying chronic condition		C- 14	4
	for those with qualifying chro Transportation: \$0 co-pay			trips to	Meals: \$0 copay/meal for 2 for those with qualifying chr			uays
	plan approved locations with			11ps to	Transportation: \$0 co-pay			trips to
	Wellness: \$0 for basic Silve			bership	plan approved locations with	in 50 m	iles	•
					Wellness: \$0 for basic Silve	er Sneak	ers mem	bership
								_
Medical Grouns	Medical Crounce Hill Dhyoi	ciane 🗁	ast Raw		Medical Cranner Hill Phys	iciane 🗜	ast Raw	
Medical Groups and Hospitals	Medical Groups: Hill Physi Hospitals: Fremont Hospital		ast Bay		Medical Groups: Hill Phys Hospitals: Fremont Hospital		ast Bay	

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1 000 1/10000000	Essence Adva	ntaga		essence	Essence Advant	age P	latinu	m	
Plan Name/Type	(HMO) (H2	_			(HMO) (H	_		111	
Star Rating	***				***				
Annual OOP Max	\$5,90	0			\$4,90)0			
Monthly Premium	\$57				\$87	,			
Doctor Visits	\$5 copay for Primary \$35 for Spe		hysician;		\$0 copay for Primary \$30 for Sp		hysician	;	
Inpatient Hospital	\$315 copay/day for days 1-7;	\$0 for 6	days 8 &	beyond	\$300 copay/day for days 1-7	; \$0 for	days 8 &	beyond	
Outpatient Hospital	20% co-insurance per amb and outpatient h			center	\$240 copay per ambula and outpatient h			iter	
Skilled Nursing	\$0 copay/day for				\$0 copay/day for days 1-20; \$100 per day for days 21-100				
Facility Ambulance	\$150 per day for \$210 copay per ground of	-		trin	\$200 copay per ground	-		trin	
	\$110 copay for emergency				\$110 per emergency room vi				
Emergency & Urgent Care	admitted to hospital within 2 care visit; \$110 copay for e outside the U.S.; Worldwid \$10 copay for la	emergen le covera	cy/urgen age (unli	t care	hospital within 24 hours; \$ \$110 copay for emergency U.S.; Worldwide cov \$10 copay for l	/urgent overage (u	care outs	ide the	
Lab Tests, Procedures, and	\$45 for diagnostic procedu	ires, test	s, and x-	rays;	\$25 for diagnostic proced	ures, tes	sts, and x		
Radiation Therapy	\$210 copay for diagr 20% of cost for thera				\$210 copay for diag 20% of cost for ther				
Renal Dialysis	20% co-insurance	•			20% co-insurance				
Outpatient Mental Health Visits	\$30 copay per indiv \$20 per group the				\$20 copay per indi \$10 per group th				
Eyewear	See Optional Benefi				See Optional Benef		_		
Eye Exams	\$5-\$35 copay per Medio Routine exams r See Optional Benefit	not cove	red;		\$0-\$30 copay per Medi Routine exams See Optional Benefi	not cove	ered;	ŕ	
Hearing Aids	Not Cov				Not Cov				
Hearing Exams	\$0 copay per Medicar				\$0 copay per Medica				
Dental	\$35 copay per Medica See Optional Benefit	Packag	es below		\$20 copay per Medic See Optional Benefit	t Packag	ges below	7	
Chiropractic	\$20 copay per Medica Routine care no	ot cover	ed		\$20 copay per Medic Routine care n	ot cove	red	,	
Podiatry	\$35 copay per Medica Routine foot care	not cov	ered		Routine foot care	copay per Medicare covered visit; Routine foot care not covered			
	Cost-sharing shown is for preferred pharmacies	30 days	90 days	90 days	Cost-sharing shown is for preferred pharmacies		90 days	90 days	
	· · ·		retail	mail	· · ·	days	retail	mail	
	Preferred Generic Generic	\$5 \$15	\$15 \$45	\$10 \$30	Preferred Generic Generic	\$5 \$15	\$15 \$45	\$10 \$30	
	Preferred Brand	\$47	\$141	\$94	Preferred Brand	\$47	\$141	\$94	
Prescription Drugs	Non-Preferred Brand	\$100	\$300	\$200	Non-Preferred Brand	\$100	\$300	\$200	
(Part D)	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance \$0 deductible; after total year	33%	N/A	N/A	
	\$0 deductible; after total year \$4,660, you pay no more than				\$4,660, you pay no more than	, ,			
	for brand name drugs and 25%				for brand name drugs and 25°				
	of-pocket drug expenses reacl				of-pocket drug expenses reach				
	pay the greater of \$4.15 or 5% greater of \$10.35 or 5% for br		nerics &	the	pay the greater of \$4.15 or 5% greater of \$10.35 or 5% for b	_	nerics an	d the	
			c 20	1	Acupuncture: \$10 co-pay pe		p to 15/y	ear	
	Meals: \$0 copay for up to 2 if following surgery or inpatient		-	-	Meals: \$0 copay for up to 2 n		-	-	
	for up to 2 meals/day for 14 d				following surgery or inpatient for 2 meals/day for 14 day for				
	chronic condition	24			Over the Counter: \$50 quart				
Other	Transportation: \$0 co-pay for plan approved locations, using				Transportation: \$0 co-pay for	or 24 tri	ps per ye		
Benefits/Options	pian approved locations, using	g netwo	ik provid	.01	approved locations, using net Wellness: \$0 for basic Silver	-			
	Optional Dental/Vision Plan	1 at \$2	0/month	: \$25 co	pay for one routine annual eye				
	eyeglass lenses every 2 years;	\$150 al	llowance	for frame	es or contact lenses every 2 year	rs with \$	25 copay	y;	
	Delta Care USA with \$0 cop services; Contact plan for deta				services; \$0-\$445 copays for var Gold or Platinum plan.	ious co	mprehens	sive	
	Medical Groups: Affinity Ea	ast Bay,	Sutter Ea	ast Bay,	Medical Groups: Affinity Ea	ıst Bay,	Sutter Ea	ast Bay,	
Medical Groups	PAMF, Stanford Affiliates Hospitals: Alameda, Alta Ba	tes/Sum	mit (Ber	k/Oak).	PAMF, Stanford Affiliates Hospitals: Alameda, Alta Ba	ates/Sun	nmit (Ber	·k/Oak).	
and Hospitals	Eden (Castro Valley), Highlan	nd (Oak	land), Sa	n	Eden (C. Valley), Highland (C	akland)	, San Lea	andro, St.	
_	Leandro, St. Rose (Hayward)			lto, and	Rose (Hayward), Stanford Pa		and Stan	ford	
	Stanford Valley Care (Pleas/I	Livermo	re)		Valley Care (Pleas/Livermore	り フ			

2023 N	MEDICARE HMO COM							
Please contact the	Imperial Health Pla	an of	Califo	ornia	Imperial Health P	lan of	Calif	ornia
Plan for more	800-838-8271 (Sale	es & N	Iarket	ing)	800-838-8271 (Sa	les & I	Market	ting)
information or call	800-838-8271 (Me	ember	Servic	es)	800-838-8271 (M	[ember	Servi	ces)
1-800-Medicare	www.imperialhe	<u>althpla</u>	n.com		www.imperialhe	<u>ealthpla</u>	an.com	
DI NI //D	Imperial Tr	aditio	nal		Imperial	Stron	ıg	
Plan Name/Type	(HMO) (H5				(HMO) (H		_	
Star Rating	**1/				**1			
Annual OOP Max	\$2,99				\$8,3			
		,						
Monthly Premium	\$0				\$0			
Doctor Visits	\$0 for Primary Ca \$10 for Spe		cıan;		20% for Primary (20% for S	-		
Inpatient Hospital	\$150 copay for days 1-5;		day for d	lays	\$0 copay for days 1-60; \$3			or days
	6-90; \$670 per day f				61-90; \$778 per day			
Outpatient	\$0 per ambulatory sur \$0 copay per outpatient h	_		*	20% coinsurance per ambula 20% coinsurance per outpat			
Hospital Skilled Nursing	1 7 1			VISIL	\$0 copay per day		`	inty visit
Facility	\$0 copay per day f \$164.50/day for o				\$0 copay per day \$200/day for o			
Ambulance	\$150 copay per one-wa	ay trip b	y ground		20% coinsurance per o	•		nd;
Ambulance	20% coinsurance per				20% coinsurance po			
Emergency &	\$100 per emergend \$20 copay for urgent car			d if	20% of cost, up to \$95, pe			
Urgent Care	admitted to hospital within				20% of cost up to \$6 Costs waived if admitted to			
	worldwide with \$0 copay/E	R and \$	20/urgei	nt care	Costs waived if admitted to	поѕрна	WIUIIII	72 Hours
Lab Tests,	\$0 copay for lab services procedures, x-rays, and d				20% coinsurance for lab se			
Procedures, and Radiation Therapy	20% co-insurance for th				procedures, x-rays, diag therapeutic			, and
Renal Dialysis	20% co-insurance			- 6,7	20% co-insuranc			
Outpatient Mental	20% coinsurance	•			20% coinsurance	•		
Health Visits	or group therap				or group therapy session			
Eyewear	\$0 copay for eyeglasses			es;	\$0 copay for eyeglasse			ses;
	\$250 annual a \$0 copay per Medicar			\$240 annual 20% coinsurance per Me			exam:	
Eye Exams	\$0 copay for rou	itine exa	ıms	\$0 copay for ro	utine ex	ams		
Hearing Aids	20% coinsurance for \$2,500 annual				20% coinsurance t \$1,000 annual			
	20% coinsurance for Med	licare-co	overed e		20% coinsurance for Me			xams;
Hearing Exams	20% coinsurance for routing		s; plan c	covers	20% coinsurance fo			;
	up to \$250 \$0 co-pay per Medicare-cove		t: \$0 co-	-pay for	plan covers up \$0 co-pay per Medicare-cov			n-pay for
Dental	preventive services up to \$5	00/year	; \$0 co-p	pay for	preventive services; plan	covers u	p to \$50 0	0/year;
Dentai	certain comprehensive serv \$2000/year; Imperial HMO				\$0 co-pay for certain comp \$2000 per year; Imperial H	rehensiv MO con	e service tracted r	es; up to
Chinama ati a	\$0 copay per Medica				20% co-insurance per M			
Chiropractic	Routine visits n				Routine visits	not cove	red	
Podiatry	\$0 co-pay per Medica				\$0 co-pay per Medic			t;
	\$0 co-pay for 6 routing Cost-sharing shown is for	30	per year	100	Routine visits Cost-sharing shown is for	30	90	100
	preferred pharmacies	days	days	days	preferred pharmacies	days	days	days
	2 4 10	40	40	mail	P. 4. 1.0	2501		mail
	Preferred Generic Generic	\$0 \$5	\$0 \$10	\$0 \$10	Preferred Generic Generic	25% 25%	25% 25%	25%
	Preferred Brand	\$45	\$90	\$90	Preferred Brand	25%	25%	25%
Prescription Drugs	Non-Preferred Brand	\$90	\$180	\$180	Non-Preferred Brand	25%	25%	25%
(Part D)	Specialty co-insurance	33%	33%	N/A	Specialty co-insurance	25%	25%	25%
	\$0 deductible; after total yes \$4,660, you pay \$0 for gener				\$505 deductible; after deducti			
	25% of the plan's cost for br				expenses reach \$7,400. After			
	out-of-pocket drug expenses			After	of \$4.15 or 5% for generics	and the g	greater o	f \$10.35
	that, you pay the greater of \$ generics and the greater of \$.				or 5% for brands. \$7,400 ar	ınual out	of pock	et max.
	brands. \$7,400 annual out of	f pocket	max.					
	Meals: \$0 copay for up to 7	home-d		l meals	n .nn	40-		
Other	following a surgery or hospit Over the Counter: \$120 quarters	llowana	e for	Part B Premium Reduction reimbursement	1: \$85 n	nonthly		
Benefits/Options	items in OTC mail order cata		110 Walle	- 101	- Camouroomont			
_	Transportation: \$0 co-pay		mited ro	und	NOTE: This plan has a \$220		l deduct	ible in
	trips to plan approved location Wellness: \$0 for basic Silve		nembersl	hip	addition to the Part D deduct	1016		
	Medical Groups: Brown &	Toland,	Imperia	ıl	Medical Groups: Brown &	Toland	Imperio	l Health
i e	Health Holdings, Nivano Phy	ysicians.	, Physici	ian			ian Partı	ners IPA
Modical Craws					Holdings, Nivano Physicians, Physician Partners I			
Medical Groups	Partners IPA	it (Berk	/Oak). F	Eden	Hospitals: Alta Bates/Summ	it (Berk		
Medical Groups and Hospitals						it (Berk		

2025 17					FOR ALAMEDA COUNTY		
Please contact the	Imperial Health Pl				Imperial Health Plan of California		
Plan for more information or call	800-838-8271 (Sal			<u> </u>	800-838-8271 (Sales & Marketing)		
1-800-Medicare	800-838-8271 (M			es)	800-838-8271 (Member Services)		
1-000-Medicare	www.imperialhe				www.imperialhealthplan.com		
Plan Name/Type	Imperial I	•			Imperial Courage		
Gt. D. t.	(HMO) (H:		12)		(HMO) (H5496-016)		
Star Rating	**1				★★1/2		
Annual OOP Max	\$899	9			\$2,999		
Monthly Premium	\$0				\$0		
Doctor Visits	\$0 for Primary Care Physic	ician; \$0	for Spec	cialist	20% for Primary Care Physician; 20% for Specialist		
Inpatient Hospital	\$0 copay for \$670 per day for				\$150 copay for days 1-5; \$0 co-pay/day for days 61-90; \$670 per day for days 91-150		
Outpatient Hospital	\$0 per ambulatory sur \$0 copay per outpatient				\$0 per ambulatory surgical center visit; \$0 copay per outpatient hospital facility visit		
Skilled Nursing	\$0 copay per day				\$0 copay per day for days 1-20;		
Facility	\$164.50 /day for	-			\$164.50 /day for days 21-100		
Ambulance	\$125 copay per one-w 20% coinsurance pe				\$125 copay per one-way trip by ground; 20% coinsurance per each trip by air		
Emergency &	\$100 per emergen			ad if	\$100 per emergency room visit;		
Urgent Care	\$0 copay for urgent care admitted to hospital				\$0 copay for urgent care; ER copay waived if admitted to hospital within 48 hours; \$50,000 max		
	\$50,000 max worldw				worldwide with \$0 copay/ER and \$20/urgent care		
Lab Tests, Procedures, and	\$0 copay for lab service				\$0 copay for lab services, diagnostic tests &		
Radiation Therapy	procedures, x-rays, and c 20% co-insurance for the				procedures, x-rays, and diagnostic radiology; 20% co-insurance for therapeutic radiology		
Renal Dialysis	20% co-insurance			-	20% co-insurance per treatment		
Outpatient Mental	20% coinsurance	•			20% coinsurance per individual		
Health Visits	or group thera				or group therapy session		
Eyewear	\$0 copay for eyeglasse \$250 annual a	allowand	ce		\$0 copay for eyeglasses or contact lenses; \$250 annual allowance		
Eye Exams	\$0 copay per Medica \$0 copay for ro	utine ex	ams	;	\$0 copay per Medicare-covered exam; \$0 copay for routine exams		
Hearing Aids	20% coinsurance f \$1,000 annual	allowar	nce		20% coinsurance for hearing aids; \$1,250 annual allowance		
Haaring Evans	20% coinsurance for Me				20% coinsurance for Medicare-covered exams;		
Hearing Exams	20% coinsurance for plan covers up to				20% coinsurance for routine exams; plan covers up to \$250/year		
	\$0 co-pay per Medicare-cov				\$0 co-pay per Medicare-covered visit; \$0 co-pay for		
Dental	preventive services up to \$ certain comprehensive serv				preventive services; plan covers up to \$500/year; \$0 co-pay for certain comprehensive services; up to		
	\$2000/year; Imperial HM				\$2000 per year; Imperial HMO contracted provider		
Chiropractic	\$0 copay per Medica Routine visits i				20% co-insurance per Medicare-covered visit; Routine visits not covered		
Podiatry	\$0 co-pay per Medic \$0 co-pay for 6 routi			*	\$0 co-pay per Medicare-covered visit; \$0 co-pay for 6 routine visits per year		
	Cost-sharing shown is for	30	90	100	The first of ordering the feet year		
	preferred pharmacies	days	days	days			
	Preferred Generic	\$0	\$0	mail \$0			
	Generic	\$3	\$9	\$5	THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.		
Prescription Drugs	Preferred Brand	\$30	\$90	\$75	I RESCRIETION DRUG COVERAGE.		
(Part D)	Non-Preferred Brand Specialty co-insurance	\$75 33%	\$150 33%	\$180 N/A			
	\$0 deductible; after total ye	arly dru	ig costs	reach	YOU CANNOT BELONG TO THIS PLAN AND		
	\$4,660, you pay \$0 for generation 25% of the plan's cost for be				ALSO ENROLL IN A STAND-ALONE		
	out-of-pocket drug expenses		_		MEDICARE PRESCRIPTION DRUG PLAN.		
	that, you pay the greater of \$	4.15 or	5% for g	generics			
	and the greater of \$10.35 or annual out of pocket max.	o% for	orands. S	Þ/,4UU			
	Meals: \$0 copay for up to 7	home-d	lelivered	meals	Meals: \$0 copay for up to 7 home-delivered meals		
041	following a surgery or hospi	tal stay			following a surgery or hospital stay Over the Counter: \$120 quarterly allowance		
Other Benefits/Options	Over the Counter: \$120 quitems in OTC mail order cata		llowance	e for	Part B Premium Reduction: \$75 monthly		
Deficites/Options	Transportation: \$0 co-pay	for unli	mited ro	and	reimbursement Transportation: \$0 co-pay for unlimited round		
	trips to plan approved location	ons			trips to plan approved locations		
	Wellness: \$0 for basic Silve			=	Wellness: \$0 for basic Silver&Fit membership		
MPIG	Medical Groups: Brown & Holdings, Nivano Physicians				Medical Groups: Brown & Toland, Imperial Health Holdings, Nivano Physicians, Physician Partners IPA		
Medical Groups and Hospitals	Hospitals: Alta Bates/Summ	it (Berk	/Oak), E	den	Hospitals: Alta Bates/Summit (Berk/Oak), Eden		
and Hospitals	Medical Center (C. Valley), Washington (Fremont)	St. Rose	(Haywa	rd) and	Medical Center (C. Valley), St. Rose (Hayward) and Washington (Fremont)		
<u> </u>	" asimigion (Fielliont)				manington (i temont)		

2023 1	MEDICARE HMO CON	IEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY									
Please contact the			Ka	iser Pe	ermanente						
Plan for more		800)-777-	1238 (S	(Sales & Marketing)						
information or call		80	0-443	-0815 (Member Services)						
1-800-Medicare					iserpermanente.org						
	Kaiser Perma	nente	Senio	r	Kaiser Perma	nente	Senio	r			
Plan Name/Type	Advantage Ba				Advai						
	(HMO) (H				(HMO) (H	_	132)				
Cton Doting			(39)				<i>)32)</i>				
Star Rating Annual OOP Max	***				***						
	\$6,0				\$3,900 \$70						
Monthly Premium	\$0 \$5 copay for Primar		N:-:-				N!!				
Doctor Visits	\$5 copay for Primar \$15 for Sp		nysician	ı;	\$0 copay for Primar \$10 for S		Pnysician	;			
Inpatient Hospital	\$265 copay/day	for days			\$195 copay/day	for day					
	\$0 per day for day				\$0 per day for day						
Outpatient	\$250 per ambulatory s				\$180 per ambulatory						
Hospital	\$0-\$250 copay per outpation			ity visit	\$0-\$180 copay per outpati			ty visit			
Skilled Nursing	\$0 copay/day for \$100 per day for				\$0 copay/day f \$100 per day fo						
Facility		-		- 4mi-m				tui n			
Ambulance	\$200 copay per air or gr \$110 for emerger			: unp	\$200 copay per air or g \$110 for emerge			unp			
Emergency &	\$5 for urgent				\$0 for urgen						
Urgent Care	Worldwide				Worldwide						
Lab Tests,	\$0 copay for lab, diagnos				\$0 copay for lab, diagnostic	tests, p	rocedures	s, x-rays;			
Procedures, and	\$5 copay for x-rays				\$195 copay for diag			;			
Radiation Therapy	diagnostic radiology; \$0 fo			liology	\$0 for therapeu						
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insurance	e per tre	atment				
Outpatient Mental	\$2 copay per indi				\$0 copay per ind						
Health Visits	\$5 per group the				\$0 per group th						
Eyewear	\$150 allowance for eye See Optional Bene			ars;	\$150 allowance for ey See Optional Ber			ars;			
	\$5-\$15 copay per Med			am:	\$0-\$10 copay per Med			am:			
Eye Exams	\$5 per routi			,	\$0 per rout			,			
Hearing Aids	\$1,250 allowance per	aid, eve	ery 3 yea	rs	\$1,250 allowance pe	r aid, ev	ery 3 yea	rs			
Hearing Exams	\$15 copay per Medic			n;	\$10 copay per Medic			n;			
Treating Exams	\$0 copay for re \$0 copay for certain prev			4: -	\$0 copay for r \$0 copay for certain pre			4: -			
Dental	services; See Optional B				services; See Optional F						
2011011	additional den				additional de						
Chiropractic	\$5 copay per Medic			;	\$0 copay per Medic			;			
•	Routine care i			4.	Routine care			4.			
Podiatry	\$15 copay per Medio Routine foot car			ι;	\$10 copay per Medi Routine foot ca			I;			
	Cost-sharing shown is for	30	100	100	Cost-sharing shown is for 30 100 100						
	preferred pharmacies	days	day	days	preferred pharmacies	days	days	days			
			retail	mail	-	1	retail	mail			
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0			
	Generic Preferred Brand	\$12 \$45	\$36 \$135	\$24 \$90	Generic Preferred Brand	\$5 \$45	\$15 \$135	\$10 \$90			
Prescription Drugs	Non-Preferred Brand	\$100	\$300	\$200	Non-Preferred Brand	\$100	\$300	\$200			
(Part D)	Specialty co-insurance	33%	33%	33%	Specialty co-insurance	33%	33%	33%			
	\$0 deductible; after total year				\$0 deductible; after total year						
	\$4,660, you pay \$0 copay for for generic and 25% for bran				\$4,660 , you pay \$0 copay for generic and 25% for brand to						
	drugs until out-of-pocket dru				until out-of-pocket drug exp						
	After that, you pay \$0 for ge	nerics a	nd \$12 fo	or brands.	that, you pay \$0 for generic	s and \$1 2	2 for bran	ıds.			
	Meals: \$0 copay for home-d				Meals: \$0 copay for home-o						
	hospitalization due to congest day for four weeks, once per		rt failure	two per	hospitalization due to conge day for four weeks, once pe		irt failure	, two per			
	Medical Financial Assistan		ram: av	ailable to	Medical Financial Assistar		ram: ava	ailable to			
	eligible members; contact pla				eligible members; contact pl						
Other	Over the Counter: \$60 quan				Over the Counter: \$60 qua						
Benefits/Options	from OTC catalogue; each of Wellness: \$0 for Silver&Fit				from OTC catalogue; each of Wellness: \$0 for Silver&Fit						
Denomina Options	carress. 40 for brivered it	5J111 111C			Since of the sirvered in	SJIII III					
	Optional Benefit Plan: Ad	vantage	Plus at		Optional Benefit Plan: Ad	lvantage	Plus at				
	\$14/month: -Dental: Copays vary dependent	ding un	n the se	rvice:	\$14/month: -Dental: Copays vary deper	dingun	on the sec	rvice:			
	Delta Care USA HMO netwo		m the se	ivice,	Delta Care USA HMO netw	- 1	on the sei	vice,			
	-Vision: \$0 copay for eyewe	ar with			ce -Vision: \$0 copay for eyewear with \$290 allowance						
	(in addition to \$150 allowand	ce above	e) every t	wo years							
Medical Groups	Medical Groups: Kaiser Per				Medical Groups: Kaiser Pe						
and Hospitals	Hospitals: Kaiser Oakland,	San Lea	ındro, Fr	emont	Hospitals: Kaiser Oakland	San Lea	andro, Fr	emont			
			- 10		•						

	TEDICARE HMO COM	IPAKI	SON (CHARI	FOR ALAMEDA COU	NIX		
Please contact the			Ur	nited He	ealth Care			
Plan for outline of		844-	723-0	6473 (Sa	les and Marketing)			
coverage & provider					Member Services)			
information or call		07			icareplans.com			
1-800-Medicare		~		*				_
Plan Name/Type	UnitedHealthcare (HMO-POS)				AARP Medicare A (HMO-POS)		0	
Star Rating	***	**			***	⊤ ★		
Annual OOP Max	\$3,4	00			\$6,70	00		
Monthly Premium	\$57				\$25			
Doctor Visits	\$0 copay for Primar \$15 for Sp	ecialist		n;	\$0 copay for Primary \$10 for Sp	ecialist		ι;
Inpatient Hospital	\$250 copay/day \$0 for days 8 and be			d)	\$300 copay/day \$0 for days 8 and be			.)
Outpatient Hospital	\$75 copay for ambulator \$200 copay for outpa				\$200 copay for ambulator \$250 copay for outpa			,
Skilled Nursing Facility	\$0 copay/day fo \$196 per day for days 2			-100	\$0 copay for \$196 copay/day for days			5-100
Emergency & Urgent Care	\$90 copay per emergency admitted to hospital within care visit; \$0 copay for	24 hour	s; \$40 p	er urgent	\$90 copay per emergency admitted to hospital within a care visit; \$0 copay for	24 hours	s; \$40 pe	er urgent
Ambulance	\$265 copay per trip	by grou	ınd or ai	r	\$250 copay per trip	by grou	nd or air	
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnosti \$15 copay per x-ray; \$10 radiology; \$60 copay for	5 copay	for dia	gnostic	\$0 copay for lab, diagnosti \$15 copay per x-ray; \$60 radiology; \$60 copay for	copay 1	or diagr	nostic
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insurance	e per trea	atment	
Outpatient Mental	\$25 copay for individu				\$25 copay for individu			
Health Visits	\$15 copay for group				\$15 copay for group			
Eyewear	\$0 copay for standard ler allowance toward fram through United He	es or co	ntact lei	nses;	\$0 copay for standard lenses, with \$100 annual allowance toward frames or contact lenses; through United Healthcare Vision			
Eye Exams	\$0 copay for Medica \$0 copay for one and				\$0 copay for Medica \$0 copay for one ann			
Hearing Aids	\$175 - \$1,225 copay per aid; up to 2 aids each year; through United Healthcare Hearing				\$175 - \$1,225 copay per aid through United Hea			
Hearing Exams	\$0 copay for Medica \$0 copay for one and				\$0 copay for Medica \$0 copay for one ann			
Dental	\$0 copays for certain preverservices; \$1,000 combined network dentists but high See Optional Ben	ed limit; her copa	can use iys may	out of apply	\$0 copay for certain preventive services; can use out of network dentists but higher copays may apply See Optional Benefit Plan below			
Chiropractic	\$15 copay for Medic Routine care 1	care-cov	ered vis		\$10 copay for Medicare-covered visit; Routine care not covered			
Podiatry	\$15 copay per Medic \$15 copay/visit for 6 ro	care-cov	ered vis		\$10 copay per Medic \$10 copay/visit for 6 ro	are-cove	ered visi	
	Cost-sharing shown is for preferred pharmacies	30 days	100 days retail	100 days mail	Cost-sharing shown is for preferred pharmacies	30 days	100 days retail	100 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic Preferred Brand	\$12 \$47	\$36 \$141	\$0 \$131	Generic Preferred Brand	\$12 \$47	\$36 \$141	\$0 \$131
Prescription Drugs	Non-Preferred Brand Specialty co-insurance	\$100 33%	\$300 N/A	\$290 N/A	Non-Preferred Brand Specialty co-insurance	\$100 33%	\$300 N/A	\$290 N/A
(Part D)	\$0 deductible; after total yea				\$0 deductible; after total year			
	\$4,660, you pay you pay \$0				\$4,660, you pay you pay \$0			
	no more than 25% of the pla drugs and 25% for generics				and no more than 25% of the name drugs and 25% for ger	•		
	expenses reach \$7,400. Afte				drug expenses reach \$7,400.			
	of \$4.15 or 5% for generics or 5% for brands.				greater of \$4.15 or 5% for g of \$10.35 or 5% for brands.			
	Over the Counter: \$40 allo	Wanca -	er avort	er for	Over the Counter: \$40 allo	wance p	er quart	er for
Other Benefits/Options	items from network retail loc Transportation: \$0 copay for year to plan-approved, medic Wellness: \$0 for Renew Ac	cation or or 24 on cally rela	OTC care- e-way to ated loca	atalog rips per ations	items from network retail loc Wellness: \$0 for Renew Ac Optional Dental Platinum includes certain preventive a benefits with varied cost-sha	cation or tive Fitr Rider a and comp	OTC caness mer	atalog nbership onth:
Medical Groups and Hospitals	Medical Groups: Canopy H Bay, Canopy Health John M Canopy Health Meritage Me Hospitals: Alameda, Highla Leandro, and Washington (F	uir Phys dical No nd (Oak	sicians, a etwork land), S	and	Medical Groups: Brown an Physicians East Bay Hospitals: St. Rose (Haywa	d Tolan	d East B	ay; Hill

Please contact the Plan for outline of	United Health Care 844 723 6473 (Sales and Maybratine)								
coverage & provider	844-723-6473 (Sales and Marketing)								
information or call	877-596-3258 (Member Services) www.aarpmedicareplans.com								
1-800-Medicare Plan Name/Type	United Health Care Advantage Assure (HMO) (H0543-183)				AARP SecureHorizons Plan 1 (HMO-POS) (H0543-070)				
Star Rating	****				***				
Annual OOP Max	\$8,30	00			\$6,700				
Monthly Premium	\$27.50				\$118				
Doctor Visits	20% coinsurance for Primary Care Physician; 20% coinsurance for Specialist				\$0 copay for Primary Care Physician; \$10 for Specialist				
Inpatient Hospital	\$1,600 copay per stay; unlimited days				\$390 copay/day for days 1-5; \$0 for days 6 and beyond (unlimited)				
Outpatient Hospital	20% coinsurance for ambulatory surgical center visit; 20% coinsurance for outpatient hospital visit				\$370 copay for ambulatory surgical center visit; \$370 copay for outpatient hospital visit				
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$200 copay/day for days 21-100				\$0 copay/day for days 1-20; \$196 per day for days 21-55; \$0 for 56-100				
Emergency & Urgent Care	\$90 copay for emergency room visit; waived if admitted to hospital within 24 hours; \$40 per urgent care visit; \$0 copay for worldwide coverage				\$90 copay for emergency room visit; waived if admitted to hospital within 24 hours; \$40 per urgent care visit; \$0 copay for worldwide coverage				
Ambulance	20% coinsurance per t	rip by g	round or	air	\$250 copay per trip	by grou	nd or air		
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic tests and procedures; 20% coinsurance for x-rays, diagnostic radiology, and therapeutic radiology				\$0 copay for lab, diagnostic tests, and procedures; \$15 copay per x-ray; \$105 copay for diagnostic radiology; \$60 copay for therapeutic radiology				
Renal Dialysis	20% co-insurance per treatment				20% co-insurance			1053	
Outpatient Mental	20% coinsurance for individual therapy session;				\$25 copay for individual therapy session;				
Health Visits	20% coinsurance for group therapy session				\$15 copay for group therapy session				
Eyewear	\$0 copay for standard lenses, with \$100 annual allowance for frames or contact lenses; through United Healthcare Vision				\$0 copay for standard lenses, with \$100 annual allowance for frames or contact lenses; through United Healthcare Vision				
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	Plan pays up to \$2,500 per year for 2 aids/year; through United Healthcare Hearing				\$175 - \$1,225 copay per aid; up to 2 aids each year; through United Healthcare Hearing				
Hearing Exams	20% coinsurance for Medicare-covered exam; \$0 copay for one annual routine exam				\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam				
Dental	Not Covered				See Optional Benefits Plan below				
Chiropractic	20% coinsurance for Medicare-covered visit; Routine care not covered				\$10 copay for Medicare-covered visit; Routine care not covered				
Podiatry	\$0 co-pay per Medicare-covered visit; \$0 co-pay per routine visit, up to 4 per year				\$10 copay per Medicare-covered visit; \$10 copay/visit for 6 routine visits per year				
	Cost-sharing shown is for preferred pharmacies Preferred Generic	30 days	100 days retail 25%	100 days mail 25%	Cost-sharing shown is for preferred pharmacies Preferred Generic	30 days	100 days retail	100 days mail	
	Generic Generic	25%	25%	25%	Generic Generic	\$12	\$36	\$0	
	Preferred Brand	25%	25%	25%	Preferred Brand	\$47	\$141	\$131	
Prescription Drugs	Non-Preferred Brand Specialty co-insurance	25% 25%	25% N/A	25% N/A	Non-Preferred Brand Specialty co-insurance	\$100 27%	\$300 N/A	\$290 N/A	
(Part D)	\$505 deductible; after total yearly drug costs reach				\$0 deductible for Tiers 1-2; \$350 for Tiers 3, 4, & 5;				
	\$4,660, you pay no more than 25% of the plan's cost				after total yearly drug costs reach \$4,660, you pay \$0 for preferred generics and no more than 25% of the plan's cost for brand name and 25% for generics until out-of-pocket drug expenses reach \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.				
	for brand name and 25% for generics until out-of-pocket drug expenses reach \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.								
Other Benefits/Options	Cost-Sharing Waived: most co-insurance and copays are waived for those with full Medi-Cal/LIS Transportation: \$0 copay for 36 one-way trips per year to plan-approved, medically related locations				Optional Dental Platinum Rider at: \$56/month: includes certain preventive and comprehensive benefits with varied cost-sharing				
Medical Groups and Hospitals	Medical Groups: Affinity East Bay, PAMF, and Sutter East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), and Washington (Fremont)				Medical Groups: Affinity East Bay, PAMF, and Sutter East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), and Washington (Fremont)				

2023 M				HAKI	FOR ALAMEDA COUNTY			
Please contact the	SCAN Heal	th Pl	an		Wellcare by Health Net			
Plan for more	877-870-4867 (Sale	es & N	Iarket	ing)	844-917-0175 (Sales & Marketing)			
information or call	800-559-3500 (Me	ember	Servi	ces)	866-907-5799 (Member Services)			
1-800-Medicare	•			,	www.wellcarenow.com			
Plan Name/Type	www.scanhealthplan.com SCAN Classic (HMO) (H05425-075)				Wellcare Patriot Giveback (HMO (H0562-044)			
Star Rating	****1/2			***				
Annual OOP Max	\$4,00	0			\$4,500			
Monthly Premium	\$0				\$0			
Doctor Visits	\$0 copay for Primary Care Physician; \$10 for Specialist				\$5 copay for Primary Care Physician; \$10 for Specialist			
Inpatient Hospital	\$250 copay/day f \$0 per day for days 7 and	l beyond	d; unlim	\$200 copay/day for days 1-5; \$0 per day for days 6 and beyond				
Outpatient Hospital	\$0 per ambulatory surg \$10-\$125 copay per outpatie	nt hospi	ital facil		\$100 per ambulatory surgical center visit; \$200 copay per outpatient hospital facility visit			
Skilled Nursing Facility	\$0 copay/day for \$75 for days		-20;	\$0 copay/day for days 1-20; \$75/day for days 21-80; \$0 for days 81-100				
Ambulance	\$180 copay per one-way	trip by g	ground o	or air	\$125 copay per one-way trip by ground or air			
Emergency & Urgent Care	\$90 copay per ER visit; waived if admitted to hospital immediately; \$10 per urgent care visit; Worldwide coverage.				\$110 copay per ER visit; \$10 per urgent care visit; copays waived if admitted to hospital within 24 hours; \$50,000 plan limit for ER & urgent care worldwide; \$110 copays; not waived if admitted			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagn tests, x-rays and diagnostic for therapeutic radio	radiolo	gy; \$60	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$200 co-pay for diagnostic radiology; 20% co-insurance for therapeutic radiology				
Renal Dialysis	20% co-insurance per treatment				20% co-insurance per treatment			
Outpatient Mental Health Visits	\$10 copay for in group therapy			\$25 copay for individual or group therapy session				
Eyewear	\$235 allowance for eyewear every 2 years				\$100 annual allowance for eyeglasses or contacts			
Evo Evomo	\$0 copay per Medicare-covered exam;				\$0-\$10 copay per Medicare-covered exam;			
Eye Exams	\$0 copay for one annual routine exam \$450 - \$750 copay per aid; up to 2 aids each year;				\$0 copay for one annual routine exam			
Hearing Aids	through plan-contracted provider				Not Covered			
Hearing Exams	\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam				\$10 copay for Medicare-covered exam; \$0 copay for one annual routine exam			
Dental	\$0 co-pay for certain preventive services, diagnostic screenings, and x-rays; See Optional Benefits Plan below				See Optional Benefits Plan below			
Chiropractic	\$0 copay per Medicar Routine visits n			\$0 copay per Medicare covered visit; \$0 copay for 36 routine visits per year				
Podiatry	\$10 copay per Medica \$0 copay for 6 routin			\$10 copay per Medicare-covered visit; \$10 co-pay/visit, for 12 routine visits per year				
	Cost-sharing shown is for preferred pharmacies	30 days	100 days retail	100 days mail				
Prescription Drugs	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance		\$0 \$0 \$141 \$300 N/A		THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.			
(Part D)	\$0 deductible; after total yearly drug costs reach \$4,660, you pay \$0 for drugs in Tiers 1 & 2 and no more than 25% of the plan's cost for brand name drugs until out-of-pocket drug expenses reach \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.				YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.			
Other Benefits/Options	Over the Counter: \$100 qua balance carries over to next of year Transportation: \$0 copay for year to plan-approved location Wellness: \$0 for basic Silve membership; \$0 copay for Fi years Optional Dental Package: \$ copays for certain preventive services	or 24 on ons or Sneak tness Ti	e-way t ers racker e	Acupuncture: \$0 copay per visit for 36 routine visits per year Part B Premium Reduction: \$25 monthly reimbursement Routine Physical: \$0 copay for one annual exam Tobacco Cessation Counseling: \$0 copay/visit for 5 visits per year Wellness: 32 credits/month for basic gym membership or at-home fitness boxes/videos Optional Dental Package: \$11/month; \$0-\$2,250 copays for certain preventive & comprehensive svo				
Medical Groups and Hospitals	Medical Groups: Brown & Toland Hospitals: Alameda, San Leandro, St. Rose (Hayward)				Medical Groups: Brown & Toland Hospitals: Alameda, San Leandro, St. Rose (Hayward)			
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Please contact the Plan for more information or call	Wellcare by Health Net 844-917-0175 (Sales & Marketing) 866-907-5799 (Member Services)								
1-800-Medicare Plan Name/Type	Wellcare Premium Ultra (HMO) Wellcare No Premium (H0562-009-0) (H0562-113-0)							(O)	
Star Rating	(H0562-				(H0562-113-0) ★★★				
Annual OOP Max	\$6,70				\$5,500				
Monthly Premium	\$13				\$0				
Doctor Visits	\$10 copay for Primar \$15 for Sp	ecialist		1;	\$0 copay for Primary Care Physician; \$15 for Specialist				
Inpatient Hospital	\$325 copay/day for days 1-6; \$0 per day for days 7 and beyond				\$275 copay/day for days 1-7; \$0 per day for days 8 and beyond				
Outpatient Hospital	\$200 per ambulatory s \$350 copay per outpatien	\$200 per ambulatory surgical center visit; \$250 copay per outpatient hospital facility visit							
Skilled Nursing Facility	\$0 copay for days 1-20; \$150 copay/day for days 21-70; \$0 per day for days 71-100				\$0 copay for days 1-20; \$150 per day for days 21-60; \$0 for days 61-100				
Ambulance	\$250 copay per one-way	trip by	ground o	or air	\$270 copay per one-way	y trip by	ground o	or air	
Emergency & Urgent Care	\$95 copay per ER visit; \$15 per urgent care visit; copays waived if admitted to hospital within 24 hours; \$50,000 plan limit for ER coverage worldwide, with \$95 copays, not waived if admitted				\$110 copay per ER visit; \$20 per urgent care visit; copays waived if admitted to hospital within 24 hours; \$50,000 plan limit for ER and urgent care worldwide; with \$110 copays, not waived if admitted				
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$350 copay per diagnostic service; 20% co-insurance for therapeutic radiology				\$0 copay for lab, diagnost x-rays; \$250 co-pay for 20% co-insurance for t	diagnos	tic radiol	ogy;	
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insuranc	e per tre	atment		
Outpatient Mental Health Visits	\$25 copay for individual or group therapy session				\$25 copay for individual or group therapy session				
Eyewear	Routine eyewear available for additional premium; See Optional Benefit Plan below				\$200 annual allowance for eyeglasses or contacts				
Eye Exams	\$0-\$15 copay per Medicare-covered exam; \$0 copay for one annual routine exam				\$0-15 copay per Medicare-covered exam; \$0 copay for one annual routine exam				
Hearing Aids	Not Cov	vered			\$750 allowance for up to two aids each year				
Hearing Exams	\$15 copay for Medicare-covered exam; \$0 copay for one annual routine exam				\$15 copay for Medicare-covered exam; \$0 copay for one annual routine exam				
Dental	See Optional Benefit Plan below				\$0 copays for certain preventive services; \$0-\$2,250 copays for certain comprehensive services				
Chiropractic	\$15 copay per Medicare covered visit See Optional Benefit Plans below				\$0 copay per Medicare covered visit; \$0 copay for 24 routine visits per year				
Podiatry	\$15 copay per Medicare-covered visit; \$15 co-pay per visit for 6 routine visits per year				\$15 copay per Medicare-covered visit; \$15 copay per visit for 12 routine visits per year				
	Cost-sharing shown is for	30	90	90	Cost-sharing shown is for	30	90	90	
	preferred pharmacies	days	days retail	days mail	preferred pharmacies	days	days retail	days mail	
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0	
	Generic Preferred Brand	\$5 \$37	\$15 \$111	\$0 \$74	Generic Preferred Brand	\$5 \$37	\$15 \$111	\$0 \$74	
Prescription Drugs	Non-Preferred Brand	\$90	\$270	\$180	Non-Preferred Brand	\$90	\$270	\$180	
(Part D)	Specialty co-insurance	29%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A	
	\$0 deductible for Tiers 1&2; \$220 deductible for Tiers 3,4, & 5; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.				\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.				
Other Benefits/Options	Routine Physical: \$0 copay for one annual exam Tobacco Cessation Counseling: \$0 copay/visit for 5 visits per year Wellness: 32 credits/month for basic gym membership or at-home fitness boxes/videos Wellcare Premium Ultra at \$26 per month: - Dental: \$0 co-pay for certain preventive services and \$0-\$2,250 copays for comprehensive services - Acupuncture and Chiropractic: \$10 co-pay per visit, up to 36 combined visits per year - Eyewear: \$300 annual allowance				Acupuncture: \$0 copay for 24 routine visits per year Over the Counter: \$70 quarterly allowance for plan- approved items at CVS or in catalog Routine Physical: \$0 copay for one annual exam Tobacco Cessation Counseling: \$0 copay/visit for 5 visits per year Transportation: \$0 copay per trip for up to 24 one- way trips per year to plan-approved locations Wellness: 32 credits/month for basic gym membership or at-home fitness boxes/videos				
Medical Groups and Hospitals	Medical Groups: Brown & Toland, Hill Physicians East Bay, Sutter East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), St. Rose (Hayward), San Leandro, and Stanford Valley Care (Pleas/Livermore)				Medical Groups: Brown and Toland Hospitals: Alameda, San Leandro, St. Rose (Hayward)				

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 (\$226 in 2023). 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
- COVID 19 Vaccine and Boosters
- 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
- Shingles Vaccine
- 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 2023 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. Detailed information is available here: https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings