# 2024 Medicare Advantage Plan HMO Comparison Chart ~ FINAL~ for Alameda County

~Rev. 11/02/23 ~

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 2024, there are 26 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 2024, there are six Medicare PPOs in Alameda County. See our 2024 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 2024, there are 17 Special Needs Plans in Alameda County. See our **2024 Special Needs Plan Comparison Chart** for more information and details: www.lashicap.org/hicap.

#### **Enrollment:**

In the fall of 2023, 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, 2024. In 2024, 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 guaranteed 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, disenroll or change plans on a quarterly basis. The change will take effect on 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: 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 <a href="www.lashicap.org/hicap">www.lashicap.org/hicap</a>.

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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2024 141	EDICARE HIVIO CON	II AKK	JOIN C.	IIAKI F	OR ALAMEDA COUNTY		
Please contact the Plan for more information or call 1-800-Medicare	Aetna M 833-859-6031 (S 833-570-6670 (I www.aetnam	ales & l	Marke r Servi	<i>U</i>	Aetna Medicare 833-859-6031 (Sales & Marketing) 833-570-6670 (Member Services) www.aetnamedicare.com		
Plan Name/Type	Aetna Medic (HMO) (I			n	Aetna Medicare Eagle Plan (HMO) (H4982-013)		
Star Rating	**	<b>+</b> *			***		
Annual OOP Max	\$3,9	900			\$4,200		
<b>Monthly Premium</b>	\$	0			\$0		
<b>Doctor Visits</b>	\$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 \$0 copay for ambulator	ys 8 and	beyond	vicit:	\$50 co-pay/day for days 1-3; \$0 for days 4-90; \$0 for days 91 and beyond (unlimited) \$0 copay for ambulatory surgical center visit;		
Outpatient Hospital	\$150 copay for outpatie				\$50 copay for amountary surgical center visit, \$50 copay for outpatient hospital facility visit		
Skilled Nursing Facility	\$0 copay/day \$75 per day fo				<b>\$0</b> copay/day for days 1-20; <b>\$196</b> 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 emergen admitted to hospital; \$1 \$110 per emergency or ur waived if admi	15 per urg gent care	gent care visit wo	visit;	\$110 copay per emergency room visit; waived if admitted to hospital; \$10 per urgent care visit; \$110 per emergency or urgent care visit worldwide; waived 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 diagnos rapeutic r	stic radio		\$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	atment		20% co-insurance per treatment		
Outpatient Mental Health Visits	\$25 copay per individual				\$25 copay per individual or group therapy session		
Eyewear	\$225 annual reimbu for ey		allowand	e	\$250 annual reimbursement allowance for eyewear		
Eye Exams	\$0 copay for di \$0 copay for one a			n	\$0 copay per diagnostic exam; \$0 copay for one annual routine exam		
Hearing Aids	\$1,250 annual hearing purchased through Na	aid allow	ance per	ear;	\$1,250 annual hearing aid allowance per ear; purchased through NationsHearing provider		
Hearing Exams	\$0 copay for di \$0 copay for one a	_		n	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam		
Dental	\$1,200 annual reimbursem preventive and com any licensed d	prehensiv lental pro	e service vider	es;	\$1,500 annual reimbursement allowance fo covered preventive and comprehensive service any licensed dental provider		
Chiropractic	\$0 copay for Medi \$0 copay for unlim must use American Spo	nited rout	ine visits	;	\$0 copay for Medicare covered visit; \$0 copay for unlimited routine chiropractic visits; must use American Specialty Health provider		
Podiatry	\$15 copay per Med	licare-cov	ered vis	it	\$10 copay per Medicare-covered visit		
	Cost-sharing shown is for preferred pharmacies Preferred Generic Generic Preferred Brand	30 days <b>\$0</b> <b>\$0</b> <b>\$47</b>	100 day retail \$0 \$0 \$141	100 day mail \$0 \$0 \$141	THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.		
Prescription Drugs (Part D)	Non-Preferred Brand Specialty co-insurance \$0 deductible; after total y \$5,030, you pay \$0 for Tier more than 25% of the plan drugs until out-of-pocket dr After that, you pay \$0.	\$100 33% early dru 1 and 2 o's cost for	\$300 N/A Ig costs drugs and r brand n ases reach	\$300 N/A reach d no ame n \$8,000.	YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.		
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for treatments with American Streatments with American Streatments with American Streatments with American Streatments and the plan-approved items  Transportation: \$0 copay year to plan approved locat  Wellness: \$0 copay for bas membership; \$600 annual r for various fitness activities  Medical Crouns: Province	Specialty uarterly a for 12 on ions, via sic Silver eimburse s and supp	Health pullowance He-way tr Access20 Sneakers Hermont alle	rovider e for ips per Care s owance	Acupuncture: \$0 copay for unlimited acupuncture treatments with American Specialty Health provider  Over the Counter: \$105 quarterly allowance for plan-approved items  Transportation: \$0 copay for 12 one-way trips per year to plan approved locations, via Access2Care  Wellness: \$0 copay for basic Silver Sneakers membership		
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown a Hospitals: Alameda, Alta F (Berk/Oak), Highland (Oak Rose (Hayward), San Leand (Pleas/Liv), and Washingto	Bates/Sun i), Eden ( dro, Stant	nmit Me CValley ford Vall	l Ctr, , St. ey Care	Medical Groups: Brown and Toland; One Medical; Hospitals: Alameda, Alta Bates/Summit, (Berk/Oak), Highland (Oak), Eden (CValley), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Hospital (Frem)		

2024	MEDICARE HMO CO	VIFAR	15011	JIAKI	FOR ALAMEDA CC	JUNI :	L			
Please contact the Plan for more information or call	Aetna Mo 833-859-6031 (Sa 833-570-6670 (M	les & I Iembei	Marketi Servic	٠,	Aetna I 833-859-6031 (8 833-570-6670 (	Sales & Memb	k Marko er Serv			
1-800-Medicare	www.aetname	dicare	.com		www.aetnar		_			
Plan Name/Type	Aetna Medicar (HMO (H			n	Aetna Medicaro (HMO-POS					
Star Rating	<b>★</b> ★1					<b>₹1/2</b>				
Annual OOP Max	\$2,90	00			\$2	,900				
<b>Monthly Premium</b>	\$0				*	3.70				
Doctor Visits	\$0 copay for Primar \$0 for Spo	ecialist			\$0 copay for Primary Care Physician; \$0 for Specialist					
Inpatient Hospital	\$250 copay/day \$0 per day for day \$0 copay for ambulatory	s 8 and	beyond	:: .	\$250 copay/day for days 1-7; \$0 per day for days 8 and beyond \$0 copay per ambulatory surgical center visit;					
Outpatient Hospital	\$150 copay for outpatien				\$150 per outpatient					
Skilled Nursing Facility	\$0 copay/day for \$75 per day for				\$0 copay/day \$75 per day t					
Ambulance	\$225 copay per ground	or air an	nbulance 1	trip	\$225 copay per groun					
Emergency & Urgent Care	\$110 copay per emergenc admitted to hospital; \$0 \$110 per emergency or urge ER copay waived if a	\$110 copay per emerge admitted to hospital; \$110 per emergency or u ER copay waived i	<b>\$0</b> per u rgent ca	rgent care	visit; orldwide;					
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, dia and x-rays; \$0 copay for \$60 copay for thera	diagnos	tic radiolo		\$0 copay for lab services, and x-rays; \$0 copay for the	or diagr	nostic radi	ology;		
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insura	nce per	treatment			
Outpatient Mental Health Visits	\$25 copay per individual o				\$25 copay for individual or group therapy session					
Eyewear	\$275 annual reimbur for eye	wear			\$325 annual reimbursement allowance for eyewear; must use EyeMed provider \$0 copay for diagnostic exam;					
Eye Exams	\$0 copay for diag	nual rout	ine exam		\$0 copay for one	annual r	outine exa			
Hearing Aids	\$1,250 annual hearing a purchased through Nati	onsHear	ing provi		\$1,250 annual hearing purchased through N	ationsH	earing pro			
Hearing Exams	\$0 copay for diag \$0 copay for one and				\$0 copay for one	_		ım		
Dental	\$1,600 annual reimburseme preventive and compr any licensed de	ehensiv ntal prov	e services ⁄ider		\$2,500 annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider					
Chiropractic	\$0 copay for Medica \$0 copay for unliming must use American Spec	ted routi	ne visits;	ider	\$15 copay for Medicare-covered visits; \$0 copay/visit for unlimited routine visits; must use American Specialty Health provider					
Podiatry	\$0 copay per Medic				\$0 copay per Med					
n : c n	Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand	30 days \$0 \$0 \$47	100 days retail \$0 \$0 \$141	100 days mail \$0 \$0 \$141	Cost-sharing shown is for preferred pharmacies Preferred Generic Generic Preferred Brand	30 days  \$0 \$0 \$47	100 days retail \$0 \$0 \$141	100 days mail \$0 \$0 \$141		
Prescription Drugs	Non-Preferred Brand	\$100	\$300	\$300	Non-Preferred Brand	\$100	\$300	\$300		
(Part D)	Specialty co-insurance \$0 deductible; after total yes \$5,030, you pay \$0 for Tier I more than 25% of the plan's drugs until out-of-pocket dru After that, you pay \$0.	and 2 c	lrugs and brand na	no me	Specialty co-insurance \$0 deductible; after total \$5,030, you pay \$0 for Tic more than 25% of the plan drugs until out-of-pocket After that, you pay \$0.	er 1 and n's cost : lrug exp	2 drugs ar for brand enses read	nd no name ch <b>\$8,000.</b>		
Supplemental Benefits and Optional Plans	treatments with American Sp Over the Counter: \$105 quaplan-approved items Transportation: \$0 copay for year to plan approved location Wellness: \$0 copay for basic membership; \$600 annual res	Acupuncture: \$0 copay for unlimited acupuncture treatments with American Specialty Health provider Over the Counter: \$105 quarterly allowance for					Acupuncture: \$0 copay for unlimited acupuncture treatments with American Specialty Health provider Groceries: \$40 monthly allowance for those with Extra Help, through NationsBenefits card Over the Counter: \$50 monthly allowance for planapproved items through Nations OTC catalog Transportation: \$0 copay for 12 one-way trips per year to plan approved locations via Access2Care Wellness: \$0 copay for basic Silver Sneakers membership; \$600 annual reimbursement allowance for various fitness activities and supplies			
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown & Hospitals: Alameda, Alta Ba (Berk/Oak), Highland (Oak), Rose (Hayward), San Leand (Pleas/Liv), and Washington	ites/Sum Eden (C o, Stanf	mit Med CValley), ord Valle	Ctr, St. y Care	Medical Groups: Brown Hospitals: Alameda, Alta (Berk/Oak), Highland (Oa Rose (Hayward), San Lea (Pleas/Liv), and Washingt	Bates/S k), Eder ndro, Sta	ummit Mo (CValley unford Va	ed Ctr, y), St. lley Care		

Please contact the Plan for more information or call 1-800-Medicare	MEDICARE HIMO CO	88	Alig 8-979- 66-634	nment l -2247 (S 2247 (N	Health Plan Sales & Marketing) (Member Services) hthealthplan.com				
Plan Name/Type	Alignment Hea Veterans (HM		alPlus	ş +	Alignment Healt (HMO) (H3			,	
Star Rating	***	<b>*</b> *			***	<b>k</b>			
Annual OOP Max	\$5,9				\$2,900				
Monthly Premium	\$0				\$0				
Doctor Visits	\$0 for Primary Care Phys \$1,632 deductible; \$0 of				\$0 for Primary Care Physician; \$0 for Specialist  \$0 copay/day for days 1-4;				
Inpatient Hospital	\$408 copay/day f \$816copay/day f	or days or days	61-90; 91-150	ŕ	\$100 copay/day fo \$0 copay/day for days 1	r days 5 1-90 an	-10; d beyond		
Outpatient Hospital	1 5	<b>\$0</b> copay for ambulatory surgical center; <b>\$0</b> copay for outpatient hospital facility					center vi		
Skilled Nursing	\$0 copay/day for days 1-20;				\$0 copay/day for				
Facility	<b>\$204</b> /day for days 21-100				\$100 copay/day for	•			
Ambulance	20% co-insurance per ground or air ambulance trip; Not waived if admitted to hospital 20% coinsurance for ER and urgent care visits; ER				\$175 copay per ground or Waived if admitted	d to hosp	ital		
Emergency & Urgent Care	cost waived if admitted wit ER/urgent care visit worldw	hin 72 h	ırs; <b>\$75</b> c	copay for	\$85 copay for ER visit; copay \$0 for urgent care visit; \$20 co visit worldwide with \$10	pay for	ER/urger	nt care	
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab service procedures, x-rays, and 20% coinsurance for the service of the service	diagnos	tic radio	logy;	\$0 copay for lab services, procedures, x-rays, and di 20% coinsurance for the	agnostic	radiolog	y;	
Renal Dialysis	20% co-insuranc	e per tre	eatment		\$30 copay per t	reatmen	t		
Outpatient Mental Health Visits	20% co-insurance or group there				\$40 copay per in				
Eyewear	See Flex Allowance under	1.		Benefits	or group therapy session  \$150 annual allowance for eyewear				
Eye Exams	\$0 copay for dia \$0 copay for one an			m	\$0 copay for diagn \$0 copay for one annu	ostic ex	am;		
Hearing Aids	See Flex Allowance under				See Flex Allowance under S	upplem	ental Ben	efits	
Hearing Exams	\$0 copay for dia	gnostic	exam		\$0 copay for diagn				
Dental	\$0 copay for cert	•			\$0 copay for certain pre \$20-\$425 copays for certain c				
Chiropractic	and comprehen  \$0 copay per Medic			it	\$0 copay per Medicar			vices	
Podiatry	\$0 copay for Medic	are-cov	ered visi	t	\$5 copay for Medicar	e-covere	ed visit		
	Cost-sharing shown is for	30	100	100	Cost-sharing shown is for 30 100 100				
	preferred pharmacies	days	days retail	days mail	preferred pharmacies	days	days retail	days mail	
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0	
Prescription Drugs	Generic Preferred Brand	\$20 25%	\$60 25%	\$60 25%	Generic Preferred Brand	\$3 \$40	\$9 \$120	\$9 \$120	
(Part D)	Non-Preferred Brand	25%	25%	25%	Non-Preferred Brand	\$93	\$279	\$279	
	Specialty co-insurance \$545 deductible; after total	25% yearly d	N/A  rug cost	N/A streach	Specialty co-insurance  \$0 deductible; after total year	33% dy drug	N/A costs rea	N/A nch	
	\$5,030, you pay no more than				\$5,030, you pay no more than	<b>25%</b> of	the plan's	s cost	
	for brand names and 25% for pocket expenses reach \$8,000				for brand names and 25% for pocket expenses reach \$8,000.				
	Essentials Allowance: \$400				Acupuncture: \$0 co-pay/visit	for unli	mited vis	its	
	groceries, gas, utilities, and h qualifying chronic conditions		ety for ti	nose with	Essentials Allowance: \$100 q groceries, gas, utilities, and ho				
	Flex Allowance: \$600 comb dental, vision, hearing, acupu				with qualifying chronic condit	ions	-		
	podiatry services	inclure,	сшгорга	ctic, and	Flex Allowance: \$500 combine for dental, vision, hearing, chin				
Supplemental	In-Home Support Services: per quarter OR \$300 annual of		-		Over the Counter: \$100 quar Pet Services: \$0 copay for 7 b			4	
Benefits and	Meals: \$0 copay for up to 2	neals/d	ay for 14	days (2x/	walks/year for those w/qualify	ing chro	nic condi	tions	
Optional Plans	year) for those with qualifyin <b>Pet Services: \$0</b> copay for 7	_			Pest Control: \$0 copay for 1 st those with qualifying chronic of			or	
	walks/year for those w/qualif	ying ch	ronic cor	nditions	Transportation: \$0 copay for	28 one-	way trips	to	
	<b>Pest Control: \$0</b> copay for 1 with qualifying chronic cond		e per year	r for those	plan approved locations within Wellness: \$0 copay for basic §				
	<b>Transportation: \$0</b> copay for year to plan approved location				Enhanced Dental Option: \$2 comprehensive services, with				
	Wellness: \$0 copay for basic	gym m	embersh	ip	\$1,500 limit per year				
Medical Groups	Medical Groups: Alignment Toland	t Netwo	ork, Brov	vn &	Medical Groups: Alignment Toland	Networl	k; Brown	&	
and Hospitals (may not be full list;	Hospitals: Alameda; Alta Ba				Hospitals: Alameda; Alta Bate				
check with plan)	Eden (C. Valley), Highland ( Stanford Valley Care (Pleas/		t. Kose (l	нау),	Eden (C. Valley), Highland (O Stanford Valley Care (Pleas/Li		Kose (Ha	y),	
	Staniolu vancy Care (Fleas/	⊔1V <i>)</i>	-4-		Staniola valley Care (Fleas/L)	iv <i>)</i>		-	

2027	MEDICARE HMO CO	WIPAI				UNTY			
Please contact the			_						
Plan for more		888	8-979-	-2247 (S					
information or call									
1-800-Medicare					thealthplan.com				
Plan Name/Type		\$0 copay for diagnostic exam; \$10 copay for diagnostic exam;							
Star Rating	***	τ <b>★</b>			**	<b>*</b> *			
Annual OOP Max	\$3,00	00			\$3,4	00			
<b>Monthly Premium</b>	\$0				\$0				
Doctor Visits	\$0 for Primary Care Phys	ician; \$0	) for Spo	ecialist	\$10 for Primary Care Phys	sician; \$	35 for Spo	ecialist	
Inpatient Hospital	5-10; <b>\$0</b> copay for days 11	and be	yond; ur	limited	\$0 copay/day for days 8	and bey	ond; unlin	nited	
Outpatient Hospital	\$200 copay for outpati	ent hosp	oital faci		\$200 for outpatient h	ospital f	acility vis		
Skilled Nursing Facility	\$50 copay/day fo	or days 2	1-100						
Ambulance	waived if a	dmitted			waived if a	admitted			
Emergency & Urgent Care	within 48 hours; \$0 fc	or urgen	t care vi	sit;	hours; \$0 for urgent care vis	it; <b>\$0</b> co	pay for E	R/urgent	
Lab Tests, Procedures, and Radiation Therapy	procedures, x-rays, and	diagnos	tic radio	logy;	procedures, x-rays, and	diagnos	tic radiolo	ogy;	
Renal Dialysis	20% co-insurance	e per tre	atment		\$30 copay pe	r treatm	ent		
Outpatient Mental	\$40 copay per	individ	ual		\$35 copay pe	r individ	ual		
Health Visits Eyewear								ars	
Eye Exams	\$0 copay for diag	gnostic	exam;		\$0 copay for diagnostic exam;				
Hearing Aids					\$1,000 allowance with \$0 copay, every 2 years				
•			•	years				ycais	
Hearing Exams	\$0 copay for one and	nual rou	tine exa		\$0 copay for one annual routine exam				
Dental									
Chiropractic	\$0 copay per Medic				\$0 copay per Medic				
Podiatry	\$0 copay for Medica				\$25 copay for Medicare-covered visit				
1 odlati y	\$0 copay for 12 routing Cost-sharing shown is for	ne visits	each ye	100	Cost-sharing shown is for	30	100	100	
	preferred pharmacies	days	days	days	preferred pharmacies	days	days	days	
	2 12		retail		P. 0. 10	-	retail	mail	
	Preferred Generic Generic	\$0 \$3	\$0 \$9	\$0 \$9	Preferred Generic Generic	\$0	\$0	\$0	
<b>Prescription Drugs</b>	Preferred Brand	\$40	\$120	\$120	Preferred Brand	\$3 \$40	\$9 \$120	\$9 \$120	
(Part D)	Non-Preferred Brand	\$100	\$300	\$300	Non-Preferred Brand	\$93	\$279	\$279	
,	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A	
	\$0 deductible; after total yes \$5,030, you pay no more tha				\$0 deductible; after total ye \$5,030, you pay no more that				
	for brand names and 25% fo				for brand names and 25% for				
	pocket expenses reach \$8,00	0. After	that, yo	ou pay <b>\$0</b> .	pocket expenses reach \$8,00				
	Acupuncture: For those wit for 12 visits per year, combin In-home Support Services:	th Extra ned with \$0 cop	Help, \$6 chiropray for 1.	0 co-pay ractic 2 hours	pocket expenses reach \$8,00	U. After	that, you	pay <b>\$0</b> .	
Supplemental Benefits and	per quarter OR \$300 annual Meals: \$0 copay for up to 2 those with qualifying chronic with Extra Help, up to 56 me Over the Counter: \$60 quanthose with Extra Help, additionally Pet Services: \$0 copay for 7	meals/decondition  cals per per secondition  cals per secondition	ay for 14 lons; <i>Fo</i> year owance <b>40</b> per q	4 days for r those; For uarter	Over the Counter: \$75 qua Pet Services: \$0 copay for 7 walks per year for those with conditions Pest Control: \$0 copay for those with qualifying chroni	boardir qualify service	ig days or ing chron	ic	
Optional Plans	walks/year for those w/qualit Pest Control: \$0 copay for I those with qualifying chronic Transportation: \$0 copay for year to plan approved locatic Wellness: \$0 copay for basic -Enhanced Dental Option: comprehensive services, with \$1,500 limit per year	fying ch I service c condition or 12 on ons with c gym m \$27/mo	e per year ons e-way to in 20 min embershouth for co	rips per les hip certain	Wellness: \$0 copay for basi participating fitness centers -Enhanced Dental Option: comprehensive services, wit \$1,500 limit per year	e gym m \$27/mo	embershi	rtain	
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Alignmer Toland Hospitals: Alameda; Alta Ba Eden (C. Valley), Highland ( Stanford Valley Care (Pleas/	ates/Sun (Oak), S	nmit (Be	erk/Oak);	Medical Groups: Brown & Hospitals: Alameda; Alta B Highland (Oak), St. Rose, (Fare (Pleas/Liv)	ates/Sun	nmit (Ber		

Please contact the Plan for more information or call 1-800-Medicare			-619- 3-707-	6164 (S -3130 (	Blue Cross Sales & Marketing) Member Services) them.com				
Plan Name/Type	Anthem Selec		_	www.tdire	Anthem Pri		MO)		
Star Rating	***				Plan too new to		asured		
Annual OOP Max	\$7,55				\$1,2	00			
<b>Monthly Premium</b>	\$0				\$0				
<b>Doctor Visits</b>	\$15 copay for Primary \$45 copay for			ι;	\$0 copay for Primar \$10 copay fo			;	
Inpatient Hospital	\$325 copay/day f \$0 copay for days 7-	or days 90 and	1-6; beyond		\$250 copay for days 1-5; \$0 copay/day for days 6-90 and beyond				
<b>Outpatient Hospital</b>	\$275 copay for ambulatory \$325 copay for outpatient				\$150 copay for ambulatory surgical center visit; \$250 for outpatient hospital facility visit				
Skilled Nursing Facility	\$0 copay for d \$196 per day for	ays 1-20	);		\$0 copay/day for days 1-20; \$188 per day for days 21-100				
Ambulance	\$250 copay per ground 20% coinsurance per a				\$250 copay per grou 20% coinsurance per				
Emergency & Urgent Care	\$90 copay for ER visit; waive within 24 hours; \$35 fo \$100,000 annual limit for ER	r urgent	care vis	sit;	\$90 copay for ER visit; wai within 24 hours; \$35 \$100,000 annual limit for E	for urger	nt care vis	sit;	
Lab Tests, Procedures, and Radiation Therapy	\$10 copay for lab services a diagnostic tests & procedure radiology; 20% coinsurance f	es; \$150	for diag	gnostic	\$10 copay for lab services diagnostic tests & procedu radiology; 20% coinsurance	res; \$15	0 for diag	gnostic	
Renal Dialysis	20% co-insurance	per trea	tment		20% co-insuranc	e per tre	atment		
Outpatient Mental Health Visits	<b>\$40</b> copay per it or group therap				\$10 copay pe or group ther				
Eyewear	\$100 annual allowan	ice for e	yewear		\$100 annual allow	ance for	eyewear		
Eye Exams	\$45 copay for diag \$0 copay for one annu				\$10 copay for diagnostic exam; \$0 copay for one annual routine exam				
Hearing Aids	\$3,000 annual allowan				\$3,000 annual allowa				
Hearing Exams	\$45 copay for diag				\$10 copay for di	agnostic	exam;		
Dental	\$0 copay for one annu \$45 copay for Medica	re cove	red visit	;	\$0 copay for one an \$10 copay for Medic				
	\$0 copay for 1 oral exam as				\$0 copay for 1 oral exam				
Chiropractic	\$15 copay per Medica \$0-45 copay for Medic				\$20 copay per Medicare-covered visit  \$0-10 copay for Medicare-covered visit;				
Podiatry	\$0 copay for 24 routin	e visits	each yea	ır	\$0 copay for unlimited routine visits each year				
	Cost-sharing shown is for preferred pharmacies	30 days	90 days retail	90 days mail	Cost-sharing shown is for preferred pharmacies	30 days	90 days retail	90 days mail	
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0	
D D	Generic Preferred Brand	\$10 \$42	\$30 \$126	\$0 \$84	Generic Preferred Brand	\$7 \$42	\$21 \$126	\$0 \$84	
Prescription Drugs (Part D)	Non-Preferred Brand	\$95	\$285	\$190	Non-Preferred Brand	\$95	\$285	\$190	
(rait D)	Specialty co-insurance \$0 deductible; after total year \$5,030, you pay no more than for brand name drugs and 25% of-pocket drug expenses reach pay \$0.	25% of 6 for ge	f the pla nerics u	n's cost ntil out-	Specialty co-insurance \$0 deductible; after total ye \$5,030, you pay no more tha for brand name drugs and 25 of-pocket drug expenses rea pay \$0.	n 25% o 5% for g ch \$8,00	of the pla enerics u 0. After	n's cost ntil out- that, you	
Supplemental Benefits and Optional Plans	Acupuncture: \$0 co-pay/visit Over the Counter: \$25 quarter Wellness: \$0 for basic Silver Optional supplemental pack 1: Preventive Dental at \$13 \$500/year; \$0 co-pays for basic 2: Dental & Vision at \$32 pe \$1,000/year with \$0 copays for services and 20-50% coinsura comprehensive services; \$150 allowance for eyewear 3: Enhanced Dental & Vision to \$2,000/year with \$0 copays services and 20-50% coinsura comprehensive services; \$200 allowance for eyewear	erly allo Sneaker ages: per mo ic preve or month or certain unce for annual n at \$48 for cert unce for annual	owance is member white up notive senth: up to a prevent certain reimbur some certain preventain preventain preventain reimbur reimbur senth up notive senth up notice senth up	ership to rvices ttive essement onth: up ventive essement	\$500/year; \$0 co-pays for basic preventive services 2: Dental & Vision at \$32 per month: up to \$1,000/year with varying copays; \$150 annual reimbursement allowance for eyewear 3: Enhanced Dental & Vision at \$48 per month; up				
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Bay Valley Physicians East Bay; Imperial Hospitals: Alta Bates/Summit (CValley), St. Rose, (Hayward (Pleas/Liv), Washington (Fren	Health t (Berk/d), Stant	Holding Oak), Ed	gs den	Medical Groups: Bay Vall Physicians East Bay; Imperi Hospitals: Alta Bates/Sumn (CValley), St. Rose, (Haywa (Pleas/Liv), Washington (Fr	al Healtl nit (Berk nrd), Stan	n Holding /Oak), E	gs den	

Please contact the	MEDICARE HMO CO			C111111					
	Brand Ne	w Da	y		Brand N	ew Da	<b>y</b>		
Plan for more	866-255-4795 (Sal	es & N	- Iarketi	ng)	866-255-4795 (Sa	les & N	- Aarketi	ing)	
information or call	866-255-4795 (M				866-255-4795 (M				
1-800-Medicare	www.bndhr			/	www.bndł			,	
	Classic C				Classic (				
Plan Name/Type	(HMO) (H0				(HMO) (H				
C4 D-4*	` /`		30)		, , ,		31)		
Star Rating	**1,				**				
Annual OOP Max	\$2,10				\$2,4 \$0				
Monthly Premium	\$37.6		C C		1.		- 6 - 6	. 1	
Doctor Visits	\$0 for Primary Care Physic			alist	\$0 for Primary Care Phys.			cialist	
Inpatient Hospital	\$50 copay/day fo \$0/day for da				<b>\$150</b> copay/day for days 1-6; <b>\$0</b> per day for days 7-150				
Outpatient	\$0 copay per ambulato				\$0-\$75 copay for ambulate			-	
Hospital	\$0-150 copay per outpatien			V1S1t	\$0-\$150 copay per outpati			y visit	
Skilled Nursing	\$0 copay for d				\$0 copay for \$200 per day fo				
Facility	\$200 per day for days 21-100 \$0-\$200 copay per trip by ground;				\$0-250 copay per	•			
Ambulance	20% coinsurance per trip by ground or air				20% co-insuranc				
Emergency &	\$0-100 copay per emergence	<b>\$0-100</b> copay per emergency room visit; waived if				ncy room	visit; wa		
Urgent Care		admitted within 72 hours; \$0 per urgent care visit; \$50,000 max worldwide with \$100 copay/visit					gent care		
Lab Tests,	\$0 copay for lab services,				\$50,000 max worldwide \$0 copay for lab, diag				
Procedures, and	diagnostic procedures,				tests, and x-rays; \$50 copay				
Radiation Therapy	20% co-insurance for th				20% co-insurance for t				
Renal Dialysis	20% co-insurance	per trea	tment		20% co-insuranc	e per trea	itment		
Outpatient Mental	625 6 11 1 1		1		\$10 copay for individ	ual thera	oy sessio	n;	
Health Visits	\$25 copay for individual or	group t	nerapy so	ession	20% co-insurance for g	roup the	rapy sess	ion	
Eyewear	\$300 annual allowar		•		\$300 annual eyewear allowance for eyewear				
Eye Exams	\$0 copay per Medicar \$0 copay for one ann				\$0 copay per Medica \$0 copay for one an				
Hearing Aids	\$149 copay per aid f limited to 2 hearing a				\$699 copay per aid for base model; limited to 2 hear				
Hearing Exams	\$0 copay for Medicar \$0 copay for one annu	e-cover	ed exam;		\$0 copay for Medica \$0 copay for one an	re-cover	ed exam;		
	\$0 copay for Medica	re cover	ed visit;		\$0 copay for Medic	are-cove	red visit;		
Dental	\$0 copay for certain pr				\$0 copay for certain p	reventiv	e service	s;	
	\$0 - \$2,160 copay for certain \$0 copay per Medica			services	\$0 - \$2,160 copay for certain comprehensive services \$0 copay per Medicare-covered visit;				
Chiropractic	\$0 copay/visit for 30 rou			ar,	<b>\$0</b> copay/visit for up to 12 routine visits per year,				
	combined with routi				combined with routine acupuncture				
Podiatry	\$0 copay per Medica			100	\$0 copay per Medicare-covered visit				
	Cost-sharing shown is for preferred pharmacies	30 days	100 days	100 days	Cost-sharing shown is for preferred pharmacies	30 days	90 days	days	
	prejerrea pharmacies	uays	retail	mail				uays	
				man	prejerrea pharmacies	aays	retail	mail	
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	retail \$0		
	Generic	\$0	\$0 \$0	\$0 \$0	Preferred Generic Generic	\$0 \$12	\$0 \$36	mail \$0 \$24	
Prescription Drugs	Generic Preferred Brand	\$0 \$47	\$0 \$0 \$94	\$0 \$0 \$94	Preferred Generic Generic Preferred Brand	\$0 \$12 \$47	\$0 \$36 \$141	mail \$0 \$24 \$94	
Prescription Drugs (Part D)	Generic Preferred Brand Non-Preferred Brand	\$0 \$47 \$100	\$0 \$0 \$94 \$200	\$0 \$0 \$94 \$200	Preferred Generic Generic	\$0 \$12	\$0 \$36	mail \$0 \$24	
	Generic Preferred Brand	\$0 \$47 \$100 33%	\$0 \$0 \$94 \$200 N/A	\$0 \$0 \$94 \$200 N/A	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total years.	\$0 \$12 \$47 \$100 32% early dru	\$0 \$36 \$141 \$300 N/A	mail \$0 \$24 \$94 \$200 N/A	
	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more than	\$0 \$47 \$100 33% arly dru	\$0 \$94 \$200 N/A g costs r	\$0 \$94 \$200 N/A each n's cost	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha	\$0 \$12 \$47 \$100 32% early dru	\$0 \$36 \$141 \$300 N/A Ig costs if	mail \$0 \$24 \$94 \$200 N/A reach	
	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more that for brand name drugs and 25'	\$0 \$47 \$100 33% arly dru n 25% of	\$0 \$94 \$200 N/A g costs r	\$0 \$94 \$200 N/A each n's cost	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for	\$0 \$12 \$47 \$100 32% early dru n 25% o generics	\$0 \$36 \$141 \$300 N/A Ig costs I	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of-	
	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more than	\$0 \$47 \$100 33% arly dru n 25% of	\$0 \$94 \$200 N/A g costs r	\$0 \$94 \$200 N/A each n's cost	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha	\$0 \$12 \$47 \$100 32% early dru n 25% o generics	\$0 \$36 \$141 \$300 N/A Ig costs I	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of-	
	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yes \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most	\$0 \$47 \$100 33% arly dru n 25% c % for g reach \$8	\$0 \$94 \$200 N/A g costs r of the pla enerics u 3,000. A	\$0 \$94 \$200 N/A each n's cost ntil fter	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach S	\$0 \$12 \$47 \$100 32% early dru n 25% o generics	\$0 \$36 \$141 \$300 N/A Ig costs I	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of-	
	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yes \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those	\$0 \$47 \$100 33% arly drun 25% of 60 for greach \$8 t co-inster w/full	\$0 \$94 \$200 N/A g costs r of the pla enerics u 3,000. A	\$0 \$94 \$200 N/A reach n's cost ntil fter	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach \$ pay \$0.	\$0 \$12 \$47 \$100 32% early dru n 25% o generics 88,000.	\$0 \$36 \$141 \$300 N/A ag costs of the plan until out After that	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of-, you	
	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yes \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi	\$0 \$47 \$100 33% arly drun 25% c % for greach \$8 t co-inst w/full it for 30	\$0 \$94 \$200 N/A g costs r of the pla enerics u 3,000. A	\$0 \$94 \$200 N/A reach n's cost ntil fter	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach s pay \$0.  Acupuncture: \$0 copay/vis	\$0 \$12 \$47 \$100 32% early dru n 25% o generics 88,000.	\$0 \$36 \$141 \$300 N/A Ig costs of the plan until out After that	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of-, you	
	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirop Flex Allowance: \$50 month	\$0 \$47 \$100 33% arrly dru a 25% c % for gg reach \$8 t co-inst e w/full it for 30 practic v by for O	\$0 \$94 \$200 N/A g costs r of the pla enerics u 3,000. A	\$0 \$94 \$200 N/A each n's cost ntil fter nd nl/LIS ar,	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y. \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach s. pay \$0.  Acupuncture: \$0 copay/vis combined with routine chiro Meals: \$0 copay for up to 15	\$0 \$12 \$47 \$100 32% early dru 25% o generics 88,000. A	\$0 \$36 \$141 \$300 N/A ng costs of the plan until out After that	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of-, you ts/year,	
	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirop Flex Allowance: \$50 month catalogue, retail, or online, \$2.	\$0 \$47 \$100 33% arly dru n 25% c % for g reach \$8 t co-inst e w/full it for 30 oractic v bly for O 20 mont	\$0 \$94 \$200 N/A g costs r of the pla enerics u 3,000. A	\$0 \$94 \$200 N/A each n's cost ntil fter nd nl/LIS ar,	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y. \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach \$ pay \$0.  Acupuncture: \$0 copay/vis combined with routine chiro Meals: \$0 copay for up to 15 for those with qualifying chr	\$0 \$12 \$47 \$100 32% early dru 25% o generics 88,000. A	\$0 \$36 \$141 \$300 N/A ng costs of the plan until out After that	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of-, you ts/year,	
(Part D)  Supplemental Benefits and	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/vist combined with routine chiror Flex Allowance: \$50 month catalogue, retail, or online, \$5' and \$100 every 6 months for	\$0 \$47 \$100 33% arly drun 25% co % for greach \$8 t co-inst t for 30 oractic v ly for O 20 mont dental	\$0 \$94 \$200 N/A g costs r of the pla enerics u 8,000. A mance a Medi-Ca visits/ye isits TC items hly for fi	\$0 \$94 \$200 N/A reach n's cost ntil fter nd nl/LIS ar, s via tness,	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach \$ pay \$0.  Acupuncture: \$0 copay/vis combined with routine chirol Meals: \$0 copay for up to 15 for those with qualifying chr for up to 30 additional meals	\$0 \$12 \$47 \$100 32% early dru 25% o generics 88,000. A	\$0 \$36 \$141 \$300 N/A Ig costs of the plan until out After that	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of- , you	
(Part D)  Supplemental	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirop Flex Allowance: \$50 month catalogue, retail, or online, \$2.	\$0 \$47 \$100 33% arly drun 25% of 60 greach \$8 t co-inster w/full it for 30 oractic v ly for O 20 mont dental wance a	\$0 \$94 \$200 N/A g costs r of the pla enerics u 8,000. A urance a Medi-Ca visits/ye isits TC items hly for fi	\$0 \$94 \$200 N/A each n's cost ntil fter and nl/LIS ar, s via tness,	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y. \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach \$ pay \$0.  Acupuncture: \$0 copay/vis combined with routine chiro Meals: \$0 copay for up to 15 for those with qualifying chr	\$0 \$12 \$47 \$100 32% or 25% or generics 88,000. A	\$0 \$36 \$141 \$300 N/A Ig costs of the plan until out After that	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of- , you	
(Part D)  Supplemental Benefits and	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yes \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirop Flex Allowance: \$50 month catalogue, retail, or online, \$5 and \$100 every 6 months for Groceries: \$25 monthly allo stores, for those with qualifyi Meals: \$0 copay/meal for 14	\$0 \$47 \$100 33% arly drun 25% c % for greach \$8 t co-inst w/full it for 30 practic v ly for O 20 mont dental wance a ing chro meals e	\$0 \$94 \$200 N/A g costs r of the pla enerics u 8,000. A Urance a Medi-Ca visits/ye isits TC items hly for fi t plan-ap nic condi-	\$0 \$94 \$200 N/A each n's cost ntil fiter at thess, proved titions th for	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach s pay \$0.  Acupuncture: \$0 copay/vis combined with routine chiro Meals: \$0 copay for up to 15 for those with qualifying chr for up to 30 additional meals Over the Counter: \$45 qua approved items via catalogue Transportation: \$0 copay for	\$0 \$12 \$47 \$100 32% or generics 8,000. A	\$0 \$36 \$141 \$300 N/A ug costs of the plan until out After that	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of- , you  ts/year, b weeks 5 copay for plan sper	
(Part D)  Supplemental Benefits and	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yes \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirop Flex Allowance: \$50 month catalogue, retail, or online, \$5 and \$100 every 6 months for Groceries: \$25 monthly allo stores, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qua	\$0 \$47 \$100 33% arly drun 25% c % for greach \$8 t co-inst w/full it for 30 practic v ly for O 20 mont dental wance a ing chro meals e alifying	\$0 \$94 \$200 N/A g costs r of the pla enerics u 8,000. A urance a Medi-Ca visits/ye isits TC items hly for fi	\$0 \$94 \$200 N/A each n's cost ntil fiter ar, s via tness, proved titions th for cond.	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach s pay \$0.  Acupuncture: \$0 copay/vis combined with routine chirol Meals: \$0 copay for up to 15 for those with qualifying chr for up to 30 additional meals Over the Counter: \$45 qua approved items via catalogue Transportation: \$0 copay for year to plan approved location	\$0 \$12 \$47 \$100 32% early dru n 25% o generics 8,000. A	\$0 \$36 \$141 \$300 N/A ug costs of the plan until out After that to 12 visis sits week for 6 litions; \$ owance for online -way trip a 50 mile	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of- , you  ts/year, b weeks copay for plan as per s	
(Part D)  Supplemental Benefits and	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yes \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirop Flex Allowance: \$50 month catalogue, retail, or online, \$5 and \$100 every 6 months for Groceries: \$25 monthly allo stores, for those with qualifyi Meals: \$0 copay/meal for 14	\$0 \$47 \$100 33% arly drun 25% of for goreach \$8 t co-instered with the control of	\$0 \$94 \$200 N/A g costs r of the pla eneries u 8,000. A urance a Medi-Ca visits/ye isits TC items hly for fi t plan-ap nic condi- ach mon chronic c e-way tri	\$0 \$0 \$94 \$200 N/A each n's cost ntil fiter  nd nl/LIS ar, s via tness, proved itions th for cond. ps per	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach s pay \$0.  Acupuncture: \$0 copay/vis combined with routine chiro Meals: \$0 copay for up to 15 for those with qualifying chr for up to 30 additional meals Over the Counter: \$45 qua approved items via catalogue Transportation: \$0 copay for	\$0 \$12 \$47 \$100 32% early dru n 25% o generics 8,000. A	\$0 \$36 \$141 \$300 N/A ug costs of the plan until out After that to 12 visis sits week for 6 litions; \$ owance for online -way trip a 50 mile	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of- , you  ts/year, b weeks copay for plan as per s	
(Part D)  Supplemental Benefits and	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirof Flex Allowance: \$50 month catalogue, retail, or online, \$5' and \$100 every 6 months for Groceries: \$25 monthly allo stores, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qua Transportation: \$0 copay for year to plan approved locatio Wellness: \$0 for basic Silver	\$0 \$47 \$100 33% arly drun 25% of or goreach \$8 t co-instered with the control of	\$0 \$94 \$200 N/A g costs r of the pla eneries u 8,000. A urance a Medi-Ca visits/ye isits TC items hly for fi t plan-ap nic condi- ach mon chronic c e-way tri n 50 mile rs memb	\$0 \$94 \$200 N/A each n's cost ntil fiter  nd h/LIS ar, s via tness, proved itions th for cond. ps per es ership	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach s pay \$0.  Acupuncture: \$0 copay/vis combined with routine chirol Meals: \$0 copay for up to 15 for those with qualifying chr for up to 30 additional meals Over the Counter: \$45 qua approved items via catalogue Transportation: \$0 copay for year to plan approved locatic Wellness: \$0 for basic Silver	\$0 \$12 \$47 \$100 32% early dru 25% o generics 8,000. A	\$0 \$36 \$141 \$300 N/A Ig costs if the plan until out After that to 12 visis sits veek for ( ditions; \$ owance for online way trip in 50 mile	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of- , you  ts/year, 6 weeks 5 copay for plan gs per s grship	
(Part D)  Supplemental Benefits and	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirop Flex Allowance: \$50 month catalogue, retail, or online, \$2 and \$100 every 6 months for Groceries: \$25 monthly allo stores, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 19 12 months, for those with qualifyi Meals: \$0 copay/meal for 19 13 months, for those with qualifyi Meals: \$0 copay/meal for 19 14 months, for those with qualifyi Meals: \$0 copay/meal for 19 15 months, for those with qualifyi Meals: \$0 copay/meal for 19 16 months, for those with qualifyi Meals: \$0 copay/meal for 19 17 months, for those with qualifyi Meals: \$0 copay/meal for 19 18 months, for those with qualifyi Meals: \$0 copay/meal for 19 19 months, for those with qualifyi Meals: \$0 copay/meal for 19 10 months, for those with qualifyi Meals: \$0 copay/meal for 19 10 months, for those with qualifyi Meals: \$0 copay/meal for 19 12 months, for those with qualifyi Meals: \$0 copay/meal for 19 12 months, for those with qualifyi Meals: \$0 copay/meal for 19 13 months, for those with qualifyi Meals: \$0 copay/meal for 19 14 months, for those with qualifyi Meals: \$0 copay/meal for 19 15 months, for those with qualifyi Meals: \$0 copay/meal for 19 16 months, for those with qualifyi Meals: \$0 copay/meal for 19 17 months, for those with qualifyi Meals: \$0 copay/meal for 19 18 months, for those with qualifyi Meals: \$0 copay/meal for 19 18 months for those with qualifyi Meals: \$0 copay/meal for 19 18 months for those with qualifyi Meals: \$0 copay/meal for 19 18 months for those with qualifyi Meals: \$0 copay/meal for 19 18 months for those with qualifyi	\$0 \$47 \$100 33% arly drun 25% co% for goreach \$8 t co-instere w/full it for 30 oractic v ly for O 20 mont dental wance a aing chrooractic with the companies of alifying or 24 onens within Sneake Health \$5	\$0 \$94 \$200 N/A g costs r of the pla enerics u 3,000. A  urance a Medi-Ca visits/ye isits TC items hly for fi t plan-ap nic condi- each mon chronic c e-way tri n 50 mile rs memb System, I	\$0 \$94 \$200 N/A each n's cost ntil fter  nd nl/LIS ar, s via tness, proved itions th for cond. ps per es ership Hill	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach \$ pay \$0.  Acupuncture: \$0 copay/vis combined with routine chirol Meals: \$0 copay for up to 15 for those with qualifying chr for up to 30 additional meals Over the Counter: \$45 qua approved items via catalogue Transportation: \$0 copay for year to plan approved location Wellness: \$0 for basic Silver	\$0 \$12 \$47 \$100 32% early dru 25% o generics 88,000. A it for up bractic via meals/w onic cond reterly all- ty, retail, c or 12 one swithin Sneaker	\$0 \$36 \$141 \$300 N/A Ig costs if the plan until out After that to 12 visisits yeek for (ditions; \$ owance for online way trip in 50 mile vstem, Hi	mail \$0 \$24 \$94 \$200 N/A reach	
(Part D)  Supplemental Benefits and Optional Plans  Medical Groups and Hospitals	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirop Flex Allowance: \$50 month catalogue, retail, or online, \$2 and \$100 every 6 months for Groceries: \$25 monthly allo stores, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 13 months, for those with qualifyi Meals: \$0 copay/meal for 14 14 months, for those with qualifyi Meals: \$0 copay/meal for 14 15 months, for those with qualifyi Meals: \$0 copay/meal for 14 16 months, for those with qualifyi Meals: \$0 copay/meal for 14 17 months, for those with qualifyi Meals: \$0 copay/meal for 14 18 months, for those with qualifyi Meals: \$0 copay/meal for 14 19 months, for those with qualifyi Meals: \$0 copay/meal for 14 10 months, for those with qualifyi Meals: \$0 copay/meal for 14 11 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 c	\$0 \$47 \$100 33% arly drun 25% co-6% for greach \$8 t co-instere w/full it for 30 oractic v ly for O 20 mont dental wance a sing chro oraclifying alifying or 24 onens within Sneake Health \$1 Il Health	\$0 \$94 \$200 N/A g costs r of the pla enerics u 3,000. A  urance a Medi-Ca visits/ye isits TC items hly for fi t plan-ap nic condi- canch mon chronic of eway tri n 50 mile rs memb System, H Holding	\$0 \$94 \$200 N/A each n's cost ntil fter  nd nl/LIS ar, s via tness, proved itions th for cond. ps per es ership Hill ss	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach \$ pay \$0.  Acupuncture: \$0 copay/vis combined with routine chirol Meals: \$0 copay for up to 15 for those with qualifying chr for up to 30 additional meals Over the Counter: \$45 qua approved items via catalogue Transportation: \$0 copay for year to plan approved location Wellness: \$0 for basic Silver  Medical Groups: Alameda Physicians East Bay; Imperia	\$0 \$12 \$47 \$100 32% or 25% or generics 38,000. An	\$0 \$36 \$141 \$300 N/A Ig costs if the plan until out After that to 12 visis sits veek for (ditions; \$ owance for online 	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of- , you  tts/year, b weeks to copay for plan be per sership	
(Part D)  Supplemental Benefits and Optional Plans  Medical Groups	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay no more that for brand name drugs and 25' out-of-pocket drug expenses that, you pay \$0.  Cost-Sharing Waived: most copays are waived for those Acupuncture: \$0 copay/visi combined with routine chirop Flex Allowance: \$50 month catalogue, retail, or online, \$2 and \$100 every 6 months for Groceries: \$25 monthly allo stores, for those with qualifyi Meals: \$0 copay/meal for 14 12 months, for those with qualifyi Meals: \$0 copay/meal for 19 12 months, for those with qualifyi Meals: \$0 copay/meal for 19 13 months, for those with qualifyi Meals: \$0 copay/meal for 19 14 months, for those with qualifyi Meals: \$0 copay/meal for 19 15 months, for those with qualifyi Meals: \$0 copay/meal for 19 16 months, for those with qualifyi Meals: \$0 copay/meal for 19 17 months, for those with qualifyi Meals: \$0 copay/meal for 19 18 months, for those with qualifyi Meals: \$0 copay/meal for 19 19 months, for those with qualifyi Meals: \$0 copay/meal for 19 10 months, for those with qualifyi Meals: \$0 copay/meal for 19 10 months, for those with qualifyi Meals: \$0 copay/meal for 19 12 months, for those with qualifyi Meals: \$0 copay/meal for 19 12 months, for those with qualifyi Meals: \$0 copay/meal for 19 13 months, for those with qualifyi Meals: \$0 copay/meal for 19 14 months, for those with qualifyi Meals: \$0 copay/meal for 19 15 months, for those with qualifyi Meals: \$0 copay/meal for 19 16 months, for those with qualifyi Meals: \$0 copay/meal for 19 17 months, for those with qualifyi Meals: \$0 copay/meal for 19 18 months, for those with qualifyi Meals: \$0 copay/meal for 19 18 months for those with qualifyi Meals: \$0 copay/meal for 19 18 months for those with qualifyi Meals: \$0 copay/meal for 19 18 months for those with qualifyi Meals: \$0 copay/meal for 19 18 months for those with qualifyi	\$0 \$47 \$100 33% arly dru a 25% c % for greach \$8 t co-inst e w/full it for 30 oractic v ly for O 20 mont dental wance a ing chroo- meals e alifying or 24 onens within Sneake Health \$1 Il Health attes/Sur	\$0 \$94 \$200 N/A g costs r of the pla enerics u 8,000. A  rance a Medi-Ca visits/ye isits TC items hly for fi t plan-ap nic conditach mon chronic c e-way tri n 50 mile rs memb System, H H Holding mmit Mee	\$0 \$0 \$94 \$200 N/A each n's cost ntil fiter  nd nl/LIS ar, s via tness, proved itions th for cond. ps per es ership Hill ss dical	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$50 deductible; after total y \$5,030, you pay no more tha for brand name and 25% for pocket drug expenses reach \$ pay \$0.  Acupuncture: \$0 copay/vis combined with routine chirol Meals: \$0 copay for up to 15 for those with qualifying chr for up to 30 additional meals Over the Counter: \$45 qua approved items via catalogue Transportation: \$0 copay for year to plan approved location Wellness: \$0 for basic Silver	\$0 \$12 \$47 \$100 32% early dru at 25% o generics 88,000. A it for up bractic via meals/wonic condens trerly alled, retail, condens within respectively.	\$0 \$36 \$141 \$300 N/A Ig costs of the plan until out After that the size of the plan until out After that the size of the plan until out After that the size of the plan until out After that the size of the plan until out After that the size of the plan until out After that the size of the plan until out After that the size of the plan until out After that the size of the plan until out After that the plan until out After the plan until out After that the plan until out After the plan until out Aft	mail \$0 \$24 \$94 \$200 N/A reach 's cost -of- , you  ts/year, b weeks 5 copay for plan as per sership	

2024		EDICARE HMO COMPARISON CHART FOR ALAMEDA C								
Please contact the	Central Health	Medio	care F	Plan	Ce	entral Health	Medi	care F	Plan	
Plan for more	866-314-2427 (Sa	les & I	Marke	ting)	860	6-314-2427 (Sa	ales &	Marke	ting)	
information or call	866-314-2427 (M	lembe	r Servi	ices)	86	66-314-2427 (N	<b>1embe</b>	r Servi	ices)	
1-800-Medicare	www.centralhe					www.centralhe				
	Central Health 1				Се	ntral Health l				
Plan Name/Type	(HMO) (H			an 1		(HMO) (H			111 11	
G. D.	<u> </u>		120)					021)		
Star Rating	***					***				
Annual OOP Max	\$3,20					\$1,1				
<b>Monthly Premium</b>	\$0					\$4				
Doctor Visits	<b>\$0</b> for Primary Care Phys				<b>\$0</b> fo	or Primary Care Phys	sician; \$	0 for Sp	ecialist	
Inpatient Hospital	\$0 copay for days 1-4; \$100 \$0 copay for d			lays 5-10;	\$0 copay per stay					
Outpatient Hospital	\$0-\$100 copay per ambulat \$0-\$150 copay per outpation					\$0 per ambulatory su 50 copay per outpati				
Skilled Nursing Facility	<b>\$0</b> copay for <b>\$204</b> /day for d					<b>\$0</b> copay for <b>\$204</b> /day for				
Ambulance	<b>\$0-\$150</b> copay per one	\$0-\$150 copay per one-way trip by ground; 20% coinsurance per trip by air					-way tr	p by gro	ound;	
	\$0-\$100 copay per emerger			waived if	\$0-\$10	20% coinsurance 20% copay per emerge			waived if	
Emergency & Urgent Care	admitted to hospital \$0 for urgent care; \$100,000 copays for ER ar		admitted to hospita argent care; \$100,00 copays for ER a	l within <b>0</b> max v	72 hours vorldwid	s;				
Lab Tests,	\$0 copay for lab service					copay for lab servic				
Procedures, and Radiation Therapy	procedures, and x-rays; \$50 20% co-insurance for t					cedures, x-rays, and % co-insurance for				
Renal Dialysis	20% co-insurance	e per tre	atment			20% co-insurance	e per tro	eatment		
Outpatient Mental Health Visits	\$40 copay per individual of	session	<b>\$0</b> cc	ppay per individual o	or group	therapy	session			
Eyewear	\$300 annual allowance f	or glass	es or co	ntacts	\$300 annual allowance for glasses or contacts					
Eye Exams	\$0 copay per Medica \$0 copay for one an	re-cove	red exar	n;		\$0 copay per Medic \$0 copay for one an	are-cove	ered exai	n;	
Hearing Aids	\$2,000 annual allowance t					00 annual allowance				
	\$0 copay for Medica				\$5,00	\$0 copay for Medical				
Hearing Exams	\$0 copay for one and					<b>\$0</b> copay for one an				
Dental	\$0 copay for Medica \$0-\$41 copay for certain \$0 - \$2,160 copay for certain	n preven	tive serv	vices;	\$0 copay for Medicare covered visit; \$0-\$41 copay for certain preventive services; \$0 - \$2,160 copay for certain comprehensive services					
Chiropractic	\$0 copay per Medic	are-cov	ered visi	it	\$0 copay per Medicare-covered visit					
Podiatry	\$0 co-pay per Medic	care-cov	ered vis	it		\$0 co-pay per Medi	care-co	vered vis	it	
1 outlier j	Cost-sharing shown is for				Cost-s	haring shown is			100	
	preferred pharmacies	days	days	days		ferred pharmacies	days	days	days	
	2 10 1			mail	D 0	10			mail	
	Preferred Generic	\$0	\$0	\$0		red Generic	\$0	\$0 \$0	\$0	
Prescription Drugs	Generic Preferred Brand	\$0 \$35	\$0 \$105	\$0 \$70	Generi	ed Brand	\$0 \$35	\$105	\$0 \$70	
(Part D)	Non-Preferred Brand	\$75	\$225	\$150		referred Brand	\$75	\$225	\$150	
	Specialty co-insurance	33%	N/A	N/A		lty co-insurance	33%	N/A	N/A	
	\$0 deductible; after total yes					ctible; after total ye				
	\$5,030, you pay \$0 for gener 25% of the plan's cost for br					you pay <b>\$0</b> for gene the plan's cost for b				
	out-of-pocket drug expenses		_		1	ocket drug expenses		_		
	you pay \$0.				you pay	\$0.				
		1	1	,		naring Waived: mo				
	Acupuncture: \$0 co-pay for Flex Allowance: \$41 month					are waived for thos acture: \$0 co-pay fo				
	and Herbal Catalogue items,	& <b>\$20</b> 1	nonthly	1010		lowance: \$50 mont				
	allowance for fitness fees				and Her	bal Catalogue items	; <b>\$20</b> mo	onthly fo	r fitness	
	Groceries: \$25 monthly allo		or those	with		65 allowance every				
Supplemental	qualifying chronic conditions In-Home Support Services:		av for u	in to 20		ies: \$25 monthly allong chronic condition		ior mose	WIII	
Benefits and	hours per year for qualifying			T		e Support Services		pay for ι	ip to 20	
Optional Plans	Meals: \$0 copay/meal for 2		-	-		er year for qualifying				
	those with qualifying chronic Scales: \$0 copay for those w					<b>\$0</b> copay/meal for 2 ith qualifying chroni				
	Transportation: \$0 co-pay					<b>\$0</b> copay for those v				
	plan approved locations with	in 50 m	iles	•	Transp	ortation: \$0 co-pay	for 48	one-way		
	Wellness: \$0 for basic Silve	r Sneak	ers men	nbership					. la au-1. !	
					pership plan approved locations within 50 miles  Wellness: \$0 for basic Silver Sneakers membersl					
Medical Croups										
Medical Groups	Medical Groups: Hill Physi		-	- •		Groups: Hill Phys				
Medical Groups and Hospitals (may not be full list;	Medical Groups: Hill Physi Hospitals: Alta Bates/Summ (CValley), Fremont and Was	it (Berk	/Oak), E		Hospita	I Groups: Hill Physils: Alta Bates/Sumny), Fremont and Wa	nit (Berl	k/Oak), I		

	MEDICARE HMO CO									
Please contact the	Imperial Health Plant				Imperial Health P					
Plan for more	800-838-8271 (Sal				800-838-8271 (Sa					
information or call	800-838-8271 (M	ember	Servi	ces)	800-838-8271 (M	[embe	r Servi	ces)		
1-800-Medicare	www.imperialhe	althpla	n.com		www.imperialho	ealthpl	an.com			
D1 11 //E	Imperial Tr	aditio	nal		Imperial	Stroi	1g			
Plan Name/Type	(HMO) (H5				(HMO) (H		_			
Star Rating	(III/IO) (III		<i>01)</i>		**		,11)			
Annual OOP Max										
	\$1,34	.9			\$8,8					
<b>Monthly Premium</b>	\$0				\$0					
<b>Doctor Visits</b>	<b>\$0</b> for Primary Ca <b>\$0</b> for Spe		ician;		20% for Primary Care Physician; 20% for Specialist					
Inpatient Hospital	<b>\$150</b> copay for days 6-90; <b>\$670</b> per day f	1-5; \$0		3	<b>\$0</b> copay for days 1-60; <b>\$400</b> co-pay/day for days 61-90; <b>\$800</b> per day for days 91-150					
Outpatient	\$200 per ambulatory su \$200 copay per outpatient				20% coinsurance per ambula 20% coinsurance per outpat					
Hospital Skilled Nursing	1 7 1 1			VISIL	1 1		•	iiity visit		
Facility	<b>\$0</b> copay per day for day for day for day	for days ays 21-1	1-20;		\$0 copay per day \$204/day for o					
Ambulance	\$150 copay per one-wa 20% coinsurance per				20% coinsurance per on 20% coinsurance per					
Emergency &	\$125 copay per emergency				20% of cost, up to \$100 pe					
Urgent Care	admitted to hospital within a urgent care; \$50,000 max we				20% of cost up to \$55 Costs waived if admitted to					
Lab Tests,	10% coinsurance fo		,		20% coinsurance for lab se	rvices	liagnosti	c tests &		
Procedures, and	diagnostic tests & \$0 copay for x-rays, & d		_		procedures, x-rays, diag					
Radiation Therapy	20% coinsurance for the				therapeutic	radiolog	y			
Renal Dialysis	20% co-insurance			- 63	20% co-insuranc	e per tre	atment			
Outpatient Mental	20% coinsurance	1			20% coinsurance	_				
Health Visits	or group therap	py sessi	on		or group thera					
Eyewear	\$250 annual allowar				\$240 annual allowance for eyewear					
Eye Exams	\$0 copay per Medicar \$0 copay for rou			ı;	20% coinsurance per Mo \$0 copay for one and					
II A ! J .	\$0 copay for he				\$0 copay for h			11		
Hearing Aids	\$500 annual a				\$500 annual					
Hearing Exams	\$0 copay for Medicar				20% coinsurance for Me			,		
-	\$0 copay for 1 annual routin \$0 co-pay per Medicare-cove				\$0 copay for one annual routine exam up to \$250/year \$0 co-pay per Medicare-covered visit; \$0 co-pay for					
D (1	preventive services up to \$5				preventive services up to \$500/year; \$0 co-pay for					
Dental	certain comprehensive serv	ices up	to \$1,00	0/year;	certain comprehensive services up to \$1,000/year;					
	must use Imperial HMO	contrac	ted prov	ider	must use Imperial HMO contracted provider					
Chiropractic	<b>\$0</b> copay per Medica				20% co-insurance per Medicare-covered visit					
Podiatry	\$0 co-pay per Medica \$0 co-pay for 6 routing				20% coinsurance per M	edicare-	-covered	visit		
	Cost-sharing shown is for	30	100	100	Cost-sharing shown is for	30	100	100		
	preferred pharmacies	days	days	days	preferred pharmacies	days	days	days		
	Preferred Generic	\$0	\$0	mail \$0	Preferred Generic	25%	25%	mail 25%		
	Generic Generic	\$5	\$12	\$10	Generic Generic	25%	25%	25%		
Prescription Drugs	Preferred Brand	\$45	\$110	\$90	Preferred Brand	25%	25%	25%		
(Part D)	Non-Preferred Brand	\$90	\$225	\$180	Non-Preferred Brand	25%	25%	25%		
	Specialty co-insurance	33%	33%	N/A	Specialty co-insurance	25%	25%	25%		
	\$0 deductible; after total yea \$5,030, you pay \$0 for gener				\$545 deductible; after deductible; after deductible; plan's cost for all drugs until					
	25% of the plan's cost for br				expenses reach \$8,000. After					
	out-of-pocket drug expenses					, ,	[] 4			
	that, you pay \$0.									
	In-home Support Services:	<b>\$0</b> cop	ay for u	p to 48						
	hours per year  Meals: \$0 copay for up to 7	home-d	lelivered	l meals	In-home Support Services:	\$0 con	av for u	to 48		
Supplemental	following a surgery or hospit				hours per year	ф0 сор	այ 101 ար	7 10 40		
Benefits and	Over the Counter: \$75 quar	•	lowance	for						
Optional Plans	items in OTC mail order cata	_		, .	Part B Premium Reduction	: \$85 r	nonthly			
	<b>Transportation:</b> \$0 co-pay per year to plan approved loc		one-way	y urips	reimbursement					
	Wellness: \$0 for basic Silve		nembers	hip						
	Medical Groups: Brown &				M.P. I.C. D.	m t ·		1.11 1.1		
Medical Groups	Holdings, Nivano Physicians				Medical Groups: Brown & Holdings, Nivano Physicians					
and Hospitals	IPA	:4 (B - *	/0.1>	7.1	Hospitals: Alta Bates/Summ					
(may not be full list;	Hospitals: Alta Bates/Summ Medical Center (C. Valley), S				Medical Center (C. Valley),					
check with plan)	Washington (Fremont)	J. 1080	(11ay W	aru j anu	Washington (Fremont)					
	<i>5</i> (				l					

2024					T FOR ALAMEDA COUNTY
Please contact the Plan for more information or call 1-800-Medicare	Imperial Health Pl 800-838-8271 (Sal 800-838-8271 (M www.imperialhe	es & N ember	Marketi Servic	ing)	Imperial Health Plan of California 800-838-8271 (Sales & Marketing) 800-838-8271 (Member Services) www.imperialhealthplan.com
Plan Name/Type	Imperial D (HMO) (H5	-			Imperial Courage (HMO) (H5496-016)
Star Rating	**1	<u>k                                      </u>			***
Annual OOP Max	\$298	3			\$2,999
<b>Monthly Premium</b>	\$0				\$0
<b>Doctor Visits</b>	\$0 copay for Primary \$0 for Spe	cialist			\$0 copay for Primary Care Physician; \$5 for Specialist
Inpatient Hospital	<b>\$50</b> copay for days 1-5 <b>\$670</b> per day for	; <b>\$0</b> for days 91	days 6-9 -150	0;	\$150 copay for days 1-5; \$0 co-pay/day for days 61-90; \$670 per day for days 91-150
Outpatient Hospital	\$100 per ambulatory su \$100 copay per outpatient				\$200 per ambulatory surgical center visit; \$200 copay per outpatient hospital facility visit
Skilled Nursing Facility	\$0 copay per day s \$200/day for day	ays 21-1	00		<b>\$0</b> copay per day for days 1-20; <b>\$200</b> /day for days 21-100
Ambulance	\$150 copay per one-w 20% coinsurance pe	r each ti	rip by air		\$150 copay per one-way trip by ground; 20% coinsurance per each trip by air
Emergency & Urgent Care	\$125 per emergency room admitted to hospital \$0 copay for u \$50,000 max worldwi	within 4 rgent ca	l8 hours; re;		\$125 copay per emergency room visit; waived if admitted to hospital within 72 hours; \$20 copay for urgent care; \$50,000 max worldwide with \$0 copay
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab service procedures, x-rays, and c 20% co-insurance for the	liagnost	ic radiolo	ogy;	10% coinsurance for lab services, diagnostic tests & procedures; \$0 copay for x-rays, & diagnostic radiology; 20% coinsurance for therapeutic radiology
Renal Dialysis	20% co-insurance	•			20% co-insurance per treatment
Outpatient Mental Health Visits	20% coinsurance or group thera				20% coinsurance per individual or group therapy session
Eyewear	\$250 annual allowar	nce for	eyewear		\$250 annual allowance for eyewear
Eye Exams	\$0 copay per Medicar \$0 copay for roo			;	\$0 copay per Medicare-covered exam; \$0 copay for routine exams
Hearing Aids	\$0 copay for he \$500 annual a	earing a	ids;		\$0 copay for hearing aids; \$500 annual allowance
Hearing Exams	\$0 copay for Medicar \$0 copay for 1 annual routing				\$0 copay for Medicare-covered exam; \$0 copay for 1 annual routine exam up to \$250/year
Dental	\$0 co-pay per Medicare-cov preventive services up to \$5 certain comprehensive serv must use Imperial HMO	500/year ices up contrac	r; <b>\$0</b> co-p to <b>\$1,000</b> ted provi	oay for D/year; ider	\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services up to \$500/year; \$0 co-pay for certain comprehensive services up to \$1,000/year; must use Imperial HMO contracted provider
Chiropractic	\$0 copay per Medica Routine visits n				20% co-insurance per Medicare-covered visit; Routine visits not covered
Podiatry	\$0 co-pay per Medica \$0 co-pay for 6 routing	are-cove	ered visit		\$0 co-pay per Medicare-covered visit; \$0 co-pay for 6 routine visits per year
Prescription Drugs (Part D)	Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yes \$5,030, you pay \$0 for gener 25% of the plan's cost for br	ics and	no more	than	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.
	out-of-pocket drug expenses that, you pay \$0.  In-home Support Services: hours per year	reach \$	8,000. A	fter	Meals: \$0 copay for up to 7 home-delivered meals following a surgery or hospital stay, up to \$105/year
Supplemental Benefits and Optional Plans	Meals: \$0 copay for up to 7 following a surgery or hospit Over the Counter: \$120 quater Transportation: \$0 co-pay per year to plan approved loc Wellness: \$0 for basic Silve	al stay, arterly a for 100 cations	up to \$10 llowance one-way	05/year trips	Over the Counter: \$75 quarterly allowance Part B Premium Reduction: \$75 monthly reimbursement Transportation: \$0 co-pay for 100 one-way trips per year to plan approved locations Wellness: \$0 for basic Silver&Fit membership
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown & Holdings, Nivano Physicians Hospitals: Alta Bates/Summ Medical Center (C. Valley), Washington (Fremont)	, Physic it (Berk	ian Partr /Oak), E	ners IPA den	Medical Groups: Brown & Toland, Imperial Health Holdings, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (C. Valley), St. Rose (Hayward) and Washington (Fremont)
			-10-		

Please contact the	MEDICARE HMO CO	WII AI			ermanente	UNII			
Plan for more		800			Sales & Marketing)				
information or call					(Member Services)				
1-800-Medicare				,	iserpermanente.org				
	Kaiser Perma				Kaiser Permanente Senior				
Plan Name/Type	Advantage Ba	sic Al	amed	a	Advan	tage			
	(HMO) (H				(HMO) (H		32)		
Star Rating	***	<del>*</del>	,		****				
Annual OOP Max	\$6,0				\$3,900				
<b>Monthly Premium</b>	\$0		v1 · ·		\$70 \$0 copay for Primary Care Physician;				
<b>Doctor Visits</b>	\$5 copay for Primar \$15 for Sp		hysician	;	\$0 copay for Primar \$10 for Sp		hysician	;	
Inpatient Hospital	\$290 copay/day	for day			\$225 copay/day				
Outpatient	\$0 per day for day \$250 per ambulatory s			sit•	\$0 per day for day \$190 per ambulatory s			oit•	
Hospital	\$0-\$250 copay per outpation			\$0-\$190 copay per outpation					
Skilled Nursing	\$0 copay/day fo	or days 1	1-20;	\$0 copay/day fo					
Facility	\$100 per day for				\$100 per day for				
Ambulance	\$250 copay per air or gr \$120 for emergen	trip	\$250 copay per air or gr \$120 for emerger			trip			
Emergency &	\$5 for urgent	\$5 for urgent care visit;					it;		
Urgent Care	Worldwide				Worldwide				
Lab Tests, Procedures, and	\$0 copay for lab, diagnos \$10 copay for x-rays				\$0 copay for lab, diagnostic \$200 copay for diag				
Radiation Therapy	diagnostic radiology; \$10 f				\$200 copay for diag				
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insuranc	e per tre	atment		
<b>Outpatient Mental</b>	\$2 copay per indi				\$0 copay per indi				
Health Visits	\$5 per group the		ssion		\$0 per group the		ssion		
Eyewear	Not cov See Optional Bene		ı below		Not covered; See Optional Benefits Plan below				
Eye Exams	\$5-\$15 copay per Med \$5 per routi			am;	\$0-\$10 copay per Med \$0 per routi			am;	
Hearing Aids	Not cov See Optional Bene	,	. halarr		Not cov See Optional Bend	,	. halarr		
Hearing Exams	\$15 copay per Medic			m	\$10 copay per Medic			m	
Truming Emmiy	\$5-\$15 co-pay per Med				\$0-\$10 co-pay per Med				
Dental	\$0 copay for certain prevention See Optional Bene			services;	\$0 copay for certain preventive & diagnostic services; See Optional Benefits Plan below				
Chiropractic	\$5 copay per Medic				\$0 copay per Medicare covered visit				
					\$10 copay per Medicare covered visit				
Podiatry	\$15 copay per Medi				<u> </u>		_		
	Cost-sharing shown is for preferred pharmacies	30 days	100 day	100 days	Cost-sharing shown is for preferred pharmacies	30 days	100 days	100 days	
		•	retail	mail	1 0 1		retail	mail	
	Preferred Generic Generic	\$4 \$18	\$12 \$54	\$8 \$36	Preferred Generic Generic	\$0 \$7	\$0 \$21	\$0 \$14	
Prescription Drugs	Preferred Brand	\$47	\$141	\$94	Preferred Brand	\$47	\$141	\$94	
(Part D)	Non-Preferred Brand	\$100	\$300	\$200	Non-Preferred Brand	\$100	\$300	\$200	
	Specialty co-insurance  \$0 deductible; after total ver	33% arly dri	33%	33% _	Specialty co-insurance  \$0 deductible; after total ye	33% arly dri	33%	33% _	
	\$5,030, you pay \$4 copay for	•	0		\$5,030, you pay \$0 copay fo				
	for generic and 25% for brar	nd name	and spec	cialty	for generic and 25% for bran	nd name	and spec	ialty	
	drugs until out-of-pocket dru	g expen	ses reach	\$8,000.	drugs until out-of-pocket dru	ig expen	ses reach	\$8,000.	
	After that, you pay \$0.  Medical Financial Assistant	oo Drog	rom: ove	ailable to	After that, you pay \$0.  Medical Financial Assistan	oo Drog	rom: ove	vilable to	
	eligible members; contact pla			illable to	eligible members; contact pl	U		illable to	
	Over the Counter: \$60 quar	terly all	owance		Over the Counter: \$60 quan				
	from OTC catalogue; each or	rder <b>\$25</b>	minimu	m	from OTC catalogue; each o	rder <b>\$25</b>	minimu	m	
Supplemental	Optional Benefit Plan: Adv	vantage	Plus at		Optional Benefit Plan: Ad	vantage	Plus at		
Benefits and	\$21/month:	1.	a		\$21/month:	1.	d		
<b>Optional Plans</b>	-Dental: Copays vary dependent Must use Delta Care USA H	<b>.</b>		vice;	-Dental: Copays vary depen Must use Delta Care USA H	<b>.</b>		vice;	
	-Hearing Aids: \$800 allowa			36	-Hearing Aids: \$800 allows			36	
	months -Vision: \$0 copay for eyewe	or with	\$300 all-	word	months -Vision: \$0 copay for eyewe	or with	\$300 all-	word	
	every two years	aı WIIII	poor and	wance	every two years	ai Willi	pour ano	wance	
M 11 1 C	-Wellness: \$0 for Silver&Fit	gym m	embersh	ip	-Wellness: \$0 for Silver&Fi	t gym m	embershi	ip	
Medical Groups and Hospitals	Medical Groups: Kaiser Per	manent	e		Medical Groups: Kaiser Pe	rmanent	e		
(may not be full list;	Hospitals: Kaiser Oakland,			emont	Hospitals: Kaiser Oakland,			emont	
check with plan)									

2024 N	MEDICARE HMO COM			CHAR					
Please contact the Plan for more information or call	SCAN Heal 877-870-4867 (Sale 800-559-3500 (Me	es & N	<b>Iarket</b>		SCAN Hea 877-870-4867 (Sal 800-559-3500 (M	es & N	<b>Aarket</b>		
1-800-Medicare	www.scanhealt			cesj	www.scanheal			cesj	
Plan Name/Type	SCAN Classi (H05425-	c (HN			SCAN MyChoice (HMO) (H05425-110) ***1/2				
Star Rating	***1	/2			***	1/2			
Annual OOP Max	\$2,80				\$2,80				
<b>Monthly Premium</b>	\$0				\$0				
Doctor Visits	\$0 copay for Primary \$0 for Spec		nysician	;	\$0 copay for Primary Care Physician; \$0 for Specialist				
Inpatient Hospital	\$150 copay/day f \$0 per day for days				\$100 copay/day for days 1-5; \$0 per day for days 6 and beyond				
Outpatient Hospital	\$0 per ambulatory surg \$0-\$125 copay per outpatien				\$0 per ambulatory sur \$0-\$125 copay per outpatie				
Skilled Nursing Facility	\$0 copay/day for \$75 for days		-20;		<b>\$0</b> copay/day fo <b>\$75</b> /day for da				
Ambulance	\$180 copay per one-way	trip by g	ground o	or air	\$105 copay per one-way	trip by	ground o	or air	
Emergency & Urgent Care	\$90 copay per ER visit; w hospital immediately; \$0 Worldwide c	per urge	nt care		\$90 copay per ER visit; v hospital immediately; \$0 Worldwide o	per urg	ent care		
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagr tests, x-rays and diagr \$60 copay for therap	nostic ra	diology	,	\$0 copay for lab, diagratests, x-rays and diagram \$60 copay for theray	nostic ra	adiology	·;	
Renal Dialysis	20% co-insurance	per trea	tment		20% co-insurance	per trea	tment		
Outpatient Mental Health Visits	\$10 copay for in group therapy				\$10 copay for in group therapy				
Eyewear	\$235 allowance for eyes	wear ev	ery 2 ye	ars	\$235 allowance for eyewear every 2 years				
Eye Exams	\$0 copay per Medicar \$0 copay for one annu			\$0 copay per Medicar \$0 copay for one ann			-		
Hearing Aids		\$450 - \$750 copay per aid; up to 2 aids each year; through plan-contracted provider					aids eac	h year;	
Hearing Exams	\$0 copay for Medicar \$0 copay for one annu	ıal routi	ne exan	1	\$0 copay for Medicar \$0 copay for one ann				
Dental	\$0 co-pay per Medica \$0 co-pay for certain pr See Optional Benef	eventiv	e servic		\$0 co-pay per Medicare-covered visit; \$0 co-pay for certain preventive services				
Chiropractic	\$0 copay per Medica: Routine visits n			;	\$0 copay per Medicare covered visit; \$0 copay for 30 routine visits per year				
Podiatry	\$0 copay per Medica	re-cove	red visit		\$10 copay per Medic	are-cov	ered visi	t	
	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  Draftomed Drawd	\$0	\$0	\$0	Generic  Draftsmad Drag d	\$0	\$0	\$0	
Prescription Drugs	Preferred Brand Non-Preferred Brand	\$37 \$90	\$91 \$250	\$91 \$250	Preferred Brand Non-Preferred Brand	\$35 \$70	\$85 \$190	\$85 \$190	
(Part D)	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A	
	\$0 deductible; after total year				\$0 deductible; after total year				
	\$5,030, you pay \$0 for drugs	in Tiers	s 1 & 2	and no	\$5,030, you pay \$0 for drugs				
	more than 25% of the plan's				more than 25% of the plan's				
	drugs until out-of-pocket dru \$8,000. After that, you pay \$		ses reac	h	drugs until out-of-pocket dru \$8,000. After that, you pay		ises reac	ch	
	Over the Counter: \$100 qua balance carries over to next of year				Acupuncture: \$0 copay per visits per year				
a .	Transportation: \$0 copay for				Over the Counter: \$75 quabalance carries over to next				
Supplemental	year to plan-approved location				year	1001101	Jat HOL C	aiciidal	
Benefits and Optional Plans	Wellness: \$0 for basic mem				Transportation: \$0 copay f				
Optional Flans	fitness clubs and studios (call Member Svcs for more info)				year to plan-approved location				
	Optional Dental Package: Scopays for certain diagnostic services				Wellness: \$0 for basic men fitness clubs and studios (cal more info)				
Medical Groups and						<b></b>			
Hospitals	Medical Groups: Brown & Hospitals: Alameda, San Les		t Rose		Medical Groups: Brown & Hospitals: Alameda, San Le				
(may not be full list;	(Hayward)	u. 0, S	12030		(Hayward)	andro, i	RUSC		
check with plan)									

Please contact the	MEDICARE HMO COI	VII AN				)1111				
Plan for outline of	United Health Care 844-723-6473 (Sales and Marketing)									
coverage & provider										
information or call		86			Member Services)					
1-800-Medicare			<u>www</u> .	aarpmed	dicareplans.com					
Plan Name/Type	UHC Cano (HMO-POS)			)	AARP Medicare A UHC (HMO-PC		_			
Star Rating	***	1/2			***	1/2				
Annual OOP Max	\$3,4	00			\$6,300					
<b>Monthly Premium</b>	\$40				\$25					
<b>Doctor Visits</b>	\$0 copay for Primar \$15 for Sp		Physicia	n;	\$0 copay for Primar \$10 for Sp	ecialist		1;		
Inpatient Hospital	\$275 copay/day \$0 for days 8 and be			1)	\$300 copay/day \$0 for days 8 and be			)		
Outpatient Hospital	\$100 copay for ambulator \$225 copay for outpa			\$225 copay for ambulator \$275 copay for outpa						
Skilled Nursing Facility	\$0 copay/day fo \$203 per day for	or days	1-20;	\$0 copay/day fo \$203 per day for						
Emergency & Urgent Care	\$135 copay per emergence admitted to hospital within care visit; \$0 copay for	24 hour	s; <b>\$40</b> p	\$90 copay per emergency admitted to hospital within care visit; \$0 copay for	24 hours	; \$40 pe	er urgent			
Ambulance	\$290 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 \$25 copay per x-ray; \$15 radiology; \$60 copay for	0 copay	for diag	gnostic	\$0 copay for lab, diagnost \$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 \$0 copay with \$100 annual				\$15 copay for group \$0 copay with \$250 annual					
Eyewear	through United Health	care Vis	ion netv	vork	through United He	through United Healthcare Vision  \$0 copay for Medicare-covered exam;				
Eye Exams	\$0 copay for Medica \$0 copay for one and	nual rou	tine exa	m	\$0 copay for one and	nual rout	ine exar	n		
Hearing Aids	\$99 - \$1,249 copay per aid through United Healthc				\$99 - \$1,249 copay per aid through United Healthc					
Hearing Exams	\$0 copay for Medica \$0 copay for one and				\$0 copay for Medica \$0 copay for one and					
Dental	\$0 copays for certain preverservices; 50% coinsurance \$750 annual allowance; dentists but higher control of the	for bridgen use opays n	ges and out of no	dentures; etwork y	\$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 i			it;	\$10 copay for Medic			t;		
	\$15 copay per Medic			it;	Routine care not covered  \$10 copay per Medicare-covered visit;					
Podiatry	\$15 copay/visit for 6 ro			1	\$10 copay/visit for 6 ro			1		
	Cost-sharing shown is for preferred pharmacies	30 days	days retail	days mail	Cost-sharing shown is for preferred pharmacies	30 days	days retail	days mail		
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0		
Duogawintian Dung	Generic Preferred Brand	\$12 \$47	\$36 \$141	\$0 \$131	Generic Preferred Brand	\$12 \$47	\$36 \$141	\$0 \$131		
Prescription Drugs (Part D)	Non-Preferred Brand	\$100	\$300	\$290	Non-Preferred Brand	\$100	\$300	\$290		
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A		
	\$0 deductible; after total yea \$5,030, you pay you pay \$0				\$0 deductible; after total year \$5,030, you pay you pay \$0					
	no more than 25% of the pla	n's cost	for bran	nd name	and no more than 25% of th	e plan's	cost for	brand		
	drugs and 25% for generics				name drugs and 25% for gen					
	expenses reach \$8,000. Afte	r tnat, y	ou pay s	50.	drug expenses reach \$8,000.  Over the Counter: \$65 qua					
Supplemental Benefits and Optional Plans	Over the Counter: \$40 quanters from network retail location Wellness: \$0 for Renew Ac	or OTC	catalog		items from network retail low Wellness: \$0 for Renew Actoptional Platinum Dental \$1,500 annual allowance with preventive and comprehensic coinsurance for bridges and National Medicare Advantage of network dentists but high	cation or ctive Fitr Rider at th \$0 cop we serving dentures ge Netwo	ess mer t \$56/me bays for ces; 50% ; UHC I ork; can	atalog nbership onth: certain 6 Dental use out		
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Canopy H Bay Hospitals: Alameda, Highla Leandro, St. Rose (Hayward	nd (Oak	land), S	an	Medical Groups: Affinity F Toland East Bay; Hill Physi- Hospitals: Alameda, Highla Leandro, St. Rose (Hayward	cians Ea and (Oal	st Bay cland), S	San		

2024 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY													
Please contact the	United Health Care				Blue Shield of California								
Plan for outline of coverage & provider	844-723-6473 (Sales and Marketing)				888-534-4263 (Sales & Marketing)								
information or call	866-261-7709 (Member Services)				800-776-4466 (Member Services)								
1-800-Medicare	www.aarpmedicareplans.com				www.blueshieldca.com/medicare								
Plan Name/Type	UHC Medicare Advantage CA-001A (HMO) (H0543-183)				Blue Shield Inspire (HMO) (H0504-041)								
Star Rating	***1/2				<b>★★★1/2</b>								
Annual OOP Max	\$8,850				\$4,400								
<b>Monthly Premium</b>	\$27.80 / Medical Deductible = \$240				\$18.50								
<b>Doctor Visits</b>	20% coinsurance for Primary Care Physician; 20% coinsurance for Specialist				\$0 copay for Primary Care Physician; \$15 for Specialist								
Inpatient Hospital	\$1,450 copay per stay; unlimited days				\$250 copay/day for days 1-5; \$0 per day for days 6 and beyond								
Outpatient Hospital	20% coinsurance for ambulatory surgical center visit; 20% coinsurance for outpatient hospital visit				\$50 copay per ambulatory surgical center visit; \$200 per outpatient hospital facility visit								
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$204 copay/day for days 21-100				<b>\$0</b> copay/day for days 1-20; <b>\$145</b> per day for days 21-100								
Emanganay &	\$100 copay for emergency room visit; waived if				\$120 copay per emergency room visit;								
Emergency & Urgent Care	admitted to hospital within 24 hours; \$40 per urgent care visit; \$0 copay for worldwide coverage				\$15 per urgent care visit; \$120 per emergency or urgent care visit worldwide; copays waived if admitted to hospital within 24 hours								
Ambulance	20% coinsurance per trip by ground or air				\$260 copay per trip by ground; 20% co-insurance per trip by air								
Lab Tests,	\$0 copay for lab, diagnostic tests and procedures;				\$0 copay for lab, diagnostic tests and procedures, and								
Procedures, and	20% coinsurance for x-rays, diagnostic radiology, and therapeutic radiology				x-rays; \$70 copay for diagnostic radiology; 20% co-insurance for therapeutic radiology								
Radiation Therapy Renal Dialysis	20% co-insurance per treatment				10% co-insurance per treatment								
Outpatient Mental	20% co-insurance per treatment  20% coinsurance for individual or				*								
Health Visits	group therapy session				\$30 copay for individual or group therapy session								
Eyewear	\$0 copay with \$100 annual allowance for eyewear; through United Healthcare Vision				\$175 annual allowance for eyewear; \$175 frame allowance every 2 years								
Eye Exams	\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam				\$15 copay for diagnostic exams; \$0 copay for one annual routine exam								
Hearing Aids	\$2,500 annual allowance for up to 2 aids each year; through United Healthcare Hearing network				\$499 - \$699 copay per aid (depending on type); limited to 2 hearing aids per year								
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	20% coinsurance per Medicare covered visit; Routine dental not covered				\$10 copay for Medicare covered visit; \$0 copay certain preventive svcs every six months								
Chiropractic	20% coinsurance for Medicare-covered visit				\$15 copay for Medicare-covered visit; \$0 copay/visit for 12 routine visits per year								
Podiatry	\$0 co-pay per Medicare-covered visit; \$0 copay/visit for 4 routine visits per year				\$15 copay per Medicare-covered visit; \$15 copay/visit for unlimited routine visits per year								
	Cost-sharing shown is for	30	100	100	Cost-sharing shown is	30	100	100					
	preferred pharmacies	days	days	days	for preferred pharmacies	days	days	days					
	Preferred Generic	25%	retail 25%	mail 25%	Preferred Generic	\$0	retail \$0	mail \$0					
	Generic	25%	25%	25%	Generic	\$5	\$7.50	\$7.50					
Prescription Drugs (Part D)	Preferred Brand Non-Preferred Brand	25% 25%	25% 25%	25% 25%	Preferred Brand Non-Preferred Brand	\$40 \$95	\$100 \$237.50	\$100 \$237.50					
	Specialty co-insurance	25%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A					
	\$545 deductible; after total yearly drug costs reach				\$0 deductible; after total ye	early dr	ug costs r	each					
	\$5,030, you pay no more than 25% of the plan's cost for brand name and 25% for generics until out-of-				\$5,030, you pay no more than 25% of the plan's cost for brand name drugs and 25% for generics until OOP								
	pocket expenses reach \$8,000. After that, you pay \$0.				expenses reach \$8,000. After that, you pay \$0.								
	Cost-Sharing Waived: most co-insurance and copays are waived for those with full Medi-Cal/LIS Over the Counter: \$100 quarterly allowance for items from network retail location or OTC catalog Transportation: \$0 copay for 36 one-way trips per year to plan-approved, medically related locations Wellness: \$0 for Renew Active Fitness membership				Mobility: \$0 copay for annual AAA Membership for members with qualifying chronic conditions  Over the Counter: \$70 quarterly allowance  Transportation: \$0 copay for 12 one-way trips per								
									Supplemental Benefits and	year to plan approved locations  Wellness: \$0 for basic Silver Sneakers membership			
									Optional Plans	Optional Supplemental Plans:			
Optional Flans					1: Dental HMO at \$15/month: \$1,000 annual								
					allowance for specialist services  2: Dental PPO at \$45/month: \$50 deductible; \$1,500								
									annual allowance				
Medical Groups					Medical Groups: Affinity East Bay; Brown & Toland;				Medical Groups: Brown & Toland, Hill Physicians East Bay				
and Hospitals	Hill Physicians East Bay				Hospitals: Alameda, Alta Bates/Summit Medical								
(may not be full list; check with plan)	Hospitals: St. Rose (Hayward), Washington (Fremont)				Center (Berk/Oak), Eden (Castro Valley), San Leandro, and Washington (Fremont)								
check with plan)					Leandro, and Washington (	remont	:)						

## **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 (\$240 in 2024). 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 & Counseling: one screening/year and up to 22 counseling sessions/year
- Pneumococcal Shots: one per lifetime
- Prostate Cancer Screening: one per year for age 50 and over
- RSV (Respiratory Syncytial Virus) Vaccine: one per year
- 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 2024 Handbook. Call 1-800-Medicare to request a copy or visit: <a href="www.medicare.gov/medicare-and-you">www.medicare.gov/medicare-and-you</a>.

#### **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: <a href="https://www.cms.gov/files/document/101323-fact-sheet-2024-medicare-advantage-and-part-d-ratings.pdf">https://www.cms.gov/files/document/101323-fact-sheet-2024-medicare-advantage-and-part-d-ratings.pdf</a>