2024 Medicare Advantage Plan PPO 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 Medicare 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, co-payments, and extra benefits can differ. The Annual Out of Pocket Maximum listed for each plan applies to all cost-sharing except plan premiums and prescription drug co-pays. In 2024, there are 26 Medicare HMOs in Alameda County. See our 2024 HMO Plan Comparison Chart for more information and details: www.lashicap.org/hicap.

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, and they are listed on pages 2–7 in this chart. One of these does not include the Medicare Part D prescription drug benefit. When people join a PPO without drug coverage, they are opting out of Part D. Enrolling in a stand-alone Part D plan will automatically trigger disenrollment from the Medicare Advantage Plan.

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 become effective 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 to an employer group plan from primary to secondary coverage when retiring and going on Medicare may offer different benefits and premiums. This chart is also available at www.lashicap.org/hicap.

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



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Please contact thePlan for more	Aetna Medicare 833-859-6031 (Sales & Marketing)							
information or call 1-800-Medicare	833-570-6670 (Member Services) www.aetnamedicare.com							
Plan Name	Aetna Medicare Elite Plan (PPO) (H5521-293)							
Star Rating	****							
	In-Network Out-of-Network							
Annual OOP Max	\$5,500* *\$250 annual deductible applies to certain medical services				\$8,950* (in and out of network combined) *\$250 annual deductible applies to certain out of network medical services			
Monthly Premium	certain medicai service	:5	\$	50	ertain out	of network medical services		
Doctor Visits	\$0 copay for PCP; \$25 for Specialist			\$10 copay for PCP; after deductible* \$50 copay for Specialist, after deductible*				
Inpatient Hospital	\$325 copay per day for days 1-4, after \$0 per day for days 5-90. \$0 per day for days 91 and beyond);	*	45% coinsurance per stay, after deductible*				
Outpatient Hospital	\$295 copay per ambulatory surgical coutpatient hospital visit, after de	ductible*	nd			ce for ambulatory surgical center tpatient hospital facility visit, after deductible*		
Skilled Nursing Facility	\$10 per day for days 1-20 \$150 per day for days 21-100 after					ance per stay, after deductible*		
Ambulance	\$285 copay per one way trip by ground or air					er one way trip by ground or air, after deductible*		
Emergency & Urgent Care	\$120 copay per ER visit; \$40 per urgent care visit; co-pay waived for ER visits only, if admitted to hospital; \$120 per emergency or urgent care visit worldwide							
Lab Tests, Procedures, and Radiation Therapy	\$0 for lab services, x-rays, diagnostic tests, and procedures; \$200 copay for diagnostic radiology; 20% coinsurance for therapeutic radiology, after deductible*				\$25 for lab services, after deductible* 45% coinsurance for outpatient x-rays, diagnostic tests and procedures, diagnostic radiology, and therapeutic radiology, after deductible*			
Renal Dialysis	20% coinsurance per treatment, after deductible* 50% coinsurance per treatment, after deductible*							
Outpatient Mental Health Visits	\$40 copay per individual or group therapy session					oinsurance for individual by session, after plan deductible*		
Eyewear	\$250 annual allowance for covered prescription eyewear							
Eye Exams	\$0 copay per diagnostic exam; \$0 copay for one annual routine exam					urance per diagnostic exam; ual routine exam, after deductible*		
Hearing Aids	\$1,250 annual allowance per ea	ar, for aids p	urch	nased th	rough Natio	nsHearing network provider		
Hearing Exams	\$0 copay per diagnostic ex \$0 copay for one annual routing	ie exam			for one annu	urance per diagnostic exam; ual routine exam, after deductible*		
Dental	\$40 copay for Medicare covere \$1,000 annual allowance for certain p comprehensive services, through Aeti	preventive ar		\$1,00	45% coinsurance for Medicare-covered visit; \$1,000 annual allowance for certain preventive and comprehensive services, through Aetna Dental PPO			
Chiropractic	\$20 copay for Medicare cover	ed visit		\$45% for Medicare covered visit, after plan deductible*				
Podiatry	\$40 copay for Medicare-covered visit 45% coinsurance for Medicare-covered visit; after plan deductible*							
	Cost-sharing shown is for preferred network pharmacies	30 days retail	da re	00 ays etail	100 days mail			
D	Preferred Generic Generic	\$0 \$0	\$0		\$0 \$0			
Prescription Drugs	Preferred Brand	\$47	_	141	\$141			
(Outpatient)	Non-Preferred Brand	\$100		300	\$300 N/A			
	Specialty co-insurance 33% N/A N/A S0 deductible; after total yearly drug costs reach \$5,030, you pay \$0 for Tier 1 and 2 drugs and no more than 25% of the plan's cost for brand name drugs until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.							
Supplemental Benefits and Options	Meals: Up to 14 home-delivered meals over 7 days after an inpatient hospital or skilled nursing facility stay OTC: \$75 quarterly allowance for plan approved items through mail order or purchased at CVS stores Wellness: \$0 for basic Silver Sneakers membership							
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown and Toland; Certain Independent Physicians Hospitals: Alameda, Eden (CVally), Highland (Oak), San Leandro, St. Rose (Hay), Stanford Valley Care (Pleas/Liv), and Washington (Fremont)					vork Medicare Provider		

2024 1	IEDICARE PPO COMPARISON CHART FO	OR ALAMEDA COUNTY						
Please contact the	Aetna Medicare							
Plan for more	833-859-6031 (Sales & Marketing)							
information or call	833-570-6670 (Member Services)							
1-800-Medicare	www.aetnamedicare.com							
	Aetna Medicare Eagle Plus Plan							
Plan Name		_						
	(PPO) (H5	3521-369)						
Star Rating	***							
	In-Network	Out-of-Network						
Annual OOP Max	\$6,700	\$9,500						
	(for in- and out-of-network combined)							
Monthly Premium	\$0							
Doctor Visits	\$0 copay for PCP; \$40 for Specialist	50% co-insurance for PCP and specialist						
	\$430 copay per day for days 1-4;	\$550 per day, days 1-5;						
Inpatient Hospital	\$0 per day for days 5-90;	\$0 per day, days 6-90;						
	\$0 per day for additional days (unlimited) \$275 copay for ambulatory surgical center visit;	\$0 per day for additional days (unlimited)						
Outpatient	\$350 copay for outpatient hospital service;	50% co-insurance per stay						
Hospital	\$450 per stay for outpatient hospital observation	, ,						
Skilled Nursing	\$0 copay/day for days 1-20;	459/ coincurance nor stay, we to 100 days						
Facility	\$150 per day for days 21-100	45% coinsurance per stay; up to 100 days						
Ambulance	\$265 copay by ground	or air one-way trip						
		, ,						
Emergency &	\$100 per ER visit; \$40 per urgent care visit; co-pays							
Urgent Care	\$100 per emergency or urg	ent care visit worldwide						
Lab Tests,	\$0 copay for lab services, x-rays; \$10 copay for	50% co-insurance for lab services; x-rays;						
Procedures, and	diagnostic tests, procedures; \$150 copay for	diagnostic tests & procedures; diagnostic and						
Radiation Therapy	diagnostic radiology; 20% for therapeutic radiology therapeutic radiology							
Renal Dialysis	20% co-insurance per treatment	50% co-insurance per treatment						
Outpatient Mental	\$40 copay per individual	50% co-insurance per individual						
Health Visits	or group therapy session	or group therapy session						
Eyewear	\$300 annual reimbursement for covered prescription eyewear							
	\$0 copay for diagnostic exam; 50% co-insurance for diagnostic exam;							
Eye Exams	\$0 copay for one annual routine exam	50% coinsurance for one annual routine exam						
Hearing Aids	\$1,250 annual allowance per ear, for aids purchase	ed through a NationsHearing network provider						
Hearing Exams	\$0 copay per diagnostic exam;	50% co-insurance per diagnostic exam;						
Treating Exams	\$0 copay for one annual routine exam	50% coinsurance for one annual routine exam						
	\$40 copay for Medicare covered visit;	50% coinsurance for Medicare-covered visit;						
Dental	\$0 copay for certain preventive and comprehensive services; \$3,000 annual allowance; through Aetna	20% coinsurance for certain preventive and						
	Dental PPO	comprehensive services; \$3,000 annual allowance						
Chiropractic	\$15 copay for Medicare covered visit	50% coinsurance for Medicare covered visit						
_	A 7							
Podiatry	\$40 copay for Medicare-covered visit	50% coinsurance for Medicare-covered visit						
	THIS PLAN DOES NOT OFFER PRE	SCRIPTION DRUG COVERAGE.						
Prescription Drugs								
(Outpatient)	YOU CANNOT BELONG TO THIS							
	STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.							
G 1	Meals: Un to 14 home-delivered meals over 7 days offer	er discharge from an innatient agute hognital						
Supplemental	Meals: Up to 14 home-delivered meals over 7 days after discharge from an inpatient acute hospital, inpatient psychiatric hospital, or skilled nursing facility stay							
Benefits and	OTC: \$105 quarterly allowance for plan approved items through mail order or purchased at CVS stores							
Options	Wellness: \$0 for basic Silver Sneakers membership							
Medical Groups	Medical Groups: Brown and Toland; Certain							
and Hospitals	Independent Physicians Hospitals : Alameda, Alta Bates/Summit (Berk/Oak),	Any Out-of-Network Medicare Provider						
(may not be full list;	Eden (Castro Valley), Highland (Oak), San Leandro,	, Out of Freemork Medicale Hoyage						
check with plan)	St. Rose (Hay), and Washington (Fremont)							
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2024 MEDICARE PPO COMPARISON CHART FOR ALAMEDA COUNTY							
Please contact thePlan for more information or call 1-800-Medicare	Aetna Medicare 833-859-6031 (Sales & Marketing) 833-570-6670 (Member Services) www.aetnamedicare.com						
Plan Name	Aetna Medicare Core Plan (PPO) (H5521-425)						
Star Rating	***						
	In-Netwo	rk		Out-of-Network			
Annual OOP Max	\$5,900			\$8,950 (in and out of network combined)			
Monthly Premium			\$	50			
Doctor Visits	\$0 copay for \$30 for Spec	ialist		\$10 copay for PCP; \$45 copay for Specialist			
Inpatient Hospital	\$425 copay per day for day \$0 per day for da \$0 per days 91 and	ys 5-90,	nited)	45% coinsurance per stay			
Outpatient Hospital	\$325 for Ambulatory Surg \$325 for Outpatient I		risit;	45% co-insurance for Ambulatory Surgical Center, 45% for Outpatient Hospital visit			
Skilled Nursing Facility	\$10 copay per day for \$150 per day for day			38% co-insurance per stay, up to 100 days			
Ambulance			*	ay trip by ground or air			
Emergency & Urgent Care	\$120 copay per ER visit; \$40 per urgent care visit; co-pays waived for ER visits if admitted to hospital; \$120 copay per emergency or urgent care visit outside of U.S.						
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab serv diagnostic tests, and \$200 copay for diagno 20% coinsurance for ther	procedures; stic radiology	\$25 copay for lab services; 45% for outpatient x-rays, diagnostic tests and procedures, diagnostic radiology, and therapeutic radiology				
Renal Dialysis	20% co-insurance p	er treatment		50% co-insurance per treatment			
Outpatient Mental Health Visits	\$40 copay per individual or group therapy session			45% co-insurance for individual or group therapy session			
Eyewear	\$360 annual allowance for covered prescription eyewear						
Eye Exams	\$0 copay per diagnostic exam; \$0 copay for one annual routine exam 45% co-insurance per diagnostic exam; 45% co-insurance for one annual routine exam						
Hearing Aids	\$1,250 annual	allowance pe	r ear, for a	ids purchased through NationsHearing			
Hearing Exams	\$0 copay per diagno \$0 copay for one annua	l routine exa		45% co-insurance per diagnostic exam; 45% co-insurance for one annual routine exam			
Dental	\$40 copay for Medicard \$1,500 annual allowance for comprehensive services; throu	ertain preven	tive and	45% coinsurance for Medicare-covered visit; \$1,500 annual allowance for certain preventive and comprehensive services; through Aetna Dental PPO			
Chiropractic	\$20 copay for Medicar	e covered vis	it	\$45% for Medicare covered visit			
Podiatry	\$40 copay for Medicare-covered visit 45% co-insurance for Medicare-covered visit						
Prescription Drugs (Outpatient)		lan's cost for		s 100 days mail order \$0 \$10 20% 50% N/A ,030, you pay \$0 for Tier 1 and \$10 for Tier 2 drugs me drugs until out-of-pocket drug expenses reach			
Supplemental Benefits and Options	OTC: \$75 quarterly allowance for plan approved items through mail order or purchased at CVS stores Wellness: \$0 for basic Silver Sneakers membership						
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown and Toland; Certain Independent Physicians Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (C. Valley), Highland (Oak), San Leandro, St. Rose (Hay), and Washington (Fremont)			Any Out-of-Network Medicare Provider			

Eye Exams S20 copay for each Medicare covered visit; \$0 copay for none annual routine exam Hearing Aids Up to \$1,000 reimbursement every two years for evaluation, fitting and hearing aids Hearing Exams S0 copay for Medicare covered exam; \$0 copay for Medicare covered exam; \$0 copay for non-Medicare covered exam; \$0 copay for mon-Medicare covered exam; \$0 for basic preventative services performed by \$20 copay if performed by a specialist Chiropractic S25 copay per Medicare-covered visit; \$0 for basic preventative services performed by \$20 copay if performed by a specialist Chiropractic S25 copay per Medicare-covered visit; \$0 copay/visit for 12 routine visits per year S25 copay per Medicare-covered visit; \$0 copay/visit for 12 routine visits per year S25 copay per Medicare-covered visit 40% co-insurance per Medicare covered visit; \$0 copay/visit for 12 routine visits per year S25 copay per Medicare-covered visit 40% co-insurance per Medicare covered visit; \$0 copay/visit for 12 routine visits per year S25 copay per Medicare-covered visit 40% co-insurance per Medicare covered visit; \$0 copay/visit for 12 routine visits per year S25 copay per Medicare-covered visit; \$0 copay/visit for 12 routine visits per year S25 copay per Medicare-covered visit 40% co-insurance per Medicare covered visit; \$0 copay/visit for 12 routine visits per year S26 copay per Medicare-covered visit 40% co-insurance per Medicare covered visit; \$0 copay/visit for 12 routine visits per year S25 copay per Medicare-covered visit 40% co-insurance per Medicare-covered visit; \$0 copay visit for 12 routine visits per year S25 copay per Medicare-covered visit 40% co-insurance per Medicare-covered visit; \$0 copay wisits for 12 routine visits per year S25 copay per Medicare-covered visit 40% co-insurance per Medicare-covered visit; \$0 copay wisits for 12 routine visits per year S25 copay per Medicare-covered visit 40% co-insurance per Medicare-covered visit; \$0 copay wisits for 12 routine visits per year S25 copay per Medicare	Please contact the Plan for more information or call 1-800-Medicare	Blue Shield of California 888-534-4263 (Sales & Marketing) 800-776-4466 (Member Services) www.blueshieldca.com/medicare							
In-Network	Plan Name								
Annual OOP Max S6,400 S11,000* (for its mit out-of-network combined) **Y5750 annual deductible applies to ALL out of network medical services. 40% co-insurance for PCP and Specialist Inpatient Hospital S200 copay for a mediatory surgical center visit; \$200 for opys 8 and over; \$100 copay for and sultary surgical center visit; \$230 for outpatient hospital facility visit Skilled Nursing Facility S150 copay for and sultary surgical center visit; \$250 copay per Medicare covered trip by air S250 copay per Medicare covered trip by air S100 copay per mengancy or ungent care visit; Warved if admitted to hospital within 24 hours; S100 copay per temergancy or ungent care visit outside the U.S. Wordwide coverage Lab Tests, Procedures, and Procedures, and Procedures, and Procedures, and Procedures, and Arrays, S75 for diagnostic radiology; Renal Dialysis Outpatient Mental Itaath Visits S250 allowance for one pair of eyeglass frames every 24 months, S35 allowance for one pair of eyeglass frames every 24 months, S35 allowance for one pair of eyeglass lenses or contact lenses every 12 months, S35 allowance for one pair of eyeglass lenses or contact lenses every 12 months, S35 allowance for one pair of eyeglass lenses or contact lenses every 12 months, S35 allowance for one pair of eyeglass lenses or contact lenses every 12 months, S35 allowance for one pair of eyeglass lenses or contact lenses every 12 months, S35 allowance for one pair of eyeglass lenses or contact lenses every 12 months, S35 allowance for one pa	Star Rating	, , , ,							
Monthly Premium S5 copay for PCP; S20 for Specialist 40% co-insurance for PCP and Specialist S200 copay greated yier days 1-7; S30 for suprained hospital S100 copay for ambulatory arguid center visit; S250 copay for for days 8 and over; 30% co-insurance S100 copay for ambulatory arguid center visit; S250 for comparison to opital facility visit Skilled Nursing S0 copay/day for days 1-100 40% co-insurance S250 copay per Medicare covered trip by ground; 20% copay per Medicare covered trip to will always a covered trip by ground; 20% copay per Medicare covered trip and the days and per covered trip and trip and the days and per covered trip and the days and per covered trip and trip and the days and per covered trip and trip a									
Doctor Visits Si copay for PCP; Si Di Or Specialist Si Di Copay for algoritari Si Di Copay for algoritari Si Di Copay for ambulatory surgical center visit Si Di	Annual OOP Max	\$6,400				*\$750 annual deductible applies to ALL out of network medical services.			
Inpatient Hospital Side Coops per day for days 1-7; So for days 8 and over; Side Coops per day for days 1-7; So for days 8 and over; Side Coops per day for days 1-20; Side Nursing Facility Side Oppay per Medicare covered trip by ground; Side Oppay per Medicare covered trip by ground; Side Oppay per Medicare covered trip by ground; Side Coops per day for days 1-20; Side Coops per Medicare covered trip by ground; Side Coops per day for days 1-20; Side Coops for each Medicare covered visit; Side Coops for each Medicare covered visit; Side Coops for each Medicare covered visit; Side Coops for for days 1-20; Side Coops for for days 1-20; Side Coops 1-20; Side Coops 1-20;	Monthly Premium			\$5′	7				
Inpatient Hospital S200 copus per days for days 1-7; S0 for days 1-7; S0 for days 1-7; S0 for days 8 and over; 300% co-insurance	Doctor Visits					40% co-insur	ance for PCP and Specialist		
Skilled Nursing So copay/day for days 1-20; Stilled Nursing So copay/day for days 1-20; Stilled Nursing So copay/day for days 1-10; Stilled Nursing Stilled Nu	Inpatient Hospital	\$200 copay per day for	or days 1-7;			30	% co-insurance		
Second per Medicare covered trip by ground; 20% copay per Medicare covered trip by air 20% copay per Medicare covered visit; 350 copay for diagnostic radiology; 20% co-insurance per treatment 200 topatient Mental Health Visits 250 allowance for one pair of cycalass frames every 24 months; 3250 allowance for one pair of cycalass frames every 24 months; 3250 allowance for one pair of prescription eyaglasses or contact lenses every 12 months with network provider 250 copay for each Medicare covered visit; 30 copay for medicare covered exam; 30 copay for medicare cove					40% co-insurance				
Emergency & Urgent Care Emergency & Urgent Care S100 copay per mergency room visit; \$5 per urgent care visit; Worldwide coverage Lab Tests, Procedures, and Radiation Therapy 20% co-insurance for diagnostic tests and procedures, and x-rays; \$75 for diagnostic tests and procedures, and x-rays; \$75 for diagnostic radiology; 20% co-insurance per treatment Outpatient Mental Health Visits S250 allowance for one pair of eyeglass frames every 24 months; \$250 allowance for one pair of prescription eyeglasses or contact lenses every 12 months in the work provider Eye Exams S20 copay for each Medicare covered visit; S0 copay for non-Medicare covered exam; S0 copay for non-Medicare covered exam; S0 copay for medicare covered exam; S10 copay for monthedicare covered exam; S10 copay for monthedicare covered visit; S10 copay for left of 12 routine visits per year Podiatry S250 copay per Medicare-covered visit; S250 copay per Medicare-covered visit; S10 copay for for left care-covered visit; S10 copay for left of 12 routine visits per year Prescription Drugs (Outpatient) Medical Groups and Hospitals (may not be full list; check with plan) Medical Groups and Hospitals (may not be full list; check with plan) Medical Groups and Hospitals (may not be full list; check with plan)						40	% co-insurance		
Waived if admitted to hospital within 24 hours;	Ambulance					0% copay per	Medicare covered trip by air		
Procedures, and Radiation Therapy 20% co-insurance for therapeutic radiology; 20% co-insurance for therapeutic radiology; 20% co-insurance for therapeutic radiology; 20% co-insurance per treatment 40% co-insurance per treatment		Waived if admitted to hospital within 24 hours;							
Supplemental Health Visits Supplemental Health Visits	Procedures, and	procedures, and x-rays; \$75 for diagnostic radiology;			40% co-insurance				
S250 allowance for one pair of eyeglass frames every 24 months; \$250 allowance for one pair of prescription eyeglasses or contact lenses every 12 months \$250 allowance for one pair of prescription eyeglasses or contact lenses every 12 months \$250 copay for each Medicare covered visit; \$0 copay for each Medicare covered visit; \$0 copay for one annual routine exam \$20 copay for Medicare covered exam; \$30 reimbursement for one annual routine exam \$20 copay for Medicare covered exam; \$30 copay for Medicare covered exam; \$40% co-insurance for Medicare covered visit; \$90 for basic preventative services performed by \$20 copay if performed by a specialist \$20% for basic preventative services \$25 copay per Medicare-covered visit; \$40% co-insurance per Medicare covered visit; \$0 copay/visit for 12 routine visits per year \$40% co-insurance per Medicare covered visit \$20% for basic preventative services \$20 copay for months with for preferred metwork retail retail retail mall order pharmacetes Preferred Generic \$5 Sos \$7.50 N/A Sos \$30 So	Renal Dialysis	20% co-insurance pe	r treatment		40% co-insurance per treatment				
24 months; \$250 allowance for one pair of prescription eyeglasses or contact lenses every 12 months with network provider		\$35 copay per visit per individual or group session			40% co-insurance				
Hearing Aids	Eyewear	24 months; \$250 allowance for one pair of prescription eyeglasses or contact lenses every 12							
So copay for Medicare covered exam; \$0 copay for non-Medicare covered exam; \$0 copay for non-Medicare covered exam; \$0 copay for non-Medicare covered exam; \$0 copay for Medicare covered exam; \$0 copay for Medicare covered exam; \$0 for basic preventative services performed by \$20 copay if performed by a specialist \$20% for basic preventative services. \$25 copay per Medicare-covered visit; \$0 copay/visit for 12 routine visits per year \$25 copay per Medicare-covered visit; \$40% co-insurance per Medicare covered visit; \$0 copay/visit for 12 routine visits per year \$25 copay per Medicare-covered visit \$40% co-insurance per Medicare covered visit; \$40% co-insurance per Medicare covered visit \$40% co-insurance per Medicare \$400 consurance per Medicare covered visit \$40% co-insurance per Medicare \$400 consurance per Medicare covered visit \$40% co-insurance per Medicare service \$500 consurance per Medicare covered visit \$40% co-insurance per Medicare per Medi	Eye Exams	1 7					,		
So copay for non-Medicare covered exam So copay for non-Medicare covered exam	Hearing Aids	• .			rs for	evaluation, fit	ting and hearing aids		
So for basic preventative services performed by \$20 copay if performed by a specialist	Hearing Exams	\$0 copay for non-Medicar	e covered exa		40% co-insurance				
Podiatry \$25 copay/visit for 12 routine visits per year \$25 copay per Medicare-covered visit Cost-sharing shown is for preferred network pharmacies	Dental	\$0 for basic preventat	ive services	ecialist	20% for basic preventative services				
Prescription Drugs (Outpatient) Prescription Drugs (Outpatient) Prescription Drugs (Outpatient) Prescription Drugs (Outpatient) Preferred Generic Generic Generic S0 S0 S0 S0 S0 S0 S0 S0 S0 S	Chiropractic								
Prescription Drugs (Outpatient) Preferred Generic S0 S0 S0 Generic S5 S7.50 N/A Preferred Brand S40 \$100 N/A Non-Preferred Brand Specialty co-insurance S95 \$237.50 N/A Specialty co-insurance S95 \$237.50 N/A Specialty co-insurance S96 of the price (plus a portion of the dispensing fee) for brand name drugs and for non-preferred until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0. Mobility: \$0 copay for annual AAA Membership for members with qualifying chronic conditions Over the Counter: \$60 quarterly allowance (two orders per quarter) for items in OTC catalogue. Wellness: \$0 for basic Silver Sneakers membership Optional Dental Package: Dental PPO at \$45 per month; up to \$1,500 annually for covered preventive and comprehensive services, \$50 deductible for comprehensive services; varying copays apply Medical Groups and Hospitals (may not be full list; check with plan) Medical Groups (Castro Valley), Highland (Oak), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Material Pretail mail order mail order mail order mail order	Podiatry	* *							
Generic \$5 \$7.50 N/A Preferred Brand \$40 \$100 N/A Non-Preferred Brand \$95 \$237.50 N/A Specialty co-insurance 33% N/A N/A After total yearly drug costs reach \$5,030, you pay \$0 for preferred generic and generic drugs; and no more than 25% of the price (plus a portion of the dispensing fee) for brand name drugs and for non-preferred until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0. Supplemental Benefits and Options Mobility: \$0 copay for annual AAA Membership for members with qualifying chronic conditions Over the Counter: \$60 quarterly allowance (two orders per quarter) for items in OTC catalogue. Wellness: \$0 for basic Silver Sneakers membership		preferred network pharmacies	retail	retail	s	mail order			
Preferred Brand \$40 \$100 N/A Non-Preferred Brand \$95 \$237.50 N/A Specialty co-insurance 33% N/A N/A After total yearly drug costs reach \$5,030, you pay \$0 for preferred generic and generic drugs; and no more than 25% of the price (plus a portion of the dispensing fee) for brand name drugs and for non-preferred until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0. Supplemental Benefits and Options Mobility: \$0 copay for annual AAA Membership for members with qualifying chronic conditions Over the Counter: \$60 quarterly allowance (two orders per quarter) for items in OTC catalogue. Wellness: \$0 for basic Silver Sneakers membership		l 							
Specialty co-insurance 33% N/A N/A After total yearly drug costs reach \$5,030, you pay \$0 for preferred generic and generic drugs; and no more than 25% of the price (plus a portion of the dispensing fee) for brand name drugs and for non-preferred until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0. Mobility: \$0 copay for annual AAA Membership for members with qualifying chronic conditions Over the Counter: \$60 quarterly allowance (two orders per quarter) for items in OTC catalogue. Wellness: \$0 for basic Silver Sneakers membership Optional Dental Package: Dental PPO at \$45 per month; up to \$1,500 annually for covered preventive and comprehensive services, \$50 deductible for comprehensive services; varying copays apply Medical Groups and Hospitals (may not be full list; check with plan) Medical Groups: Brown & Toland, Hill Physicians East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oak), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Any Out-of-Network Medicare Provider		Preferred Brand	\$40	\$100		N/A			
After total yearly drug costs reach \$5,030, you pay \$0 for preferred generic and generic drugs; and no more than 25% of the price (plus a portion of the dispensing fee) for brand name drugs and for non-preferred until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0. Mobility: \$0 copay for annual AAA Membership for members with qualifying chronic conditions Over the Counter: \$60 quarterly allowance (two orders per quarter) for items in OTC catalogue. Wellness: \$0 for basic Silver Sneakers membership Optional Dental Package: Dental PPO at \$45 per month; up to \$1,500 annually for covered preventive and comprehensive services, \$50 deductible for comprehensive services; varying copays apply Medical Groups and Hospitals (may not be full list; check with plan) Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oak), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington	(Outpatient)		-						
Supplemental Benefits and Options Options Optional Dental Package: Dental PPO at \$45 per month; up to \$1,500 annually for covered preventive and comprehensive services, \$50 deductible for comprehensive services; varying copays apply Medical Groups and Hospitals (may not be full list; check with plan) Medical Groups (Castro Valley), Highland (Oak), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Over the Counter: \$60 quarterly allowance (two orders per quarter) for items in OTC catalogue. Wellness: \$0 for basic Silver Sneakers membership Optional Dental Package: Dental PPO at \$45 per month; up to \$1,500 annually for covered preventive and comprehensive services; varying copays apply Medical Groups: Brown & Toland, Hill Physicians East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oak), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Any Out-of-Network Medicare Provider		After total yearly drug costs reach \$5,030, you pay \$0 for preferred generic and generic drugs; and no more than 25% of the price (plus a portion of the dispensing fee) for brand name drugs and for non-							
medical Groups and Hospitals (may not be full list; check with plan) and comprehensive services, \$50 deductible for comprehensive services; varying copays apply Medical Groups: Brown & Toland, Hill Physicians East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oak), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Any Out-of-Network Medicare Provider		Over the Counter: \$60 quarterly allowance (two orders per quarter) for items in OTC catalogue.							
Medical Groups and Hospitals (may not be full list; check with plan) East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oak), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Any Out-of-Network Medicare Provider	Options								
(Fremont)	and Hospitals (may not be full list;	East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oak), San Leandro, Any Out-of-No				Out-of-Netw	ork Medicare Provider		

2024	MEDICARE PPO COM				ACOUNTI			
Please contact the	United Health Care							
Plan for more	844-723-6473 (Sales and Marketing)							
information or call				Member Service				
1-800-Medicare	www.aarpmedicareplans.com							
	AARP Medicare Advantage from UHC CA-0023							
Plan Name	g							
G. D.	(PPO) (H0294-031)							
Star Rating	***1/2							
	In-Network Out-of-Network							
Annual OOP Max	\$5,90	0			\$8,700			
Monthly Premium			\$ 4	14				
Transmity 110mmm	CO	. DCD.	Ψ		CO C DCD			
Doctor Visits	\$0 copay for \$35 for Spe				60 copay for PCP; \$50 for Specialist			
	*			•				
Inpatient Hospital	\$325 copay per day \$0 copay per day for day				copay per days 1-17; r day for days 18 and beyond			
Outnotions								
Outpatient Hospital	\$250 copay for ambulatory \$300 per outpatient hos				ambulatory surgical center visit; tpatient hospital facility visit			
Skilled Nursing	1 1	1 ,		. 1	1 1			
Facility	\$0 copay per day f \$203 per day for				pay per day for days 1-39; er day for days 40-100			
•	\$200 per day for				•			
Ambulance		\$290 copa	y for ground	d or air ambulance tr	ip			
Emergency &	\$120 copay per e				ospital within 24 hours;			
Urgent Care	\$0 no			ent care visit;	sited States			
Lab Tests,	\$0 per emergency or urgent care visit outside of United States							
Procedures, and	\$0 copay for lab services; \$5		\$0 copay for lab services; \$70 copay for diagnostic tests, procedures; \$30 copay per service for x-rays;					
Radiation	tests, procedures; \$25 copay per service for x-rays; \$250 copay per service for diagnostic radiology; \$350 copay per service for diagnostic radiology;							
Therapy	\$60 copay per service for therapeutic radiology \$150 copay per service for therapeutic radiology							
Renal Dialysis	20% co-insurance	20% co-insurance per treatment 20% co-insurance per treatment						
Outpatient Mental	\$25 copay per visit for individual therapy; \$40 copay per visit for individual therapy;							
Health Visits	\$15 copay per visit for group therapy visit \$30 copay per visit for group therapy visit							
Eyewear	\$0 copay for standard lenses each year; \$100 annual allowance for frames through UnitedHealthcare Vision							
Eye Exams	\$0 copay per diag			pay per diagnostic exam;				
Eye Exams	\$0 co-pay for one ann	ual routine ex	am	\$50 co-pay	for one annual routine exam			
Hearing Aids	\$99-\$1,249 copay per hear	ring aid, up to	two hearing	aids every year, thre	ough United Healthcare Hearing			
п . Б	\$0 copay per diagnostic exam; \$50 copay per diagnostic exam;							
Hearing Exams	\$0 copay for one annu	ial routine exa	ım	\$50 copay for one annual routine exam				
		20% coinsurance for Medicare covered visit;			40% coinsurance for Medicare covered visit;			
Dental	\$0 copay for certain pro See Optional Benefits			\$0 copay for certain preventive services; See Optional Benefits Package below				
	See Optional Benefits	rackage beit)W	See Optional Benefits Package below				
Chiropractic	\$15 copay for Medicare	covered serv	rices	\$50 copay for	or Medicare covered services			
Podiatry	\$35 copay for up to 6 rou	ıtine visits per	r year	\$50 copay for	r up to 6 routine visits per year			
	Cost-sharing shown is for	30 days	100 days	100 days				
	preferred network	retail	retail	mail order				
	pharmacies Preferred Generic \$0 \$0		\$0	\$0	_			
Prescription	Generic	\$10	\$30	\$0				
Drugs	Preferred Brand	\$47	\$141	\$131				
(Outpatient)				\$290	_			
	33%	N/A	N/A I for preferred gener	ic; 25% coinsurance for generic				
	drugs and brand name drugs u							
Supplemental	Wellness: \$0 for basic Renew Active membership							
Benefits and	Optional Dental Package: Platinum Dental Rider at \$56 per month; \$1,500 annual allowance with va							
Options								
		•		enensive services, th	irough OHC Dental			
Medical Groups	Medical Groups: Alameda F Medical; PAMF/Sutter East B							
and Hospitals	Physicians	ay, Certain in	acpendent					
(may not be full list;	Hospitals: Alameda, Alta Bat			Any Out-of-Network Medicare Provider				
check with plan)	(Castro Valley), Highland (Oak), San Leandro, St. Rose (Hayward), Washington (Fremont)							
Rose (Hayward), Washington (Fremont)								

Please contact the Plan for more information or call 1-800-Medicare	United Health Care 844-723-6473 (Sales and Marketing) 866-261-7709 (Member Services) www.aarpmedicareplans.com						
Plan Name	AARP Medicare Advantage from UHC CA-0032 (PPO) (H0294-040)						
Star Rating			**	★ 1/2			
	In-Networ	·k			Out-	of-Network	
Annual OOP Max	\$6,700* *\$400 annual deductible applies to all medical services			\$10,000* *\$400 annual deductible applies to all out of network medical services			
Monthly Premium				\$0			
Doctor Visits	\$0 copay for P \$45 for Specia			\$0 copay for PCP; \$65 for Specialist			
Inpatient Hospital	\$300 copay per day for \$0 for days 5 and	or days 1-4;		\$500 copay per day for days 1-20; \$0 for days 21 and beyond			
Outpatient Hospital	\$250 copay for ambulatory su \$300 for outpatient hospic					oulatory surgical center visit; ent hospital facility visit	
Skilled Nursing Facility	\$0 copay per day for days 1-20; \$203 per day for days 21-100				1 , 1	per day for days 1-45; day for days 46-100	
Ambulance		\$290 copay p	er grour	nd or air	ambulance trip		
Emergency & Urgent Care	\$100 copay for emergency room visit; waived if admitted to hospital within 24 hours; \$40 copay for urgent care visit; \$0 per emergency or urgent care visit outside the United States						
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services; \$50 copay for diagnostic tests and procedures; \$15 copay for x-rays; \$115 copay for diagnostic radiology; \$60 copay for therapeutic radiology treatment			\$0 copay for lab services; \$70 copay for diagnostic tests and procedures; \$30 copay for x-rays; \$300 copay for diagnostic radiology; \$150 copay per therapeutic radiology treatment			
Renal Dialysis		20% c	o-insura	nce per	treatment		
Outpatient Mental Health Visits	\$25 copay for individual therapy visit; \$40 copay for individual therapy visit; \$30 copay for group therapy visit						
Eyewear	\$0 copay for standard lenses each year; \$250 annual allowance					•	
Eye Exams	\$0 copay for diagnostic exam; \$65 copay for diagnostic exam; \$0 copay for one annual routine exam \$65 copay for one annual routine exam						
Hearing Aids	\$99-\$1,249 copay for each		up to 2 a	ids ever		-	
Hearing Exams	\$0 copay for diagnos \$0 copay for one annual	routine exam		\$65 copay for diagnostic exam; \$65 copay for one annual routine exam			
Dental	20% coinsurance for Medicare covered visit; 40 See Optional Benefits Package below				40% coinsurance for Medicare covered visit; See Optional Benefits Package below		
Chiropractic	\$15 copay per Medicare			\$65 copay per Medicare-covered visit			
Podiatry	\$45 copay for 6 routine v combined with out-o		,	\$65 copay for 6 visits per year, combined with in-network			
	Cost-sharing shown is for preferred network pharmacies	30 days retail	100 e retail		100 days mail order		
Prescription Drugs (Outpatient)	Preferred Generic Generic Preferred Brand Non-Preferred Brand	\$0 \$12 \$47 \$100	\$0 \$36 \$141 \$300		\$0 \$0 \$131 \$290		
	Specialty co-insurance 33% N/A N/A After total yearly drug costs reach \$5,030, you pay \$0 for preferred generic and no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.						
Supplemental	Wellness: \$0 for basic Renew Active membership Wellness: \$0 for basic Renew Active membership						
Benefits and Options	Optional Dental Package: Platinum Dental Rider at \$62 per month; \$1,500 annual allowarying copays for certain preventive and comprehensive services, through UHC landscapes.						
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Alameda Health System; One Medical; PAMF/Sutter East Bay, Certain Independent Physicians Hospitals: Alameda, Alta Bates/Summit; Eden (Castro Valley), Highland (Oak), San Leandro, St. Rose (Hayward), Washington (Fremont)			Any Out-of-Network Medicare Provider			

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 per year and up to 22 counseling sessions/year
- RSV (Respiratory Syncytial Virus) Vaccine: one per year
- Pneumococcal Shots: one per lifetime
- Prostate Cancer Screening: one per year for age 50 and over
- Sexually Transmitted infections (STI) Screening & Counseling: one screening per year and 2 counseling sessions (with primary care physician) per year
- Shingles Vaccine
- Tobacco-use Cessation Counseling (if not diagnosed with related illness): up to 8 sessions per year
- "Welcome to Medicare" Exam: one in the year following enrollment into Part B

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

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

For more information on preventive care coverage, you can refer to the Medicare and You 2024 Handbook. Call 1-800-Medicare to request a copy or visit: www.medicare.gov/medicare-and-you.

Star Ratings:

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

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

This information is gathered from several different sources. In some cases, it is based on member surveys, information from clinicians, or information from plans. In other cases, it is based on results from Medicare's regular monitoring activities. Detailed information is available here: https://www.cms.gov/files/document/101323-fact-sheet-2024-medicare-advantage-and-part-d-ratings.pdf