2025 Medicare Advantage Plan HMO Comparison Chart ~FINAL~ for Alameda County

~Rev. 11/13/24 ~

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 normally 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. However, if the HMO also has a Point of Service (POS) option, members can go out of network only for certain plan-specified services but will pay higher out of pocket costs for those services. 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 2025, there are 24 Medicare HMOs in Alameda County, and they are listed on pages 2-13 of this chart. One of these does not include the Medicare Part D prescription drug benefit. When people join an HMO without drug coverage, they opt out of Part D. Enrolling in a stand-alone Part D plan will automatically trigger disenrollment from the Medicare Advantage Plan.

A Medicare PPO is another type of Medicare Advantage (MA) plan. A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses such as deductibles and coinsurance will apply. In 2025, there are 4 Medicare PPOs in Alameda County. See our 2025 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 2025, there are 19 Special Needs Plans in Alameda County. See our 2025 Special Needs Plan Comparison Chart for more information and details: www.lashicap.org/hicap.

Enrollment:

In the fall of 2024, 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, 2025. In 2025, 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 <u>who begin the year</u> 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.

IMPORTANT NOTE: In 2025, Medicare Part D out of pocket costs for covered medications under one's plan are capped at \$2,000. Also, plans cannot charge more than a \$35 copay per month for insulin and any drug deductibles do not apply to insulin.

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, cost-sharing, and provider networks, contact the plans directly. For preventive care benefits covered by Medicare, please see the back of this chart. Also, on the last page is an explanation of the Star Ratings provided by Medicare.

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

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



Navigating Medicare

This project was supported, in part by grant number 90SAPG0094-01-00, from the U.S.
Administration for Community Living,
Department of Health and Human Services,
Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

2025 MEDICARE	ADVANTAGE COMPA	ARISC				TY: E	IMOS	,	
Please contact the			A	etna M	edicare				
Plan for more		833	-859-6	031 (Sa	les & Marketing)				
information or call		833	3-570-6	6670 (N	Iember Services)				
1-800-Medicare					edicare.com				
	Aetna Medio	care S	Select		Aetna Med	licare	Plus		
Plan Name/Type	HMO-POS				HMO-POS				
Ston Doting			<i>3-010)</i>				<u> 2-007)</u>		
Star Rating	**					1/2			
Annual OOP Max	\$2,50	00			\$3,	400			
Monthly Premium	\$0				\$	0			
Doctor Visits	\$0 copay for Primary		Physician;	,	\$0 copay for Prima			ι;	
Doctor Visits	\$0 for Spo \$245 copay/day		a 1 5.		\$0 for S \$150 copay/da				
Inpatient Hospital	\$0 per day for day				\$0 per day for da				
Outpatient Hospital	\$0 copay for ambulatory	surgica	al center v		\$0 copay for ambulato	ry surgic	al center		
	\$125 copay for outpatien			visit	\$125 copay for outpatie		•	/ visit	
Skilled Nursing	\$0 copay/day fo				\$0 copay/day				
Facility	\$75 per day for				\$75 per day fo				
Ambulance	\$295 copay per ground				\$325 copay per ground				
_	\$140 copay per emergenc admitted to hospital; \$0				\$140 copay per emerger admitted to hospital; \$				
Emergency &	Worldwide coverage: no a				Worldwide coverage: no				
Urgent Care	per ER/urgent care visit; ER	copay v	waived if	admitted	per ER/urgent care vis	it; ER co	pay waiv	ed if	
T 1 70 4	to hospital; urgent care				admitted to hospital; urge				
Lab Tests, Procedures, and	\$0 copay for lab services, dia and x-rays; \$0 copay for				\$0 copay for lab serv procedures, x-rays and				
Radiation Therapy	\$60 copay for thera			ogy;	\$60 copay for the				
Renal Dialysis	20% co-insurance				20% co-insuran				
Outpatient Mental	20 /0 CO-msurance	per ne	aunent		20 /0 CO-IIIsuran	ee per in	catificit		
Health Visits	\$40 copay per individual of	r group	therapy s	ession	\$0 copay per individual	or group	therapy s	ession	
Eyewear	\$275 annual allowa	nce for	evewear		Not Co	overed			
	\$0 copay for diag		,						
Eye Exams	\$0 copay for one and	iual rou	tine exam		\$0 copay for one as	nnual rou	itine exar		
Hearing Aids	\$1,250 annual hearing a				\$2,000 annual hearing aid allowance per ear; purchased through NationsHearing network				
8	purchased through Nati \$0 copay for diag			ork	\$0 copay for di			Ork	
Hearing Exams	\$0 copay for one annual			ough	\$0 copay for one annua			ough	
_	NationsHeari				NationsHear				
Dental	\$1,000 annual reimburseme preventive and comp				\$1,100 annual reimbu covered preventive and				
Delitai	any licensed de			5,	any licensed d			vices,	
	\$0 copay for Medica	re cove	red visits;		\$0 copay for Medi	care cov	ered visit		
Chiropractic	\$0 copay for unlimit				\$0 copay for unlin				
D 11 4	through American Spec				through American Spe				
Podiatry	\$0 copay per Medic		1		\$0 copay per Med				
	Cost-sharing shown is for preferred pharmacies	30 days	100 days	100 days	Cost-sharing shown is	30 days	100	100	
	prejerrea pharmacies	uays	retail	mail	for preferred pharmacies	days	day retail	day mail	
	Preferred Generic	\$0	\$0	\$6	Preferred Generic	\$0	\$0	\$0	
Prescription Drugs	Generic	\$5	\$15	\$36	Generic	\$0	\$0	\$0	
(Part D)	Preferred Brand	25%	25%	25%	Preferred Brand Non-Preferred Brand	24% 25%	24% 25%	24% 25%	
	Non-Preferred Brand Specialty co-insurance	35% 33%	35% N/A	35% N/A	Specialty co-insurance	25%	N/A	N/A	
	\$0 deductible; after total year				\$590 deductible applies to	Tiers 3,	4, and 5;	after	
	\$2,000 , you pay \$0 .				total yearly drug costs re	each \$2,0	000 , you p	pay \$0 .	
	Acupuncture: \$0 copay for treatments with American Sp								
	Over the Counter: \$75 quan				Acupuncture: \$0 copay f	or unlim	ited acup	uncture	
Cummlare 4-1	approved items	·		•	treatments with American	Specialt	y Health		
Supplemental Benefits and	Transportation: \$0 copay for year (up to 60 miles each trip		• •		Transportation: \$0 copay year (up to 60 miles each		•		
Optional Plans	locations, via Access2Care	,, to pia	п арргоче	u	locations, via Access2Car	• ′ •	тан аррго	veu	
Optional Flans	Wellness: \$0 copay for basic				Wellness: \$0 copay for ba		er Sneake	rs	
	membership or one home fitt				membership or one home	fitness k	it per yea	r	
	per quarter Direct Member re for various fitness activities a			оwance					
Medical Groups and	Medical Groups: Brown an			Iedical	Medical Groups: Brown				
Hospitals	Hospitals: Alameda, Highlan				Medical; Hospitals: Alam				
(may not be full list;	(Hayward), San Leandro, Sta	inford V	alley Car	re	Rose (Hayward), San Lea Care (Pleas/Liv), and Was			пеу	
please check with plan)	(Pleas/Liv), and Washington	Hospita	al (Fremo	nt)	(Fremont)	5.011	-103pmai		
		_							

ZOZE WIEDICHIO	E ADVANTAGE COM	1 / 1 1 1 1	3011 C	илки і	OK ALAWEDA COU	111.1	11/100		
Please contact the Plan for more information or call 1-800-Medicare	Aetna Mo 833-859-6031 (Sa 833-570-6670 (M www.aetname	les & l	Market r Servi	0.	Align Sen 844-305-3879 (Sa 844-305-3879 (Na www.alignser	ales & l Iember	Market Servic		
Plan Name/Type	Aetna Medicar HMO-POS (e Val	lue Plu	1S	Align Advantage Care HMO (H3274-005)				
Star Rating	**	*			Not enough data available				
Annual OOP Max	\$2,50	00			\$1,9	000			
Monthly Premium	\$5.9	0			\$()			
Doctor Visits	\$0 copay for Primar		Physician	;	\$0 copay for Prima		hysician;		
	\$0 for Spo \$250 copay/day		s 1-5:		\$0 for Sp \$0 per				
Inpatient Hospital	\$0 per day for day	s 6 and	beyond		\$0 per day for unlim	ited addit	ional day	S	
Outpatient Hospital	\$0 copay per ambulatory \$125 per outpatient he				20% coinsurance per ambu \$225 copay per outpatie				
Skilled Nursing Facility	\$0 copay/day fo \$75 per day for	or days	1-20;		\$0 copay/day f				
Ambulance	\$295 copay per ground tr	ip: 20 %	per trip	bv air	\$125 copay per				
	\$140 copay per emergenc	y room	visit; wa	ived if	20% coinsuranc	e per trip	by air		
Emergency & Urgent Care	admitted to hospital; \$0 Worldwide coverage: no a per emergency/urgent care v admitted to hospital; urgent	per urgennual li visit; ER	ent care v mit; \$14 R copay v	visit; 0 copay vaived if	\$90 copay per emergency is care visit; waived if admit days; Coverage limited to	tted to ho	ospital wi	thin 3	
Lab Tests, Procedures, and	\$0 copay for lab services, dia and x-rays; \$0 copay for	diagnos	stic radio	logy;	\$0 copay for lab servi coinsurance for diagnostic diagnostic	ic tests, p	rocedures		
Radiation Therapy	\$60 copay for thera				20% coinsurance for	herapeut	ic radiolo	gy	
Renal Dialysis Outpatient Mental	20% co-insurance	e per tre	atment		20% co-insurance	e per tre	atment		
Health Visits	\$40 copay for individual o	r group	therapy	session	\$0 copay for individual of	or group t	herapy se	ssion	
Eyewear	\$325 annual allowa	nce for	eyewear		\$225 annual allow	ance for	eyewear		
Eye Exams	\$0 copay for dia			_	20% coinsurance for				
Hearing Aids	\$0 copay for one and \$1,250 annual hearing a purchased through Nati	id allow	ance per	ear;	\$0 copay for one ar		ine exam		
Hearing Exams	\$0 copay for dia \$0 copay for one annual NationsHearin	gnostic (exam; exam thr		20% coinsurance fo	e for diagnostic exam			
Dental	\$2,000 annual reimburseme preventive and comprany licensed de	ehensiv	e service		\$0 copay for certain \$3,000 annual allowance for Must use Liberty	r compre	hensive s	s; ervices;	
Chiropractic	\$0 copay for Medica \$0 copay/visit for unling must use American Spec	re-cove mited ro	red visits outine vis	its;	20% coinsurance for M \$30 copay/visit for 30 i (contact plan for a	outine vi	sits per y		
Podiatry	\$0 copay per Medic	are-cov	ered visi	t	20% coinsurance per M \$0 copay per routine v				
	Cost-sharing shown is for preferred pharmacies	30 days	100 days retail	100 days mail	Cost-sharing shown is for preferred pharmacies	30 days	90 days retail	90 days mail	
D	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0	
Prescription Drugs (Part D)	Generic Preferred Brand	\$10 25%	\$30 25%	\$20 25%	Generic Preferred Brand	\$10 \$47	\$30 \$135	\$30 \$135	
(Turt D)	Non-Preferred Brand	26%	26%	26%	Non-Preferred Brand	\$95	\$285	\$285	
	Specialty co-insurance	30%		N/A	Specialty co-insurance	25%	N/A	N/A	
	\$250 deductible applies to Ti total yearly drug costs reac				\$0 deductible; after total ye \$2,000, you pay \$0.	early aru	ig costs r	eacn	
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for unlimited acupuncture treatments with American Specialty Health provider OTC: \$75 quarterly allowance for plan approved items purchased online or in-store at CVS locations; no rollover Transportation: \$0 copay for 12 one-way trips per year to plan approved locations via Access2Care Wellness: \$0 copay for basic Silver Sneakers membership or one home fitness kit per year; \$150 per quarter Direct Member reimbursement allowance for various fitness activities and supplies				In-Home Support Services hours annually for help with housekeeping, meal prep, et Over the Counter: \$405 qu plan-approved items Part B Premium Rebate: \$ Transportation: \$0 copay year to plan approved locati	persona c. parterly a 610/mont for 24 on	l needs, li llowance h	ght for	
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Brown & Hospitals: Alameda, Highlan (Hayward), San Leandro, Sta (Pleas/Liv), and Washington	Toland, nd (Oak anford V	One Me), St. Ros Valley Ca	se re	Medical Groups: Brown & Hospitals: Alta Bates/Sumr Eden (Castro Valley)				

ZUZ5 MEDICAF	RE ADVANTAGE COM	rAKI				11,11	WIOS			
Please contact the					Health Plan					
Plan for more		88	8-979-	2247 (Sa	ales & Marketing)					
information or call					Member Services)					
1-800-Medicare		O.			healthplan.com					
Plan Name/Type	Alignment Hea	alth H	leroes	+	Alignment Heal	th Ha	rmon	\mathbf{y}		
Tian Name/Type	HMO (H3	3815-0	43)		HMO (H38	15-031	1)			
Stor Doting										
Star Rating	***				***					
Annual OOP Max	\$5,9				\$3,400					
Monthly Premium	\$0				\$0					
Doctor Visits	\$0 for Primary Care Phys	sician; \$	0 for Spe	ecialist	\$0 for Primary Care Physic	ian; \$0 1	for Speci	ialist		
	\$1,676 deductible per benefit	period:	\$0 copa	v for days	\$100 copay/day for	or days 1	1-5:			
Inpatient Hospital	1-60; \$419 copay/da				\$0 copay/day for					
	\$838 copay/day f	or days	91-150		\$0 copay/day for days	90 and	beyond			
Outpatient	\$0 copay for ambulate	ory surg	ical cent	er;	\$100 copay for ambulatory	surgical	l center	visit;		
Hospital	\$0 copay for outpatie	ent hosp	ital facili	ty	\$200 copay for outpatient	hospital	facility	visit		
Skilled Nursing	\$0 copay/day fo	or days	1-20;		\$0 copay/day for	days 1-2	20;			
Facility	\$209.50/day for				\$100 copay/day for					
· ·	20% co-insurance per grou	nd or ai	r ambula	nce trip;	\$175 copay per ground or	air amb	ulance t	rip;		
Ambulance	Not waived if adm	itted to	hospital	_	Waived if admitte	d to hos	oital	1.		
	20% coinsurance for ER as				\$100 copay for ER visit; copa			dmitted		
Emergency &	cost waived if admitted to	hospita	l within	3 days;	to hospital; \$0 for ur			:. c		
Urgent Care	Worldwide coverage: \$'			nit for	Worldwide coverage: \$10			nt for		
Lab Tests,	ER/urgent care w			. 0	ER/urgent care wit			0		
,	\$0 copay for lab service				\$0 copay for lab services					
Procedures, and	procedures, x-rays, and 20% coinsurance for the				procedures, x-rays, and di 20% coinsurance for the					
Radiation Therapy				ogy				в у		
Renal Dialysis	20% co-insuranc	e per tre	atment		\$30 copay per	treatmen	t			
Outpatient Mental	20% co-insurance				\$0 copay per individual or	eroup th	erany se	ssion		
Health Visits	or group thera	apy sess	ion		to topay per marviduar or	group tir	erupy se	551011		
Eyewear	\$500 allowance for ey	ewear e	very 2 ye	ears	\$150 annual allowan	ce for ey	yewear			
Eye Exams	\$0 copay for dia				\$0 copay for diag					
-	\$0 copay for one and	nual rou	tine exar	n	\$0 copay for one annu	al routir	ne exam			
Hearing Aids	Not Cov				\$195-\$1,750 copay per aid:	_		year		
Hearing Exams	\$0 copay for dia				\$0 copay for diagr					
	\$0 copay for one and			n	\$0 copay for one annu	al routir	ne exam			
Dental	\$0 copay for cert and comprehensive services			a avary 3	\$0 copay for certain pro					
Dentai	months; See enhanced de				\$20-\$570 copays for certain of	compreh	ensive s	ervices		
Chiropractic	\$0 copay per Medic				\$0 copay per Medica	re-cover	ed vicit			
	. 1 11				\$5 copay for Medicare-covered visit					
Podiatry	\$0 copay for Medic	are-cov	ered visi	t	\$5 copay for Medicar	re-cover	ed 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		
			retail	mail	2 2 2 2	40	retail	mail		
D D	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0		
Prescription Drugs	Generic	\$10	\$30	\$30	Generic	\$3	\$9	\$9		
(Part D)	Preferred Brand Non-Preferred Brand	25% 25%	25% 25%	25% 25%	Preferred Brand	\$40	\$120	\$120		
	Specialty co-insurance	25%	N/A	N/A	Non-Preferred Brand	\$100	\$300	\$300 N/A		
	\$590 deductible; after total				Specialty co-insurance \$0 deductible; after total year	33%	N/A	N/A		
	\$2,000, you pay \$0.	, curry c	ir ug cost	S I Cucii	\$2,000, you pay \$0.	ily ul ug	COSIST	cacii		
	Enhanced Dental Option: \$	36/mon	th for 0-	50%	+=, ,					
	coinsurance for certain diagn				Acupuncture: \$0 co-pay/visit	for unli	mited vi	isits/vr		
	services; \$1,500 coverage lim				Enhanced Dental Option: \$3					
	Essentials Allowance: \$100				coinsurance for certain diagno			hensive		
	groceries, gas, utilities, and h			nose with	services; \$1,500 coverage lim					
		e no rol	lover	1	Essentials Allowance: \$30 monthly allowance for					
	qualifying chronic conditions		C 10		groceries, gas, utilities, and home safety for those					
Supplemental	In-Home Support Services:	\$0 cop					with qualifying chronic conditions			
Supplemental Renefits and	In-Home Support Services: quarter OR \$300 annual care	\$0 copa	imbursen	nent	with qualifying chronic condit	ions	•			
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin	\$0 copa giver remeals/da ag chron	imbursen ay for 14 ic condit	nent days (2x/ ions	with qualifying chronic condit Over the Counter: \$30 month	ions hly allov	vance	14		
	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7	\$0 copagiver remeals/date of the copagiver remeals/date of the copaging the copagin	imbursen ay for 14 ic condit ag days o	nent days (2x/ ions r 14	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify	ions hly allov ooarding ring chro	vance days or	ditions		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 to year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif	\$0 copagiver remeals/date chron boardin ying ch	imbursen ay for 14 ic condit ag days o ronic cor	nent days (2x/ions r 14 aditions	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1	ions hly allow ooarding ving chro service p	vance days or onic conc oer year	ditions		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1	\$0 copagiver remeals/date chron boarding chron service	imbursen ay for 14 ic condit ag days o ronic cor	nent days (2x/ions r 14 aditions	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic	ions hly allow ooarding ving chro service p	vance days or onic cond oer year	ditions for		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond	\$0 copagiver remeals/date chron boardin ying chron service	imbursen ay for 14 ic condit ag days o ronic cor e per year	days (2x/ions r 14 aditions for those	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for	ions hly allow coarding ring chro service p condition 28 one-	vance days or onic cond oer year ns way trip	ditions for os each		
Benefits and	In-Home Support Services: quarter OR \$300 annual care Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond Transportation: \$0 copay for	\$0 copagiver remeals/dag chron boarding chron boarding chron service itions or 50 on	imbursen ay for 14 ic condit ig days o ronic cor e per year e-way tri	days (2x/ions r 14 aditions for those	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for year to plan approved location	ions hly allow coarding ring chro service p condition 28 one- as within	vance days or onic cond oer year ns way trip 20 mile	ditions for os each		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond	\$0 copa giver re- meals/da g chron boardin ying ch service itions or 50 on ons within	imbursen ay for 14 ic condit ig days o ronic cor per year e-way tri in 50 mil	nent days (2x/ions r 14 aditions for those ps per es	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for	ions hly allow coarding ring chro service p condition 28 one- as within	vance days or onic cond oer year ns way trip 20 mile	ditions for os each		
Benefits and Optional Plans	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond Transportation: \$0 copay for year to plan approved locatio Wellness: \$0 copay for basic	\$0 copagiver remeals/day chron boardin ying ch service itions or 50 on service gym m	imbursen ay for 14 ic condit ig days o ronic cor e per year e-way tri in 50 mil embersh	nent days (2x/ions r 14 nditions for those ps per es ip	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for year to plan approved location Wellness: \$0 copay for basic	ions hly allow coarding ring chro service p condition 28 one- us within gym men	vance days or onic conc per year ns way trip 20 mile mbership	ditions for os each os		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 1 year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond Transportation: \$0 copay for year to plan approved locatio	\$0 copagiver remeals/dag chron boardin ying ches service itions or 50 on swithing ym m Toland,	imbursen ay for 14 ic condit ig days o ronic cor e per year e-way tri in 50 mil embersh Nivano	nent days (2x/ions r 14 nditions for those ps per es ip	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for year to plan approved location	ions hly allow coarding ring chro service p condition 28 one- s within gym men	vance days or onic cond per year ns way trip 20 mile mbership	ditions for os each os p		
Benefits and Optional Plans Medical Groups	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 ryear) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond Transportation: \$0 copay for year to plan approved locatio Wellness: \$0 copay for basic Medical Groups: Brown & 20 copay for basic Medica	\$0 copa giver re- meals/da g chron boardin ying ch service itions or 50 on ns within gym m Toland, ttes/Sum o, St. Ro	imbursen ay for 14 ic condit ig days o ronic core per year e-way tri in 50 mil embersh Nivano	ment days (2x/ions r 14 aditions for those ps per es ip IPA ck/Oak),	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for those with qualifying chronic Transportation: \$0 copay for year to plan approved location Wellness: \$0 copay for basic Medical Groups: Brown & T	ions hly allow coarding ring chro service p conditio 28 one- ss within gym mer foland, N es/Sumn St. Rose	vance days or onic cond oer year ns way trip 20 mile mbership livano II nit (Berk	ditions for os each ss p		

Please contact the	RE ADVANTAGE COM 	IPAK			Health Plan	NII;	111/1/	75	
Plan for more		88			ales & Marketing)				
information or call					Member Services)				
1-800-Medicare					thealthplan.com				
Plan Name/Type	Alignment Health M HMO (H3	-		CalPlus	Alignment H HMO (H3			•	
Star Rating	***	t *			**1	k *			
Annual OOP Max	\$3,4				\$3,4				
Monthly Premium	\$0		0.0.0		\$0				
Doctor Visits	\$0 for Primary Care Phys \$0 copay for days 1-4; \$1				\$10 for Primary Care Phys \$295 copay for		_	ecialist	
Inpatient Hospital	5-10; \$0 copay for days 11 \$100 copay for ambula	and be	yond; u	nlimited	\$0 copay/day for days 8 \$35 copay for ambulator	and bey	ond; unli	mited	
Outpatient Hospital	\$200 copay for outpati				\$200 for outpatient h				
Skilled Nursing Facility	\$0 copay/day fo \$50 copay/day fo	-			\$0 copay/day f \$140 per day fo	-			
Ambulance	\$175 copay per trip	by grou	ınd or ai	r;	\$240 copay per trip	by grou	ınd or air	;	
Timodiunec	waived if admitt \$85 copay for ER visit; waive			o hospital	waived if admit \$90 copay for ER visit; wai			vithin 24	
Emergency &	within 48 hours; \$0 fo	or urgen	t care vi	sit;	hours; \$0 for urg	gent care	e visit;		
Urgent Care	Worldwide coverage: \$1 emergency/urgent ca				Worldwide coverage: \$ emergency/urgent ca				
Lab Tests,	\$0 copay for lab service	es, diagi	nostic te	sts &	\$0 copay for lab servic	es, diagi	nostic tes	ts &	
Procedures, and Radiation Therapy	procedures, x-rays, and 20% coinsurance for the				procedures, x-rays, and 20% coinsurance for t				
Renal Dialysis	20% coinsurance			1087	\$30 copay pe			967	
Outpatient Mental Health Visits	\$0 copay per individual or	r group	therapy	session	\$20 copay per individual	or group	therapy	session	
Eyewear	\$100 annual allowa	ance for	eyewea	r	\$300 allowance for ey	ewear e	very 2 ye	ears	
Eye Exams	\$0 copay for dia				\$0 copay for diagnostic exam;				
Hearing Aids	\$0 copay for one and \$195-\$1,750 copay per ai				\$0 copay for one an \$195-\$1,750 copay per at				
Hearing Exams	\$0 copay for dia	gnostic	exam;		\$10 copay for di	agnostic	exam;		
J	\$0 copay for one and \$0 copay for certain p				\$0 copay for one an \$10-\$30 copays for certa				
Dental	\$20-\$570 copays for certain	compr	ehensive	e services	\$20-\$570 copays for certain				
Chiropractic	\$0 copay per Medicare-cove Extra Help, \$0 co-pay for combined with	for 12 vi	isits per		\$0 copay per Medic	care-cov	ered visi	t	
Podiatry	\$0 copay for Medic			it	\$25 copay for Medi	care-co	vered visi	t	
	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	
D 141 D	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0	
Prescription Drugs (Part D)	Generic Preferred Brand	\$3 \$40	\$9 \$120	\$9 \$120	Generic Preferred Brand	\$3 \$40	\$9 \$120	\$9 \$120	
	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 ye. \$2,000, you pay \$0.	arıy ar	ug costs	reacn	\$0 deductible; after total ye \$2,000, you pay \$0.	ariy ari	ug costs	reacn	
	Acupuncture: For those with for 12 visits per year, combined								
	Enhanced Dental Option: S				Enhanced Dental Option:	\$36 /mor	nth for 0-	50%	
	coinsurance for certain diagr			rehensive	coinsurance for certain diag			ehensive	
	services; \$1,500 coverage lin In-home Support Services:			2 hours	services; \$1,500 coverage line Meals: \$0 copay for up to 2			lavs for	
	per quarter OR \$300 annual				those with qualifying chroni	c condit	ions	-	
	Meals: \$0 copay for up to 28				Over the Counter: \$25 mor	nthly all	owance;	no	
Supplemental	those with qualifying chronic with Extra Help, up to 56 me			or those	rollover Pet Services: \$0 copay for 7	/ boardii	no davs c	r 14	
Benefits and	Over the Counter: \$20 mor	nthly all	owance		walks per year for those with				
Optional Plans	those with Extra Help, additi Pet Services: \$0 copay for 7				conditions	1		fa	
	walks/year for those w/quali				Pest Control: \$0 copay for those with qualifying chroni			. 101	
	Pest Control: \$0 copay for			ar for	Transportation: \$0 copay f				
	those with qualifying chronic Transportation: \$0 copay for the copay f			rips per	year to plan approved location Wellness: \$0 copay for basi				
	year to plan approved location				participating fitness centers				
	Wellness: \$0 copay for basic participating fitness centers	gym n	ieinbers	anp at					
Medical Groups	Medical Groups: Brown &				Medical Groups: Brown &				
and Hospitals (may not be full list;	Hospitals: Alameda; Alta Ba Highland (Oak), San Leandr				Hospitals: Alameda; Alta B Highland (Oak), San Leandr				
please check with plan)	Stanford Valley Care (Pleas/		(2.44)	,/,	Stanford Valley Care (Pleas		(-14)	/,	

2023 NIEDICAR	E ADVANTAGE COM	ANIS	ON CI	TAKI	OR ALAMEDA COUN	11.1	11/10	<u> </u>	
Please contact the									
Plan for more		800)-619-	6164 (S	ales & Marketing)				
information or call					Member Services)				
1-800-Medicare		0.5			hem.com				
	Anthom	Coloo		w w w.am	Anthem	Duim			
Plan Name/Type	Anthem								
	HMO-POS (H0544	1-098)		HMO-POS	(H416)	1-005)		
Star Rating	**	*			**	*			
Annual OOP Max	\$7,55	50			\$1,2	00			
Monthly Premium	\$0				\$0				
Doctor Visits	\$15 copay for Primar	y Care l	Physiciar	1;	\$0 copay for Primary Care Physician;				
Doctor visits	\$45 copay for				\$10 copay for Specialist				
Inpatient Hospital	\$315 copay/day				\$250 copay for days 1-5; \$0 copay/day for days 6-90 and beyond				
	\$0 copay for days 7 \$275 copay for ambulator			visit:	\$150 copay for ambulator				
Outpatient Hospital	\$315 copay for outpatient				\$250 for outpatient he				
Skilled Nursing	\$0 copay for a	days 1-2	20;		\$0 copay/day fo	or days	1-20;		
Facility	\$196 per day for	\$196 per day for days 21-100 \$188 per day for					1-100		
Ambulance	\$250 copay per groun				\$250 copay per groun				
Ambulance	20% coinsurance per				20% coinsurance per				
Emergency &	\$90 copay for ER visit; waiv within 24 hours; \$35 fo				\$90 copay for ER visit; waiv within 24 hours; \$35 f				
Urgent Care	Worldwide coverage: \$1				Worldwide coverage: \$1				
organi ouro	emergency/urgent care wi				emergency/urgent care wi				
Lab Tests,	\$10 copay for lab ser				\$10 copay for lab se				
Procedures, and	\$50-\$75 for diagnostic \$10-\$150 for diagn			es;	\$25-\$50 for diagnostic \$10-\$150 for diagn			res;	
Radiation Therapy	20% coinsurance for the			ogv	20% coinsurance for the			ogv	
Renal Dialysis	20% co-insurance			- 63	20% co-insurance			-63	
Outpatient Mental						•			
Health Visits	\$40 copay per individual o	r group	therapy s	session	\$10 copay per individual or group therapy session				
Eyewear	\$100 annual allowa	nce for	eyewear		\$100 annual allowa	nce for	eyewear		
-	\$45 copay for dia		•		\$10 copay for dia		•		
Eye Exams	\$0 copay for one ann			ı	\$0 copay for one annual routine exam				
Hearing Aids	**	\$3,000 annual allowance with \$0 copay Not Covered							
Hearing Exams	\$45 copay for dia				\$10 copay for dia				
_	\$0 copay for one ann \$45 copay for Medic								
Dental	\$0 copay for 1 oral exam a				\$0 copay for 1 oral exam				
Chiropractic	\$15 copay per Medic	care-cov	ered visi	t	\$20 copay per Medic				
•	\$0-45 copay for Medi				\$0-10 copay for Medi	care-co	vered vis	it:	
Podiatry	\$0 copay for 24 routing				\$0 copay for unlimited re				
	Cost-sharing shown is for		90	90	Cost-sharing shown is for	30	90	90	
	preferred pharmacies	days	days	days	preferred pharmacies	days	days	days	
	Preferred Generic	\$0	retail \$0	mail \$0	Preferred Generic	\$0	retail \$0	mail \$0	
Prescription Drugs	Generic	\$0	\$0	\$0	Generic Generic	\$0 \$7	\$21	\$0	
(Part D)	Preferred Brand	15%	15%	15%	Preferred Brand	20%	20%	20%	
()	Non-Preferred Brand	30%	30%	30%	Non-Preferred Brand	25%	25%	25%	
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%		N/A	
	\$0 deductible; after total year	arly dru	ig costs i	each	\$0 deductible; after total yes	arly dru	ıg costs ı	reach	
	\$2,000, you pay \$0.	· . C 10			\$2,000 , you pay \$0 .				
	Acupuncture: \$0 co-pay/vis Over the Counter: \$25 quar			er year					
	Wellness: \$0 for basic Silver			ership	0 4 0 4 00	. 1 1			
	Optional supplemental paci			·	Over the Counter: \$20 quant Wellness: \$0 for basic Silver			perchin	
	1: Preventive Dental at \$13				Optional supplemental pac		as meme	Cisinp	
	\$500/year; \$0 co-pays for base 2: Dental & Vision at \$33 p			rvices	1: Preventive Dental at \$13	per mo			
Supplemental	\$1,000/year with \$0 copays f			itive	\$500/year; \$0 co-pays for ba				
Benefits and	services and 20-50% coinsur	ance for	certain		2: Dental & Vision at \$33 p services up to \$1,000/year w				
Optional Plans	comprehensive services; \$15	0 annua	l reimbui	sement	annual reimbursement allows	-			
	allowance for eyewear 3: Enhanced Dental & Vision	on at \$5	1 ner m	nth• un	3: Enhanced Dental & Visi				
	to \$2,000/year with \$0 copay				dental services up to \$2,000/	-			
	services and 20-50% coinsur	ance for	certain		\$200 annual reimbursement	anowan	ce for ey	ewear	
	comprehensive services; \$20	0 annua	l reimbu	rsement					
	allowance for eyewear				M. P. I.C. S	m 1 1	TT'11 P1		
Medical Groups	Medical Groups: Brown &		Hill Phy	sicians	Medical Groups: Brown & East Bay, Imperial Health He			sıcıans	
and Hospitals	East Bay, Imperial Health Ho		/O-1 \ E	1	Physicians	orumgs,	141 (4110		
(may not be full list;	Hospitals: Alta Bates/Summ (Castro Valley), St. Rose, (H.				Hospitals: Alta Bates/Summ				
please check with plan)	Care (Pleas/Liv), Washington	-		a vancy	(Castro Valley), St. Rose, (H			rd Valley	
		- (2 10111	/		Care (Pleas/Liv), Washington	n (Frem	ont)		

2025 MEDICAR	E ADVANTAGE COM	PAKI	SON CI	IAKT F	OR ALAMEDA COUN	TY: I		1 S		
Please contact the	Blue Shie	ld of	CA		United Hea	lth C	are			
Plan for more	888-534-4263 (Sa	les &	Marketi	ing)	844-723-6473 (Sales and Marketing)					
information or call	800-776-4466 (M				866-261-7709 (M					
1-800-Medicare	`									
1 000 Medicare	www.blueshieldc	a.com/	medicar	<u>e</u>	www.aarpmedic					
	Blue Shiel	d Inc	nire		AARP Medicare			from		
Plan Name/Type	(HMO) (H		_		UHC C	A-7P				
	(IIMO) (I	10504-	041)		HMO-POS	H0543	3-188)			
Star Rating	***	r1/2			**	+				
Annual OOP Max	\$4,3				\$4,9					
Monthly Premium	\$3!				\$40					
•	\$0 copay for Primar		Physician		\$0 copay for Primar		Physicia	n·		
Doctor Visits	\$15 for S ₁				\$25 for Sp		ily sicia	11,		
Inpatient Hospital	\$280 copay/day	for day	vs 1-5;		\$425 copay/day \$0 for days 7 and be	for day:	s 1-6;	1/		
Outpatient Hospital	\$0 per day for day \$100 copay per ambulato	ry surg	ical center		\$375 copay for ambulator	y surgio	cal cente	er visit;		
	\$250 per outpatient h			it	\$425 copay for outpa			sit		
Skilled Nursing	\$0 copay/day f				\$0 copay/day for					
Facility	\$200 per day fo \$275 copay per t				\$203 per day for	days 2.	1-100			
Ambulance	20% co-insuranc	e per tri	p by air		\$290 copay per trip	, ,				
Emanganary 6	\$125 copay per emergency				\$125 copay per emergence					
Emergency &	care visit; Worldwide cover \$120 copay per emergen				admitted to hospital within care visit; Worldwide cover					
Urgent Care	waived if admitted to he				\$0 copays for emergen				uli	
Lab Tests,	\$0 copay for lab, diagnostic				\$0 copay for lab, diagnosti					
Procedures, and	x-rays; \$75 copay for o				\$25 copay per x-ray; \$20					
Radiation Therapy	20% co-insurance for	therape	ıtic radiolo	ogy	radiology; 20% coinsurance				у	
Renal Dialysis	20% co-insuranc	e per tr	eatment		20% co-insurance	e per tre	atment			
Outpatient Mental	440 0 1 11 1	•			\$25 copay for individu	ial thera	ipv sess	ion:		
Health Visits	\$30 copay for individual of	or group	therapy s	ession	\$15 copay for group therapy session					
Eyewear	\$195 annual allowa \$195 allowance for fi			rs	\$200 annual allowa through United Health					
Eye Exams	\$15 copay for dia	gnostic	exams;		\$0 copay for Medica	re-cove	red exai	n;		
Lyc Exams	\$0 copay for one an				\$0 copay for one and					
Hearing Aids	\$449 - \$699 copay per ai limited to 2 hearing			ype);	\$99 - \$1,249 copay per aid through United Healthc					
Hearing Exams	\$0 copay for Medica				\$0 copay for Medica					
110411119	\$0 copay for one an \$15 copay for Medic				\$0 copay for one and	nual rou	tine exa	m		
Dental	\$0 copay certain preventive				\$0 copays for preventive serv			l provide	er;	
Donoui	and 1 full set of x-ra	ys every	y two years	s	See optional den	tal plan	below			
Chiropractic	\$15 copay for Medic				\$15 copay for Medic			it;		
Спиоргиене	\$0 copay/visit for 12 re				Routine care not covered					
Podiatry	\$15 copay per Medi \$15 copay/visit for unlimit				\$25 copay per Medicare-covered visit; \$25 copay/visit for 6 routine visits per year					
	Cost-sharing shown is	30	100	100		30	100		\exists	
	for preferred pharmacies	days	days	days	Cost-sharing shown is for preferred pharmacies	days	days	100 days		
	Jan prajaman pramana		retail	mail	prejerrea piarmacies	days	retail	mail		
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0		
Prescription Drugs	Generic	\$5	\$7.50	\$7.50	Generic	\$12	\$36	\$0		
(Part D)	Preferred Brand	\$40	\$100	\$100	Preferred Brand Non-Preferred Brand	\$47	\$141 N/A	\$131 N/A		
	Non-Preferred Brand Specialty co-insurance	\$95 33%	\$237.50 N/A	\$237.50 N/A	Specialty co-insurance	\$100 29%	N/A N/A	N/A N/A		
	\$0 deductible; after total ve				\$340 deductible for Tiers 3,					
	\$2,000, you pay \$0.	,	0 1		yearly drug costs reach \$2,					
			11							
	Over the Counter: \$55 qua Transportation: \$0 copay f			ns ner						
	year to plan approved location		iic way ar	ps pci			40			
	Wellness: \$0 for basic Silve		ers memb	ership	Optional Dental Plan at \$54 certain preventive and compa					
Supplemental	Optional Supplemental Pla				coinsurance for dentures and					
Benefits and	1: Dental HMO at \$16/mor				allowance	orrages	, φ2,200			
Optional Plans	certain preventive and comp participating dentists only	renensi	ve services	s;	Over the Counter: \$25 quan	terly all	owance	for item	ıs	
	2: Dental PPO at \$47/mon	th: \$50	deductible	e;	in-store or online			1. !		
	varying coinsurance for certain preventive and Wellness: \$0 for Renew Active gym membership							ersnip		
	comprehensive services; \$1,									
	participating dentists; \$1,00	u for no	n-participa	ating						
		Medical Groups: Brown & Toland, Hill Physicians						·		
Medical Groups	Medical Groups: Brown &	Toland	, Hill Phys	sicians	Madical Crounce Canana II	ealth II	ill Dha	iciane		
Medical Groups	East Bay				Medical Groups: Canopy H East Bay	ealth, H	ill Phys	icians		
and Hospitals	East Bay Hospitals: Alameda, Alta B	ates/Su	mmit (Ber	k/Oak),	East Bay Hospitals: Alameda, Highlan	nd (Oak	land), S	an		
	East Bay	ates/Su and (Oa	mmit (Ber ak), San Le	k/Oak),	East Bay	nd (Oak	land), S	an)	

	RE ADVANTAGE COM						NIY:	111/11	<i>)</i> 8		
Please contact the						ledicare Plan					
Plan for more information or call						s & Marketing)					
1-800-Medicare		80		`		mber Services)					
1 000 Medicare	C 4 LT WLT				1	thplan.com	•	<u> </u>	DI TT		
Plan Name/Type	Central Health I			an I	(Central Health Cla			rian II		
	(HMO) (H	5649- 0)23)			(HMO) (H	5649-	028)			
Star Rating	★★1	1/2				**	1/2				
Annual OOP Max	\$2,99				L	\$2,4					
Monthly Premium	\$0					\$0					
Doctor Visits	\$0 for Primary Care Phys \$0 copay for days 1-4; \$100					\$0 for Primary Care Phys.			•		
Inpatient Hospital	\$0 copay for o	days 11-	-90		\$	150 copay/day for days 1-		1 ,	-		
Outpatient Hospital	\$200 copay per ambulator \$225 copay per outpatien					\$100 per ambulatory s \$250 copay per outpatien					
Skilled Nursing Facility	\$0 copay for \$204 /day for d					\$0 copay for \$204 /day for					
Ambulance	\$300 copay per one-w 20% coinsurance			nd;		\$250 copay per one-v 20% coinsurance			nd;		
E	\$125 copay per emergenc	y room	visit; wa			\$140 copay per emergence	cy room	visit; wa			
Emergency & Urgent Care	admitted to hospital \$0 for urgent care; Worldw limit with \$125 copays	ide cov	erage: S	\$100,000		admitted to hospital \$0 for urgent care; World limit with \$140 copays f	wide co	verage:	\$50,000		
Lab Tests,	\$0 copay for lab service					\$0 copay for lab service					
Procedures, and	procedures, and x-rays; \$150	for diag	gnostic i	radiology;		procedures, x-rays; \$200 f	for diag	nostic ra	diology;		
Radiation Therapy	20% co-insurance for the	herapeu	tic radio	ology		20% co-insurance for t	herapeu	itic radio	ology		
Renal Dialysis	20% co-insurance	e per tre	atment			20% co-insuranc					
Outpatient Mental Health Visits	\$40 copay per individual o	r group	therapy	session		\$10 copay for ind 20% coinsurance for g			ecion		
Eyewear Eyewear	\$300 annual allowa	maa for	ON ON OR			\$300 annual allowa					
	\$0 copay per Medica		•			\$0 copay per Medica		•			
Eye Exams	\$0 copay for one ann				<u> </u>	\$0 copay for one an	nual rou	ıtine exa	m		
Hearing Aids	\$2,000 annual allowance t	hough N	NationsI	Hearing	\$		\$2,099 copays for hearing aids, depending on model; up to 2 aids per year \$0 copay for Medicare-covered exam;				
Hearing Exams	\$0 copay for Medica										
	\$0 copay for one and \$0 copay for Medical					\$0 copay for one an \$0 copay for Medic					
Dental	\$0-\$41 copays for certain	n prever	ntive ser	vices;		\$0 copay for certain p	preventi	ve servi	es;		
	\$0 - \$2,160 copays for certai	n compi	rehensiv	e services		0 - \$2,160 copays for certa: 60 copay per Medicare-cov					
Chiropractic	\$0 copay per Medic	are-cove	ered visi	it		visit, up to 30 per year, cor					
Podiatry	\$0 co-pay per Medic	care-cov	ered vis	sit		\$0 co-pay per Medi					
<u> </u>	Cost-sharing shown is for	30	90	100	(Cost-sharing shown is	30	90	100		
	preferred pharmacies	days	days	days		or preferred pharmacies	days	days	days		
	Duoformad Comoria	¢0	¢0	mail	<u> </u>	Due formed Comonic	¢0	¢0	mail		
Prescription Drugs	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0	_	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0		
(Part D)	Preferred Brand	\$35	\$105	\$70	_	Preferred Brand	\$35	\$105	\$70		
	Non-Preferred Brand	\$75	\$225	\$150	N	Non-Preferred Brand	\$100	\$300	\$200		
	Specialty co-insurance	31%	N/A	N/A		Specialty co-insurance	31%	N/A	N/A		
	\$100 deductible for Tiers 2-5 costs reach \$2,000, you pay		total ye	arly drug		.00 deductible for Tiers 2- sts reach \$2,000, you pay		total ye	arly drug		
	Acupuncture: \$0 co-pay for		ed visit	s/vear	_	cupuncture: \$0 co-pay for		30 visits/	vear		
	Dental Plan Option: \$45/m			<i>s, j</i>		ombined with chiropractic	up to t	, , , ,	, cur,		
	preventive and comprehensive			10% to		ental Plan Option: \$21/m					
	70% coinsurance; \$1,500 an Flex Allowance: \$96 quarter			or OTC		eventive and comprehensi					
	and herbal catalog items incl					% coinsurance; \$1,500 and twork providers	muai m	int for ne)11-		
a	& \$20 monthly allowance for	_		<i>G</i>		ex Allowance: \$129 quart	erly all	owance f	or OTC		
Supplemental	Groceries: \$50 monthly allo			-		d herbal catalog items incl			ring aids		
Benefits and	for those with qualifying chro In-Home Support Services:					\$60 monthly allowance for roceries: \$50 monthly allowance			hy foods		
Optional Plans	hours per year for qualifying			.p to 20		r those with qualifying chi			119 10003		
	Meals: \$0 copay/meal for 2 i					leals: \$0 copay/meal for 15					
	those with qualifying chronic times/year	conditi	ions; up	to 4		r those with qualifying childitional meals with \$5 cop			up to 30		
	Transportation: \$0 co-pay f	for 12 o	ne-way	trips to		ransportation: \$0 co-pay			trips to		
	plan approved locations with	in 50 m	iles	•	pla	an approved locations with	nin 50 n	niles	•		
Medical Groups	Wellness: \$0 for basic Silve	r Sneak	ers men	ibersnip	W	Yellness: \$0 for basic Silve	er Sneal	kers men	ibersnip		
and Hospitals	Medical Groups: Hill Physi- Hospitals: Eden (Castro Vall			naton		ledical Groups: Hill Physospitals: Eden (Castro Val					
	TOSTILLAS FORD (L'astro Val	iev i and	vv asnir	TALOU		osoniais: eden it asmo Val	u⊨vian/	. vv ach11	IVIOR		
(may not be full list; please check with plan)	(Fremont)	,,				remont)	ncy) an	a wasiiii	igton		

Please contact the Plan for outline of coverage & provider information or call 1-800-Medicare	E ADVANTAGE COM	Chinese Community Health Plan 888-681-3888 (Sales and Marketing) 888-775-7888 (Member Services)								
Plan Name/Type	CCHP Senio HMO (H0		0	1	CCHP Senior V HMO (H0		_	am		
Star Rating	**1	1/2			**	1/2				
Annual OOP Max	\$3,0	00			\$3,5	00				
Monthly Premium	\$31				\$0					
Doctor Visits	\$0 copay for Primar \$0 for Spo		Physicia	nn;	\$0 copay for Primary Care Physician; \$15 for Specialist					
Inpatient Hospital	\$200 copay/day \$0 for day	for day ys 8-90			\$250 copay/day \$0 for day	for days	s 1-7;			
Outpatient Hospital	\$300 copay for ambulator \$310 copay for outpa				\$300 copay for ambulator \$310 copay for outpa	tient hos	spital vis			
Skilled Nursing Facility	\$0 copay/day for \$75 per day for	days 21	-100		\$0 copay/day for \$100 per day for					
Emergency & Urgent Care	\$110 copay per emergenc admitted to hospital within care visit; Worldwide cove \$90 copays for E	24 hour rage: \$	s; \$20 ¡ 25,000	er urgent	\$125 copay per emergence admitted to hospital within care visit; Worldwide cove \$90 copays for E	24 hours e rage: \$	s; \$25 pe 5,000 lir	r urgent		
Ambulance	\$180 copay per trip	by grou	ınd or a	ir	\$200 copay per trip	by grou	nd or air			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic x-rays; \$100 copay for 0 20% coinsurance for the	diagnos nerapeu	ic radio	ology;	\$0 copay for lab, diagnostic x-rays; \$150 copay for 20% coinsurance for the	diagnost nerapeut	ic radiol ic radiol	ogy;		
Renal Dialysis Outpatient Mental	20% co-insurance	e per tre	atment		20% co-insuranc	e per trea	atment			
Health Visits	\$15 copay per individual of	0 1			\$20 copay per individual of	• •				
Eyewear	\$0 copay with \$150 allow eyewear; through VSI				\$0 copay with \$100 allow eyewear; through VS					
Eye Exams	\$20 copay for Medica \$20 copay for one an			*	\$35 copay for Medic \$35 copay for one an					
Hearing Aids	\$3,000 annual allowance t	though l	Nations	Hearing	\$3,000 annual allowance	hough N	NationsH	earing		
Hearing Exams	\$0 copay for Medica \$0 copay for one and	nual rou	tine exa	am	\$0 copay for Medica \$0 copay for one and	nual rout	ine exar	n		
Dental	\$0 copays for certain p See Optional Den			ices;	\$0 copays for certain preventive services; See Optional Dental plan below					
Chiropractic	\$15 copay for Medic Routine care r			sit;	\$15 copay for Medicare-covered visit; Routine care not covered					
Podiatry	\$15 copay per Medic Routine care r			sit;	\$20 copay per Medicare-covered visit; Routine care not covered					
	Cost-sharing shown is for preferred pharmacies	30 days	90 days retail		Cost-sharing shown is for preferred pharmacies	30 days	90 days retail	90 days mail		
Prescription Drugs	Preferred Generic Generic	\$3 \$7	\$9 \$21	\$6 \$14	Preferred Generic Generic	\$0 \$3	\$0 \$9	\$0 \$0		
(Part D)	Preferred Brand	\$30	\$90	\$60	Preferred Brand	\$35	\$105	\$70		
·	Non-Preferred Brand	\$50	\$150	\$100	Non-Preferred Brand	\$75	\$225	\$150		
	\$0 deductible; after total year \$2,000, you pay \$0.	30% arly dru	N/A ig costs	N/A s reach	\$0 deductible; after total yes \$2,000, you pay \$0.	30% arly dri	N/A ug costs	N/A reach		
Supplemental Benefits and Optional Plans	Dental Plan Option: \$18.50 for certain preventive and co through DeltaCare USA Den Grocery Flex Card: \$20 mc healthy foods; can be combin Over the Counter: \$52 mon approved items from networl Nations OTC catalog; can be flex card allowance Transportation: \$0 copay for plan-approved locations	mprehe ital HM onthly al ned with ithly all k retail l combin	nsive see O netwo llowance o OTC a owance ocation ned with	ervices; ork ee for allowance for plan- a or h grocery	Acupuncture: \$10 copay for Dental Plan Option: \$18.5 for certain preventive and continuous DeltaCare USA Det Over the Counter: \$65 mo approved items from networn Nations OTC catalog Transportation: \$0 copay for plan-approved locations	Mmonth omprehe otal HM onthly all ok retail	n: varyin nsive ser O netwo owance: location	g copays vices; rk for plan- or		
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Hill Physi Medical Hospitals: Alameda, Highlar Leandro		·		Medical Groups: Hill Phys Medical Hospitals: Alameda, Highl Leandro		•			

2023 MEDICAL	E ADVANTAGE COM					7111.	TITAL	O _B			
Please contact the Plan for more		Imperial Health Plan of California 800-838-8271 (Sales & Marketing)									
information or call 1-800-Medicare			0-838	-8271 (Member Services)						
Plan Name/Type	Imperial Tr HMO (H54		onal	<u>реги.</u>	Imperial (HMO (H5						
Star Rating	***				***						
Annual OOP Max	\$1,44	19			\$9,350						
Monthly Premium	\$0				\$0 / \$240 Deductible						
Doctor Visits	\$0 for Primary Ca	•	ician;		20% for Primary						
20001 (1510)	\$0 for Spe \$0 copay for days 1-3;		or days 4	l-5;	20% for S						
Inpatient Hospital	\$0 per day for \$670 per day for	days 6-9 days 91	90; -150		\$0 copay for days 1-60; \$ 4 61-90; \$838 per day						
Outpatient Hospital	\$100 per ambulatory su \$100 copay per outpatient				20% coinsurance per ambul 20% coinsurance per outpar						
Skilled Nursing	\$0 copay per day for days 1				\$0 copay per day			inty visit			
Facility	21-50; \$200 /day fo				\$209.50/day for	days 21	1-100				
Ambulance	\$150 copay per one-w 20% coinsurance per	r each tı	rip by ai	r	20% coinsurance per on 20% coinsurance per						
Emergency & Urgent Care	\$125 copay per emergency admitted to hospital within urgent care; Worldwide co	48 hour verage:	s; \$0 co \$100,0	pay for 00 limit	20% coinsurance, up to \$1 visit; 20% coinsurance up to Costs waived if admitted to	\$45 per	r urgent	care visit;			
Lab Tests,	with \$0 copay for ER and \$0 copay for lab, diagnostic				20% coinsurance for lab se						
Procedures, and	x-rays, and diagno	stic rad	iology;		procedures, x-rays, diag	nostic ra	adiology				
Radiation Therapy Renal Dialysis	20% coinsurance for th			ogy	therapeutic		<u> </u>				
Outpatient Mental	20% coinsurance 20% coinsurance	1			20% coinsurance 20% coinsurance						
Health Visits	or group thera				or group there						
Eyewear	\$500 annual allowa		•		\$240 annual allowa		•				
Eye Exams	\$0 copay per Medicar \$0 copay for rot			n;	20% coinsurance per Me \$0 copay for one an						
Hearing Aids	\$500 annual allow				\$500 annual allow			••			
Hearing Exams	\$0 copay for Medicar \$0 copay for routine exa				\$0 copay for Medica \$0 copay for exams						
Dental	\$0 co-pay per Medicare-cov preventive services up to \$2 certain comprehensive serv must use Imperial Tradition	500/year ices up	r; \$0 co- to \$3,0 0	pay for 00/year;	\$0 co-pay per Medicare-co- preventive services up to \$ certain comprehensive ser must use Imperial Giveba	500/yea vices up	r; \$0 co- to \$2,0 0	pay for 00/year;			
Chiropractic	\$0 copay per Medica	re-cove	red visit		20% co-insurance per Medicare-covered visit; Routine care not covered						
Podiatry	Routine care n \$0 co-pay per Medica \$0 co-pay for 6 routing	are-cove	ered visi		20% coinsurance 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	100 days	100 days			
Prescription Drugs	Preferred Generic	\$0	\$0	mail \$0	Preferred Generic	25%	25%	mail 25%			
(Part D)	Generic	\$10	\$30	\$10	Generic Desferred Description	25%	25%	25%			
	Preferred Brand Non-Preferred Brand	\$45 \$90	\$135 \$270	\$90 \$180	Preferred Brand Non-Preferred Brand	25% 25%	25% 25%	25% 25%			
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	25%	25%	25%			
	\$0 deductible; after total yes \$2,000, you pay \$0.	arly dru	ıg costs	reach	\$590 deductible; after total \$2,000, you pay \$0.	yearly d	drug cos	ts reach			
	In-home Support Services:	\$0 cop	ay for u	p to 48							
	hours per year Meals: \$0 copay for up to 7	home-d	elivered	meals							
C1- 4 1	following a surgery or hospit				In-home Support Services: hours per year	\$0 copa	ay for up	to 48			
Supplemental Benefits and	benefit period Over the Counter: \$95 quar	tarly all	lowance	for	Over the Counter: \$75 qua			for items			
Optional Plans	items in OTC mail order cata	ılogue; 1	no rollo	ver	in OTC mail order catalogue Part B Premium Reduction						
•	Transportation: \$0 co-pay to per year to plan approved loc		one-way	y trips	reimbursement	ι, φισσ	monuny				
	Wellness: \$0 for one home f through Silver&Fit program		it per ye	ar							
Modical Con	Medical Groups: Imperial H			,	Medical Groups: Imperial I						
Medical Groups and Hospitals	MedCare Partners IPA, Niva Physician Partners IPA	no Phys	sicians,		MedCare Partners IPA, Niva Partners IPA	.no Phys	sicians, P	hysician			
(may not be full list;	Hospitals: Alta Bates/Summ				Hospitals: Alta Bates/Summ						
please check with plan)	Medical Center (Castro Valle St. Rose (Hayward)	ey), San	Leandr	o, and	Medical Center (Castro Vall Rose (Hayward)	ey), San	Leandro	o, and St.			

2028 MEDICAN					FUR ALAMEDA COUNTY: HIVIOS
Please contact the Plan for more information or call 1-800-Medicare		800 800	-838-8)-838-	3271 (S 8271 (I	Plan of California sales & Marketing) Member Services) healthplan.com
Plan Name/Type	Imperial D HMO (H5	ynan	nic		Imperial Courage HMO (H5496-016)
Star Rating	***	1/2			★★★1/2
Annual OOP Max	\$297	7			\$2,999
Monthly Premium	\$0				\$0
Doctor Visits	\$0 copay for Primary \$0 for Spe		hysician;		\$0 copay for Primary Care Physician; \$5 for Specialist
Inpatient Hospital	\$0 copay for 6 \$670 per day for				\$150 copay for days 1-5; \$0 co-pay/day for days 61-90; \$670 per day for days 91-150
Outpatient Hospital	\$100 per ambulatory su \$100 copay per outpatient	ırgical c	enter vis		\$200 per ambulatory surgical center visit; \$200 copay per outpatient hospital facility visit
Skilled Nursing Facility	\$0 copay per day for days 1 21-50; \$200/day for	-20; \$1	00/day fo		\$0 copay per day for days 1-20; \$200/day for days 21-100
Ambulance	\$150 copay per one-w 20% coinsurance pe				\$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 within urgent care; Worldwide co with \$0 copays for emerg	visit; co 48 hour verage:	opay wai s; \$0 cop \$100,00	ved if oay for 0 limit	\$125 copay per emergency room visit; waived if admitted to hospital within 48 hours; \$0 copay for urgent care; Worldwide coverage: \$50,000 limit with \$0 copay for emergency and \$20 for urgent care
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;	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance 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	\$500 annual allowa		•		\$250 annual allowance for eyewear
Eye Exams	\$0 copay per Medicar \$0 copay for ro			;	\$0 copay per Medicare-covered exam; \$0 copay for routine exams
Hearing Aids	\$500 annual allow				\$500 annual allowance \$0 copay
Hearing Exams	\$0 copay for Medicar \$0 copay for routine exa				\$0 copay for Medicare-covered exam; \$0 copay for routine exams up to \$250/year
Dental	\$0 co-pay per Medicare-cov preventive services up to \$ certain comprehensive serv must use Imperial Dynam	500/year rices up ic contra	r; \$0 co-p to \$4,000 acted pro	oay for D/year; vider	\$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 \$1,500/year; must use Imperial Courage contracted provider
Chiropractic	\$0 copay per Medica Routine visits r				\$0 copay per Medicare-covered visit; Routine visits not covered
Podiatry	\$0 co-pay per Medica \$0 co-pay for 6 routi				\$0 co-pay per Medicare-covered visit; \$0 co-pay for 6 routine visits per year
	Cost-sharing shown is for preferred pharmacies	30 days	100 days	100 days mail	THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.
Prescription Drugs (Part D)	Preferred Generic Generic	\$0 \$6	\$0 \$18	\$0 \$5	
(Fart D)	Preferred Brand Non-Preferred Brand	\$45 \$90	\$135 \$270	\$90 \$180	YOU CANNOT BELONG TO THIS PLAN AND
	Specialty co-insurance \$0 deductible; after total yes \$2,000, you pay \$0.	33% arly dru	N/A ig costs i	N/A reach	ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.
Supplemental Benefits and Optional Plans	In-home Support Services: hours per year Meals: \$0 copay for up to 7 following a surgery or hospit benefit period Over the Counter: \$140 qua items in OTC mail order cate Part B Premium Reduction Transportation: \$0 co-pay per year to plan approved loc Wellness: \$0 for one home f through Silver&Fit program	home-deal stay, arterly a alogue; 1 1: \$60 m for 100 e cations	elivered in up to \$10 llowance no rollow conthly represent the per year	meals 05 per efor er eimburs trips	Meals: \$0 copay for up to 7 home-delivered meals following a surgery or hospital stay; up to \$105 per benefit period Over the Counter: \$75 quarterly allowance for items in OTC mail order catalogue; no rollover 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 one home fitness kit per year through Silver&Fit program
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Imperial F MedCare Partners IPA, Niva Physician Partners IPA Hospitals: Alta Bates/Summ Medical Center (Castro Valle St. Rose (Hayward)	no Phys it (Berk	icians, /Oak), E		Medical Groups: Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (CastroValley), San Leandro, and St. Rose (Hayward)

2025 MEDICAL	RE ADVANTAGE COM	ADVANTAGE COMPARISON CHART FOR ALAMEDA (
Please contact the					ermanente						
Plan for more		800	0-777-	1238 (S	ales & Marketing)						
information or call		80	0-443	-0815 (1	Member Services)						
1-800-Medicare					iserpermanente.org						
	Kaiser Permai				Kaiser Perma	nente	Senio	r			
Plan Name/Type	Advantage Ba				Advan		Scino	-			
Tian rume, Type	HMO (H0			а	HMO (H0	_	22)				
a. 5 4	,		39)		·		34)				
Star Rating	***				***	★ 1/2					
Annual OOP Max	\$6,00				\$3,4						
Monthly Premium	\$0				\$70						
Doctor Visits	\$5 copay for Primary			1;	\$0 copay for Primar		Physician	;			
	\$10 for Sp \$260 copay/day				\$5 for Spo \$225 copay/day	for day	s 1-5·				
Inpatient Hospital	\$0 per day for day				\$0 per day for day						
Outpatient	\$225 per ambulatory s	urgical	center vi	sit;	\$190 per ambulatory s	urgical	center vi	sit;			
Hospital	\$0-\$225 copay per outpatie	ent hosp	ital facil	ity visit	\$0-\$190 copay per outpation	ent hosp	ital facil	ity visit			
Skilled Nursing	\$0 copay/day fo				\$0 copay/day fo						
Facility	\$100 per day for	days 2	1-100		\$100 per day for	days 2	1-100				
Ambulance	\$250 copay per air or gr	ound ar	nbulance	trip	\$250 copay per air or gr	ound ar	nbulance	trip			
E 0	\$125 for emergen				\$140 for emerger						
Emergency &	\$5 for urgent Worldwide coverage: no li			oney for	\$0 for urgent Worldwide coverage: no li			ones, for			
Urgent Care	emergency care visit and				emergency care visit ar						
Lab Tests,	\$0 copay for lab, diagnostic				\$0 copay for lab, diagnosti						
Procedures, and	x-rays; \$200 copay for o				x-rays; \$200 copay for o						
Radiation Therapy	\$0 for therapeut	tic radio	ology		\$0 for therapeur	tic radio	ology				
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insurance	e per tre	atment				
Outpatient Mental	\$2 copay per indi	vidual s	ession;		\$0 copay per indi	vidual s	ession;				
Health Visits	\$5 per group the	erapy se	ssion		\$0 per group the	erapy se	ssion				
Eyewear	Not cove		.		Not cov		.				
J	See Optional Advanta				See Optional Advanta						
Eye Exams	\$5-\$10 copay per Medi \$5 per routi			am;	\$0-\$5 copay per Medi \$0 per routi			ım;			
	Not cove				Not cov						
Hearing Aids	See Optional Advanta		Plan belo	ow	See Optional Advanta	,	Plan bel	ow			
Hearing Exams	\$10 copay per Medic	are-cov	ered exa	m	\$5 copay per Medica	are-cove	ered exar	n			
C	\$10 co-pay per Medic				\$5 co-pay per Medic	are-cov	ered visi	t;			
Dental	\$0 copay for certain preventi				\$0 copay for certain preventi						
	See Optional Advanta				See Optional Advanta						
Chiropractic	\$5 copay per Medica Routine visits			;	\$0 copay per Medic Routine visits			;			
D. 31-4	\$10 copay per Medic			t;	\$5 copay per Medic			;			
Podiatry	Routine visits	not cove	ered		Routine visits	not cove	ered				
	Cost-sharing shown is for	30	100	100	Cost-sharing shown is for	30	100	100			
	preferred pharmacies	days	day	days	preferred pharmacies	days	days	days			
	Preferred Generic	\$4	retail \$12	mail \$8	Preferred Generic	\$0	retail \$0	mail \$0			
Prescription Drugs	Generic	\$10	\$30	\$20	Generic	\$7	\$21	\$14			
(Part D)	Preferred Brand	\$47	\$141	\$94	Preferred Brand	\$47	\$141	\$94			
	Non-Preferred Brand	\$100	\$300	\$200	Non-Preferred Brand	\$100	\$300	\$200			
	Specialty co-insurance \$0 deductible; after total year	33%	33%	33%	Specialty co-insurance \$0 deductible; after total year	33%	33%	33%			
	\$2,000, you pay \$0.	urry ure	ig costs i	cacii	\$2,000, you pay \$0.	arry ur	ig costs	cach			
	Home Medical Care: home	treatme	nt plan a	s an							
	alternative to hospital care ar	•			Medical Financial Assistan	-	•	ailable to			
	when found medically appro	•			eligible members; contact pla			c :			
	Medical Financial Assistan eligible members; contact pla	-	•	anable to	Over the Counter: \$60 quanter from OTC catalogue; \$25 mi						
	Over the Counter: \$60 quar			for items	nom o ro catalogue, que m		01401, 11	, 10110 (01			
Supplemental	from OTC catalogue; \$25 mi				Optional Advantage Plus P						
Ronofite and	Optional Advantage Plus P -Dental: Copays vary depend				-Dental: Copays vary dependent Must use Delta Care USA H			rvice;			
Benefits and				ivice,	-Hearing Aids: \$800 allowa			v 36			
Optional Plans				. 20	_	-		,			
	Must use Delta Care USA HI -Hearing Aids: \$800 allowa		ear every	y 30	months; \$0 copay for evaluate	ion and	ntung				
	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat	nce per tion and	fitting		-Vision \$300 allowance for e	yewear	every tw				
	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat -Vision: \$300 allowance for	nce per tion and eyewea	fitting r every to	wo years	-Vision \$300 allowance for 6 -Wellness: \$0 for One Pass §	eyewear gym me	every tw				
	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat	nce per tion and eyewea gym me	fitting r every to	wo years	-Vision \$300 allowance for e	eyewear gym me	every tw				
Optional Plans	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat -Vision: \$300 allowance for -Wellness: \$0 for One Pass §	nce per tion and eyewea gym me	fitting r every to	wo years	-Vision \$300 allowance for 6 -Wellness: \$0 for One Pass §	eyewear gym me	every tw				
Optional Plans Medical Groups	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat -Vision: \$300 allowance for -Wellness: \$0 for One Pass §	nce per tion and eyewea gym me	fitting r every tv mbership	wo years	-Vision \$300 allowance for 6 -Wellness: \$0 for One Pass §	eyewear gym me it	every tw mbership				
Optional Plans	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat -Vision: \$300 allowance for -Wellness: \$0 for One Pass g one annual at home fitness ki	nce per tion and eyewea gym me it	fitting r every to mbership	wo years o and/or	-Vision \$300 allowance for e-Wellness: \$0 for One Pass sone annual at home fitness ki	eyewear gym me it rmanent	every tw mbership	and/or			

2020 1/12/21/21/11	E ADVANTAGE COMP	TITIO				1111.		<i>J</i> ₀			
Please contact the		SCAN Health Plan									
Plan for more		877-	870-4	867 (S	ales & Marketing)						
information or call					Member Services)						
1-800-Medicare		ouv		`	· · · · · · · · · · · · · · · · · · ·						
1-000-Medicare				<u>.scanhe</u>	althplan.com						
DI N/T	SCAN C	lassic			SCAN My	'Choi	ce				
Plan Name/Type	HMO (H054	425-07	(5)		HMO (H05	425-1	10)				
Ct. D. C.	· ·		-,				/				
Star Rating	***				★★★★ 1/2						
Annual OOP Max	\$1,50	0			\$1,50	0					
Monthly Premium	\$0				\$0						
Doctor Visits	\$0 copay for Primary		ysician	;	\$0 copay for Primary		hysician	;			
Doctor Visits	\$0 for Spec	cialist			\$0 for Spe	cialist					
Inpatient Hospital	\$100 copay/day f				\$100 copay/day						
Inpatient Hospital	\$0 per day for days	6 and b	eyond		\$0 per day for days	s 6 and b	beyond				
Outpatient Hospital	\$0 per ambulatory sur				\$0 per ambulatory sur						
	\$0-\$125 copay per outpatien	nt hospit	al facil	ty visit	\$0-\$125 copay per outpatie	nt hospi	ital facili	ty visit			
Skilled Nursing	\$0 copay/day for				\$0 copay/day fo						
Facility	\$75 per day for d	lays 21-	100		\$75 per day for	days 21-	-100				
Ambulance	\$180 copay per one-way	trip by g	round o	or air	\$105 copay per one-way	trip by	ground o	r air			
	\$90 copay per ER visit; w				\$90 copay per ER visit; w		_				
Emergency &	admitted to hospital; \$0 p				admitted to hospital; \$0						
Urgent Care	Worldwide coverage: no li				Worldwide coverage: no l						
	emergency care visit and	1 \$0 for	urgent o	are	emergency care visit an	d \$0 for	urgent c	are			
Lab Tests,	\$0 copay for lab, diagn	ostic pr	ocedure	·S.	\$0 copay for lab, diag	nostic p	rocedure	S,			
Procedures, and	tests, x-rays and diagr	nostic ra	diology		tests, x-rays and diag	nostic ra	adiology				
Radiation Therapy	\$60 copay for therap	eutic ra	diology		\$60 copay for therap	eutic ra	diology				
Renal Dialysis	20% co-insurance	per trea	tment		20% co-insurance	per trea	atment				
Outpatient Mental	\$10 copay for in	dividua	lor		\$10 copay for it		ıl or				
Health Visits	group therapy				group therap						
Eyewear	\$200 annual allowan	oo for o	TIOTILOOP		\$200 annual allowa	-					
Eyeweai							•				
Eye Exams	\$0 copay per Medicar \$0 copay for one annu				\$0 copay per Medicare-covered exam;						
•					\$0 copay for one annual routine exam \$550-\$850 copay per aid; up to 2 aids each ye						
Hearing Aids	\$550-\$850 copay per aid; u										
	through TruHearing n				through TruHearing		_				
Hearing Exams	\$0 copay for Medicar			,	\$0 copay for Medicar						
	\$0 copay for one annu				\$0 copay for one ann \$0 co-pay per Medica						
Dental	\$0 co-pay per Medica \$0 co-pay for certain preve				\$0 co-pay per Medica \$0 co-pay for certain prev			/			
Dentai	services; See Optional I				services; \$2,000		_	iostic			
	· •				\$0 copay per Medica						
Chiropractic	\$0 copay per Medicar \$0 copay for 30 routing				\$5 copay for 30 routine visits per year, combined with chiropractic						
	φο copay for 30 fouri	ic visits	per yea								
Podiatry	\$0 copay per Medica	re-cove	ed visit		\$0 copay per Medica	ire-cove	red visit				
	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			
	D 6 10	d.o.	retail	mail	D. C. LC.	φo	retail	mail			
Prescription Drugs	Preferred Generic Generic	\$0	\$0 \$0	\$0 \$0	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0			
(Part D)	Preferred Brand	\$0 \$42	\$126	\$126	Preferred Brand	\$35	\$126	\$126			
(Fart D)	Non-Preferred Brand	50%	50%	50%	Non-Preferred Brand	50%	50%	50%			
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A			
	\$0 deductible; after total year	arly dru	g costs	reach	\$0 deductible; after total ye	arly dr	ug costs	reach			
	\$2,000 , you pay \$0 .				\$2,000 , you pay \$0 .						
	Acupuncture: \$0 copay per	visit for	36 rou	ine							
	visits per year				Acupuncture: \$0 copay per	visit fo	r 30 rout	ine			
	Essential Dental Plan: \$10/1				visits per year, combined wi						
	for certain diagnostic and con In-Home Support Services:				In-Home Support Services		irs for pe	ersonal			
Cumplemental	care following a hospitalizati		is for po	rsonai	care following a hospitalizat						
Supplemental Benefits and	Meals: up to 84 home-delive		ls per y	ear	Meals: up to 84 home-delive			ear			
	following a hospital stay or d	lue to a	chronic		following a hospital stay or condition	lue to a	CHIOHIC				
Optional Plans	condition				Over the Counter: \$75 qua	rterly al	lowance	items			
	Over the Counter: \$75 quar				in-store at CVS or home del						
	in-store at CVS or home deli over to next quarter but not c	•		umes	over to next quarter but not						
	Transportation: \$0 copay for			rips per							
	year to plan-approved location	ns with	in 50 m	iles							
Medical Groups and	Medical Groups: Brown &	Toland,	Imperia		Medical Groups: Brown &			1			
Hospitals	Health Holdings, SCAN Dire	ect Cont	ract		Health Holdings, SCAN Dir						
(may not be full list;	Hospitals: Alameda, Alta Ba			'4 D -	Hospitals: Alameda, Alta B			4 D -			
please check with plan)	(Berk/Oak), Highland (Oak), (Hayward), Stanford Valley				(Berk/Oak), Highland (Oak) (Hayward), Stanford Valley						
· · · · · · · · · · · · · · · · · · ·	(11aywaru), Stamoru variey	Cart (Pl	eas/Liv	,	(11ay waru), Stantoru valley	Care (P	icas/LIV				

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 (\$257 in 2025). 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: www.medicare.gov/medicare-and-you.

Star Ratings

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

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

This information is gathered from several different sources. In some cases it is based on member surveys, information from clinicians, or information from plans. In other cases, it is based on results from Medicare's regular monitoring activities. Detailed information is available here: https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings

2025 Medicare Advantage Plan HMO Comparison Chart ~FINAL~ for Alameda County

~Rev. 11/13/24 ~

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 normally 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. However, if the HMO also has a Point of Service (POS) option, members can go out of network only for certain plan-specified services but will pay higher out of pocket costs for those services. 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 2025, there are 24 Medicare HMOs in Alameda County, and they are listed on pages 2-13 of this chart. One of these does not include the Medicare Part D prescription drug benefit. When people join an HMO without drug coverage, they opt out of Part D. Enrolling in a stand-alone Part D plan will automatically trigger disenrollment from the Medicare Advantage Plan.

A Medicare PPO is another type of Medicare Advantage (MA) plan. A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses such as deductibles and coinsurance will apply. In 2025, there are 4 Medicare PPOs in Alameda County. See our 2025 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 2025, there are 19 Special Needs Plans in Alameda County. See our 2025 Special Needs Plan Comparison Chart for more information and details: www.lashicap.org/hicap.

Enrollment:

In the fall of 2024, 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, 2025. In 2025, 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 <u>who begin the year</u> 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.

IMPORTANT NOTE: In 2025, Medicare Part D out of pocket costs for covered medications under one's plan are capped at \$2,000. Also, plans cannot charge more than a \$35 copay per month for insulin and any drug deductibles do not apply to insulin.

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, cost-sharing, and provider networks, contact the plans directly. For preventive care benefits covered by Medicare, please see the back of this chart. Also, on the last page is an explanation of the Star Ratings provided by Medicare.

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

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



Navigating Medicare

This project was supported, in part by grant number 90SAPG0094-01-00, from the U.S.
Administration for Community Living,
Department of Health and Human Services,
Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

2025 MEDICARE	ADVANTAGE COMPA	ARISC				TY: E	IMOS	,	
Please contact the			A	etna M	edicare				
Plan for more		833	-859-6	031 (Sa	les & Marketing)				
information or call		833	3-570-6	6670 (N	Iember Services)				
1-800-Medicare					edicare.com				
	Aetna Medio	care S	Select		Aetna Med	licare	Plus		
Plan Name/Type	HMO-POS				HMO-POS				
Ston Doting			<i>3-010)</i>		★★1/2				
Star Rating	**								
Annual OOP Max	\$2,50	00			\$3,	400			
Monthly Premium	\$0				\$	0			
Doctor Visits	\$0 copay for Primary		Physician;	,	\$0 copay for Prima			ι;	
Doctor Visits	\$0 for Spo \$245 copay/day		a 1 5.		\$0 for S \$150 copay/da				
Inpatient Hospital	\$0 per day for day				\$0 per day for da				
Outpatient Hospital	\$0 copay for ambulatory	surgica	al center v		\$0 copay for ambulato	ry surgic	al center		
	\$125 copay for outpatien			visit	\$125 copay for outpatie		•	/ visit	
Skilled Nursing	\$0 copay/day fo				\$0 copay/day				
Facility	\$75 per day for				\$75 per day fo				
Ambulance	\$295 copay per ground				\$325 copay per ground				
_	\$140 copay per emergenc admitted to hospital; \$0				\$140 copay per emerger admitted to hospital; \$				
Emergency &	Worldwide coverage: no a				Worldwide coverage: no				
Urgent Care	per ER/urgent care visit; ER	copay v	waived if	admitted	per ER/urgent care vis	it; ER co	pay waiv	ed if	
T 1 70 4	to hospital; urgent care				admitted to hospital; urge				
Lab Tests, Procedures, and	\$0 copay for lab services, dia and x-rays; \$0 copay for				\$0 copay for lab serv procedures, x-rays and				
Radiation Therapy	\$60 copay for thera			ogy;	\$60 copay for the				
Renal Dialysis	20% co-insurance				20% co-insuran				
Outpatient Mental	20 /0 CO-msurance	per ne	aunent		20 /0 CO-IIIsuran	ee per in	catificit		
Health Visits	\$40 copay per individual of	r group	therapy s	ession	\$0 copay per individual	or group	therapy s	ession	
Eyewear	\$275 annual allowa	nce for	evewear		Not Co	overed			
		\$0 copay for diagnostic exam; \$0 copay for diagnostic exam;							
Eye Exams	\$0 copay for one and	iual rou	tine exam		\$0 copay for one as	nnual rou	itine exar		
Hearing Aids	\$1,250 annual hearing a				\$2,000 annual hearing aid allowance per ear; purchased through NationsHearing network				
8	purchased through Nati \$0 copay for diag			ork	\$0 copay for di			Ork	
Hearing Exams	\$0 copay for one annual			ough	\$0 copay for one annua			ough	
_	NationsHeari				NationsHear				
Dental	\$1,000 annual reimburseme preventive and comp				\$1,100 annual reimbu covered preventive and				
Delitai	any licensed de			5,	any licensed d			vices,	
	\$0 copay for Medica	re cove	red visits;		\$0 copay for Medi	care cov	ered visit		
Chiropractic	\$0 copay for unlimit				\$0 copay for unlin				
D 11 4	through American Spec				through American Spe				
Podiatry	\$0 copay per Medic		1		\$0 copay per Med				
	Cost-sharing shown is for preferred pharmacies	30 days	100 days	100 days	Cost-sharing shown is	30 days	100	100	
	prejerrea pharmacies	uays	retail	mail	for preferred pharmacies	days	day retail	day mail	
	Preferred Generic	\$0	\$0	\$6	Preferred Generic	\$0	\$0	\$0	
Prescription Drugs	Generic	\$5	\$15	\$36	Generic	\$0	\$0	\$0	
(Part D)	Preferred Brand	25%	25%	25%	Preferred Brand Non-Preferred Brand	24% 25%	24% 25%	24% 25%	
	Non-Preferred Brand Specialty co-insurance	35% 33%	35% N/A	35% N/A	Specialty co-insurance	25%	N/A	N/A	
	\$0 deductible; after total year				\$590 deductible applies to	Tiers 3,	4, and 5;	after	
	\$2,000 , you pay \$0 .				total yearly drug costs re	each \$2,0	000 , you p	pay \$0 .	
	Acupuncture: \$0 copay for treatments with American Sp								
	Over the Counter: \$75 quan				Acupuncture: \$0 copay f	or unlim	ited acup	uncture	
Cummlare 4-1	approved items	·		•	treatments with American	Specialt	y Health		
Supplemental Benefits and	Transportation: \$0 copay for year (up to 60 miles each trip		• •		Transportation: \$0 copay year (up to 60 miles each		•		
Optional Plans	locations, via Access2Care	,, to pia	п арргоче	u	locations, via Access2Car	• ′ •	тан аррго	veu	
Optional Flans	Wellness: \$0 copay for basic				Wellness: \$0 copay for ba		er Sneake	rs	
	membership or one home fitt				membership or one home	fitness k	it per yea	r	
	per quarter Direct Member re for various fitness activities a			оwance					
Medical Groups and	Medical Groups: Brown an			Iedical	Medical Groups: Brown				
Hospitals	Hospitals: Alameda, Highlan				Medical; Hospitals: Alam				
(may not be full list;	(Hayward), San Leandro, Sta	inford V	alley Car	re	Rose (Hayward), San Lea Care (Pleas/Liv), and Was			пеу	
please check with plan)	(Pleas/Liv), and Washington	Hospita	al (Fremo	nt)	(Fremont)	5.011	-103pmai		
		_							

ZOZE WIEDICHIO	E ADVANTAGE COM	1 / 1 1 1 1	3011 C	илки і	OK ALAWEDA COU	111.1	11/100		
Please contact the Plan for more information or call 1-800-Medicare	Aetna Mo 833-859-6031 (Sa 833-570-6670 (M www.aetname	les & l	Market r Servi	0.	Align Sen 844-305-3879 (Sa 844-305-3879 (Na www.alignser	ales & l Iember	Market Servic		
Plan Name/Type	Aetna Medicar HMO-POS (e Val	lue Plu	1S	Align Adva	Care			
Star Rating	**	*			Not enough data available				
Annual OOP Max	\$2,50	00			\$1,9	000			
Monthly Premium	\$5.9	0			\$()			
Doctor Visits	\$0 copay for Primar		Physician	;	\$0 copay for Prima		hysician;		
	\$0 for Spo \$250 copay/day		s 1-5:		\$0 for Sp \$0 per				
Inpatient Hospital	\$0 per day for day	s 6 and	beyond		\$0 per day for unlim	ited addit	ional day	S	
Outpatient Hospital	\$0 copay per ambulatory \$125 per outpatient he				20% coinsurance per ambu \$225 copay per outpatie				
Skilled Nursing Facility	\$0 copay/day fo \$75 per day for	or days	1-20;		\$0 copay/day f				
Ambulance	\$295 copay per ground tr	ip: 20 %	per trip	bv air	\$125 copay per				
	\$140 copay per emergenc	y room	visit; wa	ived if	20% coinsuranc	e per trip	by air		
Emergency & Urgent Care	admitted to hospital; \$0 Worldwide coverage: no a per emergency/urgent care v admitted to hospital; urgent	per urgennual li visit; ER	ent care v mit; \$14 R copay v	visit; 0 copay vaived if	\$90 copay per emergency is care visit; waived if admit days; Coverage limited to	tted to ho	ospital wi	thin 3	
Lab Tests, Procedures, and	\$0 copay for lab services, dia and x-rays; \$0 copay for	diagnos	stic radio	logy;	\$0 copay for lab servi coinsurance for diagnostic diagnostic	ic tests, p	rocedures		
Radiation Therapy	\$60 copay for thera				20% coinsurance for	herapeut	ic radiolo	gy	
Renal Dialysis Outpatient Mental	20% co-insurance	e per tre	atment		20% co-insurance	e per tre	atment		
Health Visits	\$40 copay for individual o	r group	therapy	session	\$0 copay for individual of	or group t	herapy se	ssion	
Eyewear	\$325 annual allowa	nce for	eyewear		\$225 annual allow	ance for	eyewear		
Eye Exams	\$0 copay for dia			_	20% coinsurance for				
Hearing Aids	\$0 copay for one and \$1,250 annual hearing a purchased through Nati	id allow	ance per	ear;	\$0 copay for one ar		ine exam		
Hearing Exams	\$0 copay for dia \$0 copay for one annual NationsHearin	gnostic (exam; exam thr		20% coinsurance for diagnostic exam				
Dental	\$2,000 annual reimburseme preventive and comprany licensed de	ehensiv	e service		\$0 copay for certain \$3,000 annual allowance for Must use Liberty	r compre	hensive s	s; ervices;	
Chiropractic	\$0 copay for Medica \$0 copay/visit for unling must use American Spec	re-cove mited ro	red visits outine vis	its;	20% coinsurance for M \$30 copay/visit for 30 in (contact plan for a	outine vi	sits per y		
Podiatry	\$0 copay per Medic	are-cov	ered visi	t	20% coinsurance per M \$0 copay per routine v				
	Cost-sharing shown is for preferred pharmacies	30 days	100 days retail	100 days mail	Cost-sharing shown is for preferred pharmacies	30 days	90 days retail	90 days mail	
D	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0	
Prescription Drugs (Part D)	Generic Preferred Brand	\$10 25%	\$30 25%	\$20 25%	Generic Preferred Brand	\$10 \$47	\$30 \$135	\$30 \$135	
(Turt D)	Non-Preferred Brand	26%	26%	26%	Non-Preferred Brand	\$95	\$285	\$285	
	Specialty co-insurance	30%		N/A	Specialty co-insurance	25%	N/A	N/A	
	\$250 deductible applies to Ti total yearly drug costs reac				\$0 deductible; after total ye \$2,000, you pay \$0.	early aru	ig costs r	eacn	
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for unlimited acupuncture treatments with American Specialty Health provider OTC: \$75 quarterly allowance for plan approved items purchased online or in-store at CVS locations; no rollover Transportation: \$0 copay for 12 one-way trips per year to plan approved locations via Access2Care Wellness: \$0 copay for basic Silver Sneakers membership or one home fitness kit per year; \$150 per quarter Direct Member reimbursement allowance for various fitness activities and supplies				In-Home Support Services hours annually for help with housekeeping, meal prep, et Over the Counter: \$405 qu plan-approved items Part B Premium Rebate: \$ Transportation: \$0 copay year to plan approved locati	persona c. parterly a 610/mont for 24 on	l needs, li llowance h	ght for	
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Brown & Hospitals: Alameda, Highlan (Hayward), San Leandro, Sta (Pleas/Liv), and Washington	Toland, nd (Oak anford V	One Me), St. Ros Valley Ca	se re	Medical Groups: Brown & Hospitals: Alta Bates/Sumr Eden (Castro Valley)				

ZUZ5 MEDICAF	RE ADVANTAGE COM	rAKI				11,11	WIOS			
Please contact the					Health Plan					
Plan for more		88	8-979-	2247 (Sa	ales & Marketing)					
information or call					Member Services)					
1-800-Medicare		O.			healthplan.com					
Plan Name/Type	Alignment Hea	alth H	leroes	+	Alignment Heal	th Ha	rmon	\mathbf{y}		
Tian Name/Type	HMO (H3	3815-0	43)		HMO (H38	15-031	1)			
Stor Doting										
Star Rating	***				***					
Annual OOP Max	\$5,9				\$3,400					
Monthly Premium	\$0				\$0	\$0				
Doctor Visits	\$0 for Primary Care Phys	sician; \$	0 for Spe	ecialist	\$0 for Primary Care Physic	ian; \$0 1	for Speci	ialist		
	\$1,676 deductible per benefit	period:	\$0 copa	v for days	\$100 copay/day for	or days 1	1-5:			
Inpatient Hospital	1-60; \$419 copay/da				\$0 copay/day for					
	\$838 copay/day f	or days	91-150		\$0 copay/day for days	90 and	beyond			
Outpatient	\$0 copay for ambulate	ory surg	ical cent	er;	\$100 copay for ambulatory	surgical	l center	visit;		
Hospital	\$0 copay for outpatie	ent hosp	ital facili	ty	\$200 copay for outpatient	hospital	facility	visit		
Skilled Nursing	\$0 copay/day fo	or days	1-20;		\$0 copay/day for	days 1-2	20;			
Facility	\$209.50/day for				\$100 copay/day for					
· ·	20% co-insurance per grou	nd or ai	r ambula	nce trip;	\$175 copay per ground or	air amb	ulance t	rip;		
Ambulance	Not waived if adm	itted to	hospital	_	Waived if admitte	d to hos	oital	1.		
	20% coinsurance for ER as				\$100 copay for ER visit; copa			dmitted		
Emergency &	cost waived if admitted to	hospita	l within	3 days;	to hospital; \$0 for ur			:. c		
Urgent Care	Worldwide coverage: \$'			nit for	Worldwide coverage: \$10			nt for		
Lab Tests,	ER/urgent care w			. 0	ER/urgent care wit			0		
,	\$0 copay for lab service				\$0 copay for lab services					
Procedures, and	procedures, x-rays, and 20% coinsurance for the				procedures, x-rays, and di 20% coinsurance for the					
Radiation Therapy				ogy				в у		
Renal Dialysis	20% co-insuranc	e per tre	atment		\$30 copay per	treatmen	t			
Outpatient Mental	20% co-insurance				\$0 copay per individual or	eroup th	erany se	ssion		
Health Visits	or group thera	apy sess	ion		to topay per marviduar or	group tir	erupy se	551011		
Eyewear	\$500 allowance for ey	ewear e	very 2 ye	ears	\$150 annual allowan	ce for ey	yewear			
Eye Exams	\$0 copay for dia				\$0 copay for diag					
-	\$0 copay for one and	nual rou	tine exar	n	\$0 copay for one annu	al routir	ne exam			
Hearing Aids	Not Cov				\$195-\$1,750 copay per aid:	_		year		
Hearing Exams	\$0 copay for dia				\$0 copay for diagr					
	\$0 copay for one and			n	\$0 copay for one annu	al routir	ne exam			
Dental	\$0 copay for cert and comprehensive services			a avary 3	\$0 copay for certain pro					
Dentai	months; See enhanced de				\$20-\$570 copays for certain of	compreh	ensive s	ervices		
Chiropractic	\$0 copay per Medic				\$0 copay per Medica	re-cover	ed vicit			
	. 1 11				\$5 copay for Medicare-covered visit					
Podiatry	\$0 copay for Medic	are-cov	ered visi	t	\$5 copay for Medicar	re-cover	ed 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		
			retail	mail	2 2 2 2	40	retail	mail		
D D	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0		
Prescription Drugs	Generic	\$10	\$30	\$30	Generic	\$3	\$9	\$9		
(Part D)	Preferred Brand Non-Preferred Brand	25% 25%	25% 25%	25% 25%	Preferred Brand	\$40	\$120	\$120		
	Specialty co-insurance	25%	N/A	N/A	Non-Preferred Brand	\$100	\$300	\$300 N/A		
	\$590 deductible; after total				Specialty co-insurance \$0 deductible; after total year	33%	N/A	N/A		
	\$2,000, you pay \$0.	, curry c	ir ug cost	S I Cucii	\$2,000, you pay \$0.	ily ul ug	COSIST	cacii		
	Enhanced Dental Option: \$	36/mon	th for 0-	50%	+=, ,					
	coinsurance for certain diagn				Acupuncture: \$0 co-pay/visit	for unli	mited vi	isits/vr		
	services; \$1,500 coverage lim				Enhanced Dental Option: \$3					
	Essentials Allowance: \$100				coinsurance for certain diagno			hensive		
	groceries, gas, utilities, and h			nose with	services; \$1,500 coverage lim					
		e no rol	lover	1	Essentials Allowance: \$30 monthly allowance for					
	qualifying chronic conditions		C 10							
Supplemental	In-Home Support Services:	\$0 cop					with qualifying chronic conditions			
Supplemental Renefits and	In-Home Support Services: quarter OR \$300 annual care	\$0 copa	imbursen	nent	with qualifying chronic condit	ions	•			
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin	\$0 copa giver remeals/da ag chron	imbursen ay for 14 ic condit	nent days (2x/ ions	with qualifying chronic condit Over the Counter: \$30 month	ions hly allov	vance	14		
	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7	\$0 copagiver remeals/date of the copagiver remeals/date of the copaging the copagin	imbursen ay for 14 ic condit ag days o	nent days (2x/ ions r 14	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify	ions hly allov ooarding ring chro	vance days or	ditions		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 to year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif	\$0 copagiver remeals/date chron boardin ying ch	imbursen ay for 14 ic condit ag days o ronic cor	nent days (2x/ions r 14 aditions	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1	ions hly allow ooarding ving chro service p	vance days or onic conc oer year	ditions		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1	\$0 copagiver remeals/date chron boarding chron service	imbursen ay for 14 ic condit ag days o ronic cor	nent days (2x/ions r 14 aditions	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic	ions hly allow ooarding ving chro service p	vance days or onic cond oer year	ditions for		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond	\$0 copagiver remeals/date chron boardin ying chron service	imbursen ay for 14 ic condit ag days o ronic cor e per year	days (2x/ions r 14 aditions for those	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for	ions hly allow coarding ring chro service p condition 28 one-	vance days or onic cond oer year ns way trip	ditions for os each		
Benefits and	In-Home Support Services: quarter OR \$300 annual care Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond Transportation: \$0 copay for	\$0 copagiver remeals/dag chron boarding chron boarding chron service itions or 50 on	imbursen ay for 14 ic condit ig days o ronic cor e per year e-way tri	days (2x/ions r 14 aditions for those	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for year to plan approved location	ions hly allow coarding ring chro service p condition 28 one- as within	vance days or onic cond oer year ns way trip 20 mile	ditions for os each		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond	\$0 copa giver re- meals/da g chron boardin ying ch service itions or 50 on ons within	imbursen ay for 14 ic condit ig days o ronic cor per year e-way tri in 50 mil	nent days (2x/ions r 14 aditions for those ps per es	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for	ions hly allow coarding ring chro service p condition 28 one- as within	vance days or onic cond oer year ns way trip 20 mile	ditions for os each		
Benefits and Optional Plans	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 r year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond Transportation: \$0 copay for year to plan approved locatio Wellness: \$0 copay for basic	\$0 copagiver remeals/day chron boardin ying ch service itions or 50 on service gym m	imbursen ay for 14 ic condit ig days o ronic cor e per year e-way tri in 50 mil embersh	nent days (2x/ions r 14 nditions for those ps per es ip	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for year to plan approved location Wellness: \$0 copay for basic	ions hly allow coarding ring chro service p condition 28 one- us within gym men	vance days or onic conc per year ns way trip 20 mile mbership	ditions for os each os		
Benefits and	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 1 year) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond Transportation: \$0 copay for year to plan approved locatio	\$0 copagiver remeals/dag chron boardin ying ches service itions or 50 on swithing ym m Toland,	imbursen ay for 14 ic condit ig days o ronic cor e per year e-way tri in 50 mil embersh Nivano	nent days (2x/ions r 14 nditions for those ps per es ip	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for 1 those with qualifying chronic Transportation: \$0 copay for year to plan approved location	ions hly allow coarding ring chro service p condition 28 one- s within gym men	vance days or onic cond per year ns way trip 20 mile mbership	ditions for os each os p		
Benefits and Optional Plans Medical Groups	In-Home Support Services: quarter OR \$300 annual care; Meals: \$0 copay for up to 2 ryear) for those with qualifyin Pet Services: \$0 copay for 7 walks/year for those w/qualif Pest Control: \$0 copay for 1 with qualifying chronic cond Transportation: \$0 copay for year to plan approved locatio Wellness: \$0 copay for basic Medical Groups: Brown & 20 copay for basic Medica	\$0 copa giver re- meals/da g chron boardin ying ch service itions or 50 on ns within gym m Toland, ttes/Sum o, St. Ro	imbursen ay for 14 ic condit ig days o ronic core per year e-way tri in 50 mil embersh Nivano	ment days (2x/ions r 14 aditions for those ps per es ip IPA ck/Oak),	with qualifying chronic condit Over the Counter: \$30 mont Pet Services: \$0 copay for 7 to walks/year for those w/qualify Pest Control: \$0 copay for those with qualifying chronic Transportation: \$0 copay for year to plan approved location Wellness: \$0 copay for basic Medical Groups: Brown & T	ions hly allow coarding ring chro service p conditio 28 one- ss within gym mer foland, N es/Sumn St. Rose	vance days or onic cond oer year ns way trip 20 mile mbership livano II nit (Berk	ditions for os each ss p		

Please contact the	RE ADVANTAGE COM 	IPAK			Health Plan	NII;	111/1/	75	
Plan for more		88			ales & Marketing)				
information or call					Member Services)				
1-800-Medicare					thealthplan.com				
Plan Name/Type	Alignment Health M HMO (H3	-		CalPlus	Alignment H HMO (H3			•	
Star Rating	***	t *			**1	k *			
Annual OOP Max	\$3,4				\$3,4				
Monthly Premium	\$0		0.0.0		\$0				
Doctor Visits	\$0 for Primary Care Phys \$0 copay for days 1-4; \$1				\$10 for Primary Care Physician; \$35 for Specialist \$295 copay for days 1-7;				
Inpatient Hospital	5-10; \$0 copay for days 11 \$100 copay for ambula	and be	yond; u	nlimited	\$0 copay/day for days 8 \$35 copay for ambulator	and bey	ond; unli	mited	
Outpatient Hospital	\$200 copay for outpati				\$200 for outpatient h				
Skilled Nursing Facility	\$0 copay/day fo \$50 copay/day fo	-			\$0 copay/day f \$140 per day fo	-			
Ambulance	\$175 copay per trip	by grou	ınd or ai	r;	\$240 copay per trip	by grou	ınd or air	;	
Timbulance	waived if admitt \$85 copay for ER visit; waive			o hospital	waived if admit \$90 copay for ER visit; wai			vithin 24	
Emergency &	within 48 hours; \$0 fo	or urgen	t care vi	sit;	hours; \$0 for urg	gent care	e visit;		
Urgent Care	Worldwide coverage: \$1 emergency/urgent ca				Worldwide coverage: \$ emergency/urgent ca				
Lab Tests,	\$0 copay for lab service	es, diagi	nostic te	sts &	\$0 copay for lab servic	es, diagi	nostic tes	ts &	
Procedures, and Radiation Therapy	procedures, x-rays, and 20% coinsurance for the				procedures, x-rays, and 20% coinsurance for t				
Renal Dialysis	20% coinsurance			1087	\$30 copay pe			967	
Outpatient Mental Health Visits	\$0 copay per individual or	r group	therapy	session	\$20 copay per individual	or group	therapy	session	
Eyewear	\$100 annual allowa	ance for	eyewea	r	\$300 allowance for ey	ewear e	very 2 ye	ears	
Eye Exams	\$0 copay for dia				\$0 copay for dia				
Hearing Aids	\$0 copay for one and \$195-\$1,750 copay per ai				\$0 copay for one an \$195-\$1,750 copay per at				
Hearing Exams	\$0 copay for dia	gnostic	exam;		\$10 copay for di	agnostic	exam;		
J	\$0 copay for one and \$0 copay for certain p				\$0 copay for one an \$10-\$30 copays for certa				
Dental	\$20-\$570 copays for certain	compr	ehensive	e services	\$20-\$570 copays for certain				
Chiropractic	\$0 copay per Medicare-cove Extra Help, \$0 co-pay for combined with	for 12 vi	isits per		\$0 copay per Medic	care-cov	ered visi	t	
Podiatry	\$0 copay for Medic			it	\$25 copay for Medi	care-co	vered visi	t	
	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	
D 141 D	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0	
Prescription Drugs (Part D)	Generic Preferred Brand	\$3 \$40	\$9 \$120	\$9 \$120	Generic Preferred Brand	\$3 \$40	\$9 \$120	\$9 \$120	
	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 ye. \$2,000, you pay \$0.	arıy ar	ug costs	reacn	\$0 deductible; after total ye \$2,000, you pay \$0.	ariy ari	ug costs	reacn	
	Acupuncture: For those with for 12 visits per year, combined								
	Enhanced Dental Option: S				Enhanced Dental Option:	\$36 /mor	nth for 0-	50%	
	coinsurance for certain diagr			rehensive	coinsurance for certain diag			ehensive	
	services; \$1,500 coverage lin In-home Support Services:			2 hours	services; \$1,500 coverage line Meals: \$0 copay for up to 2			lavs for	
	per quarter OR \$300 annual				those with qualifying chroni	c condit	ions	-	
	Meals: \$0 copay for up to 28				Over the Counter: \$25 mor	nthly all	owance;	no	
Supplemental	those with qualifying chronic with Extra Help, up to 56 me			or those	rollover Pet Services: \$0 copay for 7	/ boardii	no davs c	r 14	
Benefits and	Over the Counter: \$20 mor	nthly all	owance		walks per year for those with				
Optional Plans	those with Extra Help, additi Pet Services: \$0 copay for 7				conditions	1		fa	
	walks/year for those w/quali				Pest Control: \$0 copay for those with qualifying chroni			. 101	
	Pest Control: \$0 copay for			ar for	Transportation: \$0 copay f				
	those with qualifying chronic Transportation: \$0 copay for the copay f			rips per	year to plan approved location Wellness: \$0 copay for basi				
	year to plan approved location				participating fitness centers				
	Wellness: \$0 copay for basic participating fitness centers	gym n	ieinbers	anp at					
Medical Groups	Medical Groups: Brown &				Medical Groups: Brown &				
and Hospitals (may not be full list;	Hospitals: Alameda; Alta Ba Highland (Oak), San Leandr				Hospitals: Alameda; Alta B Highland (Oak), San Leandr				
please check with plan)	Stanford Valley Care (Pleas/		(2.44)	,/,	Stanford Valley Care (Pleas		(-14)	/,	

2023 NIEDICAR	E ADVANTAGE COM	ANIS	ON CI	TAKI	OR ALAMEDA COUN	11.1	11/10	<u> </u>	
Please contact the									
Plan for more		800)-619-	6164 (S	ales & Marketing)				
information or call					Member Services)				
1-800-Medicare		0.5			hem.com				
	Anthom	Coloo		w w w.am	Anthem	Duim			
Plan Name/Type	Anthem								
	HMO-POS (H0544	1-098)		HMO-POS	(H416)	1-005)		
Star Rating	**	*			**	*			
Annual OOP Max	\$7,55	50			\$1,2	00			
Monthly Premium	\$0				\$0				
Doctor Visits	\$15 copay for Primar	y Care l	Physiciar	1;	\$0 copay for Primary Care Physician;				
Doctor visits	\$45 copay for				\$10 copay for Specialist				
Inpatient Hospital	\$315 copay/day				\$250 copay fo			1	
	\$0 copay for days 7 \$275 copay for ambulator			visit:	\$0 copay/day for day \$150 copay for ambulator				
Outpatient Hospital	\$315 copay for outpatient				\$250 for outpatient he				
Skilled Nursing	\$0 copay for a	days 1-2	20;		\$0 copay/day fo	or days	1-20;		
Facility	\$196 per day for	days 21	1-100		\$188 per day for	days 2	1-100		
Ambulance	\$250 copay per groun				\$250 copay per groun				
Ambulance	20% coinsurance per				20% coinsurance per				
Emergency &	\$90 copay for ER visit; waiv within 24 hours; \$35 fo				\$90 copay for ER visit; waiv within 24 hours; \$35 f				
Urgent Care	Worldwide coverage: \$1				Worldwide coverage: \$1				
organi ouro	emergency/urgent care wi				emergency/urgent care wi				
Lab Tests,	\$10 copay for lab ser				\$10 copay for lab se				
Procedures, and	\$50-\$75 for diagnostic \$10-\$150 for diagn			es;	\$25-\$50 for diagnostic \$10-\$150 for diagn			res;	
Radiation Therapy	20% coinsurance for the			ogv	20% coinsurance for the			ogv	
Renal Dialysis	20% co-insurance			- 63	20% co-insurance			-63	
Outpatient Mental						•			
Health Visits	\$40 copay per individual o	r group	therapy s	session	\$10 copay per individual or group therapy session				
Eyewear	\$100 annual allowa	nce for	eyewear		\$100 annual allowa	nce for	eyewear		
-	\$45 copay for dia		•		\$10 copay for dia		•		
Eye Exams	\$0 copay for one ann			ı	\$0 copay for one annual routine exam				
Hearing Aids	\$3,000 annual allowa			ıy	Not Cov				
Hearing Exams	\$45 copay for dia				\$10 copay for dia				
_	\$0 copay for one ann \$45 copay for Medic				\$0 copay for one annual routine exa \$10 copay for Medicare covered vis				
Dental	\$0 copay for 1 oral exam a				\$0 copay for 1 oral exam				
Chiropractic	\$15 copay per Medic	care-cov	ered visi	t	\$20 copay per Medic				
•	\$0-45 copay for Medi				\$0-10 copay for Medi	care-co	vered vis	it:	
Podiatry	\$0 copay for 24 routing				\$0 copay for unlimited re				
	Cost-sharing shown is for		90	90	Cost-sharing shown is for	30	90	90	
	preferred pharmacies	days	days	days	preferred pharmacies	days	days	days	
	Preferred Generic	\$0	retail \$0	mail \$0	Preferred Generic	\$0	retail \$0	mail \$0	
Prescription Drugs	Generic	\$0	\$0	\$0	Generic Generic	\$0 \$7	\$21	\$0	
(Part D)	Preferred Brand	15%	15%	15%	Preferred Brand	20%	20%	20%	
()	Non-Preferred Brand	30%	30%	30%	Non-Preferred Brand	25%	25%	25%	
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%		N/A	
	\$0 deductible; after total year	arly dru	ig costs i	each	\$0 deductible; after total yes	arly dru	ıg costs ı	reach	
	\$2,000, you pay \$0.	· . C 10			\$2,000 , you pay \$0 .				
	Acupuncture: \$0 co-pay/vis Over the Counter: \$25 quar			er year					
	Wellness: \$0 for basic Silver			ership	0 4 0 4 00	. 1 1			
	Optional supplemental paci			•	Over the Counter: \$20 quant Wellness: \$0 for basic Silver			perchin	
	1: Preventive Dental at \$13				Optional supplemental pac		as meme	Cisinp	
	\$500/year; \$0 co-pays for base 2: Dental & Vision at \$33 p			rvices	1: Preventive Dental at \$13	per mo			
Supplemental	\$1,000/year with \$0 copays f			itive	\$500/year; \$0 co-pays for ba				
Benefits and	services and 20-50% coinsur	ance for	certain		2: Dental & Vision at \$33 p services up to \$1,000/year w				
Optional Plans	comprehensive services; \$15	0 annua	l reimbui	sement	annual reimbursement allows	-			
	allowance for eyewear 3: Enhanced Dental & Vision	on at \$5	1 ner m	nth• un	3: Enhanced Dental & Visi				
	to \$2,000/year with \$0 copay				dental services up to \$2,000/	-			
	services and 20-50% coinsur	ance for	certain		\$200 annual reimbursement	anowan	ce for ey	ewear	
	comprehensive services; \$20	0 annua	l reimbu	rsement					
	allowance for eyewear				M. P. I.C. S	m 1 1	TT'11 P1		
Medical Groups	Medical Groups: Brown &		Hill Phy	sicians	Medical Groups: Brown & East Bay, Imperial Health He			sıcıans	
and Hospitals	East Bay, Imperial Health Ho		/O-1 \ E	1	Physicians	orumgs,	141 (4110		
(may not be full list;	Hospitals: Alta Bates/Summ (Castro Valley), St. Rose, (H.				Hospitals: Alta Bates/Summ				
please check with plan)	Care (Pleas/Liv), Washington	-		a vancy	(Castro Valley), St. Rose, (H			rd Valley	
		- (2 10111	/		Care (Pleas/Liv), Washington	n (Frem	ont)		

2025 MEDICAR	E ADVANTAGE COM	PAKI	SON CI	IAKT F	OR ALAMEDA COUN	TY: I		1 S		
Please contact the	Blue Shie	ld of	CA		United Hea	lth C	are			
Plan for more	888-534-4263 (Sa	les &	Marketi	ing)	844-723-6473 (Sales and Marketing)					
information or call	800-776-4466 (M				866-261-7709 (M					
1-800-Medicare	`									
1 000 Medicare	www.blueshieldc	a.com/	medicar	<u>e</u>	www.aarpmedic					
	Blue Shiel	d Inc	nire		AARP Medicare			from		
Plan Name/Type	(HMO) (H		_		UHC C	A-7P				
	(IIMO) (I	10304-	041)		HMO-POS	H0543	3-188)			
Star Rating	***	r1/2			**	+				
Annual OOP Max	\$4,3				\$4,9					
Monthly Premium	\$3!				\$40					
•	\$0 copay for Primar		Physician		\$0 copay for Primar		Physicia	n·		
Doctor Visits	\$15 for S ₁				\$25 for Sp		ily sicia	11,		
Inpatient Hospital	\$280 copay/day	for day	vs 1-5;		\$425 copay/day \$0 for days 7 and be	for day:	s 1-6;	1/		
Outpatient Hospital	\$0 per day for day \$100 copay per ambulato	ry surg	ical center		\$375 copay for ambulator	y surgio	cal cente	er visit;		
	\$250 per outpatient h			it	\$425 copay for outpa			sit		
Skilled Nursing	\$0 copay/day f				\$0 copay/day for					
Facility	\$200 per day fo \$275 copay per t				\$203 per day for	days 2.	1-100			
Ambulance	20% co-insuranc	e per tri	p by air		\$290 copay per trip	, ,				
Emanganary 6	\$125 copay per emergency				\$125 copay per emergence					
Emergency &	care visit; Worldwide cover \$120 copay per emergen				admitted to hospital within care visit; Worldwide cover					
Urgent Care	waived if admitted to he				\$0 copays for emergen				uli	
Lab Tests,	\$0 copay for lab, diagnostic				\$0 copay for lab, diagnosti					
Procedures, and	x-rays; \$75 copay for o				\$25 copay per x-ray; \$20					
Radiation Therapy	20% co-insurance for	therape	ıtic radiolo	ogy	radiology; 20% coinsurance				у	
Renal Dialysis	20% co-insuranc	e per tr	eatment		20% co-insurance	e per tre	atment			
Outpatient Mental	440 0 1 11 1	•			\$25 copay for individu	ial thera	ipv sess	ion:		
Health Visits	\$30 copay for individual of	or group	therapy s	ession	\$15 copay for group therapy session					
Eyewear	\$195 annual allowa \$195 allowance for fi			rs	\$200 annual allowa through United Health					
Eye Exams	\$15 copay for dia	gnostic	exams;		\$0 copay for Medica	re-cove	red exai	n;		
Lyc Exams	\$0 copay for one an				\$0 copay for one and					
Hearing Aids	\$449 - \$699 copay per ai limited to 2 hearing			ype);	\$99 - \$1,249 copay per aid through United Healthc					
Hearing Exams	\$0 copay for Medica				\$0 copay for Medica					
110411119	\$0 copay for one an \$15 copay for Medic				\$0 copay for one and	nual rou	tine exa	m		
Dental	\$0 copay certain preventive				\$0 copays for preventive serv			l provide	er;	
Donoui	and 1 full set of x-ra	ys every	y two years	s	See optional den	tal plan	below			
Chiropractic	\$15 copay for Medic				\$15 copay for Medic			it;		
Спиоргиене	\$0 copay/visit for 12 re				Routine care not covered \$25 copay per Medicare-covered visit:					
Podiatry	\$15 copay per Medi \$15 copay/visit for unlimit				\$25 copay per Medicare-covered visit; \$25 copay/visit for 6 routine visits per year					
	Cost-sharing shown is	30	100	100		30	100		\exists	
	for preferred pharmacies	days	days	days	Cost-sharing shown is for preferred pharmacies	days	days	100 days		
	Jan prajaman pramana		retail	mail	prejerrea piarmacies	days	retail	mail		
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0		
Prescription Drugs	Generic	\$5	\$7.50	\$7.50	Generic	\$12	\$36	\$0		
(Part D)	Preferred Brand	\$40	\$100	\$100	Preferred Brand Non-Preferred Brand	\$47	\$141 N/A	\$131 N/A		
	Non-Preferred Brand Specialty co-insurance	\$95 33%	\$237.50 N/A	\$237.50 N/A	Specialty co-insurance	\$100 29%	N/A N/A	N/A N/A		
	\$0 deductible; after total ve				\$340 deductible for Tiers 3,					
	\$2,000, you pay \$0.	,	0 1		yearly drug costs reach \$2,					
			11							
	Over the Counter: \$55 qua Transportation: \$0 copay f			ns ner						
	year to plan approved location		iic way ar	ps pci			40			
	Wellness: \$0 for basic Silve		ers memb	ership	Optional Dental Plan at \$54 certain preventive and compa					
Supplemental	Optional Supplemental Pla				coinsurance for dentures and					
Benefits and	1: Dental HMO at \$16/mor				allowance	orrages	, φ2,200			
Optional Plans	certain preventive and comp participating dentists only	renensi	ve services	s;	Over the Counter: \$25 quan	terly all	owance	for item	ıs	
	2: Dental PPO at \$47/mon	th: \$50	deductible	e;	in-store or online			1. !		
	varying coinsurance for certain preventive and Wellness: \$0 for Renew Active gym membership							ersnip		
	comprehensive services; \$1,									
	participating dentists; \$1,00	u for no	n-participa	ating						
		Medical Groups: Brown & Toland, Hill Physicians						·		
Medical Groups	Medical Groups: Brown &	Toland	, Hill Phys	sicians	Madical Crounce Canana II	ealth II	ill Dha	iciane		
Medical Groups	East Bay				Medical Groups: Canopy H East Bay	ealth, H	ill Phys	icians		
and Hospitals	East Bay Hospitals: Alameda, Alta B	ates/Su	mmit (Ber	k/Oak),	East Bay Hospitals: Alameda, Highlan	nd (Oak	land), S	an		
	East Bay	ates/Su and (Oa	mmit (Ber ak), San Le	k/Oak),	East Bay	nd (Oak	land), S	an)	

	RE ADVANTAGE COM						NIY:	111/11	<i>)</i> 8		
Please contact the						ledicare Plan					
Plan for more information or call						s & Marketing)					
1-800-Medicare		80		`		mber Services)					
1 000 Medicare	C 4 LT WLT				1	thplan.com	•	<u> </u>	DI TT		
Plan Name/Type	Central Health I			an I	(Central Health Cla			rian II		
	(HMO) (H	5649- 0)23)			(HMO) (H	5649-	028)			
Star Rating	★★1	1/2				**	1/2				
Annual OOP Max	\$2,99				L	\$2,4					
Monthly Premium	\$0					\$0					
Doctor Visits	\$0 for Primary Care Phys \$0 copay for days 1-4; \$100					\$0 for Primary Care Phys.			•		
Inpatient Hospital	\$0 copay for o	days 11-	-90		\$	150 copay/day for days 1-		1 ,	-		
Outpatient Hospital	\$200 copay per ambulator \$225 copay per outpatien					\$100 per ambulatory s \$250 copay per outpatien					
Skilled Nursing Facility	\$0 copay for \$204 /day for d					\$0 copay for \$204 /day for					
Ambulance	\$300 copay per one-w 20% coinsurance			nd;		\$250 copay per one-v 20% coinsurance			nd;		
E	\$125 copay per emergenc	y room	visit; wa			\$140 copay per emergence	cy room	visit; wa			
Emergency & Urgent Care	admitted to hospital \$0 for urgent care; Worldw limit with \$125 copays	ide cov	erage: S	\$100,000		admitted to hospital \$0 for urgent care; World limit with \$140 copays f	wide co	verage:	\$50,000		
Lab Tests,	\$0 copay for lab service					\$0 copay for lab service					
Procedures, and	procedures, and x-rays; \$150	for diag	gnostic i	radiology;		procedures, x-rays; \$200 f	for diag	nostic ra	diology;		
Radiation Therapy	20% co-insurance for the	herapeu	tic radio	ology		20% co-insurance for t	herapeu	itic radio	ology		
Renal Dialysis	20% co-insurance	e per tre	atment			20% co-insuranc					
Outpatient Mental Health Visits	\$40 copay per individual o	r group	therapy	session		\$10 copay for ind 20% coinsurance for g			ecion		
Eyewear Eyewear	\$300 annual allowa	maa for	ON ON OR			\$300 annual allowa					
	\$0 copay per Medica		•			\$0 copay per Medica		•			
Eye Exams	\$0 copay for one ann				<u> </u>	\$0 copay for one an	nual rou	ıtine exa	m		
Hearing Aids	\$2,000 annual allowance t	hough N	NationsI	Hearing	\$		copays for hearing aids, depending on odel; up to 2 aids per year				
Hearing Exams	\$0 copay for Medica					\$0 copay for Medica					
	\$0 copay for one and \$0 copay for Medical					\$0 copay for one an \$0 copay for Medic					
Dental	\$0-\$41 copays for certain	n prever	ntive ser	vices;		\$0 copay for certain p	preventi	ve servi	es;		
	\$0 - \$2,160 copays for certai	n compi	rehensiv	e services		0 - \$2,160 copays for certa: 60 copay per Medicare-cov					
Chiropractic	\$0 copay per Medic	are-cove	ered visi	it		visit, up to 30 per year, cor					
Podiatry	\$0 co-pay per Medic	care-cov	ered vis	sit		\$0 co-pay per Medi					
<u> </u>	Cost-sharing shown is for	30	90	100	(Cost-sharing shown is	30	90	100		
	preferred pharmacies	days	days	days		or preferred pharmacies	days	days	days		
	Duoformad Comoria	¢0	¢0	mail	<u> </u>	Due formed Comonic	¢0	¢0	mail		
Prescription Drugs	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0	_	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0		
(Part D)	Preferred Brand	\$35	\$105	\$70	_	Preferred Brand	\$35	\$105	\$70		
	Non-Preferred Brand	\$75	\$225	\$150	N	Non-Preferred Brand	\$100	\$300	\$200		
	Specialty co-insurance	31%	N/A	N/A		Specialty co-insurance	31%	N/A	N/A		
	\$100 deductible for Tiers 2-5 costs reach \$2,000, you pay		total ye	arly drug		.00 deductible for Tiers 2- sts reach \$2,000, you pay		total ye	arly drug		
	Acupuncture: \$0 co-pay for		ed visit	s/vear	_	cupuncture: \$0 co-pay for		30 visits/	vear		
	Dental Plan Option: \$45/m			<i>s, j</i>		ombined with chiropractic	up to t	, , , ,	, cur,		
	preventive and comprehensive			10% to		ental Plan Option: \$21/m					
	70% coinsurance; \$1,500 an Flex Allowance: \$96 quarter			TOTC		eventive and comprehensi					
	and herbal catalog items incl					% coinsurance; \$1,500 and twork providers	muai m	int for ne)11-		
a	& \$20 monthly allowance for	_		<i>G</i>		ex Allowance: \$129 quart	erly all	owance f	or OTC		
Supplemental	Groceries: \$50 monthly allo			-		d herbal catalog items incl	_		ring aids		
Benefits and	for those with qualifying chro In-Home Support Services:					\$60 monthly allowance for roceries: \$50 monthly allowance			hy foods		
Optional Plans	hours per year for qualifying			.p to 20		r those with qualifying chi			119 10003		
	Meals: \$0 copay/meal for 2 i					leals: \$0 copay/meal for 15					
	those with qualifying chronic times/year	conditi	ions; up	to 4		r those with qualifying childitional meals with \$5 cop			up to 30		
	Transportation: \$0 co-pay f	for 12 o	ne-way	trips to		ransportation: \$0 co-pay			trips to		
	plan approved locations with	in 50 m	iles	•	pla	an approved locations with	nin 50 n	niles	•		
Medical Groups	Wellness: \$0 for basic Silve	r Sneak	ers men	ibersnip	W	Yellness: \$0 for basic Silve	er Sneal	kers men	ibersnip		
and Hospitals	Medical Groups: Hill Physi- Hospitals: Eden (Castro Vall			naton		ledical Groups: Hill Physospitals: Eden (Castro Val					
	TOSTILLAS FORD (L'astro Val	iev i and	vv asnir	TALOU		osoniais: eden it asmo Val	u⊨vian/	. vv ach11	IVIOR		
(may not be full list; please check with plan)	(Fremont)	,,				remont)	ncy) an	a wasiiii	igton		

Please contact the Plan for outline of coverage & provider information or call 1-800-Medicare	E ADVANTAGE COM	Chinese Community Health Plan 888-681-3888 (Sales and Marketing) 888-775-7888 (Member Services)								
Plan Name/Type	CCHP Senio HMO (H0		0	1	CCHP Senior V HMO (H0		_	am		
Star Rating	**1	1/2			**	1/2				
Annual OOP Max	\$3,0	00			\$3,5	00				
Monthly Premium	\$31				\$0					
Doctor Visits	\$0 copay for Primar \$0 for Spo		Physicia	nn;	\$0 copay for Primary Care Physician; \$15 for Specialist					
Inpatient Hospital	\$200 copay/day \$0 for day	for day ys 8-90			\$250 copay/day \$0 for day	for days	s 1-7;			
Outpatient Hospital	\$300 copay for ambulator \$310 copay for outpa				\$300 copay for ambulator \$310 copay for outpa	tient hos	spital vis			
Skilled Nursing Facility	\$0 copay/day for \$75 per day for	days 21	-100		\$0 copay/day for \$100 per day for					
Emergency & Urgent Care	\$110 copay per emergenc admitted to hospital within care visit; Worldwide cove \$90 copays for E	24 hour rage: \$	s; \$20 ¡ 25,000	er urgent	\$125 copay per emergence admitted to hospital within care visit; Worldwide cove \$90 copays for E	24 hours e rage: \$	s; \$25 pe 5,000 lir	r urgent		
Ambulance	\$180 copay per trip	by grou	ınd or a	ir	\$200 copay per trip	by grou	nd or air			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic x-rays; \$100 copay for 0 20% coinsurance for the	diagnos nerapeu	ic radio	ology;	\$0 copay for lab, diagnostic x-rays; \$150 copay for 20% coinsurance for the	diagnost nerapeut	ic radiol ic radiol	ogy;		
Renal Dialysis Outpatient Mental	20% co-insurance	e per tre	atment		20% co-insuranc	e per trea	atment			
Health Visits	\$15 copay per individual of	0 1			\$20 copay per individual of	• •				
Eyewear	\$0 copay with \$150 allow eyewear; through VSI				\$0 copay with \$100 allow eyewear; through VS					
Eye Exams	\$20 copay for Medica \$20 copay for one an			*	\$35 copay for Medic \$35 copay for one an					
Hearing Aids	\$3,000 annual allowance t	though l	Nations	Hearing	\$3,000 annual allowance	hough N	NationsH	earing		
Hearing Exams	\$0 copay for Medica \$0 copay for one and	nual rou	tine exa	am	\$0 copay for Medica \$0 copay for one and	nual rout	ine exar	n		
Dental	\$0 copays for certain p See Optional Den			ices;	\$0 copays for certain preventive services; See Optional Dental plan below					
Chiropractic	\$15 copay for Medic Routine care r			sit;	\$15 copay for Medicare-covered visit; Routine care not covered					
Podiatry	\$15 copay per Medic Routine care r			sit;	\$20 copay per Medicare-covered visit; Routine care not covered					
	Cost-sharing shown is for preferred pharmacies	30 days	90 days retail		Cost-sharing shown is for preferred pharmacies	30 days	90 days retail	90 days mail		
Prescription Drugs	Preferred Generic Generic	\$3 \$7	\$9 \$21	\$6 \$14	Preferred Generic Generic	\$0 \$3	\$0 \$9	\$0 \$0		
(Part D)	Preferred Brand	\$30	\$90	\$60	Preferred Brand	\$35	\$105	\$70		
·	Non-Preferred Brand	\$50	\$150	\$100	Non-Preferred Brand	\$75	\$225	\$150		
	\$0 deductible; after total year \$2,000, you pay \$0.	30% arly dru	N/A ig costs	N/A s reach	\$0 deductible; after total yes \$2,000, you pay \$0.	30% arly dri	N/A ug costs	N/A reach		
Supplemental Benefits and Optional Plans	Dental Plan Option: \$18.50 for certain preventive and co through DeltaCare USA Den Grocery Flex Card: \$20 mc healthy foods; can be combin Over the Counter: \$52 mon approved items from networl Nations OTC catalog; can be flex card allowance Transportation: \$0 copay for plan-approved locations	mprehe ital HM onthly al ned with ithly all k retail l combin	nsive see O netwo llowance o OTC a owance ocation ned with	ervices; ork ee for allowance for plan- a or h grocery	Acupuncture: \$10 copay for Dental Plan Option: \$18.5 for certain preventive and continuous DeltaCare USA Det Over the Counter: \$65 mo approved items from networn Nations OTC catalog Transportation: \$0 copay for plan-approved locations	Mmonth omprehe otal HM onthly all ok retail	n: varyin nsive ser O netwo owance: location	g copays vices; rk for plan- or		
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Hill Physi Medical Hospitals: Alameda, Highlar Leandro		·		Medical Groups: Hill Phys Medical Hospitals: Alameda, Highl Leandro		•			

2023 MEDICAL	E ADVANTAGE COM					7111.	TITAL	O _B			
Please contact the Plan for more		Imperial Health Plan of California 800-838-8271 (Sales & Marketing)									
information or call 1-800-Medicare			0-838	-8271 (Member Services)						
Plan Name/Type	Imperial Tr HMO (H54		onal	<u>реги.</u>	Imperial (HMO (H5						
Star Rating	***				***						
Annual OOP Max	\$1,44	19			\$9,350						
Monthly Premium	\$0				\$0 / \$240 D	educti	ble				
Doctor Visits	\$0 for Primary Ca	•	ician;		20% for Primary						
20001 (1510)	\$0 for Spe \$0 copay for days 1-3;		or days 4	l-5;	20% for S						
Inpatient Hospital	\$0 per day for \$670 per day for	days 6-9 days 91	90; -150		\$0 copay for days 1-60; \$ 4 61-90; \$838 per day						
Outpatient Hospital	\$100 per ambulatory su \$100 copay per outpatient				20% coinsurance per ambul 20% coinsurance per outpar						
Skilled Nursing	\$0 copay per day for days 1				\$0 copay per day			inty visit			
Facility	21-50; \$200 /day fo				\$209.50/day for	days 21	1-100				
Ambulance	\$150 copay per one-w 20% coinsurance per	r each tı	rip by ai	r	20% coinsurance per on 20% coinsurance per						
Emergency & Urgent Care	\$125 copay per emergency admitted to hospital within urgent care; Worldwide co	48 hour verage:	s; \$0 co \$100,0	pay for 00 limit	20% coinsurance, up to \$1 visit; 20% coinsurance up to Costs waived if admitted to	\$45 per	r urgent	care visit;			
Lab Tests,	with \$0 copay for ER and \$0 copay for lab, diagnostic				20% coinsurance for lab se						
Procedures, and	x-rays, and diagno	stic rad	iology;		procedures, x-rays, diag	nostic ra	adiology				
Radiation Therapy Renal Dialysis	20% coinsurance for th			ogy	therapeutic		<u> </u>				
Outpatient Mental	20% coinsurance 20% coinsurance	1			20% coinsurance 20% coinsurance						
Health Visits	or group thera				or group there						
Eyewear	\$500 annual allowa		•		\$240 annual allowa		•				
Eye Exams	\$0 copay per Medicar \$0 copay for rot			n;	20% coinsurance per Me \$0 copay for one an						
Hearing Aids	\$500 annual allow				\$500 annual allow			••			
Hearing Exams	\$0 copay for Medicar \$0 copay for routine exa				\$0 copay for Medica \$0 copay for exams						
Dental	\$0 co-pay per Medicare-cov preventive services up to \$2 certain comprehensive serv must use Imperial Tradition	500/year ices up	r; \$0 co- to \$3,0 0	pay for 00/year;	\$0 co-pay per Medicare-co- preventive services up to \$ certain comprehensive ser must use Imperial Giveba	500/yea vices up	r; \$0 co- to \$2,0 0	pay for 00/year;			
Chiropractic	\$0 copay per Medica	re-cove	red visit		20% co-insurance per Medicare-covered visit; Routine care not covered						
Podiatry	Routine care n \$0 co-pay per Medica \$0 co-pay for 6 routing	are-cove	ered visi		Routine care not covered 20% coinsurance 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	100 days	100 days			
Prescription Drugs	Preferred Generic	\$0	\$0	mail \$0	Preferred Generic	25%	25%	mail 25%			
(Part D)	Generic	\$10	\$30	\$10	Generic Desferred Description	25%	25%	25%			
	Preferred Brand Non-Preferred Brand	\$45 \$90	\$135 \$270	\$90 \$180	Preferred Brand Non-Preferred Brand	25% 25%	25% 25%	25% 25%			
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	25%	25%	25%			
	\$0 deductible; after total yes \$2,000, you pay \$0.	arly dru	ıg costs	reach	\$590 deductible; after total \$2,000, you pay \$0.	yearly d	drug cos	ts reach			
	In-home Support Services:	\$0 cop	ay for u	p to 48							
	hours per year Meals: \$0 copay for up to 7	home-d	elivered	meals							
C1- 4 1	following a surgery or hospit				In-home Support Services: hours per year	\$0 copa	ay for up	to 48			
Supplemental Benefits and	benefit period Over the Counter: \$95 quar	tarly all	lowance	for	Over the Counter: \$75 qua			for items			
Optional Plans	items in OTC mail order cata	ılogue; 1	no rollo	ver	in OTC mail order catalogue Part B Premium Reduction						
•	Transportation: \$0 co-pay to per year to plan approved loc		one-way	y trips	reimbursement	ι, φ100 Ι	monuny				
	Wellness: \$0 for one home f through Silver&Fit program		it per ye	ar							
Modical Con	Medical Groups: Imperial H			,	Medical Groups: Imperial I						
Medical Groups and Hospitals	MedCare Partners IPA, Niva Physician Partners IPA	no Phys	sicians,		MedCare Partners IPA, Niva Partners IPA	.no Phys	sicians, P	hysician			
(may not be full list;	Hospitals: Alta Bates/Summ				Hospitals: Alta Bates/Summ						
please check with plan)	Medical Center (Castro Valle St. Rose (Hayward)	ey), San	Leandr	o, and	Medical Center (Castro Vall Rose (Hayward)	ey), San	Leandro	o, and St.			

Please contact the Plan for more information or call 1-800-Medicare		Impe 800	rial H -838-8)-838-	ealth l 271 (S 8271 (I	Plan of California sales & Marketing) Member Services) healthplan.com			
Plan Name/Type	Imperial D HMO (H5				Imperial Courage HMO (H5496-016)			
Star Rating	***	1/2			★★★ 1/2			
Annual OOP Max	\$29	7			\$2,999			
Monthly Premium	\$0				\$0			
Doctor Visits	\$0 copay for Primary \$0 for Spe		hysician;		\$0 copay for Primary Care Physician; \$5 for Specialist			
Inpatient Hospital	\$0 copay for 6 \$670 per day for				\$150 copay for days 1-5; \$0 co-pay/day for days 61-90; \$670 per day for days 91-150			
Outpatient	\$100 per ambulatory st \$100 copay per outpatient	ırgical c	enter vis		\$200 per ambulatory surgical center visit; \$200 copay per outpatient hospital facility visit			
Hospital Skilled Nursing Facility	\$0 copay per day for days 1 21-50; \$200/day for	-20; \$1	00/day fo		\$0 copay per duy for days 1-20; \$200/day for days 21-100			
Ambulance	\$150 copay per one-w			l;	\$150 copay per one-way trip by ground;			
Emergency & Urgent Care	20% coinsurance pe \$125 per emergency room admitted to hospital within urgent care; Worldwide co with \$0 copays for emerg	visit; co 48 hour verage:	opay wai s; \$0 cop \$100,00	ay for 0 limit	20% coinsurance per each trip by air \$125 copay per emergency room visit; waived if admitted to hospital within 48 hours; \$0 copay for urgent care; Worldwide coverage: \$50,000 limit with \$0 copay for emergency and \$20 for urgent care			
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;	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance 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	\$500 annual allowa		•		\$250 annual allowance for eyewear			
Eye Exams	\$0 copay per Medica \$0 copay for ro			;	\$0 copay per Medicare-covered exam; \$0 copay for routine exams			
Hearing Aids	\$500 annual allow	ance \$0	copay		\$500 annual allowance \$0 copay			
Hearing Exams	\$0 copay for Medicar \$0 copay for routine exa				\$0 copay for Medicare-covered exam; \$0 copay for routine exams up to \$250/year			
Dental	\$0 co-pay per Medicare-cov preventive services up to \$ certain comprehensive serv must use Imperial Dynam	500/year rices up ic contra	r; \$0 co-p to \$4,000 acted pro	oay for D/year;	\$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 \$1,500/year; must use Imperial Courage contracted provider			
Chiropractic	\$0 copay per Medica Routine visits i				\$0 copay per Medicare-covered visit; Routine visits not covered			
Podiatry	\$0 co-pay per Medica \$0 co-pay for 6 routi	are-cove	ered visit		\$0 co-pay per Medicare-covered visit; \$0 co-pay for 6 routine visits per year			
Prescription Drugs	Cost-sharing shown is for preferred pharmacies Preferred Generic	30 days	100 days	100 days mail	THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.			
(Part D)	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yes \$2,000, you pay \$0.	\$6 \$45 \$90 33% arly dru	\$18 \$135 \$270 N/A ig costs i	\$5 \$90 \$180 N/A	YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.			
Supplemental Benefits and Optional Plans	In-home Support Services: hours per year Meals: \$0 copay for up to 7 following a surgery or hospit benefit period Over the Counter: \$140 quitems in OTC mail order catar Part B Premium Reduction Transportation: \$0 co-pay is per year to plan approved low Wellness: \$0 for one home for through Silver&Fit program	home-deal stay, arterly a alogue; 1 1: \$60 m for 100 e cations	elivered in up to \$10 up to \$10 up to \$10 up to \$10 up to rollove to the total per year to the year to year to the year to year to year to year to year to year to year year to year to year to year year year year year year year year	meals 05 per for er eimburs trips	Meals: \$0 copay for up to 7 home-delivered meals following a surgery or hospital stay; up to \$105 per benefit period Over the Counter: \$75 quarterly allowance for items in OTC mail order catalogue; no rollover 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 one home fitness kit per year through Silver&Fit program			
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Imperial I MedCare Partners IPA, Niva Physician Partners IPA Hospitals: Alta Bates/Summ Medical Center (Castro Valle St. Rose (Hayward)	no Phys it (Berk	icians, /Oak), E		Medical Groups: Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), San Leandro, and St. Rose (Hayward)			

2025 MEDICAL	RE ADVANTAGE COM	ADVANTAGE COMPARISON CHART FOR ALAMEDA CO									
Please contact the					ermanente						
Plan for more		800	0-777-	1238 (S	ales & Marketing)						
information or call		80	0-443	-0815 (1	Member Services)						
1-800-Medicare					iserpermanente.org						
	Kaiser Permai				Kaiser Perma	nente	Senio	r			
Plan Name/Type	Advantage Ba				Advan		Scino	-			
Tian rume, Type	HMO (H0			а	HMO (H0	_	22)				
a. 5 4	,		39)		·		34)				
Star Rating	***				★★★★ 1/2						
Annual OOP Max	\$6,00				\$3,4						
Monthly Premium	\$0				\$70						
Doctor Visits	\$5 copay for Primary			1;	\$0 copay for Primar		Physician	;			
	\$10 for Sp \$260 copay/day				\$5 for Spo \$225 copay/day	for day	s 1-5·				
Inpatient Hospital	\$0 per day for day				\$0 per day for day						
Outpatient	\$225 per ambulatory s	urgical	center vi	sit;	\$190 per ambulatory s	urgical	center vi	sit;			
Hospital	\$0-\$225 copay per outpatie	ent hosp	ital facil	ity visit	\$0-\$190 copay per outpation	ent hosp	ital facil	ity visit			
Skilled Nursing	\$0 copay/day fo				\$0 copay/day fo						
Facility	\$100 per day for	days 2	1-100		\$100 per day for	days 2	1-100				
Ambulance	\$250 copay per air or gr	ound ar	nbulance	trip	\$250 copay per air or gr	ound ar	nbulance	trip			
E 0	\$125 for emergen				\$140 for emerger						
Emergency &	\$5 for urgent Worldwide coverage: no li			oney for	\$0 for urgent Worldwide coverage: no li			ones, for			
Urgent Care	emergency care visit and				emergency care visit ar						
Lab Tests,	\$0 copay for lab, diagnostic				\$0 copay for lab, diagnosti						
Procedures, and	x-rays; \$200 copay for o				x-rays; \$200 copay for o						
Radiation Therapy	\$0 for therapeut	tic radio	ology		\$0 for therapeur	tic radio	ology				
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insurance	e per tre	atment				
Outpatient Mental	\$2 copay per indi	vidual s	ession;		\$0 copay per indi	vidual s	ession;				
Health Visits	\$5 per group the	erapy se	ssion		\$0 per group the	erapy se	ssion				
Eyewear	Not cove		.		Not covered; See Optional Advantage Plus Plan below						
J	See Optional Advanta										
Eye Exams	\$5-\$10 copay per Medi \$5 per routi			am;	\$0-\$5 copay per Medi \$0 per routi			ım;			
	Not cove				Not cov						
Hearing Aids	See Optional Advanta		Plan belo	ow	See Optional Advanta	,	Plan bel	ow			
Hearing Exams	\$10 copay per Medic	are-cov	ered exa	m	\$5 copay per Medica	are-cove	ered exar	n			
	\$10 co-pay per Medic				\$5 co-pay per Medic	are-cov	ered visi	t;			
Dental	\$0 copay for certain preventi				\$0 copay for certain preventi						
	See Optional Advanta				See Optional Advanta						
Chiropractic	\$5 copay per Medica Routine visits			;	\$0 copay per Medic Routine visits			;			
D. 31-4	\$10 copay per Medic			t;	\$5 copay per Medic			;			
Podiatry	Routine visits	not cove	ered		Routine visits	not cove	ered				
	Cost-sharing shown is for	30	100	100	Cost-sharing shown is for	30	100	100			
	preferred pharmacies	days	day	days	preferred pharmacies	days	days	days			
	Preferred Generic	\$4	retail \$12	mail \$8	Preferred Generic	\$0	retail \$0	mail \$0			
Prescription Drugs	Generic	\$10	\$30	\$20	Generic	\$7	\$21	\$14			
(Part D)	Preferred Brand	\$47	\$141	\$94	Preferred Brand	\$47	\$141	\$94			
	Non-Preferred Brand	\$100	\$300	\$200	Non-Preferred Brand	\$100	\$300	\$200			
	Specialty co-insurance \$0 deductible; after total year	33%	33%	33%	Specialty co-insurance \$0 deductible; after total year	33%	33%	33%			
	\$2,000, you pay \$0.	urry ure	ig costs i	cacii	\$2,000, you pay \$0.	arry ur	ig costs	cach			
	Home Medical Care: home	treatme	nt plan a	s an							
	alternative to hospital care ar	•			Medical Financial Assistan	-	•	ailable to			
	when found medically appro	•			eligible members; contact pla			c :			
	Medical Financial Assistan eligible members; contact pla	-	•	anable to	Over the Counter: \$60 quanter from OTC catalogue; \$25 mi						
	Over the Counter: \$60 quar			for items	nom o ro catalogue, que m		01401, 11	, 10110 (01			
Supplemental	from OTC catalogue; \$25 mi				Optional Advantage Plus P						
Ronofite and	Optional Advantage Plus P -Dental: Copays vary depend				-Dental: Copays vary dependent Must use Delta Care USA H			rvice;			
Benefits and				ivice,	-Hearing Aids: \$800 allowa			v 36			
Optional Plans				. 20	_	-		,			
	Must use Delta Care USA HI -Hearing Aids: \$800 allowa		ear every	y 30	months; \$0 copay for evaluate	ion and	ntung				
	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat	nce per tion and	fitting		-Vision \$300 allowance for e	yewear	every tw				
	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat -Vision: \$300 allowance for	nce per tion and eyewea	fitting r every to	wo years	-Vision \$300 allowance for 6 -Wellness: \$0 for One Pass §	eyewear gym me	every tw				
	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat	nce per tion and eyewea gym me	fitting r every to	wo years	-Vision \$300 allowance for e	eyewear gym me	every tw				
Optional Plans	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat -Vision: \$300 allowance for -Wellness: \$0 for One Pass §	nce per tion and eyewea gym me	fitting r every to	wo years	-Vision \$300 allowance for 6 -Wellness: \$0 for One Pass §	eyewear gym me	every tw				
Optional Plans Medical Groups	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat -Vision: \$300 allowance for -Wellness: \$0 for One Pass §	nce per tion and eyewea gym me	fitting r every tv mbership	wo years	-Vision \$300 allowance for 6 -Wellness: \$0 for One Pass §	eyewear gym me it	every tw mbership				
Optional Plans	Must use Delta Care USA HI -Hearing Aids: \$800 allowa months; \$0 copay for evaluat -Vision: \$300 allowance for -Wellness: \$0 for One Pass g one annual at home fitness ki	nce per tion and eyewea gym me it	fitting r every to mbership	wo years o and/or	-Vision \$300 allowance for e-Wellness: \$0 for One Pass sone annual at home fitness ki	eyewear gym me it rmanent	every tw mbership	and/or			

2020 1/12/21/21/11	E ADVANTAGE COMP	TITIO				1111.		<i>J</i> ₀			
Please contact the		SCAN Health Plan									
Plan for more		877-	870-4	867 (S	ales & Marketing)						
information or call					Member Services)						
1-800-Medicare		ouv		`	· · · · · · · · · · · · · · · · · · ·						
1-000-Medicare				<u>.scanhe</u>	althplan.com						
DI N/T	SCAN C	lassic			SCAN My	'Choi	ce				
Plan Name/Type	HMO (H054	425-07	(5)		HMO (H05	425-1	10)				
Ct. D. C.	· ·		-,				/				
Star Rating	***				★★★★ 1/2						
Annual OOP Max	\$1,50	0			\$1,50	0					
Monthly Premium	\$0				\$0						
Doctor Visits	\$0 copay for Primary		ysician	;	\$0 copay for Primary		hysician	;			
Doctor Visits	\$0 for Spec	cialist			\$0 for Spe	cialist					
Inpatient Hospital	\$100 copay/day f				\$100 copay/day						
Inpatient Hospital	\$0 per day for days	6 and b	eyond		\$0 per day for days	s 6 and b	beyond				
Outpatient Hospital	\$0 per ambulatory sur				\$0 per ambulatory sur						
	\$0-\$125 copay per outpatien	nt hospit	al facil	ty visit	\$0-\$125 copay per outpatie	nt hospi	ital facili	ty visit			
Skilled Nursing	\$0 copay/day for				\$0 copay/day fo						
Facility	\$75 per day for d	lays 21-	100		\$75 per day for	days 21-	-100				
Ambulance	\$180 copay per one-way	trip by g	round o	or air	\$105 copay per one-way	trip by	ground o	r air			
	\$90 copay per ER visit; w				\$90 copay per ER visit; w		_				
Emergency &	admitted to hospital; \$0 p				admitted to hospital; \$0						
Urgent Care	Worldwide coverage: no li				Worldwide coverage: no l						
	emergency care visit and	1 \$0 for	urgent o	are	emergency care visit an	d \$0 for	urgent c	are			
Lab Tests,	\$0 copay for lab, diagn	ostic pr	ocedure	·S.	\$0 copay for lab, diag	nostic p	rocedure	S,			
Procedures, and	tests, x-rays and diagr	nostic ra	diology		tests, x-rays and diag	nostic ra	adiology				
Radiation Therapy	\$60 copay for therap	eutic ra	diology		\$60 copay for therap	eutic ra	diology				
Renal Dialysis	20% co-insurance	per trea	tment		20% co-insurance	per trea	atment				
Outpatient Mental	\$10 copay for in	dividua	lor		\$10 copay for it		ıl or				
Health Visits	group therapy				group therap						
Eyewear	\$200 annual allowan	oo for o	TIOTILOOP		\$200 annual allowa	-					
Eyeweai							•				
Eye Exams	\$0 copay per Medicar \$0 copay for one annu				\$0 copay per Medicare-covered exam;						
•					\$0 copay for one annual routine exam						
Hearing Aids	\$550-\$850 copay per aid; u				\$550-\$850 copay per aid;						
	through TruHearing n				through TruHearing		_				
Hearing Exams	\$0 copay for Medicar			,	\$0 copay for Medicar						
	\$0 copay for one annu				\$0 copay for one ann \$0 co-pay per Medica						
Dental	\$0 co-pay per Medica \$0 co-pay for certain preve				\$0 co-pay per Medica \$0 co-pay for certain prev			/			
Dentai	services; See Optional I				services; \$2,000		_	iostic			
	· •				\$0 copay per Medica						
Chiropractic	\$0 copay per Medicar \$0 copay for 30 routing				\$5 copay for 30 routine visits per year, combined with chiropractic						
	φο copay for 30 fouri	ic visits	per yea								
Podiatry	\$0 copay per Medica	re-cove	ed visit		\$0 copay per Medica	ire-cove	red visit				
	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			
	D 6 10	d.o.	retail	mail	D. C. LC.	φo	retail	mail			
Prescription Drugs	Preferred Generic Generic	\$0	\$0 \$0	\$0 \$0	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0			
(Part D)	Preferred Brand	\$0 \$42	\$126	\$126	Preferred Brand	\$35	\$126	\$126			
(Fart D)	Non-Preferred Brand	50%	50%	50%	Non-Preferred Brand	50%	50%	50%			
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A			
	\$0 deductible; after total year	arly dru	g costs	reach	\$0 deductible; after total ye	arly dr	ug costs	reach			
	\$2,000 , you pay \$0 .				\$2,000 , you pay \$0 .						
	Acupuncture: \$0 copay per	visit for	36 rou	ine							
	visits per year				Acupuncture: \$0 copay per	visit fo	r 30 rout	ine			
	Essential Dental Plan: \$10/1				visits per year, combined wi						
	for certain diagnostic and con In-Home Support Services:				In-Home Support Services		irs for pe	ersonal			
Cumplemental	care following a hospitalizati		is for po	rsonai	care following a hospitalizat						
Supplemental Benefits and	Meals: up to 84 home-delive		ls per y	ear	Meals: up to 84 home-delive			ear			
	following a hospital stay or d	lue to a	chronic		following a hospital stay or condition	lue to a	CHIOHIC				
Optional Plans	condition				Over the Counter: \$75 qua	rterly al	lowance	items			
	Over the Counter: \$75 quar				in-store at CVS or home del						
	in-store at CVS or home deli over to next quarter but not c	•		umes	over to next quarter but not						
	Transportation: \$0 copay for			rips per							
	year to plan-approved location	ns with	in 50 m	iles							
Medical Groups and	Medical Groups: Brown &	Toland,	Imperia		Medical Groups: Brown &			1			
Hospitals	Health Holdings, SCAN Dire	ect Cont	ract		Health Holdings, SCAN Dir						
(may not be full list;	Hospitals: Alameda, Alta Ba			'4 D -	Hospitals: Alameda, Alta B			4 D -			
please check with plan)	(Berk/Oak), Highland (Oak), (Hayward), Stanford Valley				(Berk/Oak), Highland (Oak) (Hayward), Stanford Valley						
· · · · · · · · · · · · · · · · · · ·	(11aywaru), Stamoru variey	Cart (Pl	eas/Liv	,	(11ay waru), Stantoru valley	Care (P	icas/LIV				

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 (\$257 in 2025). 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: www.medicare.gov/medicare-and-you.

Star Ratings

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

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

This information is gathered from several different sources. In some cases it is based on member surveys, information from clinicians, or information from plans. In other cases, it is based on results from Medicare's regular monitoring activities. Detailed information is available here: https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings