2025 Medicare Advantage Special Needs Plan (SNP) ~ Final ~ Comparison Chart 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 a referral to see a specialist. The Medicare HMO will not pay for services received outside the plan's network unless it is urgent or emergency care. See our 2025 HMO Comparison Chart for more information and details: www.lashicap.org/hicap.

A Medicare PPO is another type of Medicare Advantage (MA) plan. A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses such as deductibles and coinsurance will apply. See our 2025 PPO Comparison Chart 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 need a nursing home level of care. 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. Five are for people with Medicare and full Medi-Cal (duals, with no share of cost). These are called D-SNPs and they have no premiums or co-payments. NOTE: Four out of five D-SNPs are closed to enrollment in 2025 due to low ratings or incomplete data. Another type of Special Needs Plan is for people with specific chronic or disabling conditions, such as diabetes, dementia, or cardiovascular disorders. It is called a C-SNP and certain cost-sharing applies. In 2025, there are 12 C-SNPs in Alameda County. The third type of Special Needs Plan is for people in institutions like a nursing home or for people who need a nursing home level of care at home. It is called an I-SNP and certain cost-sharing applies. In 2025, there are two I-SNPs in Alameda County.

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 who <u>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 and highlights the areas where the Medicare Advantage plans may differ in benefits. For more detailed information about coverage and cost-sharing, contact the plans directly. For preventive care benefits covered by Medicare, please see the back of this chart. Also, on the last page is an explanation of the Star Ratings provided by Medicare.

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

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



Navigating Medicare

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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.

		FOR ALAMEDA COUNTY: D-SINFS
Please contact the Plan for more	Aetna Medicare 833-859-6031 (Sales & Marketing)	Anthem Blue Cross 844-309-6996 (Sales & Marketing)
information or call 1-800-Medicare	833-570-6670 (Member Services) www.aetnamedicare.com	833-707-3130 (Member Services) www.shop.anthem.com/medicare/ca
Plan Name/Type	Aetna Medicare Preferred D-SNP (H4982-008) / For People with Medicare and FULL Medi-Cal	Anthem Dual Advantage D-SNP (H4471-007) / For People with Medicare and FULL Medi-Cal
Star Rating	★★1/2 Plan suppressed by Medicare; CLOSED to enrollment due to low ratings or incomplete data	Plan too new to be measured Plan suppressed by Medicare; CLOSED to enrollment due to low ratings or incomplete data
Annual OOP Max	\$9,350	\$9,350
Monthly Premium	\$0	\$0
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist	\$0 for Primary Care Physician; \$0 for Specialist
Inpatient Hospital	\$0 per day; Unlimited number of days	\$0 per day for days 1 - 150
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit
Skilled Nursing Facility	\$0 per day; 100 days per benefit period	\$0 copay per day for days 1 - 100
Ambulance	\$0 copay per trip by ground or air	\$0 copay per trip by ground or air
Emergency & Urgent Care	\$0 copay per emergency room or urgent care visit; Worldwide coverage: "some coverage" per Medicare.gov	\$0 copay per ER or urgent care visit; Worldwide coverage: \$0 copay; \$100,000 annual limit
Lab Tests, Procedures, and Radiation Therapy	\$0 copay per service	\$0 copay per service
Renal Dialysis	\$0 co-insurance per treatment	\$0 co-insurance per treatment
Outpatient Mental Health Visits	\$0 copay for individual or group therapy session	\$0 copay for individual or group therapy session
Eyewear	"Some coverage" per Medicare.gov	\$300 annual allowance for eyewear
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for 1 annual routine exam	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam
Hearing Aids	"Some coverage" per Medicare.gov	\$3,000 annual allowance
Hearing Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 co-pay per Medicare-covered exam; \$0 copay for one annual routine exam
Dental	\$0 copay for limited preventive and comprehensive services; through Liberty Dental network	\$0 copay for Medicare covered visit; \$1,400 annual allowance for certain preventive and comprehensive services
Chiropractic	\$0 copay per Medicare covered visit; Routine visits: "Some coverage" per Medicare.gov	\$0 co-pay per Medicare covered visit; \$0 copay for 12 routine visits per year
Podiatry	\$0 copay per Medicare covered visit; Routine visits: "Some coverage" per Medicare.gov	\$0 co-pay per Medicare covered visit; \$0 copay for unlimited routine visits per year
Prescription Drugs (Outpatient)	\$0 deductible: \$0 copay for 30-, 60-, or 100-day supply of all covered drugs; specialty drugs have 30 day limit	\$0 deductible; \$0 copay for 30-, 60-, or 100-day supply of all covered drugs; specialty drugs have 30 day limit
Supplemental Benefits and Optional Plans	Acupuncture: Routine visits: "Some coverage" per Medicare.gov Extra Benefits Card: "Some coverage" per Medicare.gov Over the Counter (OTC): "Some coverage" per Medicare.gov Transportation: \$0 copay/trip; "Some coverage" per Medicare.gov Wellness: \$0 for Silver Sneakers gym membership	Acupuncture: \$0 copay per visit for unlimited routine visits per year Community Resource Support: Referrals and coordination for community services Meals: \$0 copay for 2 meals per day for 5 days following inpatient hospital or SNF stay Options Allowance: \$70 monthly allowance for assistive devices, eligible food items, OTC products, and utilities Transportation: \$0 copay/trip for 48 trips per year to plan-approved locations within 60 miles Wellness: \$0 for Silver Sneakers gym membership; one fitness tracker every other year
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Brown & Toland, One Medical Hospitals: Alameda, Alta Bates/Summit Med Ctr, (Berk/Oak), Highland (Oak), Eden (CastroValley), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Hospital (Frem)	Medical Groups: Brown & Toland; Hill Physicians East Bay, Imperial Health Holdings, Nivano Physicians Hospitals: Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), Washington (Fremont)

2025 MEDICARI	E ADVANTAGE COMPARISON CHART	FOR ALAMEDA COUNTY: D-SNPS
Please contact the Plan for more information or call 1-800-Medicare	Central Health Medicare 1-866-314-2427 (Sales & Marketing) 1-866-314-2427 (Member Services) www.centralhealthplan.com	Imperial Health Plan of CA 1-800-838-8271 (Sales & Marketing) 1-800-838-8271 (Member Services) www.imperialhealthplan.com
Plan Name/Type	Centra Health Dual Access D-SNP (H5649-024) / For People with Medicare and FULL Medi-Cal	Imperial Dual Plan D-SNP (H5496-011) / For People with Medicare and FULL Medi-Cal
Star Rating	★★1/2 Plan suppressed by Medicare; CLOSED to enrollment due to low ratings or incomplete data	★★★1/2 Plan suppressed by Medicare; CLOSED to enrollment due to low ratings or incomplete data
Annual OOP Max	\$9,350	\$2,999
Monthly Premium	\$0	\$0
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist	\$0 copay for Primary Care Physician; \$0 for Specialist
Inpatient Hospital	\$0 per stay	\$0 copay/day for days 1 - 150
Outpatient Hospital Skilled Nursing	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit
Facility	\$0 copay per day for days 1 - 100	\$0 copay for days 1 - 100
Ambulance	\$0 copay per trip by ground or air	\$0 copay per trip by ground or air
Emergency & Urgent Care	\$0 copay per ER or urgent care visit; Worldwide coverage: \$110 copay for emergency or urgent care visit; \$50,000 limit	\$0 copay per emergency room or urgent care visit; Worldwide coverage: \$0 copay; \$100,000 limit
Lab Tests, Procedures, and Radiation Therapy	\$0 copay per service	\$0 copay per service
Renal Dialysis	\$0 coinsurance per treatment	\$0 copay per treatment
Outpatient Mental Health Visits	\$0 copay for individual or group therapy session	\$0 copay per individual or group therapy session
Eyewear	\$300 annual allowance for eyewear	\$500 annual allowance for eyewear
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 copay per Medicare-covered exam; \$0 co-pay for routine exams
Hearing Aids	Not covered; refer to Medi-Cal benefits	\$2,500 annual allowance
Hearing Exams	\$0 co-pay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 copay for Medicare-covered exam; \$0 copay for routine exams
Dental	\$0 copay for Medicare covered visit; Routine dental not covered; refer to Medi-Cal benefits	\$0 copay for Medicare covered visit; \$0 co-pay for preventive services; \$500 coverage limit per year; \$0 co-pay for comprehensive services; \$1,500 coverage limit per year
Chiropractic	\$0 co-pay per Medicare covered visit; \$0 copay for 30 routine visits per year, combined with acupuncture	\$0 co-pay per Medicare-covered visit
Podiatry	\$0 co-pay per Medicare covered visit	\$0 copay per Medicare-covered visit; \$0 copay for 6 routine visits per year
Prescription Drugs (Outpatient)	\$0 deductible; \$0 copay for 30-, 60-, or 100-day supply of all covered drugs; specialty drugs have 30 day limit	\$0 deductible: Depending on your income, you pay the following: Generics: \$0 to \$4.90 Brand Name Drugs: \$4.90 to \$12.15 After annual drug costs reach \$2,000, you pay \$0.
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for 30 routine visits per year, combined with chiropractic Groceries: \$50 monthly allowance for healthy foods for those w/qualifying chronic conditions In-Home Support Services: \$0 copay for 20 hours per year for those with qualify chronic cond Meals: \$0 copay per meal for 14 meals/month for those with qualifying chronic conditions Over the Counter (OTC): \$150 quarterly allowance for plan approved items, including OTC hearing aids Scales: \$0 copay for those with qualifying chronic conditions Transportation: \$0 copay/trip for 24 one-way trips/year to plan approved locations w/in 50 miles Wellness: \$0 for Silver Sneakers gym membership	Groceries: \$460 quarterly allowance for those with qualifying chronic conditions In-Home Support Services: \$0 copay for up to 60 hours per year for help with shopping, care reminders, light housekeeping, and transportation Meals: \$0 co-pay for up to 7 home-delivered meals following surgery or hospital stay; \$105 allowance per benefit period Over the Counter (OTC): \$140 quarterly allowance for items in plan's OTC mail order catalog; no rollover Transportation: \$0 copay for 100 one-way trips to plan approved locations Wellness: \$0 for one Silver&Fit at-home fitness kit per year
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Hill Physicians East Bay Hospitals: Eden (Castro Valley) and Washington (Fremont)	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)

	ADVANTAGE COMPARISON CHAR
Please contact the	Kaiser Permanente
	1-800-777-1238 (Sales &
Plan for more information or call	Marketing)
1-800-Medicare	1-800-443-0815 (Member Services)
1-000-Meancare	www.healthy.kaiserpermanente.org
	Kaiser Dual Complete North P4
	D-SNP (H8794-004)
Plan Name/Type	For People with Medicare and
	FULL Medi-Cal
Star Rating	Plan too new to be measured
Annual OOP Max	\$9,350
Monthly Premium	\$0
-	\$0 for Primary Care Physician;
Doctor Visits	\$0 for Specialist
Inpatient Hospital	\$0 per day;
Inputient Hospital	Unlimited days per benefit period
Outpatient Hospital	\$0 copay per ambulatory surgical center visit; \$0 copay per outpatient hospital visit
Skilled Nursing	\$0 copay per day;
Facility	100 days per benefit period
Ambulance	7 1 1
	\$0 copay per trip by ground or air
Emergency &	\$0 copay per emergency room or urgent care visit; Worldwide coverage
Urgent Care	visit; Worldwide coverage
Lab Tests,	, do
Procedures, and	\$0 copay per service
Radiation Therapy	
Renal Dialysis	\$0 copay per treatment
Outpatient Mental Health Visits	\$0 copay per individual or group therapy session
Eyewear	\$350 annual allowance for eyewear
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for routine exams
Hearing Aids	Not Covered; refer to Medi-Cal benefits
_	\$0 co-pay per Medicare-covered exam
Hearing Exams	\$0 copay for Medicare covered visit;
Dental	Routine dental not covered; refer to Medi-Cal benefits
Chiropractic	\$0 co-pay per Medicare covered visit
Podiatry	\$0 co-pay per Medicare covered visit
Prescription Drugs (Outpatient)	\$0 deductible: Depending on your income, you pay the following: Generics: \$0 to \$4.90 Brand Name Drugs: \$4.90 to \$12.15 After total yearly drug costs reach \$2,000, you pay \$0.
Supplemental Benefits and Optional Plans	Over the Counter (OTC): \$140 quarterly allowance for items in OTC catalogue; each order must be at least \$25 Wellness: \$0 copay for One Pass fitness program, including gym membership
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Kaiser Permanente Hospitals: Kaiser Oakland, San Leandro, Fremont

2025 MEDICAR	E ADVANTAGE COMI	PARIS				NTY: (-5INP	S		
Please contact the		Alignment Health Plan								
Plan for more					Sales &Marketing)					
information or call 1-800-Medicare					Member Services) thealthplan.com					
Plan Name/Type	Alignment Healt C-SNP (H3	th Brea 3815-04	athEa	ısy	Alignment Health Clarity C-SNP (H3815-042) / For People with Chronic Disabling Mental Disorders					
Stor Dating	For People with Chro ★★★		ig Disc	oruers	- U		Disora	ers		
Star Rating Annual OOP Max	\$8,85				**** #9.950					
Monthly Premium	\$18.2				\$8,850 \$24.10					
Doctor Visits	\$0 for Primary Care Physic		for Space	nialist.	\$24.10 \$0 for Primary Care Physician; \$0 for Specialist					
Inpatient Hospital	\$1,676 deductible; \$0 copay/day for days 1-60; \$419 copay/day for days 61-90; \$838 copay/day for days 91-150; all costs for additional days				\$1,676 deductible; \$0 c \$419 copay/day for days of days 91-150; all cost	opay/day : 51-90; \$83	for days 1 88 copay/o	-60; day for		
Outpatient Hospital	20% coinsurance per amb and outpatient h	20% coinsurance per an and outpatien	nbulatory	surgical c						
Skilled Nursing Facility	\$0 copay/day fo \$209.50 copay/day				\$0 copay/day \$209.50 copay/da					
Ambulance	20% coinsurance per t	rip by gro	ound or a	air	20% coinsurance per	trip by g	round or a	iir		
	20% coinsurance per ER vis	1 , 0			20% coinsurance per ER v					
Emergency & Urgent Care	hospital within 48 hours; \$ Worldwide coverage: \$2 ER/urgent care with	60 per urg 25,000 an	gent care nual lim	visit;	hospital within 48 hours: Worldwide coverage: ER/urgent care	\$0 per ur \$25,000 ar	gent care nnual limi	visit;		
Lab Tests, Procedures, and Radiation Therapy	20% coinsurance for lab s and procedures; \$0 copay for radiology; 20% coinsurance	20% coinsurance for lab so and procedures; \$0 copay radiology; 20% coinsurance	for x-ray	s and diag	nostic					
Renal Dialysis	20% coinsurance	per treat	ment		20% co-insuran	ce per trea	atment			
Outpatient Mental Health Visits	20% coinsurance f group therap				20% coinsurance group thera					
Eyewear	\$500 allowance for eyes	wear ever	y two ye	ears	\$500 allowance for eyewear every two years					
Eye Exams	\$0 copay per Medica	are-cover	ed exam	ι;	\$0 copay per Medicare-covered exam;					
Hearing Aids	\$0 copay for one and \$0 copay for up to 2 he				\$0 copay for one annual routine exam \$0 copay for up to 2 hearing aids each year					
	\$0 copay per Medica				\$0 copay per Medicare-covered exam;					
Hearing Exams	\$0 copay for one ann	ual routi	ne exam		\$0 copay for one annual routine exam					
Dental	20% coinsurance per Mo \$0 copay for certain prev comprehensive services; \$	entive, di 500 quart	agnostic erly allo	and wance	20% coinsurance per Medicare covered visit; \$0 copay for certain preventive, diagnostic and comprehensive services; \$500 quarterly allowance					
Chiropractic	\$0 copay per Medicare cove		–		\$0 copay per Medicare covered visit; \$0 copay for 24					
Podiatry	routine visits each year, con \$0 copay per Medic			uncture	routine visits each year, combined with acupuncture \$0 copay per Medicare-covered visit					
1 outait y		30	100	100		30	100	100		
	Cost-sharing shown is for preferred pharmacies	days	days	days	Cost-sharing shown is for preferred pharmacies	days	days	days		
		retail	retail	mail		retail	retail	mail		
Prescription Drugs	Preferred Generic Generic	25% 25%	25% 25%	25% 25%	Preferred Generic Generic	25% 25%	25% 25%	25% 25%		
(Outpatient)	Preferred Brand	25%	25%	25%	Preferred Brand	25%	25%	25%		
(Outpatient)	Non-Preferred Brand	25%	25%	25%	Non-Preferred Brand	25%	25%	25%		
	Specialty co-insurance	25%	N/A	N/A	Specialty co-insurance	25%	N/A	N/A		
	\$590 deductible; after total	yearly d	rug cost	s reach	\$590 deductible; after tota	l yearly d	rug costs	reach		
	\$2,000, you pay \$0. Acupuncture: \$0 copay per	visit for	24 routi	ne	\$2,000, you pay \$0. Acupuncture: \$0 copay pe	r visit for	24 routin	e visits		
	visits per year, combined wi				per year, combined with ch			20113		
	In-Home Support Services				In-Home Support Service					
	per quarter OR \$300 annual	_			per quarter OR \$300 annua	_				
	Meals: \$0 copay for 28 mea with qualifying chronic cond		aays 10	or tnose	Meals: \$0 copay for 28 me with qualifying chronic cor		4 days foi	tnose		
	Over the Counter: \$135 mg		owance	for	Over the Counter: \$135 m		lowance f	or		
Supplemental	eligible items; no rollover	_			eligible items; no rollover					
Benefits and	Part B Premium Rebate: \$ Pet Services: \$0 copay for 7			r 11	Part B Premium Rebate: Pet Services: \$0 copay for			14		
Optional Plans	walks/year for those w/quali				walks/year for those w/qua					
	Pest Control: \$0 copay for	1 service	per year		Pest Control: \$0 copay for	1 service	per year			
	those with qualifying chronic Transportation: \$0 copay 5			o nlan	those with qualifying chron Transportation: \$0 copay			nlon		
	approved locations within 50		year to	o pian-	approved locations within 5		er year to	piali-		
	Wellness: \$0 copay for basic		embersh	ip at	Wellness: \$0 copay for bas	ic gym m	embership	o at		
Madias! C	participating fitness centers	m t :		TD.4	participating fitness centers					
Medical Groups and Hospitals	Medical Groups: Brown & Hospitals: Alameda; Alta B				Medical Groups: Brown & Hospitals: Alameda; Alta I					
(may not be full list;	Highland (Oak), San Leandr				Highland (Oak), San Leand					
please check with plan)	Stanford Valley Care (Pleas									
please check with plan)	Stanford Valley Care (Pleas/	Liv)			Stanford Valley Care (Pleas/Liv)					

2025 MEDICARE	ADVANTAGE COMPA	RISO	N CH	ART FO	OR ALAMEDA COUNT	г ү: С-	SNPs	5		
Please contact the		Alignment Health Plan								
Plan for more		888	-979-	2247 (S	Sales &Marketing)					
information or call		86	6-634	-2247	Member Services)					
1-800-Medicare				,	thealthplan.com					
	Alignment Health H				Alignment Health Heart & Diabetes					
TO 1 1/1	C-SNP (H3815-010)					CalPlus C-SNP (H3815-039) / For				
Plan Name/Type	Cardiovascular Disord				People with Cardiov					
	Failure and/or			Heart	Chronic Heart Failu					
Star Rating	***		**		or Dia,	octes .				
Annual OOP Max	\$790	\$7,3								
Monthly Premium	\$0	<u>'</u>			\$29.					
Doctor Visits	\$0 copay for PCP; \$0 c	onay for	Special	list	\$0 copay for PCP; \$0		r Speciali	ist		
Inpatient Hospital	\$0 copay for unlimited	\$275 copay/day	for days	1-6;	150					
Outpatient Hospital	\$0 copay per ambulator	\$0 copay for days 20% coinsurance per amb	ılatory su	ırgical ce	enter or					
Skilled Nursing	outpatient hospita				outpatient hospit					
Facility Facility	\$0 copay for d \$50 copay/day for	days 32	2-100		\$0 copay/day f \$204 copay/day f	or days 2	1-100			
Ambulance	\$100 copay per trip by groun waived if admitte	d to hos	pital .	-	20% coinsurance per t not waived if adm			air;		
Emergency &	\$20 copay per ER visit; waive	ed if adn	nitted to	hospital	20% coinsurance per ER vi	sit; waiv	ed if adm			
Urgent Care	within 48 hours; \$0 per Worldwide Coverage ; \$0 co				hospital within 48 hours; Worldwide Coverage; \$75					
Lab Tests,	\$0 copay for lab services, x-r				20% coinsurance for lab ser					
Procedures, and	procedures, diagno	stic radi	ology,	com and	and procedures; \$0 copay	for x-rays	and diag	gnostic		
Radiation Therapy	and therapeutic	radiolog	gy		radiology; 20% coinsurance	for there	apeutic ra	adiology		
Renal Dialysis	20% co-insurance	per trea	tment		20% co-insuranc	e per trea	ıtment			
Outpatient Mental	\$0 copay per i	ndividua	al		20% coinsurance	per indi	vidual			
Health Visits	or group therap	y sessio	on		or group ther	apy sessi	on			
Eyewear	\$200 annual allowar	nce for e	yewear		\$500 allowance for eye	wear eve	ry two ye	ears		
Eye Exams	\$0 copay per Medicar				\$0 copay per Medicare-covered exam;					
<u> </u>	\$0 copay for one ann		ne exan	n	\$0 copay for one annual routine exam					
Hearing Aids	Not cove				\$0 copay for 2 hearing aids each year \$0 co-pay per Medicare-covered exam;					
Hearing Exams	\$0 co-pay per Medica \$0 for one annual			n	\$0 co-pay per Medicare-covered exam; \$0 for one annual routine exam					
	\$0 copay per Medicare cover			0 copays	\$0 copay per Medicare covered visit; \$10-\$30 copays					
Dental	for certain preventive &	diagnost	tic servi	ces;	for certain preventive svcs; \$15-\$570 copays for					
	\$15-\$570 copays for certain c				certain comprehensive svcs; \$500 quarterly limit \$0 copay per Medicare covered visit; \$0 copay for 12					
Chiropractic	\$0 copay per Medica	ire covei	red visit		routine visits per year, con					
Podiatry	\$0 copay per Medica \$0 copay for 12 routing				\$0 copay per Medicare covered visit					
		30	100	100		30	100	100		
	Cost-sharing shown is for preferred pharmacies	days	days	days	Cost-sharing shown is for preferred pharmacies	days	days	days		
	1 0 1	retail	retail	mail	1 0 1	retail	retail	mail		
Prescription Drugs	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0	Preferred Generic Generic	25% 25%	25% 25%	25% 25%		
(Outpatient)	Preferred Brand	\$30	\$90	\$75	Preferred Brand	25%	25%	25%		
(Outputient)	Non-Preferred Brand	\$100	\$300	\$300	Non-Preferred Brand	25%	25%	25%		
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	25%	N/A	N/A		
	\$0 deductible; after total yea \$2,000, you pay \$0.	rly drug	g costs 1	reach	\$590 deductible; after total \$2,000, you pay \$0.	yearly d	rug costs	s reach		
	Enhanced Dental Option: \$3	36 mont	hly pren	nium:	Acupuncture: \$0 co-pay for	r 12 routi	ne visits	per		
	0%-50% coinsurance for cert				year, combined with chiropr		110 (15115	per		
	comprehensive services; \$1,5				Flex Allowance: \$300 quart			r		
	Essentials Allowance: \$25 m groceries, utilities, and home	_			services related to vision, de acupuncture, chiropractic an		_	,		
	qualifying chronic conditions			witti	In-Home Support Services					
	In-Home Support Services:	\$0 copa	y for 12		per quarter OR \$300 annual	_				
Supplemental	per quarter OR \$300 annual c Meals: \$0 copay for 28 meals	_			Meals: \$0 copay for 28 mean per year for those with quality					
Benefits and	per year for those with qualify				Over the Counter (OTC):					
Optional Plans	Over the Counter (OTC): \$2	25 montl	hly allo	wance	Pest Control: \$0 copay for	one annu	al service			
	Pest Control: \$0 copay for or those with qualifying chronic			e for	those with qualifying chroni Pet Services: \$0 copay for 7			. 14		
	Pet Services: \$0 copay for 7			r 14	walks/year for those w/quali					
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	E ADVANTAGE COM						Y: C	-9111	3
Please contact the	Central Health Medicare								
Plan for more		1-80	66-314	-2427 (Sales & N	(Iarketing			
information or call		1-8	66-31	4-2427	(Member	Services)			
1-800-Medicare					ealthplan.com				
	Central Health l	Embr				ral Health En	ıhrac	e Cho	nice
	C-SNP (H			ui C	Cent	icc			
Plan Name/Type	For People with Card			cooco	C-SNP (H5649-026) For People with Cardiovascular Diseas				20000
	Chronic Heart Failui				Chronic Heart Failure, and/or Diabetes				
C4 D-4!			1/01 D1a	ibetes					
Star Rating	**1				★★1/2				
Annual OOP Max	\$2,73			\$9,350					
Monthly Premium	\$0					\$13.40		~ .	
Doctor Visits	\$0 for Primary Care Phys					PCP; 0-30% coinsu			
Inpatient Hospital	\$0 copay for days 1-5; \$20 \$35 per day for		day for	eductible; \$0 copay f days 61-90; \$838 pe	r day for	r days 9	1-150		
Outpatient Hospital	\$0 - \$100 per ambulatory \$0 - \$150 per outpat				\$0 copa 20% coin	y per ambulatory sur surance per outpatie	gical ce nt hospi	nter visi tal facili	it; \$0- ity visit
Skilled Nursing	\$0 for day					\$0 copay for da	-		
Facility	\$209.50 copay per da	-	•	00	\$	5209.50 copay/day fo	or days 2	21-100	
Ambulance	\$0-\$200 copay per				20%	coinsurance per tri	n bv gro	und or a	uir
- Information	20% coinsurance			hosmit-1		copay per ER visit;			
Emergency &	\$0 - \$140 per ER visit; waiv within 72 hours; \$0			nospitai		copay per ER visit; vital within 72 hours;			
Urgent Care	Worldwide coverage: \$14			ergency		vide coverage: \$110			
	or urgent care visi					or urgent care visit;	\$50,000	limit	
Lab Tests,	\$0 copay for lab services, x-	rays, dia	agnostic t	ests, and		opay for lab services			
Procedures, and	procedures; \$100 copay for	or diagn	ostic radi	ology;	coinsu	rance for diagnostic and diagnostic ra			ures
Radiation Therapy	20% coinsurance for the	nerapeut	tic radiol	ogy	20%	coinsurance for the			gy
Renal Dialysis	20% coinsurance	per tre	atment			20% co-insurance			
Outpatient Mental	\$10 copay for individu	•		on.					
Health Visits	20% coinsurance per g				\$0 copa	ay for individual or g	group the	erapy se	ssion
Eyewear	\$300 annual allowa				\$300 annual allowance for eyewear				
	\$0 copay per Medica		•	1:	\$0 copay per Medicare covered exam;				
Eye Exams	\$0 copay for one and				\$0 for one annual routine exam				
Hearing Aids	\$575-\$2099 copay per a				\$49-\$1549 copay per aid for 2 aids every 3 years				
	\$0 copay per Medicare-covered exam;				\$0 copay per Medicare-covered exam;				
Hearing Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam				\$0 copay for one annual routine exam				
Hearing Exams	\$0 copay for one and	nual rou	tine exan	n	\$0			e exam	
Hearing Exams Dental	. 1 3 1	nual rou re cove	tine exan			copay for one annu	al routin		
_	\$0 copay for one and \$0 copay for Medica	nual rou re cover eventati	tine exan red visit; ve servic	es;			al routin		
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Dental Chiropractic Podiatry Prescription Drugs (Outpatient)	\$0 copay for one and \$0 copay for Medica \$0 copay for certain pr \$0-\$2,160 copays for certain \$0 co-pay per Medicare coveroutine visits/year, combine \$0 copay for 12 rout *Cost-sharing shown is for preferred pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yes \$2,000, you pay \$0. *Acupuncture: \$0 copay for combined with chiropractic voluments of the certain comprehensive services; \$1,6 Groceries: \$40 monthly allo	recovereventation commerced visit and are covered visit and are covered visit and are covered visit so and are covered visit so are covered visit so are covered visit so are covered visits are covered visits on the control of the covered visits on the covered visits of the covered visits on the covered visits of the covered visits on the covered visits on the covered visits on the covered visits of the covered visits on the covered visits of the covered visits on the covered visi	tine exanted visit; we service prehensive; \$0 copecupuncture ered visit; \$0 copecupuncture ered visit; \$0 days retail \$0 \$27 \$101 \$270 N/A arg costs of the visits or the visits of visits or the visi	res; re svcs ay for 12 are visits r; r 100 days mail \$0 \$18 \$94 \$180 N/A reach per year, 0%- age limit	\$0 co-proutine v \$0 \$0 \$0 Cost-sha preferred Generic Preferred Non-Pref Specialty \$590 dedu \$2,000, yo Acupunct combined Groceries for those v In-Home	o copay for one annu o copay for Medicare oay per Medicare covisits per year, combi o co-pay per Medicar ocopay for 12 routing ring shown is for a pharmacies Generic Brand ferred Brand for co-insurance ctible; after total year out pay \$0. ure: \$0 copay for 12 with chiropractic : \$30 monthly allow with qualifying condi Support Services: 2	al routing all rou	d visit sit; \$0 fc h acupul ed visit; per year 100 days retail 25% 25% 25% N/A ug costs visits p	100 days mail 25% 25% 25% N/A reach
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Please contact the	Central Healt				Imperial Health					
Plan for more	1-866-314-2427 (S	Sales &	Marke	ting)	1-800-838-8271 (Sa	les & I	Marke	ting)		
information or call	1-866-314-2427 (Membe	er Servi	ices)	1-800-838-8271 (M	Iembei	r Servi	ces)		
1-800-Medicare	www.centralhea			/	www.imperialhe			,		
	Central Healt	_		n	Imperial Sen					
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Plan Name/Type	C-SNP (H		,		C-SNP (H5					
	For People with Card				For People with Cardi					
	Chronic Heart Failu		or Dia	betes	Chronic Heart Failur		or Dia	betes		
Star Rating	**1				★★★1/2					
Annual OOP Max	\$1,8				\$297	<u> </u>				
Monthly Premium	\$0)			\$0					
Doctor Visits	\$0 for Primary Care Phys	sician; \$0	for Spec	cialist	\$0 for Primary Care Physic	cian; \$0	for Spec	ialist		
Inpatient Hospital	\$0 per	\$0 copay/day for \$670 /day for da								
Outpatient Hospital	\$0 copay per ambulatory \$0 copay per outpat				\$100 per ambulatory su \$100 per outpatien			it;		
Skilled Nursing Facility	\$0 per	stay			\$0 copay for days 1-20; \$1 \$200 /day for days			21-50;		
Ambulance	\$200 copay per trip	by grou	nd or air		\$150 copay per tri 20% co-insurance	p by gro	und;			
	\$135 copay per ER visit:	; waived	if admitt	ed to	\$125 copay per emergency			ved if		
Emergency & Urgent Care	hospital within 72 hours; \$ Worldwide coverage: \$5 or urgent care visit	60 copay	for urger for emer	nt care;	admitted to hospital w/in 4 care; Worldwide coverage: or urgent care; \$1	8 hours; \$0 copay	\$0 for u for em	rgent		
Lab Tests,	\$0 copay for lab services,			tests.	\$0 copay for lab services			s &		
Procedures, and	procedures; \$75 copay fo	or diagnos	stic radio	ology;	procedures, x-rays, and d	iagnosti	c radiolo	ogy;		
Radiation Therapy	20% coinsurance for the	herapeuti	ic radiolo	ogy	20% co-insurance for the	erapeuti	c radiolo	ogy		
Renal Dialysis	20% co-insuranc	e per trea	atment		20% co-insurance	per treat	tment			
Outpatient Mental Health Visits	\$0 copay for individual o	r group tl	herapy se	ession	20% co-insurance or group thera					
Eyewear	\$150 annual allowa	ance for e	evewear		\$500 annual allowance for eyewear					
	\$0 copay for Medica		•		\$0 copay per Medicare-covered exam;					
Eye Exams	\$0 for one annua			,	\$0 copay for routine exams					
Hearing Aids	\$2,000 annual allowance,	through l	NationsH	learing	\$500 annual allowance					
Hearing Exams	\$0 copay for Medica				\$0 copay for Medicare-covered exam;					
	\$0 copay for one and \$0 copay for Medica			1	\$0 for routine exams up to \$250/year \$0 copay for Medicare covered visit;					
Dental	\$0-\$41 copay for certain \$0-\$2,160 copay for certain	preventa	ative serv		\$0 co-pay for preventive \$0 co-pay for comprehensive	services	; \$500 /y			
Chiropractic	\$0 copay per Medic			9C1 V1CC3	\$0 copay per Medica			or y cur		
-	\$0 co-pay per Medic				\$0 copay per Medica					
Podiatry	\$0 co-pay per Medic \$0 copay for 12 rout				\$0 copay for 6 routing					
		30	90	100		30	100	100		
		days	days	days	Cost sharing shown is for		days	days		
	Cost-sharing shown is	cact j b			Cost-sharing shown is for	days	auys	auys		
	for network pharmacies	retail	retail	mail	preferred pharmacies	retail	retail	mail		
	for network pharmacies Preferred Generic	retail \$0	\$0	\$0	preferred pharmacies Preferred Generic	retail \$0	retail \$0	mail \$0		
	for network pharmacies Preferred Generic Generic	retail \$0 \$0	\$0 \$0	\$0 \$0	Preferred Pharmacies Preferred Generic Generic	retail \$0 \$6	retail \$0 \$18	mail \$0 \$5		
Prescription Drugs (Outpatient)	for network pharmacies Preferred Generic Generic Preferred Brand	retail \$0 \$0 \$35	\$0 \$0 \$105	\$0 \$0 \$70	Preferred Pharmacies Preferred Generic Generic Preferred Brand	retail \$0 \$6 \$45	retail \$0 \$18 \$135	mail \$0 \$5 \$90		
	Freferred Generic Generic Preferred Brand Non-Preferred Brand	retail \$0 \$0 \$35 \$75	\$0 \$0 \$105 \$225	\$0 \$0 \$70 \$150	Preferred pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand	retail \$0 \$6 \$45 \$90	retail \$0 \$18 \$135 \$270	mail \$0 \$5 \$90 \$180		
Prescription Drugs (Outpatient)	Freferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance	retail \$0 \$0 \$35 \$75 33%	\$0 \$0 \$105 \$225 N/A	\$0 \$0 \$70 \$150 N/A	preferred pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance	retail \$0 \$6 \$45 \$90 33%	retail \$0 \$18 \$135 \$270 N/A	mail \$0 \$5 \$90 \$180 N/A		
	Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total ye	retail \$0 \$0 \$35 \$75 33%	\$0 \$0 \$105 \$225 N/A	\$0 \$0 \$70 \$150 N/A	Preferred pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand	retail \$0 \$6 \$45 \$90 33%	retail \$0 \$18 \$135 \$270 N/A	mail \$0 \$5 \$90 \$180 N/A		
	Freferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance	retail \$0 \$0 \$35 \$75 33% early dru	\$0 \$0 \$105 \$225 N/A	\$0 \$0 \$70 \$150 N/A	preferred pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea	retail \$0 \$6 \$45 \$90 33%	retail \$0 \$18 \$135 \$270 N/A	mail \$0 \$5 \$90 \$180 N/A		
	for network pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total ye \$2,000, you pay \$0. Acupuncture: \$0 copay per routine visits per year	retail \$0 \$0 \$35 \$75 33% early dru	\$0 \$105 \$225 N/A unlimite	\$0 \$0 \$70 \$150 N/A reach	preferred pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$2,000, you pay \$0.	retail \$0 \$6 \$45 \$90 33% arly drug	retail \$0 \$18 \$135 \$270 N/A g costs I	mail \$0 \$5 \$90 \$180 N/A		
	For network pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total ye \$2,000, you pay \$0. Acupuncture: \$0 copay per routine visits per year Dental Plan Option: \$45/n	retail \$0 \$0 \$35 \$75 33% early dru r visit for	\$0 \$105 \$225 N/A unlimite	\$0 \$0 \$70 \$150 N/A reach	preferred pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea	retail \$0 \$6 \$45 \$90 33% arly drug	retail \$0 \$18 \$135 \$270 N/A g costs 1	mail \$0 \$5 \$90 \$180 N/A reach		
	for network pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total ye \$2,000, you pay \$0. Acupuncture: \$0 copay per routine visits per year Dental Plan Option: \$45/n year; 10% coinsurance for p	retail \$0 \$0 \$0 \$35 \$75 33% early dru r visit for	\$0 \$105 \$225 N/A ig costs in the up to \$1 e service	\$0 \$0 \$70 \$150 N/A reach	preferred pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$2,000, you pay \$0. In-Home Support Services:	retail \$0 \$6 \$45 \$90 33% arly drug	retail \$0 \$18 \$135 \$270 N/A g costs 1	mail \$0 \$5 \$90 \$180 N/A reach		
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	preferred Generic Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total ye \$2,000, you pay \$0. Acupuncture: \$0 copay per routine visits per year Dental Plan Option: \$45/n year; 10% coinsurance for p coinsurance for comprehens Groceries: \$50 monthly alle foods, for those with qualify In-Home Support Services hours per year for qualifyin; Meals: \$0 copay/meal for 2	retail \$0 \$0 \$0 \$35 \$75 33% early dru r visit for month for preventive servi owance f ying conde s: \$0 cop g membe meals/da	\$0 \$105 \$225 N/A g costs of the up to \$1 e service ces for health litions ay for up rs	\$0 \$0 \$70 \$150 N/A reach ed ,500 per ss; 70%	preferred pharmacies Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$2,000, you pay \$0. In-Home Support Services: for help with transportation, spickup, light housekeeping, a Meals: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$130 qua items in plan's OTC mail ord	retail \$0 \$6 \$45 \$90 33% arrly drug \$0 copa shopping nd care is home-de stay; \$1 arterly all er catalog	retail \$0 \$18 \$135 \$270 N/A g costs I y 48 hours, medicareminde elivered 05 allowance og; no ro	mail \$0 \$5 \$90 \$180 N/A reach		
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2023 NIEDICAN	RE ADVANTAGE COM	ranı				1111:	C-DI	13		
Please contact the	SCAN Health Plan									
Plan for more	877-870-4867 (Sales & Marketing)									
information or call		Member Services)								
1-800-Medicare			wwv	w.scanhe	ealthplan.com					
	SCAN Ba	alanc	e		SCAN Strive					
Plan Name/Type	C-SNP (H5	5425-0	76)		C-SNP (H5425-098)					
Tian Name/Type	For People with Card			isease,	For People with Card	liovascı	ular Di	sease,		
	Chronic Heart Failui	re and	or Dia	betes	Chronic Heart Failu	re and/	or Dia	betes		
Star Rating	***	1/2			***	★ 1/2				
Annual OOP Max	\$1,50				\$9,350					
Monthly Premium	\$0				\$25.90 premium / \$24		al dedu	ctible		
Doctor Visits	\$0 for Primary Ca		ician;		\$0 for Primary C	are Phys				
Doctor Visits	\$0 for Spe	ecialist			\$0 for Sp \$1,676 deductible; \$0 co		for dovice	1 60.		
Inpatient Hospital	\$100 copay per day for days 1-5;			\$1,676 deductible; \$0 co \$419 copay/day f			1-00;			
	\$0 for days 6-90	and be	yond		\$838 copay/day f					
Outpatient	\$0 per ambulatory sur	rgical ce	nter vis	it ;	20% coinsurance per amb			center		
Hospital	\$125 copay per outpa		spital vi	sit	and outpatient		visit			
Skilled Nursing	\$0 for day:		1 100		\$0 for day		21 100			
Facility	\$75 copay/day for	•			\$209.50 copay/day					
Ambulance	\$180 copay per trip				20% coinsurance per					
Emergency &	\$90 copay per emergency				20% coinsurance up to \$1					
Urgent Care	immediately admitted to l urgent care visit; Wo				visit; 20% coinsurance up visit; Worldwi		_	ı care		
Lab Tests,	\$0 copay for lab service				\$0 copay for lab services			e for		
Procedures, and	procedures, x-rays, and o	diagnost	ic radio	logy;	diagnostic tests & proced	ures, x-ra	ıys, diagı			
Radiation Therapy	\$60 copay for therap	peutic ra	diology	,	radiology, and thera	apeutic ra	diology			
Renal Dialysis	20% co-insurance	e per trea	atment		20% co-insuranc	e per trea	tment			
Outpatient Mental Health Visits	\$10 copay per individual or	r group	therapy	session	\$0 copay per individual or group therapy session					
	\$250 annual allowar	nce for e	yewear	•	\$325 annual allowance for eyewear;					
Eyewear	through SCAN con				through SCAN contracted provider					
Eye Exams	\$0 copay per Medica: \$0 copay for 1 annu				20% coinsurance per Me			kam;		
**	\$550-\$850 copay per a				\$0 copay for 1 annual routine exam Not Covered					
Hearing Aids	through Tru				20% coinsurance per Medicare-covered exam;					
Hearing Exams	\$0 copay per Medica \$0 copay for one ann				20% coinsurance per Me routine exams					
	\$0 copay for Medicare cove				20% coinsurance for Medicar			0 copay		
Dental	certain preventive and diagno				for certain preventive and o					
	limit; through SCAN co \$0 copay per Medica				annual limit; through SCA \$20% coinsurance per N					
Chiropractic	\$0 copay per Medica				\$0 copay for 10 rout					
Podiatry	\$0 co-pay per Medic				\$0 co-pay per Medi		1 ,			
2 0 0 2 0 0 2 0 0 0 0 0 0 0 0 0 0 0 0 0		30	100	100		30	100	100		
	Cost-sharing shown is for	days	days	days	Cost-sharing shown is for	days	days	days		
	preferred pharmacies	retail	retail	mail	preferred pharmacies	retail	retail	mail		
Prescription Drugs	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0		
(Outpatient)	Preferred Brand	\$42	\$126	\$126	Preferred Brand	24%	24%	24%		
(Outputient)	Non-Preferred Brand	50%	50%	50%	Non-Preferred Brand	45%	45%	45%		
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	25%	N/A	N/A		
	\$0 deductible; after total yes \$2,000, you pay \$0.	arly dru	ig costs	reach	\$590 deductible for Tiers 3 drug costs reach \$2,000, ye			arly		
	φ 2,000 , you pay ψ 0.				Acupuncture: \$0 copay for			visits/yr		
	Acupuncture: \$0 copay for	up to 36	routine	visits	Groceries: \$70 monthly all	owance a	t preferre	ed		
	per year In-Home Support Services:	• 40 hou	rs for ne	ersonal	locations for those w/chroni combined with OTC allowa		ing cond	itions;		
	care following a hospitalizati		13 101 pc	21301141	In-Home Support Services		rs for per	rsonal		
Supplemental	Meals: 84 home-delivered m				care following a hospitalizar					
Benefits and	a hospital stay and/or due to Over the Counter: \$75 quan				Meals: 84 home-delivered random a hospital stay and/or due to					
Optional Plans	in-store at CVS or home deli	very; ba	lance ca		Over the Counter (OTC):					
	over to next quarter but not o				for items in-store at select re					
	Transportation: \$0 copay for year to plan-approved location		_		no rollover; combined with Transportation: \$0 copay					
	, san to plan approved localic	771111	50 m		year to plan-approved locati					
Medical Groups	Medical Groups: Brown &		Imperia	l Health	Medical Groups: Brown &	Toland,				
and Hospitals	Holdings, SCAN Direct Con Hospitals: Alameda, Alta Ba		nmit (Ba	erk/Oak)	Holdings, SCAN Direct Cor Hospitals: Alameda, Alta B		mit (Ras	rk/Oak)		
(may not be full list;	Highland (Oak), San Leandre				•		,			
please check with plan)	Stanford Valley Care (Pleas/				Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)					

Please contact the		11115			nior Care	11111	D1 11	5		
Plan for more		844-305-3879 (Sales &Marketing)								
information or call		844			Member Services)					
1-800-Medicare				<i>.</i> aligns	eniorcare.com					
	Align Prem				Align Sen					
Plan Name/Type	I-SNP (H3274-00				I-SNP (H3274-001) For People Needi Nursing Home Level of Care					
C4 D-4:	Needing Nursing Ho			Care						
Star Rating	Not Enough Da		nable		Not Enough D		ilable			
Annual OOP Max	\$1,90				\$9,350					
Monthly Premium	\$0 \$0 for Primary C		eician:		\$29.		Physician			
Doctor Visits	\$0 for Spe		siciali,		20% coinsurance			•		
Inpatient Hospital	\$0 copay per stay;		\$235 copay/day \$0 for days 11							
Outpatient Hospital	20% coinsurance per amb visit; \$225 copay per ou				20% coinsurance per ambioutpatient hospit			enter or		
Skilled Nursing Facility	\$0 copay/day fo	•			\$0 copay/day fo	or days 1	-100			
Ambulance	\$125 copay per tr 20% coinsurance				20% coinsurance per	trip by g	round or	air		
Emergency & Urgent Care	\$90 copay per ER visit; \$4 copays waived if admitted t	10 per ur	gent car		\$90 copay per ER visit; \$ copays waived if admitted					
Lab Tests,	\$0 copay for lab ser				\$0 copay for lab ser					
Procedures, and Radiation Therapy	20% coinsurance for diagram diagnostic and thera				20% coinsurance for diag diagnostic and there					
Renal Dialysis	20% coinsurance				20% coinsurance					
Outpatient Mental	\$0 copay per in	•			\$0 copay per i	•				
Health Visits	group therap				group therapy session					
Eyewear	\$225 annual allowa	ince for	eyewear		\$275 annual allowance for eyewear					
Eye Exams	20% coinsurance per Me \$0 copay for one ann				20% coinsurance per Medicare-covered exam; \$0 copay for one annual routine exam					
Hearing Aids	Not Cov		ine exam	.1	\$1,500 annual allowance; limited to 2 aids/year, through NationsBenefits					
Hearing Exams	20% coinsurance per Me routine exams			exam;	20% coinsurance per Medicare-covered exam \$0 copay for one annual routine exam					
	20% coinsurance per Mo	edicare o	covered		20% coinsurance per M	ledicare	covered	visit;		
Dental	\$3,000 annual allowance comprehensive services, t	hrough l	Liberty 1	Dental	\$3,000 annual allowance for certain basic and comprehensive services, through Liberty Dental					
Chiropractic	\$30 copay/visit for 12 re				20% coinsurance for M	ledicare-	covered	visit		
Podiatry	20% coinsurance for Me \$0 copay/visit for 6 rou				20% coinsurance for Medicare-covered visit; \$0 copay/visit for 6 routine visits per year					
	Cost-sharing shown is	30	90 days	90	Cost-sharing shown is	30	90 days	90 days		
	for preferred pharmacies	days retail	days retail	days mail	for preferred pharmacies	days retail	days retail	days mail		
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	25%	25%	25%		
Prescription Drugs	Generic	\$10	\$30	\$30	Generic	25%	25%	25%		
(Outpatient)	Preferred Brand Non-Preferred Brand	\$45 \$95	\$135 \$285	\$135 \$285	Preferred Brand Non-Preferred Brand	25% 25%	25% 25%	25% 25%		
	Specialty co-insurance	25%	N/A	N/A	Specialty co-insurance	25%	25%	25%		
	\$0 deductible; after total yes \$2,000, you pay \$0.	early dr	ug costs	reach	\$590 deductible; after total \$2,000, you pay \$0.	yearly	drug cos	ts reach		
Supplemental Benefits and Optional Plans	In-Home Support Services: \$0 copay; limited to 80 hours annually for help with personal needs, light housekeeping, meal prep, etc. Over the Counter: \$405 quarterly allowance for plan-approved items, including OTC hearing aids Transportation: \$0 copay for 24 trips per year to plan-approved locations				In-Home Support Services hours annually for help with housekeeping, meal prep, et Groceries: \$30 monthly all items, for those w/chronic q Over the Counter: \$285 qu plan-approved items, includ Transportation: \$0 copay plan-approved locations	n personate. owance ualifying arterly a	al needs, for cover g condition allowance hearing	red ons e for		
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Brown & Hospitals: Alta Bates/Sumr Eden Medical Center (Castr	nit Med	Ctr (Bei		Medical Groups: Brown & Hospitals: Alta Bates/Sumr Eden Medical Center (Castr	nit Med	Ctr, (Bei			

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 per 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 2025 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