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

~Rev. 11/02/23 ~

Medicare Advantage Plans contract with the Centers for Medicare and Medicaid Services (CMS) to provide all the benefits covered by Medicare and some additional benefits. In exchange, CMS (Medicare) pays the plan a fixed fee per member, per month. This amount varies by region and is also adjusted for the individual member's age, gender and health condition. To enroll in a Medicare Advantage plan, a person must have both Medicare Parts A & B. The person must also live within the plan's service area. Medicare Advantage plans must accept anybody on Medicare, including those who are under age 65 on Medicare through disability, regardless of their health condition.

Medicare HMOs are one type of Medicare Advantage (MA) plan. When joining a Medicare HMO, beneficiaries do not give up their Medicare coverage; rather they agree to receive it through the plan's network of providers. A member must choose a Primary Care Physician and receive referrals to see specialists. The HMO will *not* pay for services received outside the plan's network unless it is urgent or emergency care. In those circumstances, members should notify their plans as soon as possible. The cost-sharing varies from plan to plan. Premiums, co-payments, and extra benefits can differ. The Annual Out of Pocket Maximum listed for each plan applies to all cost-sharing *except* plan premiums and prescription drug co-pays. In 2024, there are 26 Medicare HMOs in Alameda County, and they are listed in this chart. Three of these do not include the Medicare Part D prescription drug benefit. When people join an HMO *without* drug coverage, they are opting out of Part D. *Enrolling in a standalone Part D plan will automatically trigger disenrollment from the Medicare Advantage Plan*.

A Medicare PPO is another type of Medicare Advantage (MA) plan. A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses such as deductibles and co-insurance will apply. In 2024, there are six Medicare PPOs in Alameda County. See our 2024 PPO Comparison Cart for more information and details: www.lashicap.org/hicap.

Medicare Special Needs Plans are another type of Medicare Advantage plan. They are designed for people on Medicare and Medi-Cal (duals), those with certain chronic conditions, or those who reside in nursing homes. They all must include Part D prescription drug coverage and they have a responsibility to coordinate benefits and care for their members. In 2024, there are 17 Special Needs Plans in Alameda County. See our **2024 Special Needs Plan Comparison Chart** for more information and details: <u>www.lashicap.org/hicap</u>.

Enrollment:

In the fall of 2023, Medicare beneficiaries can enroll, disenroll or change plans during the **Medicare Annual Enrollment Period, from October 15 through December 7. Changes take effect on January 1, 2024.** In 2024, members have one more opportunity to make a change: they can leave their MA plan and change back to Original Medicare during the **Medicare Advantage Open Enrollment Period, from Jan 1 through March 31.** This right only applies to those <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.

People who have both Medicare and Medi-Cal and those with the Low-Income Subsidy (Extra Help) for Part D can enroll, disenroll or change plans on a quarterly basis. The change will take effect on the first of the following month, except in the last quarter of the year (October through December), when it becomes effective on January 1.

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

ABOUT THIS CHART

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

The information in this chart applies to the individual plans under Medicare only. Group coverage (i.e., employersponsored 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 <u>www.lashicap.org/hicap</u>.

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



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Navigating Medicare

Please contact the Plan for more information or call 1-800-Medicare	Aetna M 833-859-6031 (S 833-570-6670 (I <u>www.aetnam</u>	ales & l Membe	Marke r Servi	-	Aetna Medicare 833-859-6031 (Sales & Marketing) 833-570-6670 (Member Services) www.aetnamedicare.com			
Plan Name/Type	Aetna Medica (HMO) (H			n	Aetna Medicare Eagle Plan (HMO) (H4982-013)			
Star Rating	**	**			***			
Annual OOP Max	\$3,	900			\$4,200			
Monthly Premium	\$				\$0			
Doctor Visits	\$0 copay for Prima \$15 for S			;	\$0 copay for Primary Care Physician; \$10 for Specialist			
Inpatient Hospital	\$250 copay/da \$0 per day for da	y for day iys 8 and	s 1-7; beyond		\$50 co-pay/day for days 1-3; \$0 for days 4-90; \$0 for days 91 and beyond (unlimited)			
Outpatient Hospital	\$0 copay for ambulator \$150 copay for outpatie				\$0 copay for ambulatory surgical center visit; \$50 copay for outpatient hospital facility visit			
Skilled Nursing Facility	\$0 copay/day \$75 per day fo	for days	1-20;		\$0 copay/day for days 1-20; \$196 per day for days 21-100			
Ambulance	\$225 copay per ground	l or air ai	nbulance	e trip	\$275 copay per ground or air ambulance trip			
Emergency & Urgent Care	 \$110 copay per emergen admitted to hospital; \$1 \$110 per emergency or ur waived if admi 	5 per urg gent care	gent care visit wo	visit;	 \$110 copay per emergency room visit; waived if admitted to hospital; \$10 per urgent care visit; \$110 per emergency or urgent care visit worldwide; waived if admitted to hospital 			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, d and x-rays; \$0 copay fo \$60 copay for the	iagnostic or diagnos	tests, pr stic radio	logy;	\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$100 copay for diagnostic radiology; \$60 copay for therapeutic radiology			
Renal Dialysis	20% co-insuran	ce per tre	atment		20% co-insurance per treatment			
Outpatient Mental Health Visits	\$25 copay per individual				\$25 copay per individual or group therapy session			
Eyewear	\$225 annual reimbu for ey		allowanc	e	\$250 annual reimbursement allowance for eyewear			
Eye Exams	\$0 copay for di \$0 copay for one a			n	\$0 copay per diagnostic exam; \$0 copay for one annual routine exam			
Hearing Aids	\$1,250 annual hearing purchased through Na	aid allow	ance per	ear;	\$1,250 annual hearing aid allowance per ear; purchased through NationsHearing provider			
Hearing Exams	\$0 copay for di \$0 copay for di	agnostic	exam;		\$0 copay for one annual routine exam			
Dental	\$1,200 annual reimbursem preventive and com any licensed d	prehensiv	ve service		\$1,500 annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider			
Chiropractic	\$0 copay for Medi \$0 copay for unlim must use American Sp	ited rout	ine visits	;	 \$0 copay for Medicare covered visit; \$0 copay for unlimited routine chiropractic visits; must use American Specialty Health provider 			
Podiatry	\$15 copay per Med	licare-cov	vered vis	it	\$10 copay per Medicare-covered visit			
Decentration Decen	Cost-sharing shown is for preferred pharmacies Preferred Generic Generic Preferred Brand	30 days \$0 \$0 \$47	100 day retail \$0 \$0 \$141	100 day mail \$0 \$0 \$141	THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.			
Prescription Drugs (Part D)	Non-Preferred Brand Specialty co-insurance \$0 deductible; after total y \$5,030 , you pay \$0 for Tier more than 25% of the plan drugs until out-of-pocket dr After that, you pay \$0 .	\$100 33% early dru 1 and 2 drug experi- rug experi-	\$300 N/A Ig costs and drugs and r brand n ases react	\$300 N/A reach d no ame n \$8,000.	YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.			
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay fo treatments with American S Over the Counter: \$105 q plan-approved items Transportation: \$0 copay year to plan approved locat Wellness: \$0 copay for bas membership; \$600 annual r for various fitness activities	Specialty uarterly a for 12 on ions, via ic Silver eimburse and supp	Health p Illowance ne-way tr Access20 Sneakers ment allo plies	rovider e for ips per Care s owance	Acupuncture: \$0 copay for unlimited acupuncture treatments with American Specialty Health provider Over the Counter: \$105 quarterly allowance for plan-approved items Transportation: \$0 copay for 12 one-way trips per year to plan approved locations, via Access2Care Wellness: \$0 copay for basic Silver Sneakers membership			
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown a Hospitals: Alameda, Alta F (Berk/Oak), Highland (Oak Rose (Hayward), San Leand (Pleas/Liv), and Washingto	Bates/Sun), Eden (dro, Stant	nmit Meo CValley) ford Vall	l Ctr, , St. ey Care	Medical Groups: Brown and Toland; One Medical; Hospitals: Alameda, Alta Bates/Summit, (Berk/Oak), Highland (Oak), Eden (CValley), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Hospital (Frem)			

2024]	MEDICARE HMO COM	MPAR	ISON (CHART	FOR ALAMEDA CO	UNTY	Y	
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 & I lember	Marketi Servic	0.	Aetna N 833-859-6031 (S 833-570-6670 (<u>www.aetnar</u>	Sales & Memb	k Marke oer Serv	0,
Plan Name/Type	Aetna Medicar (HMO (H0			n	Aetna Medicare (HMO-POS			
Star Rating	**1	/2				1/2		
Annual OOP Max	\$2,9	00			\$2,	900		
Monthly Premium	\$0					3.70		
Doctor Visits	\$0 copay for Primary \$0 for Spe		'hysician;		\$0 copay for Prim \$0 for S			n;
Inpatient Hospital	\$250 copay/day \$0 per day for day				\$250 copay/da \$0 per day for d	•	•	
Outpatient Hospital	\$0 copay for ambulatory	y for ambulatory surgical center visit; ay for outpatient hospital facility visit \$0 copay per ambulatory surgical center visi \$150 per outpatient hospital facility visit					r visit;	
Skilled Nursing Facility	\$0 copay/day for \$75 per day for				\$0 copay/day \$75 per day fo			
Ambulance	\$225 copay per ground	or air an	nbulance	trip	\$225 copay per groun	d or air	ambulanc	e trip
Emergency & Urgent Care	 \$110 copay per emergenc admitted to hospital; \$0 \$110 per emergency or urge ER copay waived if a 	per urge ent care	ent care vi visit worl	isit; dwide;	 \$110 copay per emerger admitted to hospital; \$ \$110 per emergency or un ER copay waived if 	50 per u rgent ca	rgent care re visit wo	visit; orldwide;
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, dia and x-rays; \$0 copay for \$60 copay for thera	diagnos	tic radiol		\$0 copay for lab services, of and x-rays; \$0 copay for \$60 copay for the	or diagr	ostic radi	ology;
Renal Dialysis	20% co-insurance	-			20% co-insurar	-	-	5
Outpatient Mental Health Visits	\$25 copay per individual o	or group	therapy so	ession	\$25 copay for individual	l or grou	ip therapy	session
Eyewear	\$275 annual reimbur for eye		allowance	;	\$325 annual reimb for eyewear; must u			
Eye Exams	\$0 copay for diag \$0 copay for one and	nual rout	tine exam		\$0 copay for d \$0 copay for one a	innual r	outine exa	
Hearing Aids	\$1,250 annual hearing a purchased through National Action (1997) and the set of the se		-		\$1,250 annual hearing purchased through Na			
Hearing Exams	\$0 copay for diag \$0 copay for one and	gnostic e	exam;		\$0 copay for d \$0 copay for one a	iagnosti	c exam;	
Dental	\$1,600 annual reimburseme preventive and computed any licensed dependence.	rehensiv	e services		\$2,500 annual reimbursen preventive and com any licensed of	prehens	sive servic	
Chiropractic	\$0 copay for Medica \$0 copay for unlimit must use American Spec	ted routi	ne visits;	ider	\$15 copay for Med \$0 copay/visit for un must use American Sp	limited	routine vi	isits;
Podiatry	\$0 copay per Medic				\$0 copay per Med			
	Cost-sharing shown is for preferred pharmacies	30 days	100 days retail	100 days mail	Cost-sharing shown is for preferred pharmacies	30 days	100 days retail	100 days mail
	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0	Preferred Generic Generic	\$0 \$0	\$0 \$0	\$0 \$0
Prescription Drugs	Preferred Brand	\$47	\$141	\$141	Preferred Brand	\$47	\$141	\$141
(Part D)	Non-Preferred Brand Specialty co-insurance	\$100 33%	\$300 N/A	\$300 N/A	Non-Preferred Brand Specialty co-insurance	\$100 33%	\$300 N/A	\$300 N/A
	\$0 deductible; after total yea \$5,030, you pay \$0 for Tier 1 more than 25% of the plan's drugs until out-of-pocket dru After that, you pay \$0.	arly dru and 2 c cost for	g costs ro lrugs and brand na	each no me	\$0 deductible; after total y \$5,030 , you pay \$0 for Tie more than 25% of the plan drugs until out-of-pocket d After that, you pay \$0 .	r 1 and r 3 cost rug exp	rug costs 2 drugs ar for brand enses read	reach nd no name ch \$8,000.
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for treatments with American Sp Over the Counter: \$105 qua plan-approved items Transportation: \$0 copay for year to plan approved locatio Wellness: \$0 copay for basic membership; \$600 annual rei for various fitness activities a Medical Groups: Brown &	ovider for os each are wance	Acupuncture: \$0 copay for treatments with American Groceries: \$40 monthly al Extra Help, through Nation Over the Counter: \$50 m approved items through Na Transportation: \$0 copay year to plan approved loca Wellness: \$0 copay for ba membership; \$600 annual for various fitness activitie Medical Groups: Brown	Speciald llowanc nsBenef onthly a ations O for 12 tions via sic Silve reimbur s and su	y Health j e for those its card illowance TC catalo one-way t a Access2 er Sneaker sement al upplies	provider e with for plan- og rips per Care rs lowance		
Medical Groups and Hospitals (may not be full list; check with plan)	Hedical Groups: Brown & Hospitals: Alameda, Alta Ba (Berk/Oak), Highland (Oak), Rose (Hayward), San Leandr (Pleas/Liv), and Washington	tes/Sum Eden (C to, Stanf	umit Med CValley), ord Valle	Ctr, St. y Care	Hedical Groups: Brown Hospitals: Alameda, Alta (Berk/Oak), Highland (Oal Rose (Hayward), San Lean (Pleas/Liv), and Washingto	Bates/S k), Eder idro, Sta	ummit Me (CValley unford Val	ed Ctr, 7), St. lley Care

2024	MEDICARE HMO CO	MPAI	RISON	CHART	FOR ALAMEDA COUN	TY				
Please contact the			U		Health Plan					
Plan for more					Sales & Marketing)					
<i>information or call</i> 1-800-Medicare		80			Member Services)					
1-000-111euicure					thealthplan.com					
Plan Name/Type	Alignment Hea Veterans (HM				Alignment Health Harmony (HMO) (H3815-031)					
Star Rating	**7	**			***	k				
Annual OOP Max	\$5,9				\$2,900)				
Monthly Premium	\$0				\$0					
Doctor Visits	\$0 for Primary Care Phys				\$0 for Primary Care Physic			ılist		
Inpatient Hospital	\$1,632 deductible; \$0 \$408 copay/day f \$816copay/day f	for days	61-90;	-60;	\$0 copay/day for \$100 copay/day fo \$0 copay/day for days 1	r days 5-	-10;			
Outpatient Hospital	\$0 copay for ambulat \$0 copay for outpatie				\$100 copay for ambulatory\$200 copay for outpatient h					
Skilled Nursing Facility	\$0 copay/day f \$204 /day for a	days 21-	-100		\$0 copay/day for \$100 copay/day for	days 21	-100			
Ambulance	20% co-insurance per grou Not waived if adm			nce trip;	\$175 copay per ground or Waived if admitted			p;		
Emorgonov &	20% coinsurance for ER a			sits; ER	\$85 copay for ER visit; copay			nitted;		
Emergency & Urgent Care	cost waived if admitted wit	hin 72 ł	nrs; \$75 c	opay for	\$0 for urgent care visit; \$20 co	pay for	ER/urgei	nt care		
Lab Tests,	ER/urgent care visit worldw				visit worldwide with \$10	<i>'</i>				
Procedures, and	\$0 copay for lab servic procedures, x-rays, and				\$0 copay for lab services, procedures, x-rays, and di					
Radiation Therapy	20% coinsurance for t				20% coinsurance for the					
Renal Dialysis	20% co-insuranc	e per tre	eatment		\$30 copay per t	reatment	t			
Outpatient Mental	20% co-insurance				\$40 copay per in					
Health Visits	or group ther	1.0		C .	or group therapy session					
Eyewear	See Flex Allowance under \$0 copay for dia			Benefits	\$150 annual allowand \$0 copay for diagn					
Eye Exams	\$0 copay for one an			n	\$0 copay for one annu					
Hearing Aids	See Flex Allowance under	r Supple	emental E	Benefits	See Flex Allowance under S			efits		
Hearing Exams	\$0 copay for dia	agnostic	exam		\$0 copay for diagn \$0 copay for one annu					
Dental	\$0 copay for cert and comprehen	-			\$0 copay for certain pre \$20-\$425 copays for certain c	ventive	services;	rvices		
Chiropractic	\$0 copay per Media	care-cov	vered visi	t	\$0 copay per Medicar	e-covere	ed visit			
Podiatry	\$0 copay for Medic	care-cov	vered visi	t	\$5 copay for Medicar	e-covere	ed 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		
	Preferred Generic	\$0	retail \$0	mail \$0	Preferred Generic	\$0	retail \$0	mail \$0		
	Generic	\$20	\$60	\$60	Generic	\$3	\$9	\$9		
Prescription Drugs	Preferred Brand	25%	25%	25%	Preferred Brand	\$40	\$120	\$120		
(Part D)	Non-Preferred Brand Specialty co-insurance	25% 25%	25% N/A	25% N/A	Non-Preferred Brand Specialty co-insurance	\$93 33%	\$279 N/A	\$279 N/A		
	\$545 deductible; after total				\$0 deductible; after total year					
	\$5,030, you pay no more that				\$5,030 , you pay no more than					
	for brand names and 25% fo pocket expenses reach \$8,00				for brand names and 25% for gocket expenses reach \$8,000 .					
	Essentials Allowance: \$400				Acupuncture: \$0 co-pay/visit			-		
	groceries, gas, utilities, and h	nome sat			Essentials Allowance: \$100 q	uarterly	allowanc	e for		
	qualifying chronic conditions Flex Allowance: \$600 comb		nual allov	wance for	groceries, gas, utilities, and how with qualifying chronic condition		y for tho	50		
	dental, vision, hearing, acupu				Flex Allowance: \$500 combin	ed annu				
	podiatry services In-Home Support Services:	\$0 cor	hav for 12	hours	for dental, vision, hearing, chir Over the Counter: \$100 quar			liatry		
Supplemental	per quarter OR \$300 annual				Pet Services: \$0 copay for 7 b	•		4		
Benefits and	Meals: \$0 copay for up to 2				walks/year for those w/qualify					
Optional Plans	year) for those with qualifyin Pet Services: \$0 copay for 7				Pest Control: \$0 copay for 1 s those with qualifying chronic c			br		
	walks/year for those w/qualif	fying ch	ronic cor	nditions	Transportation: \$0 copay for	28 one-	way trips	to		
	Pest Control: \$0 copay for 1 with qualifying chronic cond		e per yeai	for those	plan approved locations within Wellness: \$0 copay for basic g					
	Transportation: \$0 copay for	or 20 on			Enhanced Dental Option: \$2	7/month	for certa			
	year to plan approved location Wellness: \$0 copay for basic				comprehensive services, with (\$1,500 limit per year)-50% с	o-insurai	nce;		
Modical Crowns	Medical Groups: Alignmer				Medical Groups: Alignment	Network	; Brown	&		
Medical Groups and Hospitals	Toland				Toland					
(may not be full list;	Hospitals : Alameda; Alta Ba Eden (C. Valley), Highland (Hospitals : Alameda; Alta Bate Eden (C. Valley), Highland (O		`			
check with plan)	Stanford Valley Care (Pleas/			···· <i>」</i> ,,	Stanford Valley Care (Pleas/Li		(110	J / 7		

Please contact the Plan for more information or call 1-800-MedicareAlignment Health Plan 888-979-2247 (Sales & Marketing) 866-634-2247 (Member Services) www.alignmenthealthplan.comPlan Name/TypeAlignment Health My Choice CalPlus (HMO) (H3815-007)Alignment Health Selec (HMO) (H3815-037)Star Rating★★★★★★★★Annual OOP Max\$3,000\$3,400Monthly Premium\$0\$0					
information or call 1-800-Medicare866-634-2247 (Member Services) www.alignmenthealthplan.comPlan Name/TypeAlignment Health My Choice CalPlus (HMO) (H3815-007)Alignment Health Selec (HMO) (H3815-037)Star Rating★★★★★★★★Annual OOP Max\$3,000\$3,400					
1-800-Medicarewww.alignmenthealthplan.comPlan Name/TypeAlignment Health My Choice CalPlus (HMO) (H3815-007)Alignment Health Selec (HMO) (H3815-037)Star Rating★★★★★★★★Annual OOP Max\$3,000\$3,400					
Plan Name/TypeAlignment Health My Choice CalPlus (HMO) (H3815-007)Alignment Health Selec (HMO) (H3815-037)Star Rating★★★★★★★★Annual OOP Max\$3,000\$3,400					
Annual OOP Max \$3,000 \$3,400	Alignment Health Select (HMO) (H3815-037)				
Monthly Premium \$0					
Doctor Visits \$0 for Primary Care Physician; \$0 for Specialist \$10 for Primary Care Physician; \$35 for S	pecialist				
Inpatient Hospital\$0 copay for days 1-4; \$100 copay/day for days 5-10; \$0 copay for days 11 and beyond; unlimited\$295 copay for days 1-7; \$0 copay/day for days 8 and beyond; unlimited					
Outpatient Hospital\$100 copay for ambulatory surgical center; \$200 copay for outpatient hospital facility\$35 copay for ambulatory surgical center \$200 for outpatient hospital facility					
Skilled Nursing Facility\$0 copay/day for days 1-20; \$50 copay/day for days 21-100\$0 copay/day for days 1-20; \$140 per day for days 21-100					
Facility\$20 copul/adj for adj 21 foo\$10 per adj for adj 21 fooAmbulance\$175 copay per trip by ground or air; waived if admitted\$240 copay per trip by ground or ai waived if admitted	·••				
Emergency & \$85 copay for ER visit; waived if admitted to hospital \$90 copay for ER visit; waived if admitted					
Linergency & within 48 hours; \$0 for urgent care visit; \$12,000 annual limit for ER/urgent care worldwidehours; \$0 for urgent care visit; \$0 copay for care visit worldwide with \$25,000 annual	ER/urgent				
Lab Tests,\$0 copay for lab services, diagnostic tests &\$0 copay for lab services, diagnostic tests &					
Procedures, and procedures, x-rays, and diagnostic radiology; procedures, x-rays, and diagnostic radio	logy;				
Radiation Therapy 20% coinsurance for therapeutic radiology 20% coinsurance for therapeutic radio	logy				
Renal Dialysis 20% co-insurance per treatment \$30 copay per treatment Output 0.10 (0					
Outpatient Mental\$40 copay per individual\$35 copay per individualHealth Visitsor group therapy sessionor group therapy session					
Eyewear\$100 annual allowance for eyewear\$300 allowance for eyewear every 2 y	ears				
Eye Exams\$0 copay for diagnostic exam; \$0 copay for one annual routine exam\$0 copay for diagnostic exam; \$0 copay for one annual routine exam	m				
Hearing Aids\$1,000 allowance with \$0 copay, every 2 years\$1,000 allowance with \$0 copay, every 2					
Hearing Exams\$0 copay for diagnostic exam;\$10 copay for diagnostic exam;\$0 copay for one c					
\$0 copay for certain preventive services:					
Dental\$0 copay for certain preventive services,\$0 copay for certain preventive services,\$20-\$425 copays for certain comprehensive services\$20-\$425 copays for certain comprehensive					
Chiropractic \$0 copay per Medicare-covered visit \$0 copay per Medicare-covered visit	t				
Podiatry\$0 copay for Medicare-covered visit; \$0 copay for 12 routine visits each year\$25 copay for Medicare-covered visit	it				
Cost-sharing shown is for preferred pharmacies30 days100 days100 daysCost-sharing shown is for preferred pharmacies30 days100 days	100 days				
retail mail retail	mail				
Preferred Generic\$0\$0\$0Preferred Generic\$0\$0Generic\$3\$9\$9Generic\$3\$9	\$0 \$0				
Generic\$3\$9\$9Generic\$3\$9Prescription DrugsPreferred Brand\$40\$120\$120Preferred Brand\$40\$120	\$9 \$120				
(Part D)Non-Preferred Brand\$100\$300\$300Non-Preferred Brand\$93\$279	\$279				
Specialty co-insurance33%N/AN/ASpecialty co-insurance33%N/A\$0 deductible; after total yearly drug costs reach\$0 deductible; after total yearly drug costs\$0 deductible; after total yearly drug costs	N/A reach				
\$5,030, you pay no more than 25% of the plan's cost \$5,030, you pay no more than 25% of the plan's cost	an's cost				
for brand names and 25% for generics until out-of- pocket expenses reach \$8,000. After that, you pay \$0. pocket expenses reach \$8,000. After that, you					
Acupuncture: For those with Extra Help, \$0 co-pay					
for 12 visits per year, combined with chiropractic In-home Support Services: \$0 copay for 12 hours					
per quarter OR \$300 annual caregiver reimbursement Mealer \$0 copey for up to 2 meals/day for 14 days for Over the Counter: \$75 guerterly allowance					
Meals: \$0 copay for up to 2 meals/day for 14 days for those with qualifying chronic conditions; For thoseOver the Counter: \$75 quarterly allowance Pet Services: \$0 copay for 7 boarding days of	or 14				
with Extra Help, up to 56 meals per yearwalks per year for those with qualifying chroOver the Counter: \$60 quarterly allowance; Forconditions	onic				
SupplementalOver the Counter: \$00 quarterly anowance, F07Conditionsthose with Extra Help, additional \$240 per quarterPest Control: \$0 copay for 1 service per year	r for				
Benefits and Pet Services: \$0 copay for 7 boarding days or 14 those with qualifying chronic conditions					
Optional Planswalks/year for those w/qualifying chronic conditions Pest Control: \$0 copay for 1 service per year forWellness: \$0 copay for basic gym members participating fitness centers	np at				
those with qualifying chronic conditions-Enhanced Dental Option: \$27/month for comprehensive services, with 0-50% co-instTransportation: \$0 copay for 12 one-way trips percomprehensive services, with 0-50% co-inst					
year to plan approved locations within 20 miles \$1,500 limit per year	irance,				
Wellness: \$0 copay for basic gym membership Enhanced Dentel Ontions \$27/month for cortain					
-Enhanced Dental Option: \$27/month for certain comprehensive services, with 0-50% co-insurance;					
\$1,500 limit per year Medical Groups: Alignment Network, Brown &					
Medical Groups: Brown & Toland Toland Hospitals: Alameda: Alta Bates/Summit (Be	rk/Oak).				
Hospitals: Alameda: Alta Bates/Summit (Berk/Qak):					
(may not be full list; check with plan) Highland (Oak), St. Rose (Hay), Stanford Valley Care (Pleas/Liv) Highland (Oak), St. Rose (Hay), Stanford Valley Care (Pleas/Liv)					

2024 1	MEDICARE HMO COM	[PAR]	SON	CHART	FOR ALAMEDA COU	NTY			
Please contact the					Blue Cross				
Plan for more					Sales & Marketing)				
information or call 1-800-Medicare		83.			Member Services)				
1-000-Mealcare	Anthom Solor	ot (UI	-	www.ant	Anthem Prime (HMO)				
Plan Name/Type	Anthem Selec (H0544-0	•	MO)			(H4161-005)			
Star Rating	***				Plan too new to		asured		
Annual OOP Max	\$7,55				\$1,2	00			
Monthly Premium	\$0				\$0				
Doctor Visits	\$15 copay for Primary \$45 copay for \$			1;	\$0 copay for Primar \$10 copay for			ι;	
Inpatient Hospital	\$325 copay for days 7-	or days	1-6;		\$250 copay for \$0 copay/day for day	or days 1	1-5;	nd	
Outpatient Hospital	\$275 copay for ambulatory \$325 copay for outpatient	v surgica	al center		\$150 copay for ambulator \$250 for outpatient he	ry surgi	cal center	r visit;	
Skilled Nursing	\$0 copay for days 1-20; \$0 copay/day for days 1-20;								
Facility	\$196 per day for a \$250 copay per ground			ə [.]	\$188 per day for \$250 copay per ground	-		D.	
Ambulance	20% coinsurance per a	ir ambu	lance tr	ip	20% coinsurance per	air amb	ulance tr	rip	
Emergency &	\$90 copay for ER visit; waive within 24 hours; \$35 for				\$90 copay for ER visit; waiv within 24 hours; \$35 f				
Urgent Care	\$100,000 annual limit for ER				\$100,000 annual limit for E				
Lab Tests,	\$10 copay for lab services a				\$10 copay for lab services				
Procedures, and Radiation Therapy	diagnostic tests & procedure radiology; 20% coinsurance f				diagnostic tests & procedu radiology; 20% coinsurance				
Renal Dialysis	20% co-insurance		<u>.</u>		20% co-insurance		-		
Outpatient Mental	\$40 copay per i	-			\$10 copay per	-			
Health Visits	or group therap				or group thera				
Eyewear	\$100 annual allowan		•		\$100 annual allowa		•		
Eye Exams	\$45 copay for diag \$0 copay for one annu			n	\$10 copay for dia \$0 copay for one and			n	
Hearing Aids	\$3,000 annual allowan				\$3,000 annual allowa				
Hearing Exams	\$45 copay for diag \$0 copay for one annu			2	\$10 copay for dia \$0 copay for one and			~	
Dental	\$45 copay for Medica \$0 copay for 1 oral exam ar	re cove	red visit	•	\$10 copay for Medic \$0 copay for 1 oral exam	care cov	ered visit	t;	
Chiropractic	\$15 copay per Medica				\$20 copay per Medi				
Podiatry	\$0-45 copay for Medica \$0 copay for 24 routing				\$0-10 copay for Medi \$0 copay for unlimited ro				
	Cost-sharing shown is for	30	90	90	Cost-sharing shown is for	30	90	90	
	preferred pharmacies	days	days retail	days mail	preferred pharmacies	days	days retail	days mail	
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0	
	Generic Drafama d Dran d	\$10 \$42	\$30	\$0 \$84	Generic	\$7	\$21	\$0 \$0.1	
Prescription Drugs	Preferred Brand Non-Preferred Brand	\$42 \$95	\$126 \$285	\$84 \$190	Preferred Brand Non-Preferred Brand	\$42 \$95	\$126 \$285	\$84 \$190	
(Part D)	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A	
	\$0 deductible; after total year \$5,030 , you pay no more than				\$0 deductible; after total yes				
	for brand name drugs and 25%				\$5,030 , you pay no more tha for brand name drugs and 25				
	of-pocket drug expenses reach pay \$0 .	n \$8,00 0	. After	that, you	of-pocket drug expenses read	ch \$8,0 0	0. After	that, you	
					pay \$0 . Essential Extras: (Choose of	one): \$	50 month	ılv	
	Acupuncture: \$0 co-pay/visit Over the Counter: \$25 quarter			er year	allowance for groceries or \$1	1 50 quai	rterly for	utilities	
	Wellness: \$0 for basic Silver	Sneakei		ership	if diagnosed with chronic con allowance for assistive devic			nual	
	Optional supplemental pack 1: Preventive Dental at \$13		nth• un	to	allowance for dental/vision/h	nearing	needs; or	transport	
	\$500/year; \$0 co-pays for basi				for 60 trips/year to plan-appr Over the Counter: \$50 quar				
Supplemental	2: Dental & Vision at \$32 pe				Wellness: \$0 for basic Silver			oership	
Benefits and	\$1,000/year with \$0 copays fo services and 20-50% coinsura			itive	Optional supplemental pac		a	_	
Optional Plans	comprehensive services; \$150	annual	reimbu	rsement	1: Preventive Dental at \$13 \$500/year; \$0 co-pays for ba				
	allowance for eyewear 3: Enhanced Dental & Vision	n at \$48	8 per m	onth: up	2: Dental & Vision at \$32 p				
	to \$2,000 /year with \$0 copays	for cer	tain prev		\$1,000 /year with varying copreimbursement allowance for			11	
	services and 20-50% coinsura comprehensive services; \$200			rsement	3: Enhanced Dental & Visi	on at \$4	48 per m		
	allowance for eyewear				to \$2,000 /year with varying or reimbursement allowance for			iual	
Medical Groups	Medical Groups: Bay Valley				Medical Groups: Bay Valle	ey; Brov	vn & Tol		
and Hospitals	Physicians East Bay; Imperial Hospitals : Alta Bates/Summit				Physicians East Bay; Imperia Hospitals: Alta Bates/Summ				
(may not be full list; check with plan)	(CValley), St. Rose, (Hayward	l), Stan			(CValley), St. Rose, (Haywa	rd), Sta			
check with plan)	(Pleas/Liv), Washington (Fren	nont)			(Pleas/Liv), Washington (Fre	emont)			

Plan for more information or call soft-255-4795 (Subes & Marketing) (soft-255-4795 (Subes & Marketing) (soft-256-4795 (Subes & Marketing) (soft-256-4795 (Subes & Market	2024	MEDICARE HMO CO			CHAR					
Biological Science Sec-255-4795 (Member Services) www.hodimos.com Sec-255-4795 (Member Services) www.hodimos.com Plan Name/Type Classic Cure I (HMO) (H0038-050) Classic Cure II (HMO) (H0038-050) Classic Cure II (HMO) (H0038-050) Star Rating **1/2 **1/2 Annual OOP Max \$\$2,100 \$\$2,499 Monthly Premium \$\$0 for Primary Care Physician: \$0 for Specialic \$\$0 for Primary Care Physician: \$0 for Specialic \$\$0 for primary Care Physician: \$0 for Specialic \$\$0 for primary Care Physician: \$15 for Specialic \$\$0 for days 1-20; \$\$0 for	Please contact the			•				•		
L-600-Medicare Dot are way, huttime composition Dot are way, huttime composition Plan Name/Type Classic Care I (HMO) (1008/8-050) Classic Care I (HMO) (1008/8-050) Star Rating ***1/2 ***1/2 Annual OOP Max \$2,100 \$2,2499 Monthly Premium \$37,600 \$0 Monthly Premium \$0 for Primary Care Physician : 815 for Specialist Body for days 7-150 \$0 for Primary Care Physician : 815 for Specialist Body for days 7-150 Moltal Instrume \$0 copy per anabulatory supparation center, Solid or days 7-150 \$0 for primary Care Physician : 815 for Specialist Body for days 7-150 Shilled Nursing \$0 copy for days 1-20; Solid or primary Care Physician : 815 for days 2-120; Solid or primary for days 7-150 \$0-957 copy or and by ground; 20% co-instrume per trip by difference withit Shillod Nursing; 20% co-instrume per trip by difference withit Shillod Nursing; 20% co-instrume per trip by difference withit 20% co-instrume per trip by difference withit 20	Plan for more	866-255-4795 (Sal	es & N	Market	ing)	866-255-4795 (Sa	iles & I	Market	ing)	
Plan Name/Type Classic Care I (HMO) (H0388-050) Classic Care II (HMO) (H0388-051) Star Rating * ± 1/2 * ± 1/2 * ± 1/2 Annual OOP Max \$ 2,100 \$ 2,499 Monthly Premium \$ 50 copy day for days 1-6; \$ 10 for Primary Care Physician, \$ 10 for Specialis Doctor Visits \$ 90 for Primary Care Physician, \$ 0 for Specialis \$ 90 for Primary Care Physician, \$ 10 for Specialis Doctor Visits \$ 90 for primary Care Physician, \$ 0 for Specialis \$ 90 for Primary Care Physician, \$ 10 for Specialis Skilled Nursing \$ 90 oper per angutation hough facility visits \$ 90 oper day for days 1-6; Skilled Nursing \$ 50 opps (for days 1-20; \$ 90 opps (for days 1-20; Skilled Nursing \$ 50 opps (for days 1-20; \$ 50 opps (for days 2-1.00; Digger Care Physican \$ 50 opps (for days 2-1.00; \$ 50 opps (for days 2-1.00; Skillot Directly, Fully Scional Care Physican \$ 50 opps (for days 2-1.00; \$ 50 opps (for days 2-1.00; Lab Tests, All Yaros, \$ 50 opps (for days 2-1.00; \$ 50 opps (for days 2-1.00; \$ 50 opps (for days 2-1.00; Skillot Otherry \$ 50 opps (for days 2-1.00; \$ 50 opps (for days 2-1.00; \$ 50 opps (for days 2-1.00; <tr< th=""><th>information or call</th><th>866-255-4795 (M</th><th>ember</th><th>· Servic</th><th>es)</th><th>866-255-4795 (N</th><th>ſembe</th><th>r Servio</th><th>es)</th></tr<>	information or call	866-255-4795 (M	ember	· Servic	es)	866-255-4795 (N	ſembe	r Servio	es)	
Plan Namel (Type (HMO) (H0838-050) (HMO) (H0838-051) Star Rating Annual OOP Max 52,100 52,499 Star Rating Annual OOP Max 52,100 52,499 Doctor Visits 90 for Primory Care Physicians (Sf or Specials) 90 for Primory Care Physicians (Sf or Specials) Doctor Visits 90 core primory Care Physicians (Sf or Specials) 90 for Primory Care Physicians (Sf or Specials) Doubtor Visits 90 core primory Care Physicians (Sf or Specials) 90 for Primory Care Physicians (Sf or Specials) Monthly Premium 90 core primory Care Physicians (Sf or Specials) 90 for Primory Primory Primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primory Primory Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primor Physicians (Sf or Physicians) 90 core primory P	1-800-Medicare	www.bndh	mo.cor	n	· ·	www.bndł	imo.co	m	·	
Plan Namel (Type (HMO) (H0838-050) (HMO) (H0838-051) Star Rating Annual OOP Max 52,100 52,499 Star Rating Annual OOP Max 52,100 52,499 Doctor Visits 90 for Primory Care Physicians (Sf or Specials) 90 for Primory Care Physicians (Sf or Specials) Doctor Visits 90 core primory Care Physicians (Sf or Specials) 90 for Primory Care Physicians (Sf or Specials) Doubtor Visits 90 core primory Care Physicians (Sf or Specials) 90 for Primory Care Physicians (Sf or Specials) Monthly Premium 90 core primory Care Physicians (Sf or Specials) 90 for Primory Primory Primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primory Primory Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) 90 core primory Physicians (Sf or Specials) Star Barting Physicians (Sf or Specials) 90 core primor Physicians (Sf or Physicians) 90 core primory P		Classic ([¬] are l	[Classic (Care 1	T		
Star Rating ++1/2 ++1/2 Annual OOP Max \$2,100 \$2,499 Monthly Premium \$37,60 \$0 Monthly Dremium \$37,60 \$0 Inpatient Hospital \$0 for Primary Care Physician; \$0 for Speciality \$0 for Primary Care Physician; \$15 for Speciality Star Doutpatient \$0 for primary Care Physician; \$0 for Speciality \$0 for Primary Care Physician; \$15 for Speciality Subled Nursing \$0 copy for days 1, 21; \$0 for Speciality \$0 for Speciality Subled Nursing \$20 cops for adays 1, 21; \$0 for Speciality \$0 for Speciality Subled Nursing \$20 cops for adays 1, 21; \$0 for Speciality \$0 for Speciality Procedures, and \$0 cops for adays 2, 100 \$0 cops for adays 1, 21; \$0 cops for adays 1, 21; Ear Procedures, and \$0 cops for adays 1, 21; \$0 cops for adays 1, 21; \$0 cops for adays 1, 21; Ear Procedures, and \$0 cops for adays 1, 21; \$0 cops for adays 1, 21; \$0 cops for adays 1, 21; Lab Tests, \$0 cops for adays 1, 21; \$0 cops for adays 1, 21; \$0 cops for adays 1, 21; Procedures, and \$0 cops for adays 1, 21; </th <th>Plan Name/Type</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>	Plan Name/Type									
Annual OOP Max \$2,100 \$2,499 Monthly Prenium \$0 \$0 Monthly Prenium \$0 \$0 Ductor Visits \$0 for Primary Care Physician; \$15 for Specialist \$0 for Primary Care Physician; \$15 for Specialist Inpatient Hospital \$0 copus per sublatory surgical center; \$0 soft opus per sublatory surgical center; Hospital \$0 copus per sublatory surgical center; \$0 soft opus per sublatory surgical center; Skilled for Auge 21-100 \$20 opus per sublatory surgical center; \$0 copus per sublatory surgical center; Skilled for Nursing \$0 copus per sublatory surgical center; \$0 copus per sublatory	~			50)				(151)		
Monthly Premium \$37.60 \$0 Doctor Visits 50 for Primary Care Physician; 50 for Specialist S0 for Primary Care Physician; 50 for Specialist S1 for Primary Care Physician; 50 for Specialist Skilled Nursing S80 copey dire days 1-6; S0 per anablatory surgical center; s80 status on per anaptacin hospital facility visit S0 status on per for anaptacin hospital facility visit Skilled Nursing S80 copey for days 1-20; Secong For days for days 2-100 S0 status on per for the per subscitement hospital facility visit Status on per subscitement on per subscitement hospital facility visit S0 status on per subscitement hospital facility visit Status on per subscitement hospital facility visit S0 status on per subscitement hospital facility visit Status on per subscitement hospital facility visit S0 status on per subscitement hospital facility visit Status on per subscitement hospital facility visit S0 status on per subscitement hospital facility visit Status on per subscitement hospital facility visit S0 status on per subscitement hospital facility visit Status on per subscitement hospital facility visit S0 status on per subscitement hospital facility visit Status on per subscitement hospital facility visit S0 status on per subscitement hospital facility visit Status on per subscitement hospital facility visit S0 copay for hospital ho							-			
Doctor Visits S0 tor Primary Care Physician; S0 tor Speciality S0 tor Primary Care Physician; S15 for Speciality Inpatient Hospital S0 copuy per anabilatory surgical center; 40-100 per dy for days 1-20; 50-100 opps per outpatient hospital facility visit S150 copuy for anabilatory surgical center; 40-100 per dy for days 1-20; 50-120 opps per outpatient hospital facility visit S0-526 opps per outpatient hospital facility visit Skilled of Mursing Facility S0 -000 opps per outpatient hospital facility visit S0 -000 opps per outpatient on per angen care visit; 40-100 opps of tab scripcs; 20% coinsurance per trip by ground or air S0 -000 opps per outpatient on per angen care visit; 40-100 opps of tab scripcs; 20% coinsurance for diagnostic procedures, tests, and scrays; 20% co-insurance for therapeut care visit; 40-100 on ana worldvide with S10 on opps visit. S0 opps for diagnostic procedures, 40-100 opps for diagnostic procedures,										
Inpatient Hospital SSD copy tor day 1-150 SSD production for day 2-160 Ontpatient S0 copy or conjunction hospial facility visit S0-S75 copy for day 1-260 Solled Nursing SSD copy or entrophology 1-207 S0-S75 copy for antibulancy sangial center visit; Solled Nursing SSD-OB copy per trophology 1-207 S0 copy for day 1-207 Facility SSD-OB copy per trophology 1-207 S0 copy for day 1-207 Solled Nursing SSD-OB copy per trophology 1-207 S0-S10 copy per trophology 1-207 Solled Nursing SSD-OB copy per trophology 1-207 S0-S10 copy per trophology 1-200 SSD-OB copy per trophology 1-207 SSD-OB copy per trophology 1-207 S0-S10 copy per trophology 1-207 SSD-OB copy per trophology 1-207 SSD-OB copy per trophology 1-207 S0-S10 copy per trophology 1-207 Precedures, and SSD-OB copy per trophology 1-207 S0-S10 copy per trophology 1-207 Radiation Therapy S20 copy 1-207 S0-copy 2-207 S0-copy 2-207 Radiation Therapy S20 copy 1-207 S0-copy 2-207 S0-copy 2-207 Radiation Therapy S20 copy 1-207 S0-copy 2-207 S0-copy 2-207 Reand Dialysis 202 copy 1-207	Monthly Premium	\$37.6	50			\$0)			
Implementation Stock is program and intervent in the service: Stock is program and intervent is provided in the service: Outpatication Stock is program and intervent is provided in the service: Stock is program and intervent is provided in the service: Skilled Nursing Stock is program and intervent is provided in the service: Stock is provided in the service: Skilled Nursing Stock is provided in the service: Stock is provided in the service: Skilled Nursing Stock is provided in the service: Stock is provided in the service: Ambulance Stock is provided in the service: Stock is provided in the service: Care Lab Tests, Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Renal Dialysis Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service: Stock is provided in the service is	Doctor Visits	· ·			cialist				cialist	
Hospital \$9-150 copay per outpatient hospital Tacility visit \$90-5150 copay per outpatient hospital Tacility visit Skilled Nursing \$90-500 copay per outpatient hospital Tacility visit \$90-500 copay per day for days 1.20; Facility \$90-500 copay per trip by ground, 200 \$90-500 copay per trip by ground, 200% \$90-500 copay per trip by ground, 200% Ambulance \$90-100 copay per mempracy from visit, waived if a damined with 21 damined with 20 copay per damined with waite examt Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic Systematic	Inpatient Hospital									
Facility 3200 per day for days 21-100 S200 per day for days 21-100 Ambulance 50-3200 copus per trip by ground: 20% consumme per trip by ground or air information on the services of the service of the service hardward in dmitted within 72 hours; 80 per ugent care visit S00000 max wordwardward with 510 copus per trip by air dmitted within 72 hours; 80 per ugent care visit S00000 max wordwardward with 5130 copus per trip by air dmitted within 72 hours; 80 per ugent care visit S00000 max wordwardward with 510 copus per trip by air dmitted within 72 hours; 80 per ugent care visit S00000 max wordwardward with 510 copus per trip by air dmitted within 72 hours; 80 per ugent care visit S0000 max wordwardward with 5135 copus per diagnostic radiology 20% consume to the specific notiology 20% consume to the specific notion 20% consume the specific notion 20% consume to the specific notion 20% consume to the specific notion 20% consume the specific nothe specific nother 20% consume the specific notion 20% consume t	Outpatient Hospital									
Ambulance S0-530 copay per trip by ground: 20% coinsurance for therapeutic natiology: 20% coinsurance for therapeutic natiology: 20% coinsurance per triatment S0-135 copay for lab, figures in any site s50,000 max worldwide with 5135 copay/sist Radiation Therapy Real Dialysis S0 copay for individual or group therapy session S0 copay for individual or group therapy session S0 copay for individual or group therapy session S25 copay for individual or group therapy session S10 orange coinsurance for therapeutic natiology: 20% co-insurance for therapeutic natiology: 20% co-insurance for therapy session S10 orange coinsurance for depay session S25 copay for individual or group therapy session S10 orange or group therapy session S10 orange or group therapy session S26 copay for Mclicare-covered visit; S0 copay visit for 30 routine visits per year, combined with routine acupancture S0 copay for Mclicare-covered visit; S0 copay visit for 30 routine visits per year, combined with routine acupancture Preferre	Skilled Nursing									
Ambniance 20% consumine per trip by ground or air 20% so-insurance per trip by ground or air Emergency & Urgent Curre 50-1000 max word/wide with 510 copy per memory solution in the solutin the solution in the solutin the solution in the sol	Facility	1 2								
Emergency & model: 59-100 copus per emergency room visit, waived if sign.000 max worldwide with \$100 copus/visit. 59-5135 copus per emergency room visit, waived if sign.000 max worldwide with \$100 copus/visit. Lab Tests, Radiation Therapy Read Dialysis S0 copus for lab services, 20% coinsurance for diagnostic procedures, tests, ad x-rays; 20% co-insurance for therapeutic radiology 20% co-insurance for group therapy session 20% copus for individual therapy session 20% copus for one annual routine exam 50 copus for detain preventive services; 50 copus for detain preventive services; 50 copus for detain preventive services; 50 copus per Medicare-covered visit; 50 copus for detain preventive services; 50 copus per Medicare-covered visit; 50 copus p	Ambulance				air					
Entrogent Curve submitted within 72 hours; 50 per ugent care visit; admitted within 72 hours; 50 per ugent care visit; Lab Tests, Procedures, and Radiation Therapy S0 copay for lab services, 20% coinsurance for diagnostic procedures, tests, and x-ray; admitted within 72 hours; 50 per ugent care visit; S0 copay for lab services, 20% coinsurance for diagnostic procedures, tests, and x-ray; S0 copay for lab, diagnostic procedures, tests, and x-ray; S80 copa for diagnostic procedures, s80 copay for one annual routine carn s90 copay for one annual routine exam s90 copay for certain prevent; s90 copay for declaratic covered visit; s90 copay for Medicare-covered visit; s90 copay for Medicare-co	F 0							aived if		
Lab Tests, Procedures, and Radiation Therapy So copay for abservices, 20% coinsurance for diagnostic procedures, tests, and x-rays; Renal Dialysis So copay for abservices, 20% coinsurance for diagnostic procedures, tests, and x-rays; Renal Dialysis So copay for abservices, 20% coinsurance for diagnostic procedures, tests, and x-rays; Renal Dialysis So copay for abservices, 20% coinsurance for therapeutic radiology 20% coinsurance for expectant Sto copay per Medicare-covered exam; Sto copay for neannal routine exam Sto copay for neannal routine exam Sto copay for decinare covered visit; Sto copay for decinare covered visit; Sto copay for decinare covered visit; Sto copay for certain presentive services; Sto - S2.160 copay for certain comprehensive services; Sto - S2.160 copay for decinare covered visit; Sto copay f	e •									
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Renal Dialysis 20% co-insurance per treatment 20% co-insurance per treatment Outpatient Mental Health Visits \$25 copay for individual or group therapy session \$10 copay for individual therapy session Systems \$300 annual allowance for cycwear \$300 annual eycwear allowance for cycwear Eye Exams \$0 copay for one annual routine exam \$0 copay for one annual routine exam Be copay for one annual routine exam \$0 copay for medicare-covered exam; \$0 copay for Medicare-covered visit; \$0 copay per Medicare-covered visit; \$0 copay for Medicare-covered visit; \$0 copay per Medicare-covered vi	Procedures, and									
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(Oak), San Leandro, and Washington (Fremont) [(Oak), San Leandro, and Washington (Fremont)]		1 /								
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	MEDICARE HMO CO			_					_	
Please contact the	Central Health N					Central Health				
Plan for more	866-314-2427 (Sales & Marketing) 866-314-2427 (Sales & Marketing)									
information or call	866-314-2427 (Member Services) 866-314-2427 (Member Services)								ices)	
1-800-Medicare	www.centralhea	www.centralhealthplan.com www.centralhealthplan.com								
	Central Health I	Premi	ier Pla	an I	Central Health Premier Plan II					
Plan Name/Type	(HMO) (H				(HMO) (H5649-021)					
Stor Doting			(20)							
Star Rating	***				★★★1/2 \$1,199					
Annual OOP Max	\$3,20					· · · · · · · · · · · · · · · · · · ·				
Monthly Premium	\$0				+ -	\$4				
Doctor Visits	\$0 for Primary Care Physic		-		\$0	for Primary Care Phy	sician; S	50 for Sp	ecialist	
Inpatient Hospital	\$0 copay for days 1-4; \$100 \$0 copay for d	ays 11-	150			\$0 copay	-			
Outpatient Hospital	\$0-\$100 copay per ambulate \$0-\$150 copay per outpatie				\$0-	\$0 per ambulatory s \$150 copay per outpa				
Skilled Nursing Facility	\$0 copay for (\$204 /day for d					\$0 copay fo \$204 /day for				
Ambulance	\$0-\$150 copay per one- 20% coinsurance	way tri	p by gro	ound;	1	\$0-\$150 copay per on 20% coinsurance	e-way tr	ip by gro	und;	
	\$0-\$100 copay per emergen	ncy roon	n visit; v		\$0-\$	100 copay per emerge	ency roo	m visit; v		
Emergency & Urgent Care	admitted to hospital \$0 for urgent care; \$100,000				\$0 fc	admitted to hospitar r urgent care; \$100,0				
	copays for ER an					copays for ER				
Lab Tests,	\$0 copay for lab service					60 copay for lab servi				
Procedures, and	procedures, and x-rays; \$50					rocedures, x-rays, and				
Radiation Therapy	20% co-insurance for the	herapeu	tic radio	ology		20% co-insurance for	-		ology	
Renal Dialysis	20% co-insurance	e per tre	atment			20% co-insuran	ce per tr	eatment		
Outpatient Mental Health Visits	\$40 copay per individual o	r group	therapy	session	\$0	copay per individual	or group	therapy	session	
Eyewear	\$300 annual allowance f	or glass	es or co	ntacts	\$	300 annual allowance	for glas	ses or co	ntacts	
Eye Exams	\$0 copay per Medica \$0 copay for one ann	re-cove	red exar	n;	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam				n;	
Hearing Aids	\$2,000 annual allowance t				\$3.	000 annual allowance				
	\$0 copay for Medica	U		U	φ0,	\$0 copay for Media	U		Ŭ	
Hearing Exams	\$0 copay for one and					\$0 copay for one at				
	\$0 copay for Medica					\$0 copay for Medi				
Dental	\$0-\$41 copay for certain				\$0-\$41 copay for certain preventive services; \$0 - \$2 160 copay for certain comprehensive services					
	\$0 - \$2,160 copay for certain				\$0 - \$2,160 copay for certain comprehensive services \$0 copay per Medicare-covered visit					
Chiropractic	\$0 copay per Medic	are-cov	ered visi	It		\$0 copay per Med	icare-co	vered visi	it	
Podiatry	\$0 co-pay per Medic	care-cov	vered vis	it	\$0 co-pay per Medicare-covered visit					
	Cost-sharing shown is for	30	90	100	Cost-sharing shown is 30 90 100					
	preferred pharmacies	days	days	days	for p	referred pharmacies	days	days	days	
	Preferred Generic	\$0	\$0	mail \$0	Pref	erred Generic	¢0	* •	mail	
	Generic	\$0 \$0	\$0 \$0	ψυ	1101			50	\$0	
Prescription Drugs			JU	\$0	Gen		\$0 \$0	\$0 \$0	\$0 \$0	
	Preferred Brand	\$35	\$105	\$0 \$70	Gen Pref		\$0 \$0 \$35	\$0 \$0 \$105	\$0 \$0 \$70	
(Part D)	Preferred Brand Non-Preferred Brand	\$35 \$75	\$105 \$225	\$70 \$150	Pref Non	eric erred Brand -Preferred Brand	\$0 \$35 \$75	\$0 \$105 \$225	\$0 \$70 \$150	
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(Part D) Supplemental Benefits and Optional Plans Medical Groups	Preferred BrandNon-Preferred BrandSpecialty co-insurance\$0 deductible; after total yea\$5,030, you pay \$0 for gener25% of the plan's cost for brout-of-pocket drug expensesyou pay \$0.Acupuncture: \$0 co-pay forFlex Allowance: \$41 monthand Herbal Catalogue items,allowance for fitness feesGroceries: \$25 monthly alloqualifying chronic conditionsIn-Home Support Services:hours per year for qualifyingMeals: \$0 copay for those withqualifying chronicScales: \$0 copay for those withWellness: \$0 for basic Silve	\$35 \$75 33% arly dru ics and and nam reach \$ unlimit ly allow & \$20 n wance f \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	\$105 \$225 N/A Ig costs no more ne drugs 8,000. A red visits vance fo nonthly for those bay for u rs ay for 14 tons; 4 ti ing chro one-way iles ers men ast Bay	\$70 \$150 N/A reach than a until After that, s/year r OTC with up to 20 4 days for imes/year onic cond. trips to hbership	Prefi Non Spec \$0 dea \$5,03 25% out-of you p Cost- copay Acup Flex 4 and H fees; \$ Groce qualif In-He hours Meals those Scale: Trans plan a Wellr	eric erred Brand Preferred Brand ialty co-insurance ductible; after total y 0, you pay \$0 for genue of the plan's cost for 1 -pocket drug expense ay \$0 . Sharing Waived: mo s are waived for tho uncture: \$0 co-pay for Allowance: \$50 mon erbal Catalogue items 5165 allowance every eries: \$25 monthly all ying chronic condition ome Support Service per year for qualifyin s: \$0 copay/meal for 2 with qualifying chrons s: \$0 copay for those sportation: \$0 co-pa pproved locations with ess: \$0 for basic Silver cal Groups: Hill Phy	\$0 \$35 \$75 33% early dr erics and prand na s reach \$ st co-in se with or unlim thly allo s; \$20 m six mor owance ns s: \$0 cc g memb 2 meals/c ic condi w/qualif y for 48 hin 50 r yer Snea	\$0 \$105 \$225 N/A rug costs I no more me drugs \$8,000. A surance full Med ited visits wance fo onthly fo ths for do for those opay for u ers day for 14 tions; 4 t ying chrco one-way niles kers men East Bay	\$0 \$70 \$150 N/A reach than	
(Part D) Supplemental Benefits and Optional Plans Medical Groups and Hospitals	Preferred BrandNon-Preferred BrandSpecialty co-insurance\$0 deductible; after total yea\$5,030, you pay \$0 for gener25% of the plan's cost for brout-of-pocket drug expensesyou pay \$0.Acupuncture: \$0 co-pay forFlex Allowance: \$41 monthand Herbal Catalogue items,allowance for fitness feesGroceries: \$25 monthly alloqualifying chronic conditionsIn-Home Support Services:hours per year for qualifyingMeals: \$0 copay for those withTransportation: \$0 co-payplan approved locations withWellness: \$0 for basic SilveMedical Groups: Hill PhysicHospitals: Alta Bates/Summ	\$35 \$75 33% arly dru ics and and nam reach \$ unlimit ly allow & \$20 n wance f \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	\$105 \$225 N/A Ig costs no more ne drugs 8,000. A red visits vance fo nonthly for those bay for u rs ay for 14 tons; 4 ti ing chro one-way iles ers mem ast Bay /Oak), E	\$70 \$150 N/A reach than	Prefi Non Spec \$0 dea \$5,03 25% out-of you p Cost- copay Acup Flex 4 and H fees; \$ Groce qualif In-He hours Meals those Scale Trans plan a Wellr Medi Hosp	eric erred Brand Preferred Brand ialty co-insurance ductible; after total y 0, you pay \$0 for genue of the plan's cost for 1 -pocket drug expense ay \$0 . Sharing Waived: mo s are waived for tho uncture: \$0 co-pay fe Allowance: \$50 mon erbal Catalogue items 5165 allowance every eries: \$25 monthly all ying chronic condition per year for qualifying s: \$0 copay for those sportation: \$0 co-pa pproved locations wite ess: \$0 for basic Silver cal Groups: Hill Phy itals : Alta Bates/Sum	\$0 \$35 \$75 33% early dr erics and partices and part	\$0 \$105 \$225 N/A rug costs I no more me drugs \$8,000. 2 surance full Med ited visits wance fo onthly fo ths for da for those opay for u ers lay for 14 tions; 4 t ying chrco one-way niles kers men East Bay k/Oak), F	\$0 \$70 \$150 N/A reach than	
(Part D) Supplemental Benefits and Optional Plans Medical Groups	Preferred BrandNon-Preferred BrandSpecialty co-insurance\$0 deductible; after total yea\$5,030, you pay \$0 for gener25% of the plan's cost for brout-of-pocket drug expensesyou pay \$0.Acupuncture: \$0 co-pay forFlex Allowance: \$41 monthand Herbal Catalogue items,allowance for fitness feesGroceries: \$25 monthly alloqualifying chronic conditionsIn-Home Support Services:hours per year for qualifyingMeals: \$0 copay for those withqualifying chronicScales: \$0 copay for those withWellness: \$0 for basic Silve	\$35 \$75 33% arly dru ics and and nam reach \$ unlimit ly allow & \$20 n wance f \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	\$105 \$225 N/A Ig costs no more ne drugs 8,000. A red visits vance fo nonthly for those bay for u rs ay for 14 tons; 4 ti ing chro one-way iles ers mem ast Bay /Oak), E	\$70 \$150 N/A reach than	Prefi Non Spec \$0 dea \$5,03 25% out-of you p Cost- copay Acup Flex 4 and H fees; \$ Groce qualif In-He hours Meals those Scale Trans plan a Wellr Medi Hosp	eric erred Brand Preferred Brand ialty co-insurance ductible; after total y 0, you pay \$0 for genue of the plan's cost for 1 -pocket drug expense ay \$0 . Sharing Waived: mo s are waived for tho uncture: \$0 co-pay for Allowance: \$50 mon erbal Catalogue items 5165 allowance every eries: \$25 monthly all ying chronic condition ome Support Service per year for qualifyin s: \$0 copay/meal for 2 with qualifying chrons s: \$0 copay for those sportation: \$0 co-pa pproved locations with ess: \$0 for basic Silver cal Groups: Hill Phy	\$0 \$35 \$75 33% early dr erics and partices and part	\$0 \$105 \$225 N/A rug costs I no more me drugs \$8,000. 2 surance full Med ited visits wance fo onthly fo ths for da for those opay for u ers lay for 14 tions; 4 t ying chrco one-way niles kers men East Bay k/Oak), F	\$0 \$70 \$150 N/A reach than	

2024					T FOR ALAMEDA CO				
Please contact the Plan for more information or call	Imperial Health Pla 800-838-8271 (Sal 800-838-8271 (Me	es & N ember	/larket	ting) ces)	Imperial Health F 800-838-8271 (S 800-838-8271 (N	ales &	Marke	ting)	
<i>1-800-Medicare</i> Plan Name/Type	www.imperialhea Imperial Tr	aditio	onal		www.imperialh Imperial (IIMO) (7	Stro	ng	<u>.</u>	
Star Rating	(HMO) (H5		07)		(HMO) (H		014)		
Annual OOP Max	\$1,34				★★★ \$8,850				
Monthly Premium	\$1,54	••			\$8,850				
	\$0 for Primary Ca	re Phys	ician;		20% for Primary		ysician;		
Doctor Visits	\$0 for Spe \$150 copay for days	cialist		-	20% for \$ \$\$0 copay for days 1-60; \$	Specialis	t	Con dorra	
Inpatient Hospital	6-90; \$670 per day f				61-90; \$800 per da				
Outpatient Hospital	\$200 per ambulatory su \$200 copay per outpatient	hospita	l facilit		20% coinsurance per ambu 20% coinsurance per outpa	tient hos	spital fac		
Skilled Nursing Facility	\$0 copay per day f \$200 /day for da				\$0 copay per day \$204 /day for				
Ambulance	\$150 copay per one-wa 20% coinsurance per	ay trip b	oy groun		20% coinsurance per or 20% coinsurance p	ne-way t	rip by gr		
Emergency &	\$125 copay per emergency	room v	visit; wa	ived if	20% of cost, up to \$100 p	er emerg	gency roo	om visit;	
Urgent Care	admitted to hospital within 7 urgent care; \$50,000 max we	orldwid	e with \$		20% of cost up to \$55 Costs waived if admitted to				
Lab Tests, Procedures, and	10% coinsurance for diagnostic tests &	proced	lures;		20% coinsurance for lab so procedures, x-rays, dia				
Radiation Therapy	\$0 copay for x-rays, & d 20% coinsurance for the				therapeutic			, and	
Renal Dialysis		20% coinsurance for therapeutic radiology20% co-insurance20% co-insurance per treatment20% co-insurance							
Outpatient Mental	20% coinsurance or group therap				20% coinsurance per individual or group therapy session				
Health Visits Eyewear	\$250 annual allowar	•			\$240 annual allow				
Eye Exams	\$0 copay per Medicar	e-cover	ed exan		20% coinsurance per M	edicare-	covered	exam;	
	\$0 copay for rou \$0 copay for he				\$0 copay for one ar \$0 copay for			n	
Hearing Aids	\$500 annual a	llowanc	ce		\$500 annual	allowar	ice		
Hearing Exams	\$0 copay for Medicar \$0 copay for 1 annual routin				20% coinsurance for Me \$0 copay for one annual rou				
Dental	\$0 co-pay per Medicare-covo preventive services up to \$5 certain comprehensive servi must use Imperial HMO	5 00 /yea1 ices up	r; \$0 co- to \$1,00	pay for 0/year;	\$0 co-pay per Medicare-co preventive services up to certain comprehensive ser must use Imperial HM	\$500 /yea rvices up	ar; \$0 co to \$1,0 (-pay for 00/year;	
Chiropractic	\$0 copay per Medica				20% co-insurance per Medicare-covered visit				
Podiatry	\$0 co-pay per Medica \$0 co-pay for 6 routin				20% coinsurance per M	/ledicare	-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	
	Preferred Generic	\$0	\$0	mail \$0	Preferred Generic	25%	25%	mail 25%	
Drogonintian Dance	Generic	\$5	\$12	\$10	Generic	25%	25%	25%	
Prescription Drugs (Part D)	Preferred Brand Non-Preferred Brand	\$45 \$90	\$110 \$225	\$90 \$180	Preferred Brand Non-Preferred Brand	25% 25%	25% 25%	25% 25%	
······································	Specialty co-insurance	33%	33%	N/A	Specialty co-insurance	25%	25%	25%	
	\$0 deductible; after total yea \$5,030 , you pay \$0 for gener				\$545 deductible; after deduc				
	25% of the plan's cost for br	and nan	ne drugs	s until	expenses reach \$8,000. Aft				
	out-of-pocket drug expenses that, you pay \$0 .	reach \$	8,000. 4	After					
	In-home Support Services:	\$0 cop	ay for u	p to 48					
	hours per year Meals: \$0 copay for up to 7	home-d	lelivered	l meals	In-home Support Services	: \$0 cor	ay for u	o to 48	
Supplemental Benefits and	following a surgery or hospit	al stay,	up to \$1	105/year	hours per year				
Optional Plans	Over the Counter: \$75 quarities in OTC mail order cata		owance	101	Part B Premium Reductio	n: \$85 1	nonthly		
- F	Transportation: \$0 co-pay	for 100	one-wa	y trips	reimbursement				
	per year to plan approved loc Wellness: \$0 for basic Silve		nembers	hip					
Madical C	Medical Groups: Brown &				Medical Groups: Brown &	t Toland	. Imperis	al Health	
Medical Groups and Hospitals	Holdings, Nivano Physicians IPA	, Physic	cian Part	iners	Holdings, Nivano Physician	s, Physic	cian Part	ners IPA	
(may not be full list;	Hospitals: Alta Bates/Summ				Hospitals : Alta Bates/Sumr Medical Center (C. Valley),				
check with plan)	Medical Center (C. Valley), S Washington (Fremont)	st. Rose	e (Hayw	ard) and	Washington (Fremont)				
	radington (Fieldon)		_9_						

					I FOR ALAMEDA COUNTY			
Please contact the Plan for more information or call 1-800-Medicare	Imperial Health Pl 800-838-8271 (Sal 800-838-8271 (M www.imperialhe	les & N ember	Marketi • Servic	ing)	Imperial Health Plan of California 800-838-8271 (Sales & Marketing) 800-838-8271 (Member Services) www.imperialhealthplan.com			
Plan Name/Type	Imperial D (HMO) (H5	ynan	nic		Imperial Courage (HMO) (H5496-016)			
Star Rating	**	*			***			
Annual OOP Max	\$298	8			\$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	\$50 copay for days 1-5 \$670 per day for	; \$0 for		0;	\$150 copay for days 1-5; \$0 co-pay/day for days 61-90; \$670 per day for days 91-150			
Outpatient Hospital	\$100 per ambulatory su \$100 copay per outpatient	t hospita	al facility	,	\$200 per ambulatory surgical center visit;\$200 copay per outpatient hospital facility visit			
Skilled Nursing Facility	\$0 copay per day \$200 /day for day				\$0 copay per day for days 1-20; \$200 /day for days 21-100			
Ambulance	\$150 copay per one-w 20% coinsurance pe	ay trip l r each ti	by ground rip by air		\$150 copay per one-way trip by ground;20% coinsurance per each trip by air			
Emergency & Urgent Care	\$125 per emergency room admitted to hospital \$0 copay for u \$50,000 max worldwi	within ² rgent ca	18 hours; re;		\$125 copay per emergency room visit; waived if admitted to hospital within 72 hours; \$20 copay for urgent care; \$50,000 max worldwide with \$0 copay			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab service procedures, x-rays, and c 20% co-insurance for th	liagnost	ic radiolo	ogy;	 10% coinsurance for lab services, diagnostic tests & procedures; \$0 copay for x-rays, & diagnostic radiology; 20% coinsurance for therapeutic radiology 			
Renal Dialysis	20% co-insurance	-			20% co-insurance per treatment			
Outpatient Mental Health Visits	20% coinsurance or group thera				20% coinsurance per individual or group therapy session			
Eyewear	\$250 annual allowar		-		\$250 annual allowance for eyewear			
Eye Exams	\$0 copay per Medicar \$0 copay for rou			;	\$0 copay per Medicare-covered exam;\$0 copay for routine exams			
Hearing Aids	\$0 copay for he \$500 annual a	allowand	ce		\$0 copay for hearing aids; \$500 annual allowance			
Hearing Exams	\$0 copay for Medican \$0 copay for 1 annual routin	ie exam	up to \$2	50/year	\$0 copay for Medicare-covered exam; \$0 copay for 1 annual routine exam up to \$250/year			
Dental	\$0 co-pay per Medicare-cov preventive services up to \$2 certain comprehensive serv must use Imperial HMO	500/year rices up contrac	r; \$0 co-p to \$1,000 ted provi	bay for D/year; ider	\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services up to \$500/year; \$0 co-pay for certain comprehensive services up to \$1,000/year; must use Imperial HMO contracted provider			
Chiropractic	\$0 copay per Medica Routine visits r				20% co-insurance per Medicare-covered visit; Routine visits not covered			
Podiatry	\$0 co-pay per Medica \$0 co-pay for 6 routing	are-cove	ered visit		\$0 co-pay per Medicare-covered visit; \$0 co-pay for 6 routine visits per year			
Prescription Drugs	Cost-sharing shown is for preferred pharmaciesPreferred GenericGenericPreferred Brand	30 days \$0 \$3 \$30	100 days \$0 \$6 \$90	100 days mail \$0 \$5 \$75	THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.			
(Part D)	Non-Preferred Brand Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay \$0 for gener 25% of the plan's cost for br out-of-pocket drug expenses that, you pay \$0.	\$75 33% arly dru ics and and nan reach \$	no more ne drugs 8,000. A	than until fter	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 Over the Counter: \$120 qua Transportation: \$0 co-pay per year to plan approved loc Wellness: \$0 for basic Silve	home-c al stay, arterly a for 100 cations	lelivered up to \$10 llowance one-way	meals 05/year trips	Meals: \$0 copay for up to 7 home-delivered meals following a surgery or hospital stay, up to \$105/year Over the Counter: \$75 quarterly allowance Part B Premium Reduction: \$75 monthly reimbursement Transportation: \$0 co-pay for 100 one-way trips per year to plan approved locations Wellness: \$0 for basic Silver&Fit membership			
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown & Holdings, Nivano Physicians Hospitals: Alta Bates/Summ Medical Center (C. Valley), S Washington (Fremont)	, Physic it (Berk	ian Partr /Oak), E	ners IPA den	Medical Groups: Brown & Toland, Imperial Health Holdings, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (C. Valley), St. Rose (Hayward) and Washington (Fremont)			
			10					

2024 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY **Kaiser Permanente** Please contact the 800-777-1238 (Sales & Marketing) Plan for more information or call 800-443-0815 (Member Services) 1-800-Medicare www.medicare.kaiserpermanente.org **Kaiser Permanente Senior Kaiser Permanente Senior** Advantage Basic Alameda **Plan Name/Type** Advantage (HMO) (H0524-059) (HMO) (H0524-032) **** **** **Star Rating Annual OOP Max** \$6.000 \$3,900 **Monthly Premium \$0** \$70 **\$5** copay for Primary Care Physician; **\$0** copay for Primary Care Physician; **Doctor Visits** \$10 for Specialist \$15 for Specialist \$290 copay/day for days 1-5; \$225 copay/day for days 1-5; **Inpatient Hospital** \$0 per day for days 6 and beyond **\$0** per day for days 6 and beyond Outpatient \$250 per ambulatory surgical center visit; **\$190** per ambulatory surgical center visit; **\$0-\$250** copay per outpatient hospital facility visit **\$0-\$190** copay per outpatient hospital facility visit **Hospital Skilled Nursing \$0** copay/day for days 1-20; \$0 copay/day for days 1-20; **\$100** per day for days 21-100 **\$100** per day for days 21-100 Facility Ambulance \$250 copay per air or ground ambulance trip **\$250** copay per air or ground ambulance trip \$120 for emergency room visit; \$120 for emergency room visit; **Emergency & \$5** for urgent care visit; **\$0** for urgent care visit; **Urgent Care** Worldwide coverage Worldwide coverage Lab Tests. **\$0** copay for lab, diagnostic tests & procedures; **\$0** copay for lab, diagnostic tests, procedures, x-rays; Procedures, and \$10 copay for x-rays; \$250 copay for **\$200** copay for diagnostic radiology; diagnostic radiology; **\$10** for therapeutic radiology **\$0** for the rapeutic radiology **Radiation Therapy Renal Dialysis** 20% co-insurance per treatment **20%** co-insurance per treatment **Outpatient Mental \$2** copay per individual session; **\$0** copay per individual session; **Health Visits \$5** per group therapy session **\$0** per group therapy session Not covered: Not covered: **Evewear** See Optional Benefits Plan below See Optional Benefits Plan below **\$5-\$15** copay per Medicare-covered exam; **\$0-\$10** copay per Medicare-covered exam; **Eye Exams \$5** per routine exam **\$0** per routine exam Not covered; Not covered: **Hearing Aids** See Optional Benefits Plan below See Optional Benefits Plan below **Hearing Exams \$15** copay per Medicare-covered exam **\$10** copay per Medicare-covered exam \$5-\$15 co-pay per Medicare-covered visit; **\$0-\$10** co-pay per Medicare-covered visit; \$0 copay for certain preventive & diagnostic services; \$0 copay for certain preventive & diagnostic services; Dental See Optional Benefits Plan below See Optional Benefits Plan below Chiropractic \$5 copay per Medicare covered visit **\$0** copay per Medicare covered visit **Podiatry** \$15 copay per Medicare covered visit **\$10** copay per Medicare covered visit Cost-sharing shown is for 100 Cost-sharing shown is for 30 100 100 100 30 preferred pharmacies preferred pharmacies days day days days days days retail mail retail mail Preferred Generic \$4 \$12 **\$8** Preferred Generic \$0 **\$0 \$0 \$14** \$18 \$54 \$7 Generic \$36 Generic \$21 Preferred Brand \$47 \$141 \$94 Preferred Brand \$47 \$141 \$94 **Prescription Drugs** Non-Preferred Brand \$100 \$300 \$200 Non-Preferred Brand \$100 \$300 \$200 (Part D) 33% 33% 33% 33% 33% Specialty co-insurance Specialty co-insurance 33% **\$0** deductible; after total yearly drug costs reach **\$0** deductible; after total yearly drug costs reach \$5,030, you pay \$4 copay for preferred generic, \$18 \$5,030, you pay \$0 copay for preferred generic, \$14 for generic and 25% for brand name and specialty for generic and 25% for brand name and specialty drugs until out-of-pocket drug expenses reach \$8,000. drugs until out-of-pocket drug expenses reach \$8,000. After that, you pay **\$0**. After that, you pay **\$0**. Medical Financial Assistance Program: available to Medical Financial Assistance Program: available to eligible members; contact plan for details eligible members; contact plan for details Over the Counter: \$60 quarterly allowance for items Over the Counter: \$60 quarterly allowance for items from OTC catalogue; each order \$25 minimum from OTC catalogue; each order **\$25** minimum Optional Benefit Plan: Advantage Plus at Optional Benefit Plan: Advantage Plus at Supplemental \$21/month: \$21/month: **Benefits and** -Dental: Copays vary depending upon the service; -Dental: Copays vary depending upon the service; **Optional Plans** Must use Delta Care USA HMO network Must use Delta Care USA HMO network -Hearing Aids: \$800 allowance per ear every 36 -Hearing Aids: \$800 allowance per ear every 36 months months -Vision: \$0 copay for eyewear with \$300 allowance -Vision: \$0 copay for eyewear with \$300 allowance every two years every two years -Wellness: \$0 for Silver&Fit gym membership -Wellness: \$0 for Silver&Fit gym membership **Medical Groups** and Hospitals Medical Groups: Kaiser Permanente Medical Groups: Kaiser Permanente Hospitals: Kaiser Oakland, San Leandro, Fremont Hospitals: Kaiser Oakland, San Leandro, Fremont (may not be full list; check with plan)

2024 N	IEDICARE HMO COM			CHAR'				
Please contact the Plan for more information or call 1-800-Medicare	SCAN Heal 877-870-4867 (Sale 800-559-3500 (Me www.scanhealt	es & N ember	larket Servio	-	SCAN Hea 877-870-4867 (Sal 800-559-3500 (M www.scanheal	es & N ember	larket Servio	
Plan Name/Type	SCAN Classi (H05425-		AO)		SCAN MyChoice (HMO) (H05425-110)			
Star Rating	***1	/2			***	1/2		
Annual OOP Max	\$2,80	0			\$2,80	0		
Monthly Premium	\$0	~ ~			\$0	~ ~		
Doctor Visits	\$0 copay for Primary \$0 for Spec	cialist		•	\$0 copay for Primary \$0 for Spe	cialist		;
Inpatient Hospital	\$150 copay/day f \$0 per day for days	8 and b	eyond		\$100 copay/day \$0 per day for days	6 and b	eyond	
Outpatient Hospital	\$0 per ambulatory surg \$0-\$125 copay per outpatier				\$0 per ambulatory sur \$0-\$125 copay per outpatie			
Skilled Nursing Facility	\$0 copay/day for \$75 for days		20;		\$0 copay/day fo \$75 /day for da			
Ambulance	\$180 copay per one-way t	trip by g	ground c	or air	\$105 copay per one-way	trip by g	ground o	or air
Emergency & Urgent Care	\$90 copay per ER visit; w hospital immediately; \$0 Worldwide co	per urge	nt care		\$90 copay per ER visit; w hospital immediately; \$0 Worldwide c	per urge	nt care	
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagn tests, x-rays and diagr \$60 copay for therap	ostic ra eutic ra	diology diology		\$0 copay for lab, diagnetic tests, x-rays and diagnetic tests, x-rays and diagnetic tests, x-rays for the test test test test test test test	nostic ra beutic ra	diology diology	
Renal Dialysis	20% co-insurance	*			20% co-insurance	*		
Outpatient Mental Health Visits	\$10 copay for in group therapy	session	1		\$10 copay for in group therapy	y sessior	1	
Eyewear	\$235 allowance for eyev	wear eve	ery 2 ye	ars	\$235 allowance for eyewear every 2 years			
Eye Exams	\$0 copay per Medicar \$0 copay for one annu				\$0 copay per Medican \$0 copay for one ann			
Hearing Aids	\$450 - \$750 copay per aid; through plan-contra			h year;	\$450 - \$750 copay per aid; through plan-contr			n year;
Hearing Exams	\$0 copay for Medicard \$0 copay for one annu	al routi	ne exan	1	\$0 copay for Medican \$0 copay for one ann			
Dental	\$0 co-pay per Medica \$0 co-pay for certain pr See Optional Benef	eventive	e service		\$0 co-pay per Medica \$0 co-pay for certain p			
Chiropractic	\$0 copay per Medicar Routine visits no				\$0 copay per Medicare covered visit;\$0 copay for 30 routine visits per year			
Podiatry	\$0 copay per Medica				\$10 copay per Medicare-covered visit			
	Cost-sharing shown is for preferred pharmacies Preferred Generic	30 days \$0	100 days retail \$0	100 days mail \$0	Cost-sharing shown is for preferred pharmacies Preferred Generic	30 days \$0	100 days retail \$0	100 days mail \$0
	Generic	\$0	\$0	\$0	Generic	\$0	\$0	\$0
Prescription Drugs	Preferred Brand	\$37	\$91	\$91	Preferred Brand	\$35	\$85	\$85
(Part D)	Non-Preferred Brand	\$90	\$250	\$250	Non-Preferred Brand	\$70	\$190	\$190
	Specialty co-insurance \$0 deductible; after total year	33%	N/A	N/A	Specialty co-insurance \$0 deductible; after total yea	33%	N/A	N/A Pach
	\$5,030, you pay \$0 for drugs				\$5,030, you pay \$0 for drugs			
	more than 25% of the plan's	cost for	brand r	name	more than 25% of the plan's	s cost for	brand 1	name
	drugs until out-of-pocket dru \$8,000. After that, you pay \$		ses reac	h	drugs until out-of-pocket dru \$8,000. After that, you pay		ses reac	h
Supplemental Benefits and Optional Plans	Over the Counter: \$100 qua balance carries over to next q year Transportation: \$0 copay for year to plan-approved location Wellness: \$0 for basic mem fitness clubs and studios (call more info) Optional Dental Package: \$ copays for certain diagnostic services	uarter b or 24 on ons with bership l Member 6 10 /mon	e-way ti in 75 mi at partic er Svcs	alendar rips per iles cipating for 5440	Acupuncture: \$0 copay pervisits per year Over the Counter: \$75 quabalance carries over to next of year Transportation: \$0 copay f year to plan-approved location Wellness: \$0 for basic men fitness clubs and studios (cal more info)	rterly all quarter b or 24 on ons with ibership	owance out not c e-way th in 75 m at partic	; alendar rips per iles cipating
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown & Hospitals: Alameda, San Lea (Hayward)		t. Rose		Medical Groups: Brown & Hospitals: Alameda, San Le (Hayward)			

2024	MEDICARE HMO CO	MPAR	RISON	CHART	FOR ALAMEDA COU	UNTY			
Please contact the Plan for outline of coverage & provider information or call			-723-0 6-261	6473 (Sa -7709 (N	ealth Care les and Marketing) Member Services)				
1-800-Medicare				careplans.com					
Plan Name/Type	UHC Canoj (HMO-POS))	AARP Medicare Advantage from UHC (HMO-POS) (H0543-235)				
Star Rating	***	1/2			***	★ ★1/2			
Annual OOP Max	\$3,4	00			\$6,3	00			
Monthly Premium	\$40	6			\$2	5			
Doctor Visits	\$0 copay for Primar \$15 for Sp	pecialist		n;	\$0 copay for Primar \$10 for Sp	ecialist	-	;	
Inpatient Hospital	\$275 copay/day \$0 for days 8 and be	eyond (u	Inlimited		\$300 copay/day \$0 for days 8 and be	eyond (u	nlimited		
Outpatient Hospital	\$100 copay for ambulator \$225 copay for outpa				\$225 copay for ambulator \$275 copay for outpa				
Skilled Nursing Facility	\$0 copay/day for \$203 per day for	or days	1-20;		\$0 copay/day for \$203 per day for	or days 1	-20;		
Emergency & Urgent Care	\$135 copay per emergenc admitted to hospital within care visit; \$0 copay for	24 hour	s; \$40 p	er urgent	\$90 copay per emergence admitted to hospital within care visit; \$0 copay for	24 hours	; \$40 pe	r urgent	
Ambulance	\$290 copay per trip by ground or air\$250 copay per trip by ground or air								
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnosti \$25 copay per x-ray; \$15 radiology; \$60 copay for	5 0 copay	for dia	gnostic	\$0 copay for lab, diagnost \$15 copay per x-ray; \$60 radiology; \$60 copay for	0 copay f	or diagr	ostic	
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insuranc	e per trea	atment		
Outpatient Mental Health Visits	\$25 copay for individu \$15 copay for group	p therap	y sessio	n	\$25 copay for individual therapy session;\$15 copay for group therapy session				
Eyewear	\$0 copay with \$100 annual through United Health	care Vis	ion netw	vork	\$0 copay with \$250 annual through United He	ealthcare	Vision		
Eye Exams	\$0 copay for Medica \$0 copay for one and				\$0 copay for Medica \$0 copay for one and				
Hearing Aids	\$99 - \$1,249 copay per aid through United Healthc	are Hea	ring net	work	\$99 - \$1,249 copay per aid through United Healthc	are Hear	ing netv	vork	
Hearing Exams	\$0 copay for Medica \$0 copay for one and	nual rou	tine exa	m	\$0 copay for Medica \$0 copay for one and				
Dental	\$0 copays for certain prevent services; 50% coinsurance \$750 annual allowance; or dentists but higher or	for bridg can use o	ges and out of ne	dentures; etwork	\$0 copay for certain preventive services; can use out of network dentists but higher copays may apply See Optional Benefit Plan below				
Chiropractic	\$15 copay for Medic Routine care r	care-cov	ered vis		\$10 copay for Medicare-covered visit; Routine care not covered				
Podiatry	\$15 copay per Medic \$15 copay/visit for 6 ro	care-cov	vered vis		\$10 copay per Medicare-covered visit; \$10 copay/visit for 6 routine visits per year				
	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	
	Preferred Generic	\$0	retail	mail \$0	Preferred Generic	\$0	retail	mail	
	Generic	\$12	\$36	\$0	Generic	\$12	\$36	\$ 0	
Prescription Drugs	Preferred Brand Non-Preferred Brand	\$47 \$100	\$141 \$300	\$131 \$290	Preferred Brand Non-Preferred Brand	\$47 \$100	\$141 \$300	\$131 \$290	
(Part D)	Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay you pay \$0 no more than 25% of the pla drugs and 25% for generics expenses reach \$8,000. After	33% rly drug for prefe in's cost until out	N/A costs re erred ges for bran t-of-poc	N/A each nerics and nd name ket drug	Specialty co-insurance \$0 deductible; after total yea \$5,030, you pay you pay \$0 and no more than 25% of the name drugs and 25% for ge drug expenses reach \$8,000.	33% arly drug for prefe ie plan's nerics ur After the	N/A costs re erred ger cost for til out-c nat, you	N/A ach herics brand of-pocket pay \$0 .	
Supplemental Benefits and Optional Plans	Over the Counter: \$40 quar from network retail location Wellness: \$0 for Renew Ac	or OTC	catalog		Over the Counter: \$65 qua items from network retail lo Wellness: \$0 for Renew Ac Optional Platinum Dental \$1,500 annual allowance wi preventive and comprehensi coinsurance for bridges and National Medicare Advanta of network dentists but high	cation of ctive Fitr Rider a th \$0 cop ve servid dentures ge Netwo	OTC ca ness men t \$56/m o pays for ces; 50% ; UHC I ork; can	atalog nbership onth: certain o Dental use out	
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Canopy H Bay Hospitals: Alameda, Highla Leandro, St. Rose (Hayward	nd (Oak	land), S	an	Medical Groups: Affinity I Toland East Bay; Hill Physi Hospitals: Alameda, Highl Leandro, St. Rose (Hayward	cians Ea and (Oal	st Bay cland), S	an	

	MEDICARE HMO COMP	ARISON	CHART	FOR ALAMEDA COU	JNTY		
Please contact the Plan for outline of coverage & provider information or call 1-800-Medicare	United Health 844-723-6473 (Sales a 866-261-7709 (Men www.aarpmedicare	nd Mark ber Servi	ces)	Blue Shield o 888-534-4263 (Sa 800-776-4466 (M www.blueshieldo	ales & ⁄Iembo	Market er Servio	ing) ces)
Plan Name/Type	UHC Medicare Advar (HMO) (H054	ntage CA	-	Blue Shiel (HMO) (F	d Ins	pire	<u> </u>
Star Rating	***1/2			***	1/2	,	
Annual OOP Max	\$8,850			\$4,4	100		
Monthly Premium	\$27.80 / Medical Dedu	ictible = \$	6240	\$18	.50		
Doctor Visits	20% coinsurance for Primar 20% coinsurance for		ician;	\$0 copay for Prima \$15 for S			;
Inpatient Hospital	\$1,450 copay per stay; u	nlimited day	/S	\$250 copay/day \$0 per day for da			
Outpatient Hospital	20% coinsurance for ambulatory 20% coinsurance for outpat			\$50 copay per ambulato \$200 per outpatient h			
Skilled Nursing Facility	\$0 copay/day for da \$204 copay/day for d			\$0 copay/day f \$145 per day fo			
Emergency & Urgent Care	admitted to hospital within 24 h	 \$100 copay for emergency room visit; waived if admitted to hospital within 24 hours; \$40 per urgent care visit; \$120 copay per emergency room visit; waived if \$15 per urgent care visit; \$120 per emergency or urgent care visit; copays waived if admitted to hospital with 					ldwide;
Ambulance	20% coinsurance per trip	by ground or	r air	\$260 copay per 20% co-insurance			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic te 20% coinsurance for x-rays, d and therapeutic ra	iagnostic rad		 \$0 copay for lab, diagnostic x-rays; \$70 copay for 20% co-insurance for 	diagnos	tic radiolo	gy;
Renal Dialysis Outpatient Mental	20% co-insurance pe 20% coinsurance for i			10% co-insurance per treatment			
Health Visits	group therapy se	ession		\$30 copay for individual			
Eyewear	\$0 copay with \$100 annual allo through United Health			\$175 annual allow: \$175 frame allowa			
Eye Exams	\$0 copay for Medicare-c \$0 copay for one annual			\$15 copay for dia \$0 copay for one an			1
Hearing Aids	\$2,500 annual allowance for up through United Healthcare			\$499 - \$699 copay per a limited to 2 heari			type);
Hearing Exams	20% coinsurance for Medica \$0 copay for one annual	routine example	m	\$0 copay for Medic \$0 copay for one ar	nual ro	utine exan	n
Dental	20% coinsurance per Medic Routine dental not		visit;	\$10 copay for Medi \$0 copay certain prevention	ve svcs	every six 1	nonths
Chiropractic	20% coinsurance for Medic			<pre>\$15 copay for Medi \$0 copay/visit for 12 r</pre>	outine v	visits per y	ear
Podiatry	\$0 co-pay per Medicare- \$0 copay/visit for 4 routin			<pre>\$15 copay per Medi \$15 copay/visit for unlimit</pre>			
	Cost-sharing shown is for preferred pharmacies 30 day	ys days retail	100 days mail	Cost-sharing shown is for preferred pharmacies	30 days	100 days retail	100 days mail
Prescription Drugs (Part D)	Preferred Generic25Generic25Preferred Brand25Non-Preferred Brand25Specialty co-insurance25	% 25% % 25% % 25%	25% 25% 25% 25% N/A	Preferred Generic Generic Preferred Brand Non-Preferred Brand	\$0 \$5 \$40 \$95 33%	\$0 \$7.50 \$100 \$237.50 N/A	\$0 \$7.50 \$100 \$237.50 N/A
	\$545 deductible; after total yearly \$5,030 , you pay no more than 25 for brand name and 25% for gene pocket expenses reach \$8,000 . A	drug costs % of the pla erics until ou	reach m's cost it-of-	Specialty co-insurance \$0 deductible; after total ye \$5,030, you pay no more that for brand name drugs and 2 expenses reach \$8,000. Aft	early dr an 25% 5% for	ug costs r of the pla generics u	reach n's cost ntil OOP
Supplemental Benefits and Optional Plans	Cost-Sharing Waived: most co- copays are waived for those with Over the Counter: \$100 quarter from network retail location or O Transportation: \$0 copay for 36 year to plan-approved, medically Wellness: \$0 for Renew Active	Mobility: \$0 copay for annumembers with qualifying chore the Counter: \$70 quembers the Counter: \$70 quembers to plan approved location wellness: \$0 for basic Silver Optional Supplemental Plate: Dental HMO at \$15/monallowance for specialist server 2: Dental PPO at \$45/monannual allowance	ronic co arterly a for 12 o ons er Sneal ans: nth: \$1 vices th: \$50	onditions allowance ne-way tri cers memb ,000 annua deductible	ps per vership al e; \$1,500		
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Affinity East H Hill Physicians East Bay Hospitals: St. Rose (Hayward), V	-		Medical Groups: Brown & East Bay Hospitals: Alameda, Alta B Center (Berk/Oak), Eden (C Leandro, and Washington (I	ates/Su Castro V	mmit Med alley), Sar	lical
	ı	-14-				,	

Medicare Coverage for Preventive Care Benefits

To help people with Medicare stay healthy, Medicare covers certain screening tests, supplies, and teaching services. People with Original Medicare can receive most of these preventive benefits without having to pay coinsurance or the Part B deductible (\$240 in 2024). Medicare Advantage plans also cannot charge cost sharing (meaning no deductible, no copayment or coinsurance) for most innetwork preventive benefits. These preventive benefits available at no cost include:

- Abdominal Aortic Aneurysm Screening: one per lifetime
- Alcohol Misuse Screening and Counseling: one screening per year and up to 4 counseling sessions per year
- Annual Wellness Visit: one per year
- Bone Mass Measurement: one every 2 years
- Breast Cancer Screening: one per year
- Cardiovascular (Heart Disease) Screening and Therapy: one screening every 5 years and one counseling session (with primary care physician) per year
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam): one every 2 years or one a year if at high risk
- Colorectal Cancer Screening: frequency varies by type of test
- COVID 19 Vaccine and Boosters
- Depression Screening: one per year
- Diabetes Screening: 2 per year if at risk
- Flu Shot: one per year
- Hepatitis B Shots: as needed depending on health status
- HIV Screening: one per year
- Medical Nutrition Therapy: as needed depending on health status
- Obesity Screening & Counseling: one screening/year and up to 22 counseling sessions/year
- Pneumococcal Shots: one per lifetime
- Prostate Cancer Screening: one per year for age 50 and over
- RSV (Respiratory Syncytial Virus) Vaccine: one per year
- Sexually Transmitted infections (STI) Screening & Counseling: one screening per year and 2 counseling sessions (with primary care physician) per year
- Shingles Vaccine
- Tobacco-use Cessation Counseling (if not diagnosed with related illness): up to 8 sessions per year
- "Welcome to Medicare" Exam: one in the year following enrollment into Part B

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

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

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

Star Ratings:

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

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

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