# 2024 Medicare Advantage Special Needs Plan (SNP) ~ FINAL ~ Comparison Chart 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 a referral to see a specialist. The Medicare HMO will not pay for services received outside the plan's network unless it is urgent or emergency care. See our 2024 HMO Comparison Chart for more information and details: <a href="https://www.lashicap.org/hicap">www.lashicap.org/hicap</a>.

A Medicare PPO is another type of Medicare Advantage (MA) plan. A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses such as deductibles and coinsurance will apply. See our 2024 PPO Comparison Chart for more information and details: www.lashicap.org/hicap.

Medicare Special Needs Plans are another type of Medicare Advantage plan. They are designed for people on Medicare and Medi-Cal (duals), those with certain chronic conditions, or those who need a nursing home level of care. They all must include Part D prescription drug coverage and they have a responsibility to coordinate benefits and care for their members. In 2024, there are 17 Special Needs Plans in Alameda County. Five are for people with Medicare and full Medi-Cal (duals, with no share of cost). These are called D-SNPS and they have no premiums or co-payments. Another Special Needs Plan is for people with specific chronic or disabling conditions, such as diabetes, dementia, or cardiovascular disorders. It is called a C-SNP and certain cost-sharing applies. In 2024, there are ten C-SNPs in Alameda County. The third type of Special Needs Plan is for people in institutions like a nursing home or for people who need a nursing home level of care at home. It is called an I-SNP and certain cost-sharing applies. In 2024, there are two I-SNPs in Alameda County.

#### **Enrollment:**

In the fall of 2023, Medicare beneficiaries can enroll, disenroll or change plans during the **Medicare Annual Enrollment Period, from October 15 through December 7. Changes take effect on January 1, 2024.** In 2024, members have one more opportunity to make a change: they can leave their MA plan and change back to Original Medicare during the **Medicare Advantage Open Enrollment Period, from Jan 1 through March 31.** This right only applies to those who begin the year enrolled in a Medicare Advantage plan. They can leave their MA plan and enroll in a stand-alone Part D plan, or they can change to another Medicare Advantage plan. If someone returns to Original Medicare during this period, they will have through March 31 to join a stand-alone Medicare Prescription Drug Plan. There are no corresponding guaranteed issue rights to get a Medigap plan without a health screening although people can apply for a Medigap at any time but must answer health screening questions.

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

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

#### **ABOUT THIS CHART**

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

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

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



**Navigating Medicare** 

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Please contact the Plan for more information or call 1-800-Medicare	Aetna Medicare 833-859-6031 (Sales & Marketing) 866-409-1221 (Member Services) www.aetnamedicare.com	Anthem Blue Cross 844-309-6996 (Sales & Marketing) 833-707-3130 (Member Services) www.shop.anthem.com/medicare/ca
Plan Name/Type	Aetna Medicare Preferred Plan D-SNP (H4982-008) For FULL DUALS	Anthem Dual Advantage D-SNP (H4471-007) For FULL DUALS
Star Rating	***	Plan to new to be measured
Annual OOP Max	\$8,850	\$8,850
<b>Monthly Premium</b>	\$0	\$0
<b>Doctor Visits</b>	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist	\$0 for Primary Care Physician; \$0 for Specialist
<b>Inpatient Hospital</b>	<b>\$0</b> per day; Unlimited number of days	<b>\$0</b> per day for days 1 - 150
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit
Skilled Nursing Facility	<b>\$0</b> per day; 100 days per benefit period	<b>\$0</b> copay per day for days 1 - 100
Ambulance	<b>\$0</b> copay per trip by ground or air	\$0 copay per trip by ground or air
Emergency & Urgent Care	\$0 copay per emergency room or urgent care visit; Worldwide coverage	\$0 copay per ER or urgent care visit; Worldwide coverage; \$0 copay; \$100,000 limit/year
Lab Tests, Procedures, and Radiation Therapy	<b>\$0</b> copay per service	<b>\$0</b> copay per service
Renal Dialysis	\$0 co-insurance per treatment	\$0 co-insurance per treatment
Outpatient Mental Health Visits	\$0 copay for individual or group therapy session	\$0 copay for individual or group therapy session
Eyewear	\$400 annual allowance for eyewear, through EyeMed provider	\$300 annual allowance for eyewear
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for 1 annual routine exam \$2,500 annual allowance per ear;	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam
Hearing Aids	through NationsHearing provider	\$3,000 annual allowance
Hearing Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	<b>\$0</b> co-pay per Medicare-covered exam; <b>\$0</b> copay for one annual routine exam
Dental	\$0 copay for certain preventive and comprehensive services; through Liberty Dental network	\$0 copay for Medicare covered visit; \$1,400 annual allowance for certain preventive and comprehensive services
Chiropractic	\$0 copay per Medicare covered visit; \$0 copay for unlimited routine visits per year, through American Specialty Health	\$0 co-pay per Medicare covered visit; \$0 copay for 12 routine visits per year
Podiatry	\$0 copay per Medicare covered visit; \$0 copay/visit for 12 routine visits per year	\$0 co-pay per Medicare covered visit; \$0 copay for unlimited routine visits per year
Prescription Drugs (Outpatient)	\$0 deductible: \$0 copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit	<b>\$0</b> deductible; <b>\$0</b> copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for unlimited routine visits/year through American Specialty Health Fall Prevention: \$150 annual allowance for approved home safety devices  Extra Benefits Card: \$50 monthly allowance for healthy foods and \$50 monthly allowance for certain OTC items, through NationsBenefits  Meals: 42 home-delivered meals over a 21-day period following hospital or skilled nursing facility stay  Transportation: \$0 copay/trip for 40 one-way trips each year to plan-approved locations, within 60 miles  Wellness: \$0 for Silver Sneakers gym membership	Acupuncture: \$0 copay per visit for unlimited routine visits per year  Community Resource Support: Referrals and coordination for community services  Meals: \$0 copay for 2 meals per day for 5 days following inpatient hospital or SNF stay  Options Allowance: \$70 monthly allowance for assistive devices, eligible food items, OTC products, and utilities  Transportation: \$0 copay/trip for 48 trips per year to plan-approved locations within 60 miles  Wellness: \$0 for Silver Sneakers gym membership; one fitness tracker every other year
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown & Toland, One Medical Hospitals: Alameda, Alta Bates/Summit Med Ctr, (Berk/Oak), Highland (Oak), Eden (CastroValley), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Hospital (Frem)	Medical Groups: Bay Valley, Brown & Toland, Hill Physicians, Imperial Health Holdings Hospitals: Alta Bates/Summit (Berk/Oak), Eden (C. Valley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), & Washington (Fremont)

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Please contact the Plan for more information or call 1-800-Medicare	Brand New Day 866-255-4795 (Sales & Marketing) 866-255-4795 (Member Services) www.bndhmo.com	Imperial Health Plan of CA 1-800-838-5197 (Sales & Marketing) 1-800-838-8271 (Member Services) www.imperialhealthplan.com
Plan Name/Type	Brand New Day Dual Access D-SNP (H0838-024) For FULL DUALS	Imperial Dual Plan D-SNP (H5496-011) For FULL DUALS
<b>Star Rating</b>	<b>★★</b> 1/2	***
<b>Annual OOP Max</b>	\$8,850	\$2,999
<b>Monthly Premium</b>	<b>\$0</b>	\$0
<b>Doctor Visits</b>	\$0 for Primary Care Physician; \$0 for Specialist	\$0 copay for Primary Care Physician; \$0 for Specialist
Inpatient Hospital	<b>\$0</b> per stay	<b>\$0</b> co-pay/day for days 1 - 150
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit
Skilled Nursing Facility	<b>\$0</b> copay per day for days 1 - 100	<b>\$0</b> copay for days 1 - 100
Ambulance	<b>\$0</b> copay per trip by ground or air	\$0 copay per trip by ground or air
Emergency & Urgent Care	\$0 copay per ER or urgent care visit; Worldwide coverage: \$100 copay for emergency or urgent care visit; \$50,000 limit	\$0 copay per emergency room or urgent care visit; Worldwide coverage: \$0 copay; \$50,000 limit
Lab Tests, Procedures, and Radiation Therapy	\$0 copay per service	\$0 copay per service
Renal Dialysis	\$0 coinsurance per treatment	\$0 copay per treatment
Outpatient Mental Health Visits	\$0 copay for individual or group therapy session	\$0 copay per individual or group therapy session
Eyewear	\$300 annual allowance for eyewear	\$260 annual allowance for eyewear
	\$0 copay per Medicare-covered exam;	\$0 copay per Medicare-covered exam;
Eye Exams	\$0 copay for one annual routine exam	\$0 co-pay for routine exams
Hearing Aids	\$149 allowance per aid for 2 aids every 3 years	\$2,500 annual allowance
Hearing Exams	\$0 co-pay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 copay for Medicare-covered exam; \$0 copay for routine exams
Dental	\$0 copay for Medicare covered visit; \$0 copay for certain preventative and comprehensive services	\$0 copay for Medicare covered visit; \$0 co-pay for preventive services; \$500/year; \$0 co-pay for comprehensive services; \$1,000/year
Chiropractic	\$0 co-pay per Medicare covered visit; \$0 copay for 30 routine visits per year, combined with acupuncture	\$0 co-pay per Medicare-covered visit
Podiatry	\$0 co-pay per Medicare covered visit	\$0 copay per Medicare-covered visit; \$0 copay for 6 routine visits per year
Prescription Drugs (Outpatient)	<b>\$0</b> deductible; <b>\$0</b> copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit	\$0 deductible: Depending on your income, you pay the following: Generics: \$0 to \$4.50 Brand Name Drugs: \$0 to \$11.20 After annual drug costs reach \$8,000, you pay \$0.
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for 30 routine visits per year, combined with chiropractic Groceries: \$50 monthly allowance for healthy foods for those with qualifying chronic conditions  Meals: \$0 copay per meal for 14 meals/month for those with qualifying chronic conditions  Over the Counter (OTC): \$33 monthly allowance for plan approved items  Scales: \$0 copay for those with qualifying chronic conditions  Transportation: \$0 copay/trip for 12 one-way trips per year to plan approved locations within 50 miles  Wellness: \$0 for Silver Sneakers gym membership	Groceries: \$105 quarterly allowance for those with qualifying chronic conditions In-Home Support Services: \$0 copay for 60 hours/yr Meals: \$0 co-pay for up to 7 home-delivered meals following surgery or hospital stay; \$105 allowance per benefit period Over the Counter (OTC): \$140 quarterly allowance for items in plan's OTC mail order catalog Transportation: \$0 co-pay for 100 one-way trips to plan approved locations Wellness: \$0 for Silver&Fit gym membership or at-home fitness kit
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Alameda Health System; Hill Physicians East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (C Valley), Highland (Oak), San Leandro, Washington (Fremont)	Medical Groups: Brown & Toland, Imperial Health Holdings, Nivano Physicians Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), St. Rose (Hayward), and Washington (Fremont)

2024 1/112/213	ARE SNP COMPARISON CHART FOR ALA
Please contact the	Kaiser Permanente
Plan for more	1-800-777-1238 (Sales & Marketing)
information or call	1-800-443-0815 (Member Services)
1-800-Medicare	www.healthy.kaiserpermanente.org
	Kaiser Medicare Medi-Cal Plan North
Plan Name/Type	/ <b>D-SNP</b> (H8794-004)
	For FULL DUALS
<b>Star Rating</b>	***
Annual OOP Max	\$3,400
<b>Monthly Premium</b>	\$0
Doctor Visits	\$0 for Primary Care Physician;
Doctor visits	\$0 for Specialist
Inpatient Hospital	\$0 per day;
	Unlimited days per benefit period  \$0 copay per ambulatory surgical center visit;
Outpatient Hospital	\$0 copay per outpatient hospital visit
Skilled Nursing	\$0 copay per day;
Facility	100 days per benefit period
Ambulance	\$0 copay per trip by ground or air
Emergency & Urgent Care	\$0 copay per emergency room or urgent care visit;  Worldwide coverage
Lab Tests,	orianido conorago
Procedures, and	<b>\$0</b> copay per service
Radiation Therapy	φυ copay per service
	\$0 construct treatment
Renal Dialysis	<b>\$0</b> copay per treatment
Outpatient Mental	<b>\$0</b> copay per individual or group therapy session
Health Visits	
Eyewear	\$350 annual allowance for eyewear
P P	\$0 copay per Medicare-covered exam;
Eye Exams	\$0 copay for routine exams
Hearing Aids	Not Covered
Hearing Exams	<b>\$0</b> co-pay per Medicare-covered exam
Treating Laums	\$0 copay for Medicare covered visit;
Dental	\$0 co-pay for certain preventive
<b>2 V.I.V.I.</b>	and comprehensive services; with Delta Care USA
Chiropractic	<b>\$0</b> co-pay per Medicare covered visit
Chiropractic	φυ co-pay per intedicate covered visit
Podiatry	<b>\$0</b> co-pay per Medicare covered visit
	<b>\$0</b> deductible: Depending on your income, you pay the following:
Prescription Drugs	Generics: \$0 to \$4.50
(Outpatient)	Brand Name Drugs: \$0 to \$11.20
( · <b>F</b>	After annual drug costs (paid by you, the plan, and by
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	Extra Help from Medicare) reach \$8,000, you pay \$0.
	Extra Help from Medicare) reach \$8,000, you pay \$0.
	Extra Help from Medicare) reach \$8,000, you pay \$0.
	Extra Help from Medicare) reach \$8,000, you pay \$0.
	Extra Help from Medicare) reach \$8,000, you pay \$0.
	Extra Help from Medicare) reach \$8,000, you pay \$0.
Supplemental	Over the Counter (OTC): \$250 quarterly allowance for
Benefits and	Over the Counter (OTC): \$250 quarterly allowance for items in OTC catalogue; each order must be at least \$25
	Over the Counter (OTC): \$250 quarterly allowance for
Benefits and	Over the Counter (OTC): \$250 quarterly allowance for items in OTC catalogue; each order must be at least \$25
Benefits and	Over the Counter (OTC): \$250 quarterly allowance for items in OTC catalogue; each order must be at least \$25
Benefits and Optional Plans	Over the Counter (OTC): \$250 quarterly allowance for items in OTC catalogue; each order must be at least \$25
Benefits and Optional Plans  Medical Groups and	Over the Counter (OTC): \$250 quarterly allowance for items in OTC catalogue; each order must be at least \$25 Wellness: \$0 copay for Silver&Fit gym membership
Benefits and Optional Plans  Medical Groups and Hospitals	Over the Counter (OTC): \$250 quarterly allowance for items in OTC catalogue; each order must be at least \$25 Wellness: \$0 copay for Silver&Fit gym membership  Medical Groups: Kaiser Permanente
Benefits and Optional Plans  Medical Groups and	Over the Counter (OTC): \$250 quarterly allowance for items in OTC catalogue; each order must be at least \$25 Wellness: \$0 copay for Silver&Fit gym membership

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Please contact the Plan for more information or call 1-800-Medicare	Align Sen 844-305-3879 (Sa 844-305-3879 (N www.alignsen	ales &N Aembei	Aarketi r Servic	<i>O</i> ,	Align Senior Care 844-305-3879 (Sales &Marketing) 844-305-3879 (Member Services) www.alignseniorcare.com				
Plan Name/Type	Align Kidney Care C-SNP (H3274-004) For People with ESRD/Dialysis				Align Memory Care C-SNP (H3274-003) For People with Diagnosis of Dementia				
<b>Star Rating</b>	Not Enough Da		lable		Not Enough D		lable		
Annual OOP Max	\$8,8				\$3,5				
<b>Monthly Premium</b>	\$41 / Medical De				\$0 / Medical Ded	ductible	= \$240		
<b>Doctor Visits</b>	\$0 for Primary Care Physic visits; 20% coinsura			ologist	<b>\$0</b> for Primary Care Phys	sician; \$0	for Spec	ialist	
Inpatient Hospital	\$1,632 deductible; \$0 co \$408 copay/day f \$816 copay/day f	for days (	61-90;	-60;	\$150 copay/day for days	1-10; <b>\$0</b> f	or days 1	1-150	
Outpatient	20% coinsurance per ambi			nter or	20% coinsurance for amb				
Hospital Skilled Nursing					20% coinsurance for out	patient no	spitai ser	vices	
Facility	\$0 copay/day for \$204 copay/day				<b>\$0</b> for days 1-20; <b>\$100</b> co		•	1-100	
Ambulance	20% coinsurance per	trip by gı	round or a	ir	20% coinsurance				
Emergency & Urgent Care	\$90 copay per ER visit; \$ copays waived if admitted				\$90 copay per ER visit; \$ copays waived if admitted				
Lab Tests, Procedures, and Radiation Therapy	\$0 co-pay for lab services and x-rays; 20% coinsurance for diagnostic tests, procedures, diagnostic and therapeutic radiology				\$0 co-pay for lab so 20% coinsurance for diag diagnostic and ther	nostic tes	ts, proced		
Renal Dialysis	20% coinsurance	e per trea	tment		20% co-insuranc	e per trea	tment		
Outpatient Mental Health Visits	20% coinsurance group therap				\$20 copay for individ \$10 copay for grou			n;	
Eyewear	\$150 annual for eyeglasses/frame	s or cont	act lenses		\$300 annual allowance for eyeglasses/frames or contact lenses				
Eye Exams	20% coinsurance per Mo \$0 copay for one an			am;	20% coinsurance per Medicare-covered exam; \$0 copay for one annual routine exam				
Hearing Aids	\$3,000 allowance				\$1,500 annual allowance; limited to 2 aids/year				
Hearing Exams	20% coinsurance per Mo				20% coinsurance per Medicare-covered exam;				
Dental	\$0 copay for one routine 20% coinsurance per M \$1,000 annual allowar and comprehenthrough Liberty I	ledicare once for consive sv	covered variation basings	isit;	\$0 copay for one annual routine exam 20% coinsurance per Medicare covered visit; \$3,000 annual allowance for certain basic and comprehensive services, through Liberty Dental network				
Chiropractic	20% coinsurance for M	ledicare-	covered v	isit	20% coinsurance per Medicare-covered visit;				
Podiatry	20% coinsurance for M \$0 copay/visit for 6 ro	ledicare-d	covered vi	isit;	\$30 copay for 12 routine visits per year  20% coinsurance per Medicare-covered visit;  \$0 copay for 4 routine visits per year				
-	Cost-sharing shown is for	30	90	90	Cost-sharing shown is for	30	90	90	
	preferred pharmacies	days retail	days retail	days mail	preferred pharmacies	days retail	days retail	days mail	
	Preferred Generic	\$2	<b>\$6</b>	\$6	Preferred Generic	\$0	\$0	\$0	
	Generic	\$15	\$45	\$45	Generic	\$10	\$30	\$30	
Prescription Drugs (Outpatient)	Preferred Brand Non-Preferred Brand	\$45 \$95	\$135 \$285	\$135 \$285	Preferred Brand Non-Preferred Brand	\$45 \$95	\$135 \$285	\$135 \$285	
(Outpatient)	Specialty co-insurance	25%	N/A	N/A	Specialty co-insurance	25%	N/A	N/A	
	\$0 deductible for Tier 1; \$5				\$0 deductible for Tiers 1&2				
	5; after total yearly drug cos 25% for generics and brand				3-5; after total yearly drug c pay <b>25%</b> for generics and b				
	drug expenses reach \$8,000				drug expenses reach \$8,000.				
Supplemental Benefits and Optional Plans	Meals: \$0 copay for up to 2 following discharge from he for 2 meals/day for up to 60 ESRD  Over the Counter: \$600 ar from plan's OTC catalog  Transportation: \$0 copay approved locations within 7  Wellness: \$0 copay for online	SNF; \$0 those with owance for year to	copay h r items	Acupuncture: \$30 copay per visit for 12 routine visits per year  Companion Care: 60 hours/year for assistance with errands, housekeeping, and companionship  Memory Fitness: \$0 copay for online subscription to BrainHQ; \$0 copay for 2 sensory kits per year  Over the Counter: \$325 quarterly allowance for OTC items, \$50 of which may only be used on incontinence supplies; unused balance carries over Transportation: \$0 copay/trip for 24 one-way trips per year to plan-approved locations					
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Certain i Hospitals: Alta Bates/Sumr Medical Center (Castro Val	nit (Berk			Medical Groups: Certain i Hospitals: Alta Bates/Sumr Medical Center (Castro Vall	nit (Berk/			

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Please contact the Plan for more information or call 1-800-Medicare	Alignment Health Plan 888-979-2247 (Sales &Marketing) 866-634-2247 (Member Services) www.alignmenthealthplan.com			Alignment Health Plan 888-979-2247 (Sales & Marketing) 866-634-2247 (Member Services) www.alignmenthealthplan.com				
Plan Name/Type	Alignment Health Heart & Diabetes C-SNP (H3815-010) For People with Cardiovascular Disorders and/or Diabetes			Alignment Health Heart & Diabetes CalPlus C-SNP (H3815-039) For People with Cardiovascular Disorders and/or Diabetes				
Star Rating	***	**			***	<b>*</b> *		
Annual OOP Max	\$79	0			\$8,8	50		
<b>Monthly Premium</b>	\$0				\$8.5	50		
<b>Doctor Visits</b>	\$0 copay for PCP; \$0	copay fo	or Specia	alist	\$0 copay for PCP; \$0	copay fo	or Specia	list
Inpatient Hospital	\$0 copay for unlimited				\$1,632 deductible; \$0 co \$408 copay/day f \$816 copay/day f	or days or days	61-90; 91-150	
<b>Outpatient Hospital</b>	\$0 copay per ambulato outpatient hospit			er or	20% coinsurance per ambu outpatient hospit			enter or
Skilled Nursing Facility	<b>\$0</b> copay for <b>\$50</b> copay/day for				<b>\$0</b> copay/day fo <b>\$204</b> copay/day f			
Ambulance	\$100 copay per trip				20% coinsurance per t			
Emergency & Urgent Care	\$70 copay per ER visit; waiv within 48 hours; \$0 per Worldwide Coverage; \$0 co	er urgen	t care vi	sit;	20% coinsurance per ER vi hospital within 72 hours; \$ Worldwide Coverage; \$75 o	\$0 per u	rgent car	e visit;
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, x-rays, diagnostic tests, procedures, and diagnostic radiology; 20% coinsurance for therapeutic radiology				20% coinsurance for lab x-rays, diagnostic tests, pradiology; 20% coinsurance	ocedure	s and dia	gnostic
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insuranc	e per tre	atment	
Outpatient Mental Health Visits	\$0 copay per in group therap				20% coinsurance pgroup therap			
Eyewear	\$200 annual allowa	ance for	eyewea	r	\$500 annual allowance for	eyewear	r every tv	vo years
Eye Exams	\$0 copay per Medica				\$0 copay per Medica			
	\$0 copay for one annual routine exam  Not covered				\$0 copay for one and			<u>n</u>
Hearing Aids	\$0 co-pay per Medic		orad ava	ım	\$2,000 allowance			a:
Hearing Exams	\$0 for one annual			1111	\$0 co-pay per Medicare-covered exam; \$0 for one annual routine exam			
Dental	20% coinsurance per M \$0 copay certain prev \$15-\$425 copays for certain	ventive s	services	;	20% coinsurance per Medicare covered visit; \$0 copay certain preventive services; \$0 copay for certain comprehensive services; \$500 quarterly limit			
Chiropractic	<b>\$0</b> copay per Medic				<b>\$0</b> copay per Medicare covered visit; <b>\$0</b> copay for 12 routine visits per year, combined with acupuncture			
Podiatry	\$0 copay per Medic \$0 copay for 12 routi	ne visits	each ye	ear	\$0 copay per Medicare covered visit			
	Cost-sharing shown is for preferred pharmacies  Preferred Generic  Generic	30 days retail \$0	100 days retail \$0	100 days mail \$0	Cost-sharing shown is for preferred pharmacies  Preferred Generic	30 days retail 25%	100 days retail 25%	100 days mail 25%
<b>Prescription Drugs</b>	Generic Preferred Brand	\$5 \$30	\$15 \$90	\$12.50 \$75	Generic Preferred Brand	25% 25%	25% 25%	25% 25%
(Outpatient)	Non-Preferred Brand	\$75	\$125	\$187.50	Non-Preferred Brand	25%	25%	25%
	\$9 deductible; after total yea \$5,030, you pay 25% for get drugs until out-of-pocket dru After that, you pay \$0.	neric and	d brand	name	\$545 deductible; after total yearly drug costs reach \$5,030, you pay 25% for generic and brand name			
Supplemental Benefits and Optional Plans	Essentials Allowance: \$200 quarterly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions, combined with OTC Over the Counter (OTC): \$200 quarterly allowance Pest Control: \$0 copay for one annual eradication service for those with qualifying chronic conditions Pet Services: \$0 copay for 7 boarding days or 14 walks/year for those with qualifying chronic condition Transportation: \$0 copay for 50 one-way trips/year to plan-approved locations within 35 miles Wellness: \$0 for basic gym membership Enhanced Dental Option: \$27 monthly premium; \$1,500 limit per year with 0%-50% coinsurance for certain diagnostic and comprehensive services				year, combined with chiropractic  Essentials Allowance: \$500 quarterly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions, combined with OTC  Over the Counter (OTC): \$500 quarterly allowance  Pest Control: \$0 copay for one annual eradication  service for those with qualifying chronic conditions			
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown & Hospitals: Alameda, Alta Ba Eden (Castro Valley), Highla (Hayward), Stanford Valley	Toland ates/Sun and (Oal	nmit (Be	erk/Oak) ose	Medical Groups: Brown & Hospitals: Alameda, Alta Ba Eden (Castro Valley), Highla (Hayward), Stanford Valley	ates/Sun and (Oal	nmit (Ber k), St. Ro	

2024 NIE1	DICARE SNP COMPAR	1301	CHAI	CIFUR	AL	ANIEDA COUNTY:	C-5N	PS	
Please contact the	Brand Ne	w Da	y			Brand Ne	w Day	y	
Plan for more	866-255-4795 (Sal		•	ng)		866-255-4795 (Sal			ng)
information or call	866-255-4795 (Me			_	866-255-4795 (Member Services)				
1-800-Medicare	www.bndhr			CS)	www.bndhmo.com				
			_	·	7			_	
	Brand New Day			are	_	Brand New Day E			oice
Plan Name/Type	C-SNP (He		,			C-SNP (H0		,	
	For People with Cardi			sease,	F	or People with Cardi			
	Chronic Heart Failure	, or Di	<u>iabetes</u>			Chronic Heart Failu	ıre, or	Diabe	etes
<b>Star Rating</b>	<b>★</b> ★1	/2				<b>★★</b> 1/	2		
<b>Annual OOP Max</b>	\$3,0	00				\$8,85	0		
<b>Monthly Premium</b>	\$0					\$41			
<b>Doctor Visits</b>	<b>\$0</b> for Primary Care Physic	ian; <b>\$0-</b>	10 for S <sub>1</sub>	pecialist		\$0 for PCP; 40% coinsu	rance fo	r Specia	ılist
				• •		<b>\$1,632</b> deductible; <b>\$0</b> cop	av/dav f	or davs	1-60:
<b>Inpatient Hospital</b>	\$0 copay for day 1; \$225 \$0 per day for			s 2-9;		\$408 copay/day fo	r days 6	1-90;	
	. 1					\$816 copay/day for			
Outpatient	\$0 - \$100 per ambulatory				2	0% coinsurance per ambul			enter or
Hospital	<b>\$0 - \$150</b> per outpat		spitai visi	τ		outpatient hospital			
Skilled Nursing	\$0 for day		o 21 100			\$0 copay for d			
Facility	\$204 copay per day \$0 - \$150 copay pe	<u> </u>				\$204 copay/day for	uays 2	1-100	
Ambulance	20% coinsurance		_			20% coinsurance per tri	p by gro	ound or	air
	<b>\$0 - \$125</b> per ER visit; waiv			hospital		\$100 copay per ER visit; v	vaived i	f admitt	ed to
Emergency &	within 72 hours; \$0	for urg	ent care;	•		hospital within 72 hours;	<b>\$0</b> for u	argent ca	are;
<b>Urgent Care</b>	Worldwide coverage: \$12			rgency		Worldwide coverage: \$100			gency
Lab Tests,	or urgent care visi					or urgent care visit;			C
Procedures, and	<b>\$0</b> copay for lab services, x-procedures; <b>\$50</b> copay for					\$0 copay for lab services; 20 ays, diagnostic tests, proceed			
Radiation Therapy	20% coinsurance for the					diology; <b>20%</b> coinsurance f			
Renal Dialysis	20% coinsurance					20% co-insurance			
Outpatient Mental						20 /0 CO-IIISUI AIICC	per trea	uniciit	
Health Visits	\$10 copay for individu 20% coinsurance per g				\$40 copay for individual or group therapy session			ession	
				31011	\$300 annual allowance for eyewear				
Eyewear	\$300 annual allowa \$0 copay per Medica		•		\$0 copay per Medicare covered exam;				
Eye Exams	\$0 copay for one and				\$0 for one annual routine exam				,
Hearing Aids	<b>\$699-\$999</b> copay per aid for				<b>\$149</b> allowance per aid for 2 aids every 3 years			rs	
Hearing Exams	\$0 copay per Medica			1;	\$0 copay per Medicare-covered exam;				
Treating Exams	\$0 copay for one and			n	\$0 copay for one annual routine exam				1
Dental	\$0 copay for Medica \$0 copay for certain pr			2051		<b>\$0</b> copay for Medicare <b>\$0-\$17</b> copay for certain p			ioos:
Dentai	\$0-\$2,160 copays for certain pr				\$0	<b>350</b> copay for certain copay			
Chinamuaatia	\$0 co-pay per Medicare cove					<b>\$0</b> co-pay per Medicare co			
Chiropractic	routine visits/year, comb	ined wit	h acupur	icture	r	outine visits per year, comb	ined wi	th acupu	ıncture
Podiatry	\$0 co-pay per Medic	care cov	ered visi	t		\$0 co-pay per Medica	re cove	red visit	
	Cost-sharing shown is for	30	100	100		Cost-sharing shown is for	30	100	100
	preferred pharmacies	days	days	days		referred pharmacies	days	days	days
	Preferred Generic	retail <b>\$0</b>	retail \$0	mail \$0	_	referred Generic	retail 25%	retail 25%	mail 25%
	Generic	\$9	\$27	\$18	_	Seneric	25%	25%	25%
<b>Prescription Drugs</b>	Preferred Brand	\$47	\$101	\$94	_	referred Brand	25%	25%	25%
(Outpatient)	Non-Preferred Brand	\$90	\$270	\$180	N	Ion-Preferred Brand	25%	25%	25%
	Specialty co-insurance	33%	N/A	N/A		pecialty co-insurance	25%	N/A	N/A
	<b>\$0</b> deductible; after total year <b>\$5,030</b> , you pay <b>\$0</b> for prefer					deductible for Tier 1; \$545			
	for generics and brands until					arly drug costs reach \$5,030 nerics and 25% for brands to			
	expenses reach \$8,000. Afte					penses reach \$8,000. After			
	Acupuncture: \$0 copay for	12 rout	ine visite	per	Ac	upuncture: \$0 copay for 1	2 routir		per
	year, combined with chiropra		1110 (1510)	Per		ar, combined with chiroprac			
	In-Home Support Services:					<b>roceries: \$30</b> monthly allow althy foods, for those with c			
	per year for those with qualif					Home Support Services:			
Supplemental	<b>Meals: \$0</b> copay per meal fo weeks for people with qualif				tho	ose with qualifying chronic	conditio	ns	
Benefits and	Scales: \$0 copay for those w					eals: \$0 copay per meal for			
<b>Optional Plans</b>	conditions	•				onths for people with qualify ver the Counter: \$50 month			
	Over the Counter (OTC): \$	<b>644</b> quar	terly allo	wance		proved OTC items	LIJ UIIO		. Piuli
	for plan approved items <b>Transportation:</b> \$0 copay/ti	in for 1	2 tring no	er vear to	Sca	ales: \$0 copay for those w/o			
	plan approved locations with			) • • • • • • • • • • • • • • • • • •		ansportation: \$0 copay for ar to plan approved location			
	Wellness: \$0 for Silver Snea	kers gy	m memb	ership		ar to plan approved location ellness: \$0 for Silver Sneak			
Medical Groups	Medical Groups: Alameda l	Health S	System: F	 Hill		edical Groups: Alameda H			
and Hospitals	Physicians East Bay / Hospit	tals: Ala	ameda, A	Alta	Ph	ysicians East Bay / <b>Hospit</b> a	ı <b>ls:</b> Alar	neda, A	lta
(may not be full list;	Bates/Summit (Berk/Oak) Ed	,	2 / /	Highland		tes/Summit (Berk/Oak) Ede			lighland
check with plan)	(Oak), San Leandro, Washin	gton (Fr	emont)		(O	ak), San Leandro, Washing	ion (Fre	mont)	

	CARE DIVI COMI ARI	3011 C	11/11/1	TON A	ALAMEDA COUNTY:	C-0111	5		
Please contact the	Central Healt				Imperial Healtl				
Plan for more	1-866-314-2427 (Sa	ales & I	Market	ing)	1-800-838-8271 (Sales & Marketing)				
information or call	1-866-314-2427 (N	<b>Aembe</b> i	r Servio	ees)	1-800-838-8271 (Member Services)				
1-800-Medicare	www.centralheal	thplan.c	<u>com</u>		www.imperialhe	althpla	n.com		
	Central Health	Focu	s Plan		Imperial Ser	ior Va	alue		
	C-SNP (H5				C-SNP (H5				
Plan Name/Type	For People with Cardi			<b>6366</b>	*		,	92692	
	Chronic Heart Fail				For People with Cardiovascular Disease Heart Failure, or Diabetes				
Star Rating	***		Diabet	CS	**		<del>Je tes</del>		
Annual OOP Max									
	\$1,80	<i>)</i>			\$1,99	<u> </u>			
Monthly Premium	\$0				\$0				
<b>Doctor Visits</b>	<b>\$0</b> for Primary Care Physi	cian; \$0	for Speci	alist	<b>\$0</b> for Primary Care Physi				
Inpatient Hospital	<b>\$0</b> per s				\$150 copay/day for days 1-: \$670/day for d	ays 91-15	50		
Outpatient Hospital	\$0 copay per ambulatory \$0 copay per outpation			sit;	\$200 per ambulatory su \$200 per outpatien			it;	
Skilled Nursing Facility	<b>\$0</b> per s	stay			<b>\$0</b> copay for 6 <b>\$200</b> /day for d				
Ambulance	\$0-\$100 copay per 20% coinsurance	per trip b	y air		\$150 copay per tr 20% co-insurance				
Emongono 0	\$0-\$125 copay per ER visit				<b>0105</b>		, 60.0		
Emergency & Urgent Care	hospital within 72 hours; \$0 Worldwide coverage: \$50 or urgent care visit;	copay fo	or emerge		\$125 copay per emergency i care; Worldwide coverage:				
Lab Tests,				tosts	100/ opingurance for 1-1	vices 1	anosti -	tasts 0	
Procedures, and	<b>\$0</b> copay for lab services, x procedures; <b>\$75</b> copay for				10% coinsurance for lab ser procedures, x-rays, and of				
Radiation Therapy	20% coinsurance for th				20% co-insurance for the				
Renal Dialysis	20% co-insurance	ner treat	ment		20% co-insurance	ner treat	ment		
Outpatient Mental	20 / 0 CO modrance	per treut				-			
Health Visits	<b>\$0</b> copay for individual or			sion	20% co-insurance per individual or group therapy session				
Eyewear	\$150 annual allowa	•			\$250 annual allowa	•			
Eye Exams	\$0 copay for Medicar				\$0 copay per Medicare-covered exam; \$0 copay for routine exams				
	\$0 for one annual routine exam					IIIIAA AV 91	ms		
Hooring Aids				orina					
Hearing Aids	\$2,000 annual allowance, the	hrough N	lationsHe	aring	\$500 annual a	ıllowance	2		
Hearing Aids Hearing Exams	\$2,000 annual allowance, the solution \$0 copay for Medican	hrough N re-covere	ationsHe	aring	\$500 annual a \$0 copay for Medicar	allowance re-covere	d exam;		
Hearing Exams	\$2,000 annual allowance, the solution copay for Medican solution copay for one ann solution copay for Medicar	nrough Nre-covere ual routing re covere	fationsHe d exam; ne exam d visit;		\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar	allowance re-covere up to \$2 re covere	d exam; 50/year d visit;		
	\$2,000 annual allowance, the solution s	hrough N re-covere ual routing re covered preventat	dationsHe d exam; ne exam d visit; ive servi	ces;	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive	re-covered up to \$2 re covered services;	d exam; 50/year d visit; \$500/ye	ear;	
Hearing Exams  Dental	\$2,000 annual allowance, the solution copay for Medicar solution copay for one ann solution copay for Medicar solution copay for certain c	hrough N re-covere ual routing re covered preventat compreh	dationsHe d exam; ne exam d visit; ive service ensive se	ces;	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive	re-covere up to \$2 re covered services; e services	d exam; 50/year 1 visit; \$500/ye;	ear;	
Hearing Exams	\$2,000 annual allowance, the solution s	hrough N re-covere ual routing re covered preventat compreh	dationsHe d exam; ne exam d visit; ive service ensive se	ces;	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive	re-covere up to \$2 re covered services; e services	d exam; 50/year 1 visit; \$500/ye;	ear;	
Hearing Exams  Dental  Chiropractic	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one ann \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$2,160 copay for Medicar \$0 copay for Medicar	hrough N re-covere ual routing re covered preventat compreh	dationsHe d exam; ne exam d visit; ive servicensive se	ces;	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive	re-covered up to \$2 re covered services; e services are-covered are-covered are-cover	d exam; 50/year d visit; \$500/ye; \$2,000 ed visit	ear;	
Hearing Exams  Dental	\$2,000 annual allowance, the solution copay for Medicar solution copay for one ann solution copay for Medicar solution copay for certain c	hrough N re-covere ual routing re covered preventat compreh are cover	dationsHe d exam; ne exam d visit; ive servicensive se ed visit	ces;	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar	re-covered sup to \$2 re covered services; re services are-covered re-covered	d exam; 50/year d visit; \$500/yea; \$2,000 ed visit; ber year	ear; D/year	
Hearing Exams  Dental  Chiropractic	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one ann \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$2,160 copay for Medicar \$0 copay for Medicar	hrough N re-covere ual routing re covered preventate compreh are covered are covered	rationsHe ad exam; ne exam d visit; ive servicensive se ed visit red visit	ces; rvices	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar	re-covered services:  e services:  e services:  e services:  are-covered re-covered visits:  30	d exam; 50/year d visit; \$500/ye; \$2,000 ed visit; ded visit; der year	ear; D/year	
Hearing Exams  Dental  Chiropractic	\$2,000 annual allowance, the \$0 copay for Medical \$0 copay for one ann \$0 copay for Medical \$0-\$41 copay for certain \$0-\$2,160 copay for certain \$0 copay for Medical \$0 copay for Medical \$0 co-pay per Medical	hrough N re-covere ual routing re covered preventate compreh are covered are covered are covered and days	dationsHe d exam; ne exam d visit; ive servicensive se ed visit red visit  90 days	ces; rvices	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing	re-covered services; e services; are-covered visits production of the covered services are-covered visits production of the covered services are-covered visits production of the covered services are visits	d exam; 50/year d visit; \$500/ye; \$500/ye ; \$2,000 ed visit ed visit; per year 100 days	ear; D/year 100 days	
Hearing Exams  Dental  Chiropractic	\$2,000 annual allowance, the \$0 copay for Medical \$0 copay for one annual \$0 copay for Medical \$0-\$41 copay for certain \$0-\$2,160 copay for certain \$0 copay for Medical \$0 copay for Medical \$0 co-pay per Medical \$0 co-pa	hrough N re-covere ual routing re covered preventate compreh are covered are covered	rationsHe ad exam; ne exam d visit; ive servicensive se ed visit red visit	ces; rvices	\$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies	re-covere services; re services; re-covere visits production of the covere services are-covere visits production of the covere	d exam; 50/year d visit; \$500/ye \$500/ye \$\$500/ye \$\$2,000 ed visit ed visit; per year  100 days retail	ear; Dyear 100 days mail	
Hearing Exams  Dental  Chiropractic  Podiatry	\$2,000 annual allowance, the solution copay for Medicar solution copay for one ann solution copay for Medicar solution copay for certain solution copay for Medicar solution copay for Medicar solution copay for Medicar solution copay per Medicar cost-sharing shown is for	hrough N re-covere ual routin re covere preventat compreh are cover are cover days retail	dationsHe d exam; ne exam d visit; ive servicensive se ed visit red visit  90 days retail	ces; rvices	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for	re-covered services; e services; are-covered visits production of the covered services are-covered visits production of the covered services are-covered visits production of the covered services are visits	d exam; 50/year d visit; \$500/ye; \$500/ye ; \$2,000 ed visit ed visit; per year 100 days	ear; D/year 100 days	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs	\$2,000 annual allowance, the solution copay for Medicar solution copay for one annual solution solution copay for Medicar solution copay for certain solution copay for Medicar solutio	re-covere ual routing e covered preventate comprehere covered are covered are covered are covered are sovered by the covered are covered are covered by the	d exam; ne exam d visit; ive servicensive se ed visit red visit  90 days retail \$0 \$0 \$105	100 days mail \$0 \$0 \$70	\$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand	re-covered services:  e services:  e services:  e services:  are-covered visits process  are-covered visits process  services:  are-covered visits process  are-covered visits	d exam; 50/year d visit; \$500/ye; \$2,000 ed visit; ed visit; per year 100 days retail \$0 \$15 \$135	100 days mail \$0 \$10	
Hearing Exams  Dental  Chiropractic  Podiatry	\$2,000 annual allowance, the solution copay for Medicar solution copay for one annual solution solution copay for Medicar solution solution copay for certain solution copay for certain solution copay for Medical solution copay for Medica	re-covered are covered are covered as a solution of the soluti	d exam; ne exam d visit; ive servicensive se ed visit red visit  90 days retail \$0 \$105 \$225	100 days mail \$0 \$70 \$150	\$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand	re-covered services:  e services:  e services:  are-covered services	d exam; 50/year 1 visit; \$500/ye; \$500/ye; \$2,000 ed visit; ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270	100 days mail \$0 \$10 \$90	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs	\$2,000 annual allowance, the solution copay for Medicar solution copay for one annual solution solution copay for Medicar solution solution copay for Medicar solution copay for certain solution copay for Medical solution copay for Medica	re-covered are covered are covered as the state of the st	rationsHe and exam; ne exam divisit; ive service ensive se ed visit  90 days retail \$0 \$105 \$225 N/A	100 days mail \$0 \$0 \$70 \$150 N/A	\$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance	re-covered services:  e services:  e services:  e services:  are-covered visits process  are-covered visits process  services:  are-covered visits process  are-covered vi	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$2,000 ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A	100 days mail \$0 \$10 \$10 \$180 N/A	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs	\$0 copay for Medicar \$0 copay for one ann \$0 copay for Medicar \$0 copay for Medicar \$0-\$41 copay for certain \$0 copay for certain \$0 copay for certain \$0 copay for Medicar \$0 copay for Medicar \$0 copay for Medicar \$0 copay for Medicar  \$10 copay for Medicar \$11 copay for Medicar \$12 copay for Medicar \$13 copay for Medicar \$14 copay for Medicar \$15 copay for Medicar \$16 copay for Medicar \$17 copay for Medicar \$18 co	hrough N re-covere ual routing to covere preventate comprehe are covere are covere are covere are covere solution to the covere are covere are covere solution to the covere are covere are covere solution to the covere are covere ar	d exam; ne exam d visit; ive servicensive se ed visit red visit 90 days retail \$0 \$105 \$225 N/A costs reac	100 days mail \$0 \$70 \$150 N/A	\$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year	re-covered services:  e services:  e services:  e services:  are-covered visits processervices:  a of days retail  \$0  \$45  \$45  \$90  33%  rly drug of	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$2,000 ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rea	100 days mail \$0 \$10 \$90 \$180 N/A ch	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs	\$2,000 annual allowance, the solution copay for Medicar solution copay for one annual solution solution copay for Medicar solution solution copay for Medicar solution copay for certain solution copay for Medical solution copay for Medica	hrough N re-covere ual routing to covere re covere preventate comprehe are covere are covere are covere 30 days retail \$0 \$35 \$75 33% rly drug of enerics a	dationsHe de exam; ne exam d visit; ive servicensive se d visit red visit  90 days retail \$0 \$105 \$225 N/A costs reach nd 25%	100 days mail \$0 \$70 \$150 N/A	\$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance	re-covered services:  are-covered services:	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$2,000 ed visit ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generic	ear; D/year  100 days mail \$0 \$10 \$90 \$180 N/A ch cs and	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$41 copay for certain \$0 copay for Medicar \$0-\$2,160 copay for Medicar \$0 copay for Medicar \$10 copay	are covered are covered are covered are soluble solubl	d exam; ne exam d visit; ive servicensive se ed visit  red visit  90 days retail \$0 \$105 \$225 N/A costs reach nd 25% eket drug u pay \$0	100 days mail \$0 \$70 \$150 N/A ch	\$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  *Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10	re-covered services:  are-covered services:  are-covered services:  are-covered visits process  are-covered visits	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$2,000 ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generical out-of-	100 days mail \$0 \$10 \$90 N/A ch cs and -pocket	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$41 copay for certain \$0-\$2,160 copay for Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$1 copay for metwork pharmacies Preferred Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0 for any general plan's cost for brands until or expenses reach \$8,000. After Acupuncture: \$0 copay per \$1 copay for medicar \$1 copay for any general \$2 copay per \$3 copay for medicar \$4 copay for med	are covered are covered are covered are soluble solubl	d exam; ne exam d visit; ive servicensive se ed visit  red visit  90 days retail \$0 \$105 \$225 N/A costs reach nd 25% eket drug u pay \$0	100 days mail \$0 \$70 \$150 N/A ch	\$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10, \$25% of the plan's cost for brown and some contact of the state	re-covered services:  are-covered services:  are-covered services:  are-covered visits process  are-covered visits	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$2,000 ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generical out-of-	100 days mail \$0 \$10 \$10 \$90 \$180 N/A ch cs and -pocket	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$41 copay for certain \$0-\$2,160 copay for Medicar \$0 copay for Medicar \$0 copay for Medicar \$0 copay for Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$1 copay for metwork pharmacies Preferred Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0 for any generate \$1 copay for metwork \$1 copay for metwork \$1 copay for copay per foutine visits per year	re-covered are covered are covered are covered are sovered are sov	ationsHe ad exam; ne exam d visit; ive servicensive se ed visit  90 days retail \$0 \$105 \$225 N/A costs reac nd 25% eket drug u pay \$0 unlimite	100 days mail \$0 \$70 \$150 N/A ch of the	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10 25% of the plan's cost for broad drug expenses reach \$8,000.	re-covered services:  are-covered services:	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$2,000 ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generical out-of- at, you p	ear; D/year  100 days mail \$0 \$10 \$90 \$180 N/A ch cs and pocket bay \$0.	
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Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs (Outpatient)	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$41 copay for certain \$0-\$2,160 copay for Medicar \$0 copay per Medicar \$0 copay per Medicar Preferred Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0 for any goplan's cost for brands until of expenses reach \$8,000. After Acupuncture: \$0 copay per routine visits per year Groceries: \$25 monthly allo foods, for those with qualifying Meals: \$0 co-pay for 2 meals \$0 co-pay for 2 meals \$1.00 copay for 2	are covered are covered are covered are solved are solv	ationsHe ad exam; ne exam d visit; ive service ensive se ed visit  90 days retail \$0 \$105 \$225 N/A costs reac nd 25% eket drug un pay \$0 unlimite or healthy tions 14 days	100 days mail \$0 \$150 N/A ch of the	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10 column \$25% of the plan's cost for brown drug expenses reach \$8,000.  In-Home Support Services: Meals: \$0 co-pay for up to 7 following surgery or hospital	re-covered services:  a up to \$2 re covered services:  a	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$2,000 ed visit; ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generical out-of- at, you p	ear; D/year  100 days mail \$0 \$10 \$90 \$180 N/A ch cs and -pocket bay \$0.	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs (Outpatient)	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$41 copay for certain \$0-\$2,160 copay for Medicar \$0-\$2,160 copay for Medicar \$0 copay for Medicar \$0 copay for Medicar \$0 copay per Medicar \$0 copay per Medicar Preferred Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0 for any goplan's cost for brands until of expenses reach \$8,000. After Acupuncture: \$0 copay per routine visits per year Groceries: \$25 monthly allo foods, for those with qualifying Meals: \$0 co-pay for 2 meals following surgery or hospital following surgery or hospital for the surgery or surgery or hospital following surgery or hospital fol	are covered are co	ationsHe ad exam; ne exam d visit; ive service ensive se ed visit  90 days retail \$0 \$105 \$225 N/A costs reac nd 25% eket drug un pay \$0 unlimite or healthy tions 14 days to 4 time	100 days mail \$0 \$0 \$150 N/A bh of the	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred Pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10 columns 25% of the plan's cost for brown drug expenses reach \$8,000.  In-Home Support Services: Meals: \$0 co-pay for up to 7 following surgery or hospital per benefit period	re-covered services:	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$500/year d visit; ed visit; ed visit; ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generical out-of- at, you per year y 60 hours elivered 05 allow	ar; D/year  100 days mail \$0 \$10 \$90 \$180 N/A ch cs and -pocket bay \$0.	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs (Outpatient)  Supplemental Benefits and	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$41 copay for certain \$0 copay for Medicar \$0-\$2,160 copay for certain \$0 copay for Medicar \$0 copay for Medicar \$0 copay for Medicar \$0 copay per Medicar Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0 for any goplan's cost for brands until or expenses reach \$8,000. After Acupuncture: \$0 copay per routine visits per year Groceries: \$25 monthly allowed foods, for those with qualifying Meals: \$0 co-pay for 2 meals following surgery or hospital Over the Counter: \$46 months.	are covered are co	ationsHe ad exam; ne exam d visit; ive service ensive se ed visit  90 days retail \$0 \$105 \$225 N/A costs reac nd 25% eket drug un pay \$0 unlimite or healthy tions 14 days to 4 time	100 days mail \$0 \$0 \$150 N/A bh of the	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10 column \$25% of the plan's cost for brown drug expenses reach \$8,000.  In-Home Support Services: Meals: \$0 co-pay for up to 7 following surgery or hospital	re-covered services:	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$500/year d visit; \$500/year d visit; ed visit; ed visit; ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generical out-of- at, you p y 60 houelivered 05 allow	ear; D/year  100 days mail \$0 \$10 \$90 \$180 N/A ch cs and -pocket bay \$0.	
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Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs (Outpatient)  Supplemental Benefits and	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$2,160 copay for certain \$0 copay for Medicar \$10 copay for Acupuncture: \$10 copay for Acupuncture: \$10 copay for Medicar \$1	are covered are co	ationsHe ad exam; ne exam d visit; ive service ensive se ed visit  90 days retail \$0 \$105 \$225 N/A  costs reac nd 25% exet drug u pay \$0 unlimite or healthy tions 14 days to 4 time wance fo  fyingway trip n 50 mile	100 days mail \$0 \$0 \$150 N/A the of the des/year r OTC	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred Pharmacies  Preferred Brand Non-Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10 25% of the plan's cost for brand brand brands are seach \$8,000.  In-Home Support Services: Meals: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quaritems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 plan approved locations Wellness: \$0 for Silver&Fit	re-covered services:	d exam; 50/year d visit; \$500/ye; \$500/ye; \$500/ye; \$500/ye; \$500/year d visit; \$2,000 ed visit; ed visit; er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generical out-of- at, you p y 60 hou elivered 05 allow owance f g ne-way f	ear; D/year  100 days mail \$0 \$10 \$90 \$180 N/A ch cs and pocket bay \$0.  ars/year meals vance for trips to	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs (Outpatient)  Supplemental Benefits and Optional Plans	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$41 copay for certain \$0 copay for Medicar \$0-\$2,160 copay for certain \$0 copay for Medicar \$0 copay for Medicar \$0 copay per Medicar \$0 copay per Medicar Preferred Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0 for any giplan's cost for brands until or expenses reach \$8,000. After Acupuncture: \$0 copay per routine visits per year Groceries: \$25 monthly allo foods, for those with qualifying Meals: \$0 co-pay for 2 meals following surgery or hospital Over the Counter: \$46 monand Herbal Catalog items Scales: \$0 copay for those with conditions Transportation: \$0 copay for those with conditions Transportation: \$0 copay for the Counter: \$40 copay for those with conditions Transportation: \$0 copay for the Counter: \$40 copay for the Counter: \$40 copay for those with conditions Conditions Copay for the Counter: \$40 copay for the Counter: \$40 copay for those with conditions Conditions Copay for the Counter: \$40 copay for the Count	are covered are co	ationsHe ad exam; ne exam d visit; ive service ensive se ed visit  90 days retail \$0 \$105 \$225 N/A  costs reac nd 25% exet drug u pay \$0 unlimite or healthy tions 14 days to 4 time wance fo  fyingway trip n 50 mile	100 days mail \$0 \$0 \$150 N/A the of the des/year r OTC	\$500 annual a \$0 copay for Medicar \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred Pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10 copay for the plan's cost for brown of the plan's of the plan's cost for brown of the plan's cost for brown of the plan's of the plan's cost for brown of the plan's cost for brown of the plan's of the plan's cost for brown of the plan's of the plan's cost for brown of the plan's of the plan's cost for brown of the plan's cost for	re-covered services:	d exam; 50/year d visit; \$500/ye; \$500/year d visit; \$500/year d visit; \$500/year d visit; \$2,000 ed visit ed visit; per year 100 days retail \$0 \$135 \$270 N/A costs rear generical out-of- at, you p y 60 houelivered 05 allow owance f g ne-way t nbership	ear; D/year  100 days mail \$0 \$10 \$10 \$90 \$180 N/A ch cs and pocket bay \$0.  ars/year meals vance for trips to	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs (Outpatient)  Supplemental Benefits and Optional Plans  Medical Groups and	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$2,160 copay for certain \$0 copay for Medicar \$10 copay for Acupuncture: \$10 copay for Acupuncture: \$10 copay for Medicar \$1	are covered are co	ationsHe ad exam; ne exam d visit; ive service ensive se ed visit  90 days retail \$0 \$105 \$225 N/A costs reace nd 25% eket drug unlimite or healthy tions 14 days to 4 time wance fo  fying e-way trip n 50 mile n member	100 days mail \$0 \$0 \$150 N/A the of the des/year r OTC	\$500 annual a \$0 copay for Medicar \$0 for routine exams \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred Pharmacies  Preferred Brand Non-Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10 25% of the plan's cost for brand brand brands are seach \$8,000.  In-Home Support Services: Meals: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quaritems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 plan approved locations Wellness: \$0 for Silver&Fit	re-covered services: e services: e services: e services: e services: e services: are-covered visits processer services: a 30 days retail     \$0     \$5     \$45     \$90     33% rly drug cor \$15 for ands untited at the services services.  **So copal home-deleter stay; \$1  **Toland, Toland,	d exam; 50/year d visit; \$500/ye; \$500/year d visit; \$500/year d visit; \$500/year d visit; \$2,000 ed visit ed visit; per year 100 days retail \$0 \$135 \$270 N/A costs rear generical out-of- at, you p y 60 houelivered 05 allow owance f g ne-way t nbership	ear; D/year  100 days mail \$0 \$10 \$10 \$90 \$180 N/A ch cs and pocket bay \$0.  ars/year meals vance for trips to	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs (Outpatient)  Supplemental Benefits and Optional Plans  Medical Groups and Hospitals	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0 copay for certain \$0 copay for Medicar \$0 copay for certain \$0 copay for Medicar \$0 copay for Medicar \$0 copay for Medicar \$0 copay per Medicar Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0 for any goplan's cost for brands until of expenses reach \$8,000. After Acupuncture: \$0 copay per routine visits per year Groceries: \$25 monthly allo foods, for those with qualifying Meals: \$0 co-pay for 2 meals following surgery or hospital Over the Counter: \$46 monual Herbal Catalog items Scales: \$0 copay for those we chronic conditions Transportation: \$0 copay for year to plan approved location Wellness: \$0 for Silver Snear Medical Groups: Hill Phys. Hospitals: Alta Bates/Summ	are covered are co	ationsHe ad exam; ne exam d visit; ive service ensive se ed visit  red visit  90 days retail \$0 \$105 \$225 N/A costs reach nd 25% eket drug u pay \$0 unlimite or healthy tions 14 days to 4 time wance fo  fying -way trip n 50 mile n member  sst Bay Oak), Ed	100 days mail \$0 \$0 \$150 N/A bh of the dd	\$500 annual a \$0 copay for Medicar \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10 columns 25% of the plan's cost for brown drug expenses reach \$8,000.  In-Home Support Services: Meals: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quaritems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quaritems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 following surgery or hospitals: Alta Bates/Summs Wellness: \$0 for Silver&Fit home fitness kit	re-covered services:  re-covered services:  re-covered services:  re-covered services:  re-covered visits process  re-covered vis	d exam; 50/year d visit; \$500/ye; \$500/year d visit; \$500/year d visit; \$500/year d visit; \$ed visit; \$ed visit; \$er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generical out-of- at, you p y 60 hou elivered 05 allow wance f g ne-way t nbership	ear; D/year  100 days mail \$0 \$10 \$90 \$180 N/A ch cs and -pocket bay \$0.  Irs/year meals vance for trips to o or at-	
Hearing Exams  Dental  Chiropractic  Podiatry  Prescription Drugs (Outpatient)  Supplemental Benefits and Optional Plans  Medical Groups and	\$2,000 annual allowance, the \$0 copay for Medicar \$0 copay for one annual \$0 copay for Medicar \$0-\$41 copay for certain \$0-\$2,160 copay for certain \$0 copay for Medicar Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0 for any goplan's cost for brands until of expenses reach \$8,000. After Acupuncture: \$0 copay per routine visits per year Groceries: \$25 monthly allo foods, for those with qualifying Meals: \$0 co-pay for 2 meals following surgery or hospital Over the Counter: \$46 monuand Herbal Catalog items Scales: \$0 copay for those we chronic conditions Transportation: \$0 copay for year to plan approved location Wellness: \$0 for Silver Snear Medical Groups: Hill Physical Property of the	are covered are co	ationsHe ad exam; ne exam d visit; ive service ensive se ed visit  red visit  90 days retail \$0 \$105 \$225 N/A costs reach nd 25% eket drug u pay \$0 unlimite or healthy tions 14 days to 4 time wance fo  fying -way trip n 50 mile n member  sst Bay Oak), Ed	100 days mail \$0 \$0 \$150 N/A bh of the dd	\$500 annual a \$0 copay for Medicar \$0 copay for Medicar \$0 co-pay for preventive \$0 co-pay for comprehensive \$0 copay per Medicar \$0 copay per Medicar \$0 copay per Medicar \$0 copay for 6 routing  Cost-sharing shown is for preferred pharmacies  Preferred Generic Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0, \$5, \$10 25% of the plan's cost for brown drug expenses reach \$8,000.  In-Home Support Services: Meals: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quantitems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quantitems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quantitems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quantitems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quantitems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 following surgery or hospital per benefit period Over the Counter: \$75 quantitems in plan's OTC mail ord Transportation: \$0 co-pay for up to 7 following surgery or hospital per benefit period	re-covered services:  re-covered services:  re-covered services:  re-covered services:  re-covered visits process  re-covered vis	d exam; 50/year d visit; \$500/ye; \$500/year d visit; \$500/year d visit; \$500/year d visit; \$ed visit; \$ed visit; \$er year 100 days retail \$0 \$15 \$135 \$270 N/A costs rear generical out-of- at, you p y 60 hou elivered 05 allow wance f g ne-way t nbership	ear; D/year  100 days mail \$0 \$10 \$90 \$180 N/A ch cs and -pocket bay \$0.  Irs/year meals vance for trips to o or at-	

Please contact the Plan for more 877-870-4867 (Salts & Marketing) information or call 1-800-Medicare  SCAN Balance C-SNP (H5425-076) For People with Diabetes Star Rating  ****1/2 Annual OOP Max Monthly Premium S0 So for Specialist S0 for Specialist S0 for Specialist S0 for Specialist S180 copps per cluy for days 1-7; S0 for Specialist S180 copps per cluy for days 1-7; So for days 1-20; S180 copps per cluy for days 1-7; S180 copps per cluy for days 1-10; S181 lownstein Hospital S0 for Specialist S181 So for days 1-20; S180 copps per cluy for days 1-10; S181 So for days 1-20; S180 copps per cluy for days 1-10; S181 So for days 1-20; S180 copps per cluy for days 1-10; S181 S180 copps per cluy for days 1-10; S180 copps per mergenity for more visit. Warded if admired in requiral immediately, 380 copps per mergenity for more visit. Warded if admired in requiral immediately, 380 copps per mergenity for more visit. Warded if admired in requiral immediately, 380 copps per mergenity for more visit. Warded if admired in requiral immediately, 380 copps per mergenity for more visit. Warded if admired in requiral immediately, 380 copps per mergenity for more visit. Warded if admired in requiral immediately, 380 copps per mergenity for more visit. Warded if admired in requiral immediately, 380 copps per mergenity for more visit. Warded if admired in requiral immediate per mergenity for more visit. Warded if admired in requiral immediately, 380 copps per mergenity for more visit. Warded if admired in requiral immediate per mergenity for more visit. Warded if admired in requiral immediates, 380 copps per mergenity for more visit. Warded if admired in requiral immediates, 38	2024 NIE1	PICARE SNP COMPAR			KIFUF					
Source   Second   S	Please contact the	SCAN Hea	lth P	lan		SCAN Hea	lth Pl	an		
Source   Second   S	Plan for more	877-870-4867 (Sal	les & N	//arket	ting)	877-870-4867 (Sales & Marketing)				
SCAN Balance   C-SNP (HS425-076)   For People with Diabetes   SCAN Balance   C-SNP (HS425-076)   For People with Diabetes   SCAN Balance   C-SNP (HS425-076)   For People with Cardiosvascular Disease and/or Congestive Heart Failure   Star Rating   \$\psi \psi \psi \psi \psi \psi \psi \psi	· ·				_					
SCAN Balance CSNP (HS425-076) For People with Diabetes  Star Rating  ****1/2  Annual OOP Max  So on Specials  So for the Star Star Star Star Star Star Star Star	· ·				ces)	· · · · · · · · · · · · · · · · · · ·				
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Plan Name/Type		SCAN R	alanc	Δ		SCAN Hea	art Fir	st		
For People with Cardiovascular Disease and/or Congestive Heart Failure  \$150 copy or Care Physician; \$30 or Specialist \$150 copay per day for days 1-7; \$150 copay per days for days 1-7; \$150 cop	DI N //T					C-SNP (H5	5425-07	<b>7</b> )		
Star Rating  *** * * * * * * * * * * * * * * * * *	Plan Name/Type	`		•					isease	
Starting		For People wit	th Dia	betes		_				
Monthly Premium   S0	Ct. D. t.	1 1 1 1 10						ranui	. •	
Doctor Visits   S0 for Primary Care Physician; S0 for Specialists   S0 for days 8-981 and beyond										
Doctor Visits   So for Primary Care Physician: So for Specialist   So for Agys 1-7;	Annual OOP Max	\$2,80	00			\$2,80	)0			
Inpatient Hospital  St 50 copay per day for days 1-7; St 60 copay per day for days 1-7; St 60 copay per symptial exteries visit; Hospital  St 60 copay per symptial exteries visit; Hospital  St 60 copay per outpatient hospital visit  Stilled Nursing Facility  St 60 copay per outpatient hospital visit  Stilled Nursing Facility  St 60 copay per outpatient hospital visit  Stilled Nursing Facility  St 60 copay per outpatient hospital visit  Stilled Nursing Facility  St 60 copay per outpatient hospital visit  St 60 copay per outpatient visit; St 60 copay per outpat	<b>Monthly Premium</b>	\$0				\$0				
This patient Hospital   Si 160 copay per day for days 1-7;   Si 150 copay per day for days 1-20;   Si 150 copay per day for days 1-20;   Si 150 copay per day 1-20;   Si 150 copay per day 1-20;   Si 150 copay per day 1-20;   Si 250 copay per	Doctor Visits	\$0 for Primary Ca	are Phys	ician;		<b>\$0</b> for Primary Ca	are Physi	cian;		
Outpatient Hospital  So for days 8-90 and beyond Outpatient Hospital  So For adays 8-90 and beyond Outpatient Hospital  So For adays 1-20: So Copay per adatic of hospital mimediately; So Copay per urgent care visit, Worldwide coverage urgent care visit, Worldwide coverage Urgent Care Lab Tests. Procedures, and Radiation Therapy Renal Dialysis  Outpatient Mental Health Visits  Eyewear  So Copay for Inh services, diagnostic tests & procedures, x-rays, and diagnostic radiology; So Copay for the services, diagnostic rediology; So Copay for Inh services, diagnostic tests & procedures, x-rays, and diagnostic rediology; So Copay for Inh services, diagnostic rediology; So Copay for Inh services, diagnostic tests & procedures, x-rays, and diagnostic rediology; So Copay for Inh services, diagnostic tests & procedures, x-rays, and diagnostic rediology; So Copay for Inh services diagnostic rediology; So Copay for Inh services diagnostic rediology; So Copay for Inh annual routine cxam So Copay for Inh annual routine c	Ductur visits									
Outpatient Hospital  Superambulatory surgical center visit; Sub-8125 copay per outpatient hospital visit Sulided Nursing Facility  Sub-8125 copay per outpatient hospital visit Sub-9125 copay per outpat	Inpatient Hospital									
Solidate Nursing   Solidate Solidate Normal   Solidate Nursing   Sol										
Skilled Nursing   Facility   S9 for days 1-20; S9 for days 1-100										
S75 copay/day for days 21-100		\$0-\$125 copay per outp	atient h	ospital v	risit	\$0-\$125 copay per outp	oatient ho	spital vi	sit	
Ambulance  S90 copay per emergency room visit; Waived if admitted to hospital immediately; \$0 copay per urgent care visit; Worldwide coverage  Emergency & S180 copay per trip by ground or air Urgent Care  Lab Tests, S90 copay for lab services, diagnostic ests & procedures, and Radiation Therapy  Renal Dialysis  20% co-insurance per treatment  S10 copay per individual or group therapy session  Lealth Visits  Eyewear  \$10 copay per individual or group therapy session  Lealth Visits  Eyewear  \$10 copay per hedicare-covered exam;  \$0 copay per Medicare-covered visit;  \$0 cop	Skilled Nursing									
Ambulance  admitted to hospital immediately; \$0 copay per urgent care visit; Worldwide coverage  Emergency & Urgent Care visit; Worldwide coverage  Urgent Care visit; Worldwide coverage  Emergency & \$180 copay per trip by ground or air  Lab Tests, Procedures, and Radiation Therapy  Renal Dialysis  20% co-insurance per treatment  20 copay per individual or group therapy session  20 copay per Medicare-covered exam;  20 copay per Medicare-covered visit  20 copay per Medicare-	Facility	\$75 copay/day for	r days 2	1-100		\$75 copay/day for	r days 21	-100		
Emergency & Urgent Care   S180 copay per trip by ground or air   S180 copay per medicar-covered exam;   S180 copay per Medicar-covered visit;   S180 copay per Medi										
Sign copay per trip by ground or air	Ambulance									
Site Copay per trip by ground or air	_	urgent care visit; Wo	rldwide	coverag	e	urgent care visit; Wo	rldwide o	coverage	;	
Lab Tests, Procedures, and Radiation Therapy \$60 copus for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; \$60 copus for flat services, diagnostic radiology; \$60 copus for diagnostic radiology; \$60 copus for diagnostic radiology; \$60 copus for flat services; \$90 copus for diagnostic radiology; \$60 copus for diagnostic radiology; \$60 copus for deficare-covered exam; \$90 copus per dedicare-covered exam; \$90 copus per dedicare-covere		\$180 copay per trip	hy grou	nd or air		\$180 copay per trip	hy graun	d or air		
Procedures, x-rays, and diagnostic radiology: \$60 copay for therapeutic radiology: \$60 copay for therapeutic radiology: \$60 copay for therapeutic radiology: \$20% co-insurance per treatment  20% copay per individual or group therapy session  \$00 copay per Medicare-covered exam; \$00 copay for I annual routine exam  \$00 copay for I annual routine exam  \$00 copay for Medicare-covered exam; \$00 copay per Medicare-covered visit  200 copay per Medicare-covered	Urgent Care	φ <b>100</b> copay per trip	o, grou	ing of all		φ <b>100</b> copay per trip	Jy groun	a or all		
Procedures, x-rays, and diagnostic radiology: \$60 copay for therapeutic radiology: \$60 copay for roll cannual routine cannual solopay for therapeutic radiology: \$60 copay for roll exam; \$60 copay for roll exam; \$60 copay for roll exam; \$60 copay for roll enses/frames every 2 years: \$60 copay for roll enses/frames eve	Lab Tests,	<b>\$0</b> copay for lab service	s, diagn	ostic tes	ts &	<b>\$0</b> copay for lab service	s, diagno	stic tests	s &	
Sol copay for therapeutic radiology   Sol copay for therapeutic radiology	Procedures, and									
Substitute   Sub		\$60 copay for therap	peutic ra	diology		<b>\$60</b> copay for thera	peutic rac	diology		
Supplemental Health Visits   \$10 copay per individual or group therapy session   \$10 copay per individual or group therapy session   \$10 copay per individual or group therapy session   \$235 allowance for lenses/frames every 2 years   \$225 allowance for lenses/frames every 2 years   \$0 copay per Medicare-covered exam; \$0 copay for 1 annual routine exam   \$0 copay for 1 annual routine exam   \$0 copay per Medicare-covered exam; \$0 copay for Medicare covered visit \$0 copay per Medicare-covered exam; \$0 copay per Medicare-covered exam; \$0 copay for Medicare covered visit \$0 copay per Medicare-covered exam; \$0 copay per Medicare-covered visit \$0 copay per Medicare-covered v		20% co-insurance	per trea	atment		20% co-insurance	e per trea	tment		
Ealth Visits   Sito copay per individual or group inerapy session	•	20 / 0 00 msurance	per tree	ttilicitt		20 / 0 CO Institution	per trea	tillelit		
Syewear   \$235 allowance for lenses/frames every 2 years	_	\$10 copay per individual or	r group	therapy	session	\$10 copay per individual of	r group tl	herapy so	ession	
So copay per Medicare-covered exam; \$0 copay per Medicare-covered exam; \$0 copay for I annual routine exam \$450-8750 copay per aid; 2 aids per year, through TruHearing \$0 copay per Medicare-covered exam; \$0 copay for I annual routine exam \$0 copay per Medicare-covered exam; \$0 copay per Medicare-covered visit; \$0 copay per Medicare-covered visit; \$0 copay per Medicare-covered visit; \$0 copay per Medicare-covered visit \$0 copay per Medicare-covered exam; \$0 copay for Medicare-covered exam; \$0 copay per Medicare-covered exam; \$0 copay for Medicare-covered exam; \$0 copa	Health Visits	1 1 1				8 1				
Hearing Aids	Eyewear	\$235 allowance for lenses	/frames	every 2	years	\$235 allowance for lenses/frames every 2 years				
Hearing Aids	E E	<b>\$0</b> copay per Medica	re-cove	ed exan	1;	\$0 copay per Medicare-covered exam;				
So copay per Medicare-covered exam; \$0 copay for one annual routine exam	Eye Exams									
So copay per Medicare-covered exam; \$0 copay for Medicare covered visit; \$0 copay per Medicare covered visit; \$0 copay per Medicare covered visit; \$0 copay per oral exam, cleaning, and x-rays; up to 2 visits each per year; See Optional Benefit Plan below    Chiropractic	Hooring Aids				ear,					
So copay for one annual routine exam   So copay for one annual routine exam   So copay for Medicare covered visit;   So copay per oral exam, cleaning, and x-rays; up to 2 visits each per year;   See Optional Benefit Plan below	Titaling Alus									
\$0 copay for Medicare covered visit; \$0 copay per Medicare covered visit; \$0 copay per oral exam, cleaning, and x-rays; up to 2 visits each per year; See Optional Benefit Plan below  Chiropractic  \$0 copay per Medicare covered visit  \$0 copay per Medicare-covered visit	Hearing Exams	1 7 1								
So copay per oral exam, cleaning, and x-rays; up to 2 visits each per year; See Optional Benefit Plan below See Optional Plans See Optional Plan					n					
Chiropractic   So copay per Medicare covered visit   So copay per Medicare-covered visit					rosic.				07/6*	
See Optional Benefit Plan below   See Optional Benefit Plan below	Dental				iays,				ays,	
Prescription Drugs (Outpatient)   Supplemental Benefits and Optional Plans   Supplemental Benefits and Optional Plans   Supplemental Benefits and Optional Plans   Medical Groups and Hospitals (may not be full list;   Medical Groups and Hospitals (may not be full list;   Medical Groups and Hospitals (may not be full list;   Medical Groups and Hospitals (may not be full list;   Medical Groups and Hospitals (may not be full list;   Medical Groups and Hospitals (may not be full list;   Medical Groups and Hospitals (May ward)   Medical Groups (Visit (Visit (May vard))   Medical Groups (Visit (Visit (May vard))   Medical Groups (Visit (Visit (May vard))   Medical Groups (Visit (Visit (Visit (May vard))   Medical Groups (Visit (Visi		•								
Prodiatry   S0 co-pay per Medicare covered visit   S0 co-pay per Medicare covered visit	Chiroproctic	•			<u> </u>					
Prescription Drugs (Outpatient)  Prescription Drugs (Outpatient)  Cost-sharing shown is for preferred pharmacies retail retail mail Preferred Generic \$0 \$0 \$0 \$0 Generic \$0 \$0 \$0 \$0 Preferred Brand \$40 \$100 \$100 Non-Preferred Brand \$90 \$250 \$250 Specialty co-insurance \$33% N/A N/A \$80 \$90 \$90 \$90 \$90 \$90 \$90 \$90 \$90 \$90 \$9	Cintopractic	\$6 copay per Medica	are-cove	Teu visii	l .	<b>\$0</b> copay per intented	are-cover	eu visit		
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Prescription Drugs (Outpatient)  Preferred Generic S0 \$0 \$0 \$0 Preferred Generic S0 \$0 \$0 \$0 Preferred Brand Supplemental Benefits and Optional Plans  Medical Groups and Hospitals (may not be full list;  Preferred Generic S0 \$0 \$0 \$0 S0 S0 Preferred Generic S0 \$0 \$0 \$0 Preferred Brand S40 \$100 \$100 Preferred Brand S90 \$250 \$250 Specialty co-insurance S33% N/A N/A N/A S0 deductible; after total yearly drug costs reach \$5,030, you pay \$0 for generics and no more than 25% of the plan's cost for brand names until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.  Over the Counter (OTC): \$100 quarterly allowance for items from plan's OTC catalog; balance carried over to next quarter but not next year Transportation: \$0 copay for up to 24 one-way trips per year to plan-approved locations within 75 miles  Optional Plans  Medical Groups and Hospitals (may not be full list;  Other plan's control of any service of the plan's control of any services  Medical Groups and Hospitals: Alameda, San Leandro, St. Rose (Hayward)			30	100	100		30	100	100	
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2024 MILDI	CARE SINF COMIFAR	190N	CHAR	ITOK	ALAMEDA COUNTY	: 1-51	(FS	
Please contact the Plan for more	Align Sen 844-305-3879 (S	Align Sen 844-305-3879 (S			ting)			
information or call 1-800-Medicare	844-305-3879 (N www.alignse	844-305-3879 (Member Services) www.alignseniorcare.com						
	Align Prei	nier (	Care		Align Sen	ior C	are	
Plan Name/Type	I-SNP (H3274-002) - For People Needing Nursing Home Level of Care				I-SNP (H3274-001) For People Needing Nursing Home Level of Care			
Star Rating	Not Enough D				Not Enough D			
Annual OOP Max	\$3,5				\$8,8			
<b>Monthly Premium</b>	\$0 / Medical De		le = \$24	10	\$41 / Medical De		le = \$24	40
Doctor Visits	\$0 for Primary (			-	\$0 copay for Primar			
Doctor visits	<b>\$0</b> for S <sub>1</sub>	pecialist			20% coinsuranc			
Inpatient Hospital	\$150 copay/day \$0 for day	s 11-15	0		\$1,632 deductible; \$0 co \$408 copay/day \$816 copay/day	for days for days	61-90; 91-150	ŕ
Outpatient Hospital	20% coinsurance per amb			center or	20% coinsurance per amb			center or
Skilled Nursing	outpatient he \$0 copay/day i				outpatient hospi \$0 copay/day f		•	
Facility	\$100 copay/day \$105 copay per	for days	21-100		\$204 copay/day	for days	21-100	
Ambulance	20% coinsurance	e per tri	p by air		20% coinsurance per			
Emergency & Urgent Care	\$90 copay per ER visit; \$ copays waived if admitted				\$90 copay per ER visit; \$ copays waived if admitted			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab se 20% coinsurance for diag diagnostic and the	gnostic t	ests, pro	cedures,	\$0 copay for lab se 20% coinsurance for diag diagnostic and ther	nostic te	ests, proc	edures,
Renal Dialysis	20% coinsurance	e per tre	eatment		20% coinsuranc	e per tre	atment	
Outpatient Mental Health Visits	\$20 copay for individual \$10 copay for ground \$10 c				20% coinsurance group thera			
Eyewear	\$225 annual allow	vancefor	eyewear	r	\$275 annual allowance for eyewear			
Eye Exams	20% coinsurance per M				20% coinsurance per Medicare-covered exam;			
<u> </u>	\$0 copay for one ar				\$0 copay for one annual routine exam \$1,500 annual allowance; limited to 2 aids/year			
Hearing Aids	\$1,500 annual allowance 20% coinsurance per M				20% coinsurance per Medicare-covered exam			•
Hearing Exams	\$0 copay for one ar				\$0 copay for one annual routine exam			
Dental	20% coinsurance per N \$1,000 annual allowand comprehensive services,	ce for ce	rtain bas	ic and	20% coinsurance per Medicare covered visit; \$3,000 annual allowance for certain basic and comprehensive services, through Liberty Dental			
Chiropractic	20% coinsurance for N \$30 copay for 12 ro	ledicare utine vis	c-covered sits per ye	visit; ear	20% coinsurance for Medicare-covered visit			
Podiatry	20% coinsurance for N				20% coinsurance for Medicare-covered visit; \$0 copay/visit for 4 routine visits per year			
,	\$0 copay/visit for 4 re	30	1sits per y	year 90	\$0 copay/visit for 4 ro	30	sits per y	90
	Cost-sharing shown is for preferred pharmacies  Preferred Generic	days retail	days retail	days mail	Cost-sharing shown is for preferred pharmacies  Preferred Generic	days retail 25%	days retail	days mail 25%
	Generic	\$10	\$30	\$30	Generic	25%	25%	25%
<b>Prescription Drugs</b>	Preferred Brand Non-Preferred Brand	\$45 \$95	\$145 \$285	\$145 \$285	Preferred Brand Non-Preferred Brand	25%	25%	25%
(Outpatient)	Specialty co-insurance	25%	N/A	N/A	Specialty co-insurance	25% 25%	25% 25%	25% 25%
	\$0 deductible for Tiers 1&							
	Tiers 3-5; after total yearly you pay 25% for generic a until out-of-pocket drug ex After that, you pay \$0.	drug co	osts reach d name d	n <b>\$5,030</b> , Irugs	\$545 deductible for all drugs; after total yearly drug costs reach \$5,030, you pay 25% for generic and brand name drugs until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.			
Supplemental Benefits and Optional Plans	Acupuncture: \$30 copay visits per year  Companion Care: 30 hou certain qualifying condition  Groceries: \$35 monthly a locations for those w/chronover the Counter: \$225 copay of which incontinence supplies; unuter Transportation: \$0 copay plan-approved locations  Wellness: \$0 copay for one	erred nditions ace for d on des over year to	locations for those w/chronic qualifying conditions Memory Fitness: \$0 copay for online subscription to BrainHQ Over the Counter: \$250 quarterly allowance for OTC items, \$50 of which may only be used on incontinence supplies; unused balance carries over			red ditions cription ce for on es over		
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Certain Hospitals: Alta Bates/Sun Medical Center (Castro Va	nmit (Be			Medical Groups: Certain a Hospitals: Alta Bates/Sum Medical Center (Castro Val	mit (Ber		
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## **Medicare Coverage for Preventive Care Benefits**

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

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

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

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

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

### **Star Ratings:**

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

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

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