

ORANGE COUNTY		Comparison Chart					
Company	Aetna	Anthem Blue Cross	Anthem Blue Cross	Blue Shield			
Plan Name	Medicare Select Plan	Senior Secure Plan I	Senior Secure Plan II	65 Plus Plan			
Telephone Numbers Website	New enrollment: 1-800-832-2640 Current members: 1-800-282-5366 artamedicare.com	New enrollment: 1-800-797-6438 Current members: 1-888-230-7338 anthem.com/ca	New enrollment: 1-800-797-6438 Current members: 1-888-230-7338 anthem.com/ca	New enrollment: 1-800-488-8000 Current Members: 1-800-776-4466 blueshieldca.com			
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.			
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium			
Size of Network	1501-2000 physicians and providers	18001-19000 physicians and providers	18001-19000 physicians and providers	8501-9000 physicians and providers			
Out of Pocket Maximum	\$3,400 In-Network	\$4,000 In-Network	\$4,000 In-Network	\$3,000 In-Network			
Doctor Visit	\$0 each visit	\$5 each visit	\$0 each visit	\$0 each visit			
Specialist Visit	\$0 each visit	\$30 each visit	\$5 each visit	\$5 each visit			
In-patient Hospitalization	\$0 copay. Unlimited days each benefit period.	Days 1-7: \$150/day, Days 8- 90: \$0/day. Unlimited days each benefit period.	Days 1-5: \$35/day, Days 6-90: \$0/day. Unlimited days each benefit period.	Days 1-5: \$50/day, Days 6-90: \$0/day. \$250 out-of-pocket limit. Unlimited days each benefit period.			
Skilled Nursing Facility	Days 1-20: \$0/day, Days 21- 100: \$150/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: \$0/day, Days 21- 100: \$150/day. No prior hospital stay required. 100 days each benefit period.	Days 1-20: \$0/day, Days 21- 100: \$150/day. No prior hospital stay required. 100 days each benefit period.	Days 1-10: \$0, Days 11-100: \$85/day. No prior hospital stay required. 100 days covered each benefit period.			
In-patient Mental Health	Days 1-6: \$100/day, Days 7- 90: \$0/day. 190-day psychiatric hospital lifetime limit.	Days 1-7: \$150/day, Days 8- 90: \$0/day. 190-day psychiatric hospital lifetime limit.	Days 1-5: \$35/day, Days 6-90: \$0/day. 190-day psychiatric hospital lifetime limit.	\$900 each stay. 190-day psychiatric hospital lifetime limit.			
Outpatient Mental Health	\$0 each indiv. or group therapy visit.	\$40 each indiv. or group therapy visit.	\$40 each indiv. or group therapy visit.	\$30 each indiv. or group therapy visit.			
Outpatient Hospital Services	\$0 each visit	\$0-\$125 each visit	\$0-\$30 each visit	\$100 each visit			
Ambulance	\$300 each service	\$200 each service	\$200 each service	\$250 each service			
Emergency Room Visit	\$65 each visit, waived if admitted immediately.	\$65 each visit, waived if admitted within 72-hrs.	\$65 each visit, waived if admitted within 72-hrs.	\$65 each visit. \$10, 000 limit outside of U.S.			
Outpatient Rehab Services	\$0 each visit	\$50 each visit	\$5 each visit	\$20 each visit			
Durable Medical Equipment	20% of cost for <i>Medicare-</i> covered items.	20% of cost for <i>Medicare-covered</i> items.	20% of cost for Medicare- covered items.	20% of cost for <i>Medicare-covered</i> items.			
Diagnostic Tests	\$0 for diagnostic procedures and tests. 20% of the cost for diagnostic radiology services.	\$0 to \$190 for diagnostic procedures and tests. \$45- \$190 for diagnostic radiology services. \$5-\$30 copay may apply for additional services.	\$0 to \$55 for diagnostic procedures and tests. \$20- \$55 for diagnostic radiology services. \$0-\$5 copay may apply for additional services.	\$0 for diagnostic procedures and tests. \$50 for diagnostic radiology services. \$0-\$5 copay may apply for additional services			
X-Rays	\$0-\$10 each X-ray	\$45 each X-ray	\$20 each X-ray	\$0 each X-ray			
Lab Services	\$0 each lab service. 20% of the cost for therapeutic radiology services.	\$0 each lab service. 20% for therapeutic radiology services. \$5 to \$30 copay may apply for additional services.	\$0 each lab service. 20% for therapeutic radiology services. \$0 to \$5 copay may apply for additional services.	\$0 each lab service. 20% for therapeutic radiology services. \$0-\$5 copay may apply for additional services.			
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs			
Dental Services	\$0 copay for <i>Medicare-covered</i> benefits. Preventive benefits not covered.	0% of cost for <i>Medicare-covered</i> benefits. Preventive benefits not covered.	0% of cost for <i>Medicare-covered</i> benefits. Preventive benefits not covered.	\$0-\$5 copay for <i>Medicare-covered</i> benefits. Preventive benefits not covered.			
Hearing Services	\$0 copay for diagnostic exams. \$0 copay for up to 1 routine exam/yr. Hearing aids not covered.	\$30 copay for diagnostic exams. Routine exams and hearing aids not covered.	\$5 copay for diagnostic exams. Routine exams and hearing aids not covered.	\$0 copay for diagnostic exams. \$0-\$5 for routine exams. Hearing aids not covered.			
Vision Services	\$0 copay to diagnose & treat eye conditions. \$0 copay for 1 routine exam per year. \$0 copay for one pair of eyewear after cataract surgery. \$0 copay for glasses/contacts (\$100 limit/2 yrs.).	\$0 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery.	\$0 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery.	\$0 copay to diagnose & treat eye conditions. \$20 for up to 1 routine exam/yr. \$0 copay for eye wear after cataract surgery. \$20 for up to 1 pair of lenses/yr. \$20 for up to 1 pair of frames/2 yrs. (\$75 limit/2 yrs.). \$0-\$5 copay may apply for additional services.			
Prescription Drugs	See separate chart	See separate chart	See separate chart	See separate chart			
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ORANGE COUNTY		Comparison Chart	rt or medical					
Company	Blue Shield	Brand New Day	Brand New Day	Care1st				
Plan Name	65 Plus Choice	Brand New Day	Brand New Day HMO Extra Care	Care1st Medicare AdvantageOptimum Plan				
	New enrollment:	New enrollment:	New enrollment:	New enrollment:				
Telephone Numbers	1-800-488-8000	1-866-255-4795	1-866-255-4795	1-800-847-1222				
Website	Current Members: 1-800-776-4466	Current Members: 1-866-255-4795	Current Members: 1-866-255-4795	Current Members: 1-800-544-0088				
	blueshieldca.com/findamedicar	brandnewdayhmo.com	brandnewdayhmo.com	care1st.com/ca/medicare				
	MA-PD (HMO)	MA-PD (HMO)	MA-PD (HMO)	MA-PD (HMO)				
Dian Tuna	Medicare Advantage Plan with Prescription Drug Benefit. Must	Medicare Advantage Plan with Prescription Drug Benefit. Must	Medicare Advantage Plan with Prescription Drug Benefit. Must	Medicare Advantage Plan with Prescription Drug Benefit. Must				
Plan Type	utilize plan physicians,	utilize plan physicians,	utilize plan physicians,	utilize plan physicians,				
	providers and hospitals.	providers and hospitals.	providers and hospitals.	providers and hospitals.				
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$29.80 Monthly Premium	\$0 Monthly Premium				
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Size of Network	501-1000 physicians and providers	251-500 physicians and providers	251-500 physicians and providers	1501-2000 physicians and providers				
Out of Pocket Maximum	\$2,000 In-Network	\$3,400 In-Network	\$6,700 In-Network	\$3,400 In-Network				
Doctor Visit	\$0 each visit	\$5 each visit	20% of the cost each visit	\$0 each visit				
Specialist Visit	\$0 each visit	\$10 each visit	20% of the cost each visit	\$3 each visit				
In-patient Hospitalization	\$0 copay. Unlimited days each benefit period.	Days 1-5: \$100/day, Days 6-60: \$0/day, Days 61-90: \$289/day. 60 lifetime reserve days at \$578/day.	Data is unavailable - contact plan	\$0 copay. Unlimited days each benefit period.				
	Days 1-20: \$0/day, Days 21-	Days 1-20: \$0/day, Days 21-		Days 1-20: \$0/day, Days 21-				
Skilled Nursing Facility	100: \$75/day. No prior hospital stay required. 100	100: \$144.50/day. No prior	Data is unavailable - contact	100: \$50/day. No prior hospital stay required. 100				
a come	days covered each benefit	hospital stay required. 100 days each benefit period.	plan	days covered each benefit				
	period.	-		period.				
	\$900 copay per Medicare-	Days 1-8: \$100/day, Days 9-60, \$0/day, Days 61-90: \$289/day. \$600	Data is unavailable - contact	Days 1-8: \$50/day, Days 9-90, \$0/day. \$400 out-of-pocket limit				
In-patient Mental Health	covered. 190-day psychiatric	out-of-pocket limit every year. 190- day psychiatric hospital lifetime limit.	plan	per benefit period. 190-day				
	hospital lifetime limit.	60 lifetime reserve days at \$578/day.		psychiatric hospital lifetime limit.				
Outpatient Mental Health	\$30 each indiv. or group therapy visit.	\$0-\$10 each indiv. or group therapy visit.	20% of the cost for each indiv. or group therapy visit.	\$10 each indiv. or group therapy visit.				
Outpatient Hospital Services	\$50 each visit	\$50 each visit	20% of the cost for each visit	\$20-\$50 each visit				
Ambulance	\$100 each service	20% of the cost for each service.	20% of the cost for each service.	\$115 each service, waived if admitted.				
	\$65 each visit.	\$65 each visit, waived if	\$65 each visit, waived if	\$50 each visit, waived if				
Emergency Room Visit	\$10, 000 limit outside of U.S.	admitted within 1-day. Not covered outside of U.S.	admitted within 3-days. Worldwide coverage.	admitted within 1-day. \$25,000 limit outside of U.S.				
Outpatient Rehab	#4F 1 ''	\$10 - 20% of the cost for each	b					
Services	\$15 each visit	visit.	20% of the cost for each visit.	\$10 each visit				
Durable Medical	0%-20% of cost Medicare-	20% of cost for Medicare-	20% of cost for <i>Medicare</i> -	0%-20% of cost for <i>Medicare</i> -				
Equipment	covered items.	covered items.	covered items.	covered items.				
	\$0 for diagnostic procedures	20% of the cost for diagnostic procedures and tests. 0% -	20% of the cost for diagnostic procedures and tests. 20% of	\$0 for diagnostic procedures				
Diagnostic Tests	and tests. \$50 for diagnostic	sts. \$50 for diagnostic 200% of the cost for diagnostic the cost for diagnostic and to		and tests. \$0 for diagnostic				
	radiology services.	radiology services.	radiology services.	radiology services.				
			2007 - 543 - 15					
X-Rays	\$0 each X-ray	\$0 each X-ray	20% of the cost for each X-ray	\$0 each X-ray				
			-					
	\$0 copay for lab services.	20% of the cost for lab	20% of the cost for lab	\$0 for lab services. 10% for				
Lab Services	20% of cost for therapeutic	services. 10% of cost for therapeutic radiology	services. 20% of the cost for therapeutic radiology	therapeutic radiology				
	radiology services.	services.	services.	services.				
David D. Olivier	2004	2007 23	2004	2004 73				
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs				
#90			\$0 copay for Medicare-					
	ተር ተር	¢0	covered benefits. \$0 for up to	\$0-\$570 for <i>Medicare-covered</i> benefits. \$0 copay for up to 1				
Dental Services	\$0-\$5 copay for <i>Medicare-covered</i> benefits. Preventive	\$0 copay for <i>Medicare-</i> covered benefits. Preventive	2 oral exams/yr, up to 1 cleaning/6 mo., up to 1	oral exam/yr, up to 1				
_ 32. 30. 11000	benefits not covered.	benefits not covered.	fluoride treatment/yr., up to	cleaning/6 mo. \$5 for up to 1 fluoride treatment/yr. \$0 for				
			1 X-ray/yr. (\$1900 limit for dental benefits/yr.)	up to 1 X-ray/2yrs.				
			uentai benents/yf.J					
	\$0 copay for diagnostic exams. \$0 copay for up to 1	20% of the cost for <i>Medicare</i> -	20% of the cost for <i>Medicare</i> -	\$10 copay for diagnostic exams. \$10 copay for up to 1				
Hoaring Comitees	routine exam. \$0 for up to 1	covered diagnostic exams.	covered diagnostic exams.	routine exam/yr. \$0 for up to				
Hearing Services	fitting-eval./2 yrs. \$0 copay	Routine exams. Hearing aids	Routine exams and hearing	1 hearing aid fitting-eval./yr.				
	for hearing aids (\$500 limit/2 yrs.).	not covered.	aids not covered.	\$0 for up to 2 hearing aids/2 yrs. (\$500 limit every year).				
	<i>yy</i> -							
			2006 of the cost to 3:					
	\$0 copay to diagnose & treat		20% of the cost to diagnose & treat eye conditions. \$0 copay	\$0 copay to diagnose & treat				
	eye conditions. \$0 for eye wear after cataract surgery.	\$0 copay to diagnose & treat	for up to 1 routine exam/yr.	eye conditions. \$0 for eye wear after cataract surgery.				
Vision Services	\$20 for up to 1 routine	eye conditions. \$0 copay for eye wear after cataract	\$0 copay for eye wear after cataract surgery. \$0 copay for	\$0 copay for up to 1 pair of				
	exam/yr. \$20 for up to 1 pair of lenses/yr. \$20 for up to 1	surgery.	up to 1 pair of lenses/yr. \$0	glasses/2 yrs. \$5 copay for up to 1 routine exam/yr. \$150				
	frame/2 yrs. (\$90 limit)		copay for up to 1 pair of frames/ 2yrs.	limit for eye wear/2 yrs.				
			mames/ 2yrs.					
Prescription Drugs	See separate chart	See separate chart	See separate chart	See separate chart				
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ORANGE COUNTY		Comparison Chart	i	or medicare.gov	
Company	CareMore Health Plan	CareMore Health Plan	Central Health	Central Health	
Plan Name	CareMore Value Plus	StartSmart Plan	Central Health Medicare Plan	Central Health Premier Plan	
Telephone Numbers Website	New enrollment: 1-866-622-2820 Current Members: 1-800-822-6991 caremore.com	New enrollment: 1-866-622-2820 Current Members: 1-800-822-8720 caremore.com	New enrollment: 1-866-314-2427 Current Members: 1-866-314-2427 centralhealthplan.com	New enrollment: 1-866-314-2427 Current Members: 1-866-314-2427 centralhealthplan.com	
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	
Size of Network	1001-1500 physicians and providers	1001-1500 physicians and providers	7501-8000 physicians and providers	7501-8000 physicians and providers	
Out of Pocket Maximum	\$3,400 In-Network	\$6,700 In-Network	\$6,700 In-Network	\$6,700 In-Network	
Doctor Visit Specialist Visit	\$0 each visit \$0 each visit	\$5 each visit \$20 each visit	\$0 each visit \$0 each visit	20% of the cost each visit 20% of the cost each visit	
In-patient Hospitalization	\$0 copay. Unlimited days each benefit period.	Days 1-5: \$100/day, Days 6- 90: \$0/day. Unlimited days each benefit period.	\$0 copay. Unlimited days each benefit period.	Data is unavailable - contact plan	
Skilled Nursing Facility	Days 1-20: \$0/day, Days 21- 100: \$25/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: \$0/day, Days 21- 100: \$50/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-14: \$0/day, Days 15-20: \$50/day, Days 21-100: \$150/day. No prior hospital stay required. 100 days covered each benefit period.	Data is unavailable - contact plan	
In-patient Mental Health	\$0 copay. Contact plan for coverage beyond 190 days.	Days 1-5: \$100/day, Days 6-90, \$0/day. \$0 copay for additional days. Contact plan for coverage beyond 190 days.	\$0 copay. 190-day psychiatric hospital lifetime limit.	Data is unavailable - contact plan	
Outpatient Mental Health	\$0 each indiv. or group therapy visit.	\$0-\$20 each indiv. or group therapy visit.	\$5 each indiv. or group therapy visit.	40% of the cost for each indiv. or group therapy visit.	
Outpatient Hospital Services	\$0 each visit	\$75 each visit	\$0 each visit	20% of the cost for each visit	
Ambulance	\$100 each service.	\$0-\$100 each service.	\$50 each service	20% of the cost of each service	
Emergency Room Visit	\$65 each visit, waived if admitted within 24-hrs. \$10,000 limit outside of U.S.	\$65 each visit, waived if admitted within 24-hrs. \$10,000 limit outside of U.S.	\$65 each visit, waived if admitted within 24-hrs. \$50,000 limit outside of U.S.	20% of the cost (max \$65) each visit, waived if admitted within 24-hrs. \$50,000 limit outside of	
Outpatient Rehab Services	\$0 each visit	\$20 each visit	\$0 each visit	20% of the cost for each visit	
Durable Medical Equipment	0%-20% of cost for <i>Medicare-covered</i> items.	0%-20% of cost for <i>Medicare-covered</i> items.	0%-20% of cost for <i>Medicare-covered</i> items.	20% of cost for <i>Medicare-</i> covered items.	
Diagnostic Tests	\$0 for diagnostic procedures and tests. \$0 - \$75 for diagnostic radiology services.	\$0 for diagnostic procedures and tests. \$0-\$75 for diagnostic radiology services. \$5-\$20 copay for office visit may apply.	\$0 for diagnostic procedures and tests. \$0 for diagnostic radiology services.	20% of the cost for diagnostic procedures and tests. 20% of the cost for diagnostic radiology services.	
X-Rays	\$0 each X-ray	\$0 each X-ray	\$0 each X-rays	20% of cost for X-rays	
Lab Services	\$0 copay for lab services. \$60 for therapeutic radiology services.	\$0 for lab services. \$10 for therapeutic radiology services. 20% of the cost for therapeutic radiology services. \$5 -\$20 copay for office visit may apply.	\$0 for lab services. 20% of cost for therapeutic radiology services.	20% of the cost for lab services. 20% of cost for therapeutic radiology services.	
Part B Chemotherapy Drugs	0%-20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	
Dental Services	\$0 for Medicare-covered benefits. \$5-\$20 for oral exams. \$35 for up to 2 cleanings/yr. \$5 for up to 2 fluoride treatments/yr. \$0-\$10 copay for up to 1 X-ray/3 yrs.	\$5-\$20 for Medicare-covered benefits. \$5-\$15 for oral exams. \$35 for up to 2 cleanings/yr. \$5 for up to 2 fluoride treatments/yr. \$0-\$10 for up to 1 X-ray every 3 yrs.	\$0 for <i>Medicare-covered</i> benefits. \$0 for up to 1 oral exam/cleaning/yr and up to 1 X-ray every 6 months.	\$0 for Medicare-covered benefits. \$0 for oral exam and up to 2 fluoride treatments/yr, up to 2 cleaning/yr and 1 X-ray every 6 months.	
Hearing Services	\$0 copay for diagnostic exams. \$0 copay for up to 1 routine exam. \$0 for up to 1 fitting-eval./yr. \$0 copay for hearing aids (\$250 limit/yr.).	\$0 copy for diagnostic exams. \$0 copay for up to 1 routine exam and 1 hearing aid fitting- eval./yr. Hearing aids not covered.	\$0 copay for diagnostic exams. \$0 copay for up to 1 routine exam and 1 hearing aid fitting-eval./yr. \$0 copay for up to 1 hearing aid/yr.(\$500 limit)	20% of the cost for diagnostic exams. \$0 copay for up to 1 routine exam and 1 hearing aid fitting-eval./yr. \$0 copay for up to 1 hearing aid/yr.(\$1,500 limit)	
Vision Services	\$0 copay to diagnose & treat eye conditions. \$0 copay for 1 routine exam/yr. \$0 for eye wear after cataract surgery. \$0 for up to 1 pair of frames/2 yrs. and 1 pair of lenses/yr. (\$100 limit for eye class frames/2yrs.). \$0 for up to 1 pair of contacts/yr. (\$100 limit/yr.)	\$5-\$20 copay to diagnose & treat eye conditions. \$0 for up to 1 routine exam/yr. \$0 for eye wear after cataract surgery. \$20 for up to 1 pair of lenses/yr. \$0 for up to 1 pair of frames/2 yrs.(\$100 limit for eye glass frames/2 yrs.). \$0 for up to 1 pair of contacts/yr. (\$100 limit/yr.)	\$0 copay to diagnose & treat eye conditions. \$0 copay for exams and for eye wear after cataract surgery. \$0 for up to 1 pair of glasses/contacts/lenses/and frames/yr. (\$75 limit/yr.).	20% of the cost to diagnose & treat eye conditions. 20% of the cost for eye wear after cataract surgery. \$0 for up to 1 routine exam/yr. \$0 for up to 1 pair of glasses /contacts /lenses /and frames/yr. (\$300 limit/yr.).	
Prescription Drugs	See separate chart	See separate chart	See separate chart	See separate chart	



ORANGE COUNTY		Comparison Char					
Company	Citizens Choice	Easy Choice	Easy Choice	Golden State			
Plan Name	Citizens Choice Healthplan	Best Plan	Plus Plan	Medicare Health Plan, Golden			
	New enrollment:	New enrollment:	New enrollment:	New enrollment:			
Telephone Numbers	1-866-646-2247 ext: 5551 Current Members:	1-866-999-3945	1-866-999-3945	1-877-541-4111			
Website	1-866-634-2247 ext: 5550	Current Members: 1-866-999-3945	Current Members: 1-866-999-3945	Current Members: 1-877-541-4111			
	citizenschoicehealth.com	easychoicehealthplan.com	easychoicehealthplan.com	GoldenStateMHP.com			
	MA-PD (HMO)	MA-PD (HMO)	MA-PD (HMO)	MA-PD (HMO)			
Dian Turns	Medicare Advantage Plan with Prescription Drug Benefit. Must	Medicare Advantage Plan with Prescription Drug Benefit. Must	Medicare Advantage Plan with Prescription Drug Benefit. Must	Medicare Advantage Plan with Prescription Drug Benefit. Must			
Plan Type	utilize plan physicians,	utilize plan physicians,	utilize plan physicians,	utilize plan physicians,			
	providers and hospitals.	providers and hospitals.	providers and hospitals.	providers and hospitals.			
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$29.90 Monthly Premium	\$0 Monthly Premium			
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Size of Network	6001-6500 physicians and providers	6501-7000 physicians and providers	2001-2500 physicians and providers	501-1000 physicians and providers			
Out of Pocket Maximum	\$3,400 In-Network	\$6,700 In-Network	\$6,700 In-Network	\$3,400 In-Network			
Doctor Visit	\$0 each visit	\$0 each visit	\$0 each visit	\$0 each visit			
Specialist Visit	\$0 each visit	\$0 each visit	\$0 each visit	\$0 each visit			
	Days 1-45: \$0/day, Days 46-						
In-patient Hospitalization	60: \$100/day, Days 61-90:	\$0 copay. Unlimited days	Data is unavailable - contact	\$0 copay. Unlimited days			
	\$0/day. Unlimited days each benefit period.	each benefit period.	plan	each benefit period.			
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	Days 1-20: \$0/day, Days 21- 100: \$85/day. No prior	\$0 copay. No prior hospital		Days 1-20: \$0/day, Days 21- 100: \$50/day. No prior			
Skilled Nursing Facility	hospital stay required. 100	stay is required. 100 days	Data is unavailable - contact plan	hospital stay required. 100			
	days covered each benefit	covered each benefit period.	piali	days covered each benefit			
	period. \$250 copay each <i>Medicare</i> -			period.			
	covered stay. Days 1-10:	\$0 copay. 190-day nsychiatric	Data is unavailable - contact	\$0 copay. 190-day nsychiatric			
In-patient Mental Health	\$115/day, Days 11-90: \$0/day. 60 lifetime day s -	hospital lifetime limit.	plan	hospital lifetime limit.			
	Days 1-60: \$0/day.						
Outpatient Mental Health	\$40 each indiv. or group	\$0 each indiv. or group	20% of the cost for each indiv. or	\$0 each indiv. or group			
	therapy visit.	therapy visit.	group therapy visit.	therapy visit.			
Outpatient Hospital Services	\$75 each visit	\$0 each visit	20% of the cost for each visit	\$0 each visit			
	\$75 each service, waived if		20% of the cost of each				
Ambulance	admitted.	\$50 each service	service	\$60 each service			
	\$65 each visit, waived if	\$50 each visit, waived if	\$65 each visit, waived if	\$65 each visit, waived if			
Emergency Room Visit	admitted within 24-hrs \$20,000 limit outside of U.S.	admitted within 24-hrs. \$25,000 limit outside of U.S.	admitted within 24-hrs. \$25,000 limit outside of U.S.	admitted within 24-hrs. No coverage outside of U.S.			
Outpatient Rehab	\$0 each visit	\$0 each visit	\$0 each visit	\$0 each visit			
Services	DO EACH VISIT	φυ each visit	DO EACH VISIT	50 each visit			
Durable Medical	0%-20% of cost for <i>Medicare</i> -	\$0 copay for Medicare-	20% of the cost for <i>Medicare</i> -	0%-20% for Medicare-			
Equipment	covered items.	covered items.	covered items.	covered items.			
	\$0 for diagnostic procedures	\$0 for diagnostic procedures	\$0 for diagnostic procedures	\$0 for diagnostic procedures			
Diagnostic Tests	and tests. \$0 for diagnostic	and tests. \$0 for diagnostic	and tests. 20% of the cost for	and tests. \$0 for diagnostic			
	radiology services.	radiology services.	diagnostic radiology services.	radiology services.			
X-Rays	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray			
	\$0 copay for lab services. \$50	\$0 copay for lab services.	\$0 copay for lab services.	\$0 copay for lab services. \$0			
Lab Services	copay for therapeutic	20% of the cost for	20% of the cost for				
	toping to the contract of the	thoropoutionad: -1	thoronoutions distan-	copay for therapeutic			
	radiology services.	therapeutic radiology services.	therapeutic radiology services.	radiology services.			
	radiology services.	services.	services.	radiology services.			
Part B Chemotherapy	radiology services. 20% of the cost for Part B	services. 20% of the cost for Part B	services. 20% of the cost for Part B	radiology services. 20% of the cost for Part B			
Part B Chemotherapy Drugs	radiology services. 20% of the cost for Part B chemotherapy drugs	services. 20% of the cost for Part B chemotherapy drugs	services.	radiology services.			
	radiology services. 20% of the cost for Part B chemotherapy drugs \$0-\$675 for Medicare-covered benefits. \$0 copay/1 oral	services. 20% of the cost for Part B chemotherapy drugs 20% of the cost for Medicare-	services. 20% of the cost for Part B chemotherapy drugs \$0 copay for Medicare-	radiology services. 20% of the cost for Part B chemotherapy drugs \$0 for Medicare-covered			
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In-patient Hospitalization Significant Protection Days 1-26-80/day, Days 2-1- 110: 575/day, Nays 2-1- 110: 575/day, Nays 2-1- 110: 575/day, Nays 2-1- 110: 575/day, Nay prior days covered each benefit period. Skilled Nursing Facility Days 1-20: 50/day, Days 2-1- 110: 575/day, Nay prior days covered each benefit period. System of the period of the		·	•	· ·	· ·		
Skilled Nursing Facility 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stream of the period. 100: \$75/day. No prior hospital stream in special stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stream in special stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stream in special stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stream in special stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stream in special stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stream in special stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stream in special stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stream in special stay required 1.00 days covered each benefit period. 100: \$75/day. No prior hospital stream in special stay special stay special st	In-patient Hospitalization	\$0 copay. Unlimited days	Days 1-5: \$275/day, Days 6- 90: \$0/day. Unlimited days	Days 1-5: \$200/day, Days 6- 90: \$0/day. Unlimited days	Days 1-4: \$100/day, Days 5- 90: \$0/day. Unlimited days		
Part	Skilled Nursing Facility	100: \$75/day. No prior hospital stay required. 100 days covered each benefit	100: \$75/day. No prior hospital stay required. 100 days covered each benefit	100: \$75/day. No prior hospital stay required. 100 days covered each benefit	100: \$75/day. No prior hospital stay required. 100 days covered each benefit		
Outpatient Aspertial Relation So each visit Services See and visit Services See and visit See an	In-patient Mental Health	psychiatric hospital lifetime	psychiatric hospital lifetime	psychiatric hospital lifetime	psychiatric hospital lifetime		
Ambulance S225 each service S226 each visit, waived if admitted immediately. S50,000 limit outside of U.S. S50,000 limi	Outpatient Mental Health	0 1	0 1				
Seb each visit, waived if admitted immediately, \$50,000 limit outside of U.S. \$50,000 limit ou		\$0 each visit	\$275 each visit	\$200 each visit	\$100 each visit		
Admitted immediately, \$50,000 limit outside of U.S. \$50,000 limi	Ambulance	-					
Services So each Visit S		admitted immediately.	admitted immediately.	admitted immediately.	admitted immediately.		
Diagnostic Tests So for diagnostic procedures and tests. \$60 for diagnostic radiology services. X-Rays \$0 each X-ray \$0 ea	I -	\$0 each visit	\$0 each visit	\$0 each visit	\$0 each visit		
Diagnostic Tests and tests. \$60 for diagnostic radiology services. A-Rays \$0 each X-ray \$0 each X-ray \$0 copay for lab services. \$60 copay for therapeutic radiology services. \$0 copay for the for Part B chemotherapy drugs \$0 copay for Medicare-covered benefits. \$0 copay for up to 1 routine exam. \$20 copay for up to 1 ro							
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Lab Services copay for therapeutic radiology services. Part B Chemotherapy Drugs 20% of the cost for Part B chemotherapy drugs \$0 copay for Medicare-covered benefits. Preventive benefits not covered. \$0 copay for Medicare-covered benefits. Preventive benefits not covered. \$30 copay for Medicare-covered benefits. Preventive benefits not covered. \$30 copay for diagnostic exams. \$30 copay for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$25 copay for diagnostic exams. \$25 copay for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$20 copay for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$20 copay for up to 1 routine exam/yr. Hearing aids not covered. \$30 copay for diagnostic exams. \$20 copay for up to 1 routine exam/yr. B10 copay to diagnose & treat eye conditions. \$0 copay for up to 1 routine exam/yr. \$0 copay for up to 1 routine exam/yr. \$0 copay for up to 1 routine exam/yr. \$10 copay for up to 1 routine	X-Rays	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray	\$0 each X-ray		
Dental Services So copay for Medicare-covered benefits. Preventive benefits not covered.	Lab Services	copay for therapeutic	copay for therapeutic	copay for therapeutic	copay for therapeutic		
## Point Services So copay for Medicare-covered benefits. Preventive benefits not covered.				chemotherapy drugs			
Hearing Services exams. \$30 copay for up to 1 routine exam/yr. Hearing aids not covered. exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered. exams. \$10 copay for up to 1 routine exam/yr. Hearing aids not covered. exams. \$10 copay for up to 1 routine exam/yr. Hearing aids not covered. \$0-\$10 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery. \$30 copay for up to 1 routine exam/yr. exams. \$10 copay for up to 1 routine exam/yr. Hearing aids not covered. \$0-\$10 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$0-\$10 copay for up to 1 routine exam/yr. \$0-\$10 copay for up to 1 routine exam/yr. \$0-\$10 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$0 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$10 copay for up to 1 routine exam/yr. \$10 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$10 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$10 copay for up to 1 routine exam/yr. \$10 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$10 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$10 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$10 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$10 copay for eye wear after cataract surgery. \$10 copay for eye wear	Dental Services	covered benefits. Preventive	covered benefits. Preventive	covered benefits. \$0 copay for up to 2 oral exams, 2 cleanings and 1 X-ray/yr. (\$500 limit/yr.) \$35 annual deductible for preventive	covered benefits. Preventive		
Vision Services \$0-\$30 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery. \$30 copay for up to 1 routine exam/yr. \$0-\$25 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery. \$30 copay for up to 1 routine exam/yr. \$0-\$10 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$0 copay for up to 1 pair of glasses/contacts/lenses and frames/2 yrs. (\$100 limit/2 yrs.).	Hearing Services	exams. \$30 copay for up to 1 routine exam/yr. Hearing	exams. \$25 for up to 1 routine exam/yr. Hearing aids not	exams. \$10 copay for up to 1 routine exam/yr. Hearing	exams. \$10 copay for up to 1 routine exam/yr. Hearing		
Prescription Drugs See separate chart See separate chart None See separate chart	Vision Services	treat eye conditions. \$0 copay for eye wear after cataract surgery. \$30 copay for up to 1	treat eye conditions. \$0 copay for eye wear after cataract surgery. \$25 copay for up to 1	treat eye conditions. \$0 copay for eye wear after cataract surgery. \$10 copay for up to 1 routine exam/yr. \$0 copay for up to 1 pair of glasses/contacts/lenses and frames/2 yrs. (\$100 limit/2	treat eye conditions. \$0 copay for eye wear after cataract surgery. \$10 copay for up to 1		
	Prescription Drugs	See separate chart	See separate chart	None	See separate chart		



ORANGE COUNTY		Comparison Chart		or medicare.gov	
Company	Health Net	Humana	Humana	Humana	
Plan Name	Gold Select	Humana Gold Plus (013)	Humana Gold Plus (030)	Humana Gold Plus HMO/POS (014)	
Telephone Numbers Website	New enrollment: 1-800-977-6738 Current Members: 1-800-275-4737 healthnet.com	New enrollment: 1-800-833-2364 Current Members: 1-800-457-4708 humana-medicare.com	New enrollment: 1-800-833-2364 Current Members: 1-800-457-4708 humana-medicare.com	New enrollment: 1-800-833-2364 Current Members: 1-800-457-4708 humana-medicare.com	
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA ONLY (HMO) Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (HMO-POS Option) Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals. May go out of network for certain services.	
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$39 Monthly Premium	
Size of Network	8001-8500 physicians and providers	2001-2500 physicians and providers	2001-2500 physicians and providers	2001-2500 physicians and providers	
Out of Pocket Maximum	\$3,400 In-Network	\$3,400 In-Network	\$1,000 In-Network	\$5,000 In/Out-Network	
Doctor Visit Specialist Visit	\$0 each visit \$0 each visit	\$0 each visit \$5 each visit	\$0 each visit \$0 each visit	\$0 each visit \$10 each visit	
In-patient Hospitalization	\$0 copay. Unlimited days each benefit period.	Days 1-10: \$50/day, Days 11- 90: \$0/day. Unlimited days each benefit period.	\$0 copay. Unlimited days each benefit period.	Days 1-10: \$50/day, Days 11-90: \$0/day. Unlimited days each benefit period. POS: Days 1-8: \$300/day, Days 9-60: \$0/day, Days 61-90: \$100/day.	
Skilled Nursing Facility	Days 1-20: \$0/day, Days 21- 100: \$75/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: \$0/day, Days 21- 100: \$75/day. No prior hospital stay required. 100 days covered each benefit period.	\$0 copay. No prior hospital stay is required. 100 days covered each benefit period.	Days 1-20: \$0/day, Days 21-100: \$75/day. No prior hospital stay required. 100 days covered each benefit period. POS: Days 1-20: \$50/day, Days 21-100: \$120/day.	
In-patient Mental Health	\$900 copay. 190-day psychiatric hospital lifetime limit.	Days 1-10: \$50/day, Days 11- 90: \$0/day. 190-day psychiatric hospital lifetime limit.	Days 1-5: \$250/day, Days 6- 90: \$0/day. 190-day psychiatric hospital lifetime limit.	Days 1-10: \$50/day, Days 11-90: \$0/day. 190-day psychiatric hospital lifetime limit. POS: Days 1-8: \$300/day, Days 9-90: \$0/day.	
Outpatient Mental Health	\$25 each indiv. or group therapy visit.	\$5 each indiv. or group therapy visit.	\$0 each indiv. or group therapy visit.	\$10 each indiv. or group therapy visit.	
Outpatient Hospital Services	\$0 each visit	\$0-\$100 or 20% of cost for each visit.	20% of cost for each visit.	\$0-\$100 or 20% of cost for each visit	
Ambulance	\$250 each service	\$125 each service	\$100 each service	\$125 each service	
Emergency Room Visit	\$65 each visit, waived if admitted immediately. \$50,000 limit outside of U.S.	\$65 each visit, waived if admitted within 24-hrs. Worldwide coverage.	\$65 each visit, waived if admitted within 24-hrs. Worldwide coverage.	\$65 each visit, waived if admitted within 24-hrs. Worldwide coverage.	
Outpatient Rehab Services	\$0 each visit	\$25 each visit	\$0 each visit	\$25 each visit	
Durable Medical Equipment	20% of cost for <i>Medicare-covered</i> items.	20% of cost for <i>Medicare-covered</i> items.	\$0 copay for <i>Medicare-covered</i> items.	20% of cost for <i>Medicare-covered</i> items.	
Diagnostic Tests	\$0 for diagnostic procedures and tests. \$60 for diagnostic radiology services.	\$0-\$100 for diagnostic procedures and tests. \$0- \$100 for diagnostic radiology services.	\$0-\$25 for diagnostic procedures and tests. \$0 for diagnostic radiology services.	\$0-\$100 for diagnostic procedures and tests. \$0-\$50 for diagnostic radiology services.	
X-Rays	\$0 each X-ray	\$0-\$100 each X-ray	\$0-\$25 each X-ray	\$0-\$25 each X-ray	
Lab Services	\$0 copay for lab services. \$60 copay for therapeutic radiology services.	\$0-\$25 copay for lab services. \$5 copay or 20% of cost for therapeutic radiology services.	\$0-\$25 copay for lab services. \$0 copay for therapeutic radiology services.	\$0-\$25 copay for lab services. \$10 copay or 20% of cost for therapeutic radiology services.	
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	
Dental Services	\$0 copay for Medicare- covered benefits. \$0 copay for oral exams/fluoride treatments/X-rays and up to 2 cleanings/yr.	\$5 copay for <i>Medicare-covered</i> benefits. \$0 copay for up to 1 oral exams/cleaning/X-ray/yr.	\$0 copay for <i>Medicare-covered</i> benefits. \$0 copay for up to 1 oral exams/cleaning/X-ray/yr.	\$10 copay for <i>Medicare-covered</i> benefits. \$0 copay for up to 1 oral exams/cleaning/X-ray/yr.	
Hearing Services	\$25 for diagnostic exams. \$25 for up to 1 routine exam/yr. Hearing aids not covered.	\$5 for diagnostic exams. Routine exams and hearing aids not covered.	\$0 for diagnostic exams. Routine exams and hearing aids not covered.	\$10 for diagnostic exams. Routine exams and hearing aids not covered.	
Vision Services	\$0-\$25 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery. \$25 copay for up to 1 routine exam/yr.	\$0-\$5 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery. \$0 copay for up to 1 routine exam/yr.	\$0 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery. \$0 copay for up to 1 routine exam/yr.	\$0-\$10 copay to diagnose & treat eye conditions. \$0 copay for eye wear after cataract surgery. \$0 copay for up to 1 routine exam/yr.	
Prescription Drugs	See separate chart	See separate chart	None	See separate chart	



Plan Name Senior Advantage Scan Classic Scan Plus New enrollment: 1-800-777-1238 Current Members: 1-800-443-0815 kp.org/medicare Plan Type MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals. Monthly Premium Size of Network Doctor Visit Days 1-10: \$170/day, Days 11 Days 1-10: \$170/day, Days 11 New enrollment: 1-800-915-7226 1-800-915-7226 1-800-915-7226 1-800-915-7226 1-800-915-7226 1-800-915-7226 1-800-915-7226 1-800-915-7226 1-800-915-7226 1-800-915-7226 1-800-947-5514 Current Members: 1-877-559-3500 scanhealthplan.com scanhealthplan.com MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals. Monthly Premium \$0 Monthly Premiu	ORANGE COUNTY		Comparison Char					
Felophono Numbers Website New amalianets Locared Members 1 300-443 6015 2 302-563 2000 southerables comment 1 300-443 6015 2 302-563 2000 southerables comment 2 300-443 6015 2 302-563 2000 southerables comment 2 300-443 6015 2 302-563 2000 southerables comment 2 300-445 6015 2 302-563 2000 southerables comment 3 300-445 6015 2 302-563 2000 southerables comment	Company	Kaiser	SCAN	SCAN	UnitedHealthcare			
Telephone Numbers Website 1.000,777.226. 1.000,945.726. 1.000,945	Plan Name	Senior Advantage	Scan Classic	Scan Plus				
Website Durrent Menthers: Durrent Menthers: 1-9001-44-94-915 1-9001-45-915 1-9001-4				New enrollment:	New enrollment:			
Monthly Premium May 10 (MM) May 10 (MM	Telephone Numbers							
Plan Type	Website	1-800-443-0815	1-877-559-3500	1-877-559-3500				
Plan Type			-	· ·				
### Wilson Services Diagnostic Tests Diagnosti				. ,				
Monthly Premium Monthly Monthly Premium Monthly Monthly Monthly Monthly Premium Monthly Monthly Monthly Monthly Premium Monthly Monthly Monthly Monthly	Plan Type							
Size of Network Specialist Visit Specialist Vi	,							
Size of Network Specialist Visit Specialist Vi								
Union Services Vision	Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium			
Substitution State Substitution State Substitution State Substitution Substituti	Size of Network				1 2			
Specials Visit Searth visit Size activisit Size a	Out of Pocket Maximum	•	-	· · · · · · · · · · · · · · · · · · ·	-			
Dispatient Hospitalization Days 1-10-537/d/sp, Dups 11 St. Organy (Intimited days each benefit period.			·	· ·				
Dispatient Hospitalization 96 - 90/day. Unamineted days 20 - 100 -	Specialist Visit	\$5 each visit	\$0 each visit	20% of the cost each visit	\$0 each visit			
Skilled Nursing Facility Sicilled Nursing Facility Society Stop	In-patient Hospitalization	90: \$0/day. Unlimited days	. 1 3		. , ,			
Soliday Contact plan for comparison of the properties of the pro	Skilled Nursing Facility	100: \$50/day. No prior hospital stay required. 100 days covered each benefit	stay is required. Unlimited		\$150/day, Days 44-100: \$0/day. No prior hospital stay required. 100 days covered each benefit			
Supplement Membrain Relation Supplement Services Supplement Su	In-patient Mental Health	90: \$0/day. Contact plan for			psychiatric hospital lifetime			
Ambulance \$200 each service \$50 each visit, waived if admitted within 24-hrs. Worldwide coverage. Outpatient Rehab Services Durable Medical Equipment \$50 each visit. Worldwide coverage. \$50 each visit. Worldwide everage. \$50 each visit. Worldwide everage. \$50 ea			0 1					
Emergency Room Visit Emergency Room Visit Emergency Room Visit Cutpatient Rehab So each visit. waived if admitted within 24-hrs. Worldwide coverage. Outpatient Rehab So each visit. Coverage. Ownered items. Diagnostic Tests Diagnostic Tests Diagnostic Tests Diagnostic Tests So So each visit. So So each visit. So each vis		\$0-\$125 each visit	\$0 each visit		\$0 each visit			
admitted within 24-hrs. worldwide coverage. worldwide coverage. 20% of the cost for each visit \$0 ea	Ambulance	\$200 each service	\$50 each service		\$200 each service			
So cach visit So cach visi	Emergency Room Visit	admitted within 24-hrs.	admitted within 24-hrs.	each visit. Worldwide	admitted within 24-hours.			
Durable Medical Equipment 20% of cost for Medicare-covered items. 20% of cost for Medicare-diagnostic radiology services. 20% of cost for diagnostic radiology services. 20% of cost for diagnostic radiology services. 20% of cost for diagnostic radiology services. 20% of cost for each X-ray 20% of cost for each X-ray 20% of cost for each X-ray 20% of cost for therapeutic radiology services. 20% of the cost for each X-ray 20% of cost for therapeutic radiology services. 20% of the cost for each X-ray 20% of the cost for therapeutic radiology services. 20% of the cost for therapeutic radiology services. 20% of the cost for Part B chemotherapy drugs 20% of the cost for Part B chemotherapy drugs 20% of the cost for Part B chemotherapy drugs 20% of the cost for Part B chemotherapy drugs 20% of the cost for Part B chemotherapy drugs 20% of the cost for Medicare-covered benefits. Preventive benefits not covered. 20% of the cost for Part B chemotherapy drugs 20% of the cost for Medicare-covered benefits. Preventive benefits not covered. 20% of the cost for Part B chemotherapy drugs 20% of the cost for Medicare-covered benefits. Preventive benefits not covered. 20% of the cost for Part B chemotherapy drugs 20% of the cost for Medicare-covered benefits. Preventive benefits not covered. 20% of the cost for Part B chemotherapy drugs 20% of the cost for Medicare-covered benefits. Preventive benefits not covered. 20% of the cost for Data Bervices. 20% of the cost for Bart Bervices. 20% of the cost for Medicare-covered benefits. Preventive benefits not covered. 20% of the cost for Bart Bervice		Ĭ .		5	_			
Diagnostic Tests So S20 for diagnostic procedures and tests. \$170 for diagnostic radiology services. \$5 copay may apply for additional services. X-Rays \$20 each X-ray \$0 for each X-ray \$0 copay for lab services. \$5 copay for therapeutic radiology services. \$5 copay for therapeutic radiology services. \$5 copay for therapeutic radiology services. \$5 copay may apply for additional services. \$6 copay for therapeutic radiology services. \$5 copay may apply for additional services. \$10 copay for therapeutic radiology services. \$5 copay may apply for additional services. \$10 copay for the cost for Part B chemotherapy drugs \$0 copay for the cost for Part B chemotherapy drugs \$0 copay for lab services. \$10 copay for the cost for Part B chemotherapy drugs \$0 copay for lab services. \$20% of cost for the cost for Part B chemotherapy drugs \$0 copay for the cost for Part B chemotherapy drugs \$0 copay for medicare-covered benefits. \$0 copay for up to 2 oral exams/2 cleanings/yr. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to 2 hearing add fitting-eval./2 yrs. \$0 copay for up to	Services	,						
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S0-\$20 copay for the services. \$0 copay for lab services. \$20% of cost for therapeutic radiology services. \$20% of cost for therapeutic radiology services. Part B Chemotherapy brugs	Diagnostic Tests	procedures and tests. \$170 for diagnostic radiology services. \$5 copay may apply	and tests. \$40 copay for	procedures and tests. 20% of cost for diagnostic radiology	procedures and tests. \$50 copay for diagnostic radiology			
Lab Services So copay for therapeutic radiology services. \$5 copay may apply for additional services. \$10 copay for therapeutic radiology services. \$20% of cost for therapeutic radiology services. \$20% of cost for therapeutic radiology services. \$20% of the cost for Part B chemotherapy drugs So copay for Medicare-covered benefits. Preventive benefits not covered.	X-Rays	\$20 each X-ray	\$0 for each X-ray	20% of cost for each X-ray	\$0 each X-ray			
Dental Services \$5 copay for Medicare-covered benefits. Preventive benefits not covered. \$5 copay for diagnostic exams. Routine exams and hearing aids not covered. \$5 copay to diagnose & treat eye conditions. \$0 for up to 1 routine exam/yr. \$10 for eye wear after cataract surgery. \$5 copay for routine exams. \$0 copay for up to 1 routine exam/yr. \$3 for up to 1 pair of glasses/contacts (\$50 limit /2 yrs.). \$5 copay for glasses/contacts (\$50 limit /2 yrs.). \$5 copay for diagnostic exams. \$0 copay for up to 1 routine exam/yr. and hearing aids/2yrs.(\$105 limit each for lenses/frames/2 yrs.) \$0 copay for up to 1 routine exam/yr. \$20% of the cost for diagnostic exams. \$0 copay for up to 1 routine exam/yr. and hearing aid fitting-eval./2 yrs. \$0 copay for up to 1 routine exam/yr. 300 copay for up to 2 copay for up to 1 routine exam/yr. and hearing aid fitting-eval./2 yrs. \$0 copay for up to 1 routine exam/yr. \$300 copay for up to 2 loaning-eval./2 yrs. \$0 copay for up to 2 loaning-eval./2 yrs. \$0 copay for up to 2 loaning-eval./2 yrs. \$0 copay for up to 1 routine exam/yr. \$300 copay for up to 2 loaning-eval./2 yrs. \$0 copay for up to 1 routine exam/yr. \$300 copay for up to 2 loaning-eval./2 yrs. \$0 copay for up to 1 routine exam/yr. \$300 copay for up to 2 loaning-eval./2 yrs. \$0 copay for up to 1 loaning aids/yr. \$0 copay for up to 2 loaning-eval./2 yrs. \$0 copay for up to 1 loaning aids/yr. \$0 copay for up to 1 loa	Lab Services	\$0 copay for therapeutic radiology services. \$5 copay may apply for additional	copay for therapeutic	20% of cost for therapeutic	for therapeutic radiology			
### Plearing Services So copay for Medicare-covered benefits. Preventive benefits not covered.	= =		-					
## Provided Services	Dental Services	covered benefits. Preventive	covered benefits. Preventive	covered benefits. \$0 copay for up to 2 oral exams/2 cleanings/yr. \$0 copay for up	covered benefits. Preventive			
Vision Services \$5 copay to diagnose & treat eye conditions. \$0 for up to 1 routine exam/yr. \$10 for eye wear after cataract surgery. \$5 copay for routine exams. \$0 copay for glasses/contacts (\$50 limit /2 yrs.). \$5 copay for glasses/contacts (\$50 limit /2 yrs.). \$5 copay for routine exams. \$0 copay for glasses/contacts (\$50 limit /2 yrs.). \$6 copay for glasses/contacts (\$105 limit each for lenses/frames/2 yrs.) \$7 copay for routine exams. \$10 copay for glasses/contacts/lenses and frames/2 yrs. (\$105 limit each for lenses/frames/2 yrs.) \$7 copay for routine exams. \$10 copay for up to 1 pair of glasses/contacts/lenses and frames/2 yrs. (\$105 limit each for lenses/frames/2 yrs.) \$7 copay for glasses/contacts/lenses and frames/2 yrs. (\$105 limit each for lenses/frames/2 yrs.) \$7 copay for glasses/contacts/lenses and frames/2 yrs. (\$105 limit each for lenses/frames/2 yrs.) \$7 copay for up to 1 pair of glasses/contacts/yr. (\$125 limit each for lenses/2 yrs. \$30 for up to 1 pair of lenses/2 yrs. \$30 for up to 1 pair of lenses/2 yrs. (\$105 limit/2 yrs.)	Hearing Services	exams. Routine exams and	exams. \$0 copay for up to 1 routine exam/yr. and hearing aid fitting-eval./2 yrs. \$0 copay for up to 2 hearing	exams. \$0 copay for up to 1 routine exam/yr. and hearing aid fitting-eval./2 yrs. \$0 copay for up to 2 hearing	exams. \$0 for up to 1 routine exam/yr. \$390 copay for up to 2 inner-ear hearing aids/yr. \$340 copay for up to 2 over-the-ear hearing			
Prescription Drugs See separate chart See separate chart See separate chart See separate chart		\$5 copay to diagnose & treat eye conditions. \$0 for up to 1 routine exam/yr. \$10 for eye wear after cataract surgery. \$5 copay for routine exams. \$0 copay for glasses/contacts (\$50 limit / 2 yrs.). eye conditions. \$0 for up to 1 routine exam/yr. \$10 for eye wear after cataract surgery. \$35 for up to 1 pair of glasses/contacts/lenses and frames/2 yrs. (\$105 limit each for lenses/frames/2 (\$125 limit each for		diagnose & treat eye conditions. \$0 for up to 1 routine exam/yr. 20% of the cost for eye wear after cataract surgery. \$0 for up to 1 pair of glasses/contacts/yr. (\$125 limit each for lenses/frames/ yr.)	\$0 copay to diagnose & treat eye conditions. \$0 for eye wear after cataract surgery. \$0 for up to 1 routine exam/yr. \$30 copay contacts (\$105 limit/2 yrs.). \$0 for up to 1 pair of lenses/2 yrs. \$30 for up to 1 pair of frames/2 yrs. (\$70			
	Prescription Drugs	See separate chart	See separate chart	See separate chart	See separate chart			



HICAP (714)560-0424 or 1-800-Medicare or medicare.gov

ORAGING ORANGE COUNTY	Orange County I	Comparison Char	•	
Company	UnitedHealthcare	UnitedHealthcare	Anthem Blue Cross	
Plan Name	MedicareComplete Premier Plan	MedicareComplete Essential Plan	Medicare Preferred Standard	
Telephone Numbers Website	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 AARPMedicarePlans.com	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 AARPMedicarePlans.com	New enrollment: 1-800-797-6438 Current members: 1-877-811-3107 anthem.com/ca	
Plan Type	MA-PD (HMO) Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA ONLY (HMO) Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	MA-PD (PPO) Preferred Provider Plan with Prescription Drug Benefit. May choose any provider. Plan Network providers at lower cost.	
Monthly Premium	\$0 Monthly Premium	\$0 Monthly Premium	\$66 Monthly Premium (\$300 Deductible)	
Size of Network	3501-4000 physicians and providers	14001-15000 physicians and providers	20000 and above physicians and providers	
Out of Pocket Maximum Doctor Visit	\$4,900 In-Network \$5 each visit	\$4,900 In-Network \$5 each visit	\$4,500 In-Network In-Network: \$15 Out: \$35	
Specialist Visit	\$10 each visit	\$10 each visit	In-Network: \$45 Out: \$55	
In-patient Hospitalization	Days 1-5: \$150/day, Days 6- 90: \$0. Unlimited days each benefit period.	\$50 copay for each <i>Medicare-covered/</i> stay. \$0 for each additional day. Unlimited days each benefit period.	In-Network: \$795 copay/ Medicare- covered stay. \$0 additional days. Out of Network: 20% of cost/ stay. Unlimited days each benefit period.	
Skilled Nursing Facility	Days 1-20: \$50/day, Days 21-72: \$75/day, Days 73-100: \$0/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-98: \$50/day, Days 99- 100: \$0/day. No prior hospital stay required. 100 days covered each benefit period.	In-Network: Days 1-20: \$0, Days 21 100: \$135/day. Out of Network: 20% of cost/stay. No prior hospital required. 100 days each benefit period	
In-patient Mental Health	Days 1-5: \$150/day, Days 6- 90: \$0/day. 190-day psychiatric hospital lifetime limit.	\$50 each stay. 190-day psychiatric hospital lifetime limit.	In-Network: \$795/stay. Out of Network: 20% of cost/stay. 190- day psychiatric hospital lifetime limit.	
Outpatient Mental Health	\$30 each indiv. or group therapy visit.	\$30 each indiv. or group therapy visit.	In-Network: \$40 each visit. Out of Network: 30% of cost each	
Outpatient Hospital Services	\$125 each visit	\$0 each visit	In-Network: \$0-\$45 or 15% of the cost, each visit. Out of Network: 25% of cost for services.	
Ambulance	\$200 each service	\$200 each service	\$200 each service: In/Out	
Emergency Room Visit	\$65 each visit, waived if admitted within 24-hours. Worldwide coverage.	\$65 each visit, waived if admitted within 24-hours. Worldwide coverage.	\$65 each visit, waived if admitted within 72-hrs.	
Outpatient Rehab Services	\$10 each visit	\$10 each visit	In-Network: \$50 each visit Out of Net.: 30% of cost each visit	
Durable Medical Equipment	20% of cost for Medicare- covered items.	20% of cost for Medicare- covered items.	In-Network: 20% of cost for Medicare-covered items Out of Network: 25% of cost for Medicare-covered items	
Diagnostic Tests	20% of cost for diagnostic procedures and tests. 20% of cost for diagnostic radiology services.	20% of cost for diagnostic procedures and tests. 20% of cost for diagnostic radiology services.	In-Network: \$0-\$200 for diagnostic procedures and tests. \$65-\$200 for diagnostic radiology services. \$15-\$45 may apply for additional services. Out of Network: 30% of cost	
X-Rays	\$0 each X-ray	\$0 each X-ray	In-Network: \$65 each X-ray Out of Network: 30% of cost for each X-ray	
Lab Services	\$12 for lab services. 20% of cost for therapeutic radiology services.	\$0 for lab services. 20% of cost for therapeutic radiology services.	In-Network: \$0 for lab services. 20% for therapeutic radiology services. \$15-\$45 may apply for additional services. Out of Network: 30% for lab services and therapeutic radiology.	
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	19% of the cost for Part B chemotherapy drugs. In or Out.	
Dental Services	\$10 copay for <i>Medicare-covered</i> benefits. Preventive benefits not covered.	\$10 copay for <i>Medicare-covered</i> benefits. Preventive benefits not covered.	0% of cost for <i>Medicare-covered</i> benefits. Preventive benefits not covered. Out: \$0 copay for comprehensive benefits.	
Hearing Services	\$10 copay for diagnostic exams. \$5 for up to 1 routine exam/yr. \$390 copay for up to 2 inner-ear hearing aids/yr. \$340 copay for up to 2 over-the-ear hearing aids/yr.	\$10 copay for diagnostic exams. \$5 for up to 1 routine exam/yr. \$380 copay for up to 2 inner-ear hearing aids/yr. \$330 copay for up to 2 over-the-ear hearing aids/yr.	In-Network: \$45 for diagnostic exams. Routine exams and hearing aids not covered. Out of Network: 30% of cost for hearing exams.	
Vision Services	\$0-\$10 copay to diagnose & treat eye conditions. \$0 for eye wear after cataract surgery. \$10 for up to 1 routine exam/yr. \$30 copay for contacts (\$105 limit/2 yrs.). \$0 for up to 1 pair of lenses/2 yrs. \$30 for up to 1 frames/2 yrs. (\$70 limit/2 yrs.)	\$0-\$10 copay to diagnose & treat eye conditions. \$0 for eye wear after cataract surgery. \$10 for up to 1 routine exam/yr. \$0 for contacts (\$125 limit/2 yrs.). \$0 for up to 1 pair of lenses/frames/yr. (\$130 limit for frames/yr.).	In-Network: \$0 copay to diagnose & treat eye conditions. \$0 for 1 pair of eye wear after cataract surgery. Out of Network: \$0 for exams. \$0 for eye wear.	
Prescription Drugs	See separate chart	None	See separate chart	

Notes:

Out of Pocket

Maximum: All local MA plans must establish a mandatory maximum out-of-pocket (MOOP) amount for all Medicare Parts A and B services to mirror the same out-ofpocket costs an average beneficiary would have under Original Medicare's fee for service program. After meeting the MOOP, a beneficiary's MA plan will cover his/her remaining Medicare-covered costs for the rest of the calendar year. The mandatory MOOP is \$6,700, but plans can voluntarily set a lower MOOP at \$3,400 in exchange for more flexibility in setting their cost-sharing amounts.

Medicare Advantage

Plans: These plans are also called Medicare Health Plans and are offered by private companies that contract with Medicare to provide Part A and Part B benefits to people with Medicare. There are several different types of Medicare Advantage Plans incuding HMO's and PPO's. In this chart you will find the type of plan, offered by each company, in the "Plan Type" row.

Dental Coverage: The dental coverage benefit section of this chart details the standard dental coverage from each plan. Standard coverage does not require an additional premium. Please verify all information with the respective plan.



Prescription Drug Plans associated with Health Maintenance Organizations (HMOs)

2013 MA-PD Medicare Advantage (HMO & PPO) Prescription Drug Plans

For Assistance, call HICAP 714-560-0424 or 1-800-Medicare

Beneficiary must have both Medicare Part A and B to enroll in a Medicare Advantage Plan with the drug benefits shown below.

or www.medicare.gov

Organization Name Non-Member Telephone No. Plan Internet Website	Plan Name	Monthly Plan Premium*	Annual Deductible for Part D	-		deductible ha g \$2,970 in fo			Coverage in Gap	Mail Order	Overall Quality Rating (Out of 5)	Dr www.medic Drug Plan Quality Rating (Out of 5)
Aetna Medicare Select Plan 800-832-2640 aetnamedicare.com	Aetna Medicare Select Plan	\$0	\$0	\$7	\$33	\$45	\$95	33%	Some Gen	Yes	3.5	3.5
Anthem Blue Cross 800-797-643	Blue Cross Senior Secure Plan I	\$0	\$0	\$7	\$43	\$85	33%	33%	Many Gen	Yes	3.0	3.0
anthem.com/ca/medicare	Blue Cross Senior Secure Plan II	\$0	\$0	\$7	\$13	\$36	\$80	33%	Many Gen	Yes	3.0	3.0
Blue Shield of California 800-488-8000	Blue Shield 65 Plus	\$0	\$0	\$5	\$40	\$80	25%	33%	Many Gen	Yes	4.0	4.0
blueshieldca.com/findmedicareplan	Blue Shield 65 Plus Choice	\$0	\$0	\$0	\$35	\$70	25%	33%	Many Gen	Yes	4.0	4.0
Brand New Day 866-255-4795	Brand New Day	\$0	\$0	\$5	\$40	n/a	n/a	n/a	Many Gen	Yes	3.0	3.0
brandnewdayhmo.com	Brand New Day HMO Extra Care	\$29.80	\$325	25%	25%	n/a	n/a	n/a	No	Yes	3.0	3.0
Care1st 800-847-1222 care1st.com/ca/medicare	AdvantageOptimum Plan	\$0	\$0	\$0	\$5	\$30	\$50	30%	Many Gen	Yes	3.5	3.5
CareMore Health Plan	Value Plus	\$0	\$0	\$0	\$5	\$25	\$85	33% / \$0	All Formulary	Yes	4.0	4.0
866-622-2820 caremore.com	StartSmart with CareMore	\$0	\$0	\$5	\$10	\$45	\$95	33% / \$10	No	Yes	4.0	4.0
Central Health Medicare Plan 866-314-2427	Central Health Medicare Plan	\$0	\$0	\$0	\$5	\$25	\$50	33%	All Gen	Yes	3.0	3.5
centralhealthplan.com	Central Health Premier Plan	\$0	\$325	25%	25%	25%	25%	25%	No	Yes	3.0	3.5
Citizens Choice Health Plan 366-646-2247 citizenschoicehealth.com	Citizens Choice Healthplan	\$0	\$0	\$0	\$15	\$60	25%	33%	Many Gen	Yes	3.0	3.0
Easy Choice Health Plan	Easy Choice Best Plan	\$0	\$0	\$0	\$10	\$40	\$90	25%	Many Gen	Yes	3.0	3.0
866-999-3945 easychoicehealthplan.com	Easy Choice Plus Plan	\$29.90	\$325	25%	25%	25%	25%	25%	No	Yes	3.0	3.0
Golden State Medicare Health Plan 1-877-551-4111 goldenstatemhp.com	Golden State Medicare Health Plan, Golden	\$0	\$0	\$0	\$40	\$80	33%	n/a	Many Gen	Yes	Not enough data availabe	3.5

^{*} The premiums listed on the document are the same as the premiums listed on the Medicare Advantage HMO, PPO Comparison Chart and are not in addition to those amounts.



Orange County HICAP

2013 MA-PD Medicare Advantage (HMO & PPO) Prescription Drug Plans

For Assistance, call HICAP 714-560-0424 or 1-800-Medicare or www.medicare.gov

Beneficiary must have both Medicare Part A and B to enroll in a Medicare Advantage Plan with the drug benefits shown below.

Prescription Drug Plans associated with Health Maintenance Organizations (HMOs) continued

Organization Name Non-Member Telephone No.	Plan Name	Monthly Plan Premium*	Annual Deductible for	Co-Payments after deductible has been met and prior to reaching \$2,970 in full drug cost					Coverage in Gap	Mail Order	Overall Quality Rating	Drug Plan Quality Rating
Plan Internet Website			Part D	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5 / 6			(Out of 5)	(Out of 5)
Health Net of California	Healthy Heart 1	\$0	\$0	\$3	\$10	\$45	\$95	33%	Many Gen	Yes	3.5	3.5
800-977-6739	Healthy Heart 2	\$39	\$0	\$3	\$10	\$45	\$95	33%	No	Yes	3.5	3.5
healthnet.com	Ruby Plan 1	\$0	\$0	\$3	\$10	\$45	\$95	133%	Many Gen	Yes	3.5	3.5
	Gold Select	\$0	\$0	\$0	\$10	\$45	\$95	33%	Many Gen	Yes	3.5	3.5
Humana Health Plan of CA, Inc. 800-833-2364	Gold Plus (013)	\$0	\$0	\$0	\$10	\$45	\$95	33%	Some Gen & Few Brands	Yes	3.0	3.5
humana-medicare.com	Gold Plus HMO/POS* (014)	\$39	\$0	\$0	\$10	\$45	\$95	33%	Few Gen & Few Brands	Yes	3.0	3.5
Kaiser Permanente Senior Advantage 800-777-1238 kp.org	Senior Advantage LA, Orange Co.	\$0	\$0	\$3	\$7	\$40	\$60	25%	All Gen & Few Brands	Yes	5.0	5.0
SCAN Health Plan 800-915-7226	SCAN Classic	\$0	\$0	\$4	\$10	\$40	\$75	33% / \$10	Many Gen	Yes	3.5	3.0
scanhealthplan.com	SCAN Plus	\$0	\$0	\$0	\$0	25%	25%	25% / \$6	No	Yes	3.5	3.0
UnitedHealthcare 800-547-5514	AARP MedciareComplete SecureHorizons Plan 2	\$0	\$0	\$0	\$5	\$45	\$92	33%	Some Gen	Yes	3.5	4.0
aarpmedicareplans.com	AARP MedicareComplete SecureHorizons Premier	\$0	\$0	\$3	\$6	\$45	\$95	33%	No	Yes	3.5	4.0

^{*} The premiums listed on the document are the same as the premiums listed on the Medicare Advantage HMO, PPO Comparison Chart and are not in addition to those amounts.

Prescription Drug Plans associated with Preferred Provider Organizations (PPOs)

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		Monthly	Annual								Overall	Drug Plan
Organization Name		Plan	Deductible	Co-Payn	nents after d	leductible ha	s been met		Coverage	Mail	Quality	Quality
Non-Member Telephone No.	Plan Name	Premium*	for	and prio	and prior to reaching \$2,970 in full drug cost					in Gap Order	Rating	Rating
Plan Internet Website			Part D	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5/6			(Out of 5)	(Out of 5)
Anthem Blue Cross	Anthem Medicare Preferred	\$66	\$90	¢ 7	\$43	\$85	33%	33% / \$7	No	Yes	Too new to be	Not enough
800-797-6438 anthem.com/ca/medicare	Standard	φου	φθυ	Φ1	φ43	φου	33 /6	33 /6 / φ/	INO	165	measured	data available

^{*} The premiums listed on the document are the same as the premiums listed on the Medicare Advantage HMO, PPO Comparison Chart and are not in addition to those amounts.