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2021 San Francisco Medicare Advantage - HMO

	Anthem Blue Cross		Allignment Health Plan		Aetna
Plan Name	**Anthem MediBlue Plus (H0544-057)**	**Anthem MediBlue Select (H0544-069)**	**Sutter Advantage (H3815-024)**	**My Choice (H3815-007)**	**Aetna Medicare Eagle Plan (H4982-013)**
Monthly Premium	**$50.00**	**$0**	**$44.00**	**$0.00**	**$0**
Website	https://shop.anthem.com	https://shop.anthem.com	www.alignmenthealthplan.com	www.alignmenthealthplan.com	www.aetnamedicare.com
MOOP	$4,900	$7,550	$3,900	$3,000	$4,200
Contacts	1-888-230-7338 Current Members 1-844-316-0357 Non Members	1-888-230-7338 Current Members 1-844-316-0357 Non Members	866-634-2247 Current Members 888-979-2247 Prospective Members	1-866-634-2247 Current Members 1-888-979-2247 Non Members	888-268-9800 Current Members 1-855-275-6627 Prospective Member
Network Provider	Brown and Toland, AMG, Imperial (only Imperial can make UCSF referrals)	Brown and Toland, AMG, Imperial (only Imperial can make UCSF referrals).	Sutter Health Providers	Brown and Toland	check website
Network Hospital	CPMC, St. Francis, UCSF, St. Mary's, Seton.	CPMC, St. Francis, UCSF, St. Mary's, Seton.		Chinese Hospital, St. Francis, St. Mary's, UCSF	check website
Physician Visit	$0 primary care. $10 specialist.	$5 primary care. $20 specialist.	$5 primary care. $20 specialist.	$0 primary care. $0 specialist	$0 primary care. $10 specialist.
Inpatient Hospital	$295 copay days 1-5. $0 copay days 6-90.	$360 copay days 1-4. $0 copay days 5-9.	$225/day for Days 1-5. $0/day for days 6-9. $0 for days 91+.	$0/day for days 1-4. $10/day for days 5-10. $0/day for days 11-90. $0/day for days 91 and beyond.	$50/day for Days 1-3. $0/day for Days 4-90.
Outpatient Surgery	$0-$250	$0-$350	$175 depending on service to ambulatory surgical center. $195 each visit to outpatient hospital facility.	$200	$175 depending on service to ambulatory surgical center. $0-$50 each visit
DME	20% / item, dialysis 20%, diabetic supplies $0	0-20%/item, dialysis 20%, diabetic supplies $0	DME 0-20% per item, dialysis 20%, diabetic supplies $0.	20% / item, dialysis $30, diabetic supplies $0	DME 20% per item, dialysis 20%, diabetes $0-20%.
Mental Health	Inpatient: $350 copay for days 1-5. $0 per day days 6-90. Outpatient group/individual therapy: $25 copay	Inpatient: $330 copay for days 1-4. $0 per day days 5-90. Outpatient group/individual therapy: $40 copay	Inpatient: $120 days 1-10, $0 dayss 11-90. $0 days 91-130. Outpatient: with psychiatrist $40, without $0.	Inpatient: $227 copay for days 1-5. $0 per day days 6-90. Outpatient: with psychiatrist $40, without psychiatrist $0.	Outpatient: $25 all.
Ambulance Service	$250	$300	$250	$175	$275
Emergency Care	$90 emergency care; urgent care $20	$90 emergency, $35 urgent care	Emergency $90. Urgent care $0-$10.	$85 emergency care; urgent care $0-$10.	Emergency $90. Urgent $10.
Diagnostic Test, X- Ray & Lab Service	$0 for lab, $0-$60 for x-rays, $0-$60 for test, $60 for diagnostic radiation.	$0 - $5 for lab services; $0-$120 for tests, $0-$50 for x-rays, $65-$165 therapeutic radiology services	$0 for lab services and tests. X-rays $15. Diagnostic radiation $150.	$0 tests, x-rays $0, lab $0, diagnostic radiation $0. $0 with limits, $0 x-ray with limits.	$0 for lab services, diagnostic procedures and tests, and x-rays. $0-$100 for radiology services (not including x-rays) and therapeutic radiology services (MRI,CT).
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $8 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $10 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred Generic: $0 Tier2: Non Preferred Generic: $0 Tier 3: Preferred Brand: $40 Tier 4: Non-Preferred Brand: $100 Tier 5: Speciality Tier: 33% Tier 6: Select Care Drugs: $5	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $3 Tier 3: Preferred brand: $40 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance Select Care $5 20% for Part B-covered drugs.	20% for Part B-covered drugs.
Other	Hearing test: $10 , Hearing Aid $0 with limits. Vision: $0 (I routine exam per year) Optional supplemental packages ($13,$32,$53) for dental and vision. OTC $140/year. Silver Sneakers. Transportation. Personal emergency response system. Glasses.	Hearing test: $0 , Hearing Aid $0 with limits. Vision: $0 (I routine exam per year) Dental. Optional supplemental packages ($12,$32,$53) for dental and vision. OTC $140/year. Silver Sneakers. Transportation. Personal emergency response system. Glasses.	Hearing Exam $0; Liberty Dental HMO $0; VSP Eye Exam,Glasses $0; eyeglasses $15; Peerfit Move gym membership. OTC $15/month using "black card". Some telehealth coverage. Optional package $22.70.	Hearing test: $0 , Liberty dental $0, some comprehensive dental, VSP vision $0, Eyeglasses $0. Option package $22 and $70. Some fitness.	Hearing exam $0. Hearing Aids $0 with limits.Preventive dental $0. Comprehensive dental $0.Eye Exam $0. Eyeglasses, contacts, $0.Fitness some coverage. Telehealth some coverage.

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	Aetna Medicare		Brand New Day		Chinese Community Health Plan
Plan Name	**Aetna Medicare Elite Plan (H5521-293)**	**Aetna Medicare Plus Plan (H4982-007)**	**Brand New Day Classic II Plan (H0838-037)**	**Brand New Day Choice Plan (H0838-033)**	**CCHP Senior Value Program (H0571-007)**
Monthly Premium	**$0 $750 annual deductible**	**$0**	**$0**	**$31.50**	**$0**
Website	www.aetnamedicare.com	www.aetnamedicare.com	https://bndhmo.com	https://bndhmo.com	https://cchphealthplan.com
MOOP	$7,550	$4,200	$999	$7,550	$7,500
Contacts	1-800-282-5366 Current Members 1-855-275-6627 Non Members	1-888-268-9800 Current Members 1-855-275-6627 Prospective Members	1-866-255-4795 Current Members 1-866-255-4795 Prospective Member	866-255-4795 Current Members 866-255-4795 Prospective Members	1-888-775-7888 Current Members 1-888-681-3888 Prospective Member
Network Provider	check website	check website	Hills Physicians, ACCESS, AAMG	Hills Physicians, ACCESS, AAMG.	CCHP; Jade
Network Hospital	check website	check website	UCSF	UCSF	Chinese Hosp, Dignity Health, CPMC
Physician Visit	$0 primary care. $40 specialist.	$0 copay for primary care or specialist.	$0 primary care. $10 specialist.	$0 primary, $0-20% specialty	$10 primary care. $35 specialist.
Inpatient Hospital	$325/day for days 1-4. $0/day for days 5-90.	$250 Days 1-5. $0 Days 6-90.	$100/day for Days 1-6; $0 for Days 7-90.	Coming soon.	Tier 1: $230/day for days 1-7. $0/day for days 8-90. Tier 2: $305/day for days 1-7. $0/day for days 8-90.
Outpatient Surgery	$0-$295	$0-$125	$100 each visit to outpatient surgery.	20%	$180-$300/visit
DME	DME 20%/item, dialysis 20%, diabetic supplies $0-20%	DME 20% per item. Dialysis 20%. Diabetic supplies $0-20%.	DME $0%-20%/item. Dialysis 20%. Diabetic supplies $0.	DME 20% per item, Dialysis 20%, Diabetic supplies $0.	DME 20% per item. Dialysis 20%. Diabetic supplies $0.
Mental Health	Inpatient: $320 copay for days 1-5. $0 per day days 6-90. Outpatient group/individual therapy: $40 copay	Inpatient: $350 copay days 1-5, $0 copay for days 6-90. Outpatient: $25	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $900/hospital stay. Plan covers 60 lifetime reserve Days. $0 per lifetime reserve day. Outpatient: group with psychiatrist 20%. All others $10.	Outpatient w/psychiatrist $40, Without psychiatrist $0.	Inpatient: $225/day for Days 1-7. $0/day for Days 8-90. Plan covers 60 lifetime reserve Days. $0 per lifetime reserve day. Outpatient group/individual therapy: $35 copay
Ambulance Service	$285	$275	$75	20%	$225
Emergency Care	$90 emergency, $40 urgent care	Emergency $90. Urgent $0.	$90 emergency, $0 urgent.	Emergency $90, urgent care $0	$90 emergency, $45 urgent care.
Diagnostic Test, X- Ray & Lab Service	$0 for tests, lab, and x-ray. Diagnostic radiation $0-$250	Diagnostic tests, lab, x-rays, and diagnostic radiation $0.	$0 for lab services, diagnostic procedures and tests, and x-rays. $0-$25 for diagnostic radiation.	Lab $0. Tests, xrays and diagnostic radiation 20%.	$0 for tests, lab and x-rays. Diagnostic radiation $200
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $0 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred generic: $0 (standard retail) Tier 2: generic: $0 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $99 Tier 5: Specialty: 33% 20% for Part B-covered drugs.	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $12 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $0 20% for Part B-covered drugs.	Tier 1: Preferred Generic: 0% Tier2: Non Preferred Generic: 25% Tier 3: Preferred Brand: 25% Tier 4: Non-Preferred Brand: 25% Tier 5: Speciality Tier: 25% Tier 6: Select Care Drugs: 0% $445 drug plan deductible	Tier 1: Preferred generic: $5 (standard retail) Tier 2: Non-preferred generic: $12 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: $31 $100 Deductible. Mail order available. 20% for Part B-covered drugs.
Other	Hearing test: $0 , Hearing Aid $0 with limits. Preventive and comprehensive dental $0 Eye exam $0. E yeglasses and contacts $0	Hearing exam $0, Hearing Aids $0 with limits, Preventive dental $0. Comprehensive Dental $0. eye exam $0. Eyeglasses, contacts $0. Fitness some coverage. Telehealth some coverage.	$0 for hearing exam, $699-$999 hearing aids. $12 for vision exam. Eyeglasses $0. Some preventive denal. Some telehealth.	Hearing exam $0, Hearing aids $149, preventive dental $0, comprehensive dental $0, eye exam $0, fitness some coverage, telehealth some coverage.	Hearing exam $35, Eye exam $35, fitness some coverage. Telehealth some coverage. $18 optional package.

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	Chinese Community Health Plan	Golden State	Health Net		Imperial Health Plan
Plan Name	**CCHP Senior Program (H0571-001)**	**Golden State Senior Health Plan (H2241-014)**	**Health Net Ruby Select (H0562-097)**	**Health Net Healthy Heart (H0562-009)**	**Imperial Traditional (H5496-007)**
Monthly Premium	**$42**	**$25.40**	**$0**	**$125.00**	**$0.00**
Website	https://cchphealthplan.com	www.gsmnp.com	https://healthnetadvantage.com	https://healthnetadvantage.com	www.imperialhealthplan.com
MOOP	$6,700	$3,000	$4,400	$6,700	$2,999
Contacts	1-888-775-7888 Current Members 1-888-681-3888 Prospective Member	877-541-4111	1-800-275-4737 Current Members 1-800-977-6738 Prospective Member	1-800-275-4737 Current Members 1-800-977-6738 Prospective Member	1-800-838-8271 Current Members 1-800-838-5914 Prospective Member
Network Provider	CCHP; Jade	check website	Brown and Toland.	Brown and Toland, Hills Physicians.	Seton, Brown and Toland.
Network Hospital	Chinese Hospital, Dignity Health, CPMC	check website	No UCSF.	St. Francis, St. Mary's, UCSF.	UCSF
Physician Visit	$5 primary care. $20 specialist.	$5 copay for primary care or specialist.	$5 primary care. $20 specialist.	$10 primary care. $15 specialist.	$0 primary, $0 specialist.
Inpatient Hospital	$100/day for Days 1-7. $0/day for Days 8-90 (Chinese Hospital).$305/day for Days 1-7. $0/day for Days 8-90 (all other)	$250 days 1-5, $0 days 6-90.	$345/day for Days 1-5; $0 for Days 6-90. $0/day each additional non-Medicare-covered hospital day.	$335/day for Days 1-4; $0 for Days 5-90. $0/day each additional non-Medicare-covered hospital day.	$100/day for Days 1-5. $0/day for Days 6-9.
Outpatient Surgery	$100-$300/visit	Ambulatory surgical center: 20% of cost Outpatient Hospital:$200	$100 each visit to outpatient surgical center. $345 each visit to outpatient hospital facility.	$100 each visit to outpatient surgical center. $275 each visit to outpatient hospital facility.	$0 -250 each visit to outpatient surgical center. $0 each visit to outpatient hospital facility.
DME	DME 20% per item. Dialysis 20%. Diabetic supplies $0.	DME $0-20% per item, Dialysis 10%, Diabetic supplies $0.	DME 20%/item. Dialysis 20%. Diabetic supplies $0-20%.	DME 20%/item. Dialysis 20%. Diabetic supplies $0-20%.	DME $20 per item, dialysis 20%, Diabetic supplies $0
Mental Health	Inpatient: $225/day for Days 1-7. $0/day for Days 8-90. Plan covers 60 lifetime reserve Days. $0 per lifetime reserve day. Outpatient group/individual therapy: $20 copay	Outpatient: individual with psychiatrist $30. All others $15.	Inpatient: Days 1-7, $250 copay/day. Days 8-90 #0 copay/day Outpatient: $15	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $900/hospital stay. Plan covers 60 lifetime reserve Days. $0 per lifetime reserve day. Outpatient: $15	Inpatient: $200 copay days 1-7, $0 cpay for days 8-90. Outpatient: with psychiatrist $0, without 20%.
Ambulance Service	$225	$200	$295	$165	$125
Emergency Care	$90 emergency, $45 urgent care.	$90 emergency. $20 urgent care.	$90 emergency, $20 urgent.	$90 emergency. $15 urgent care.	emergency $90, urgent care $0.
Diagnostic Test, X- Ray & Lab Service	$0 for lab services, for x-rays, for diagnostic procedures and tests. $200 therapeutic radiology services	Tests, lab and xrays $0. Diagnostic radiology $60	$0 for lab services, diagnostic procedures and tests, and x-rays. $60 for radiology services (not including x-rays) and therapeutic radiology services.	$0 for lab services, diagnostic procedures and tests, and x-rays. $60 for radiology services (not including x-rays) and therapeutic radiology services.	diagnostic tests, lab, x-ray, diagnostic radiation $0.
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $3 (standard retail) Tier 2: Non-preferred generic: $7 Tier 3: Preferred brand: $40 Tier 4: Non-preferred brand: $60 Tier 5: Specialty: $33 20% for Part B-covered drugs.	Tier 1: Preferred Generic: $5 Tier2: Non Preferred Generic: $10 Tier 3: Preferred Brand: $45 Tier 4: Non-Preferred Brand: 95 Tier 5: Speciality Tier: 33% coinsurance	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $3 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $0 20% for Part B-covered drugs.	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $5 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $5 20% for Part B-covered drugs.	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $5 Tier 3: Preferred brand: $45 Tier 4: Non-preferred brand: $90 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.
Other	Hearing exam $20, Hearing aids $600-2075, preventive dental $0, eye exam $20, some fitness, some telehealth. OTC $25/ quarter. Optional dental package $10.	Hearing exam $0, Hearing Aids $0, Preventivedental: covered under office visit. Comprehensive dental varies. Eye Exam $0.Fitness some coverage. Telehealth some coverage	$0 for hearing exam, $0-$1580 hearing aids. Dental. $12 for vision exam. Eyeglasses $0. Fitness some coverage. Chiropractic some coverage. Accupuncture some coverage. Transportation some coverage. OTC $30-$50/quarter. Telehealth some coverage.	Annual physical exams some coverage, telehealth some coverage, $15 for hearing servies, $15 for vision. $41/month optional supplemental package for the following benefits: chiropractic services, acupuncture, dental, vision and fitness.	Hearing exam $0. Hearing Aids $1000. Preventive dental: $0. Comrehensive dental $0. Eye exam $15. Fitness $0. Telehealth some coverage. OTC $75/quarter.

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	Kaiser Permanente		Scan	United Health Care	
Plan Name	**Kaiser Permanente Senior Advantage Basic (H0524-060)**	**Kaiser Permanente Senior Advantage, Alam, SF, Napa(H0524-032)**	**Scan Classic (H5425-019)**	**United Health Care Canopy (H0543-191-0)**	**AARP Secure Horizons (H0543-175)**
Monthly Premium	**$24.00**	**$84.00**	**$35**	**$35**	**$54.00**
Website	https://medicare.kaiser.permanente.org	https://medicarekaiserpermanente.org	www.scanhealthplan.com	www.uhcmedicaresolutions.com	www.aarpmedicareplan.com
MOOP	$6,700	$4,900	$5,000	$3,500	$4,000
Contacts	1-800-777-1230 Current Members 1-800-777-1230 Non Members	1-800-443-0815 Current Members 1-800-777-1238 Prospective Member	1-800-559-3500 Current Members 1-800-315-7226 Prospective Members	866-810-1498 Current Members 800-555-5757 Prospective members	844-808-4553 Current Members 800-555-5757 Prospective Members
Network Provider	Kaiser	Kaiser Network	Brown and Toland, Caremore.	Canopy/Hill.	Brown and Toland.
Network Hospital	Kaiser	Kaiser Permanente	St. Francis, CPMC, St. Mary's.	St. Francis, St. Mary's, UCSF.	Seton, UCSF, CPMC.
Physician Visit	$20 primary care. $30 specialist.	$10 primary, $20 specialist.	$5 primary care. $15 specialist.	$0 primary, $10 specialist.	$0 Primary care, $10 specialist
Inpatient Hospital	$310 copay days 1-7. $0 copay days 8-90.	$240/day for Days 1-7. $0/day for Days 8-90. $0 each additional non-Medicare-covered hospital day.	$250/day for Days 1-7. $0/day for Days 8-90.	$250/day for days 1-5, $0/day for days 6-90 $0 for day 91+.	$300/day for days 1-5. 0% days 6-9.$0 days 90+
Outpatient Surgery	$0-$300	$0 -250 each visit to outpatient surgical center. $0-$200 each visit to outpatient hospital facility.	$175 depending on service to ambulatory surgical center. $15-$200 each visit	$0-$195.	$0-195
DME	$0-20% per item, dialysis $0-20%, diabetic supplies $0	DME $0-20% per item, dialysis 0%-20%, Diabetic supplies $0	DME 0-20% per item, dialysis 20%, diabetes $0.	DME 20%, dialysis 20%, diabetic supplies $0.	DME 20%, dialysis 20%, diabetic supplies $0.
Mental Health	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $230/day for Days 1-7. $0/day for Days 8-90. Outpatient: group $5, individual $10. $0 for partial hospitalization program services.	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $230/day for Days 1-7. $0/day for Days 8-90. Outpatient: group $5, individual $10. $0 for partial hospitalization program services.	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $900 copay per stay. Outpatient: with psychiatrist $15, without $25.	Inpatient: $250/day for Days 1-5. $0/day for Days 6-90. 60 lifetime reserve days, 190 day maximum, partial $55/day Outpatient: group $15, individual $25.	Inpatient: $345 days 1-4, $0 days 5-90, plus 60 lifetime days . Partial hospitalization $55/day. Outpatient: group $17, individual $25.
Ambulance Service	$200	$200	$175	$250 ground or air	$250 ground or air
Emergency Care	$90 emergency care; urgent care $20	emergency $90, urgent care $10.	Emergency $90. Urgent $35.	Emergency $90. Urgent $40.	Emergency $90.Urgent Care $40.
Diagnostic Test, X- Ray & Lab Service	Tests 20%. Lab $0-20%, X-ray $30, diagnostic radiation $30-$215.	diagnostic tests $10, lab $0-$10, x-ray $20, diagnostic radiation $20-$200.	$0 for lab services, diagnostic procedures and tests, and x-rays. $60 for radiology services (not including x-rays) and therapeutic radiology services (MRI,CT).	Tests and lab $0, x-ray $15, Diagnostic radiation $0-$105.	Tests and labs $0, x-ray $15, diagnostic radiation $60.
Prescription Drugs Copay (per 30-31 Days)	Coverage gap: 25% generic, 25% brand 20% for Part B-covered drugs.	No initial coverage phase. Gap coverage phase: generic 25%, brand-name 25%.	Tier 1: Preferred generic: $3 (standard retail) Tier 2: Non-preferred generic: $5 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred Generic: $3 Tier2: Non Preferred Generic: $12 Tier 3: Preferred Brand: $47 Tier 4: Non-Preferred Brand: $100 Tier 5: Speciality Tier: 33%	Tier 1: Preferred generic: $3 (standard retail) Tier 2: Non-preferred generic: $12 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 28% Deduction $250 for tiers 3, 4,and 5 20% for Part B-covered drugs.
Other	Contact Kaiser Permanente for reduced cost sharing due to a chronic condition. Hearing test: $30. Vision: $20. Eyeglasses, contacts $0. Telehealth some coverage. Optional supplemental package $16 for dental and vision. Some fitness. Some telelhealth.	Contact Kaiser Permanente for reduced cost sharing due to a chronic condition. $20 for hearing exam, $10 for eye exam, $0 eyeglasses, telehealth some coverage, $16 Optional Suplemental Benefit (eyewear, hearing aid and some dental)	Hearing exam $10. Hearing aids $450-$750. Routine Vision Exam $0. Glasses $0. Fitness some coverage. Telehealth some coverage. Optional package for added benefits $6 and $16.	Hearing exam $0. Hearing Aids $375-$2075. Eye exam $0. Glasses $0. Fitness some coverage. Telehealth $0. Optional package $45. Transportation $0 for 24 1-way trips.	Hearing exam $0, Hearing aids $375-$2000, Eye exam $0, $100 towards glasses every 2 years, fitness coverage some, telehealth $0, optioanl package $45.

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