IMPERIAL
HEALTH PLAN
OF CALIFORNIA

2026

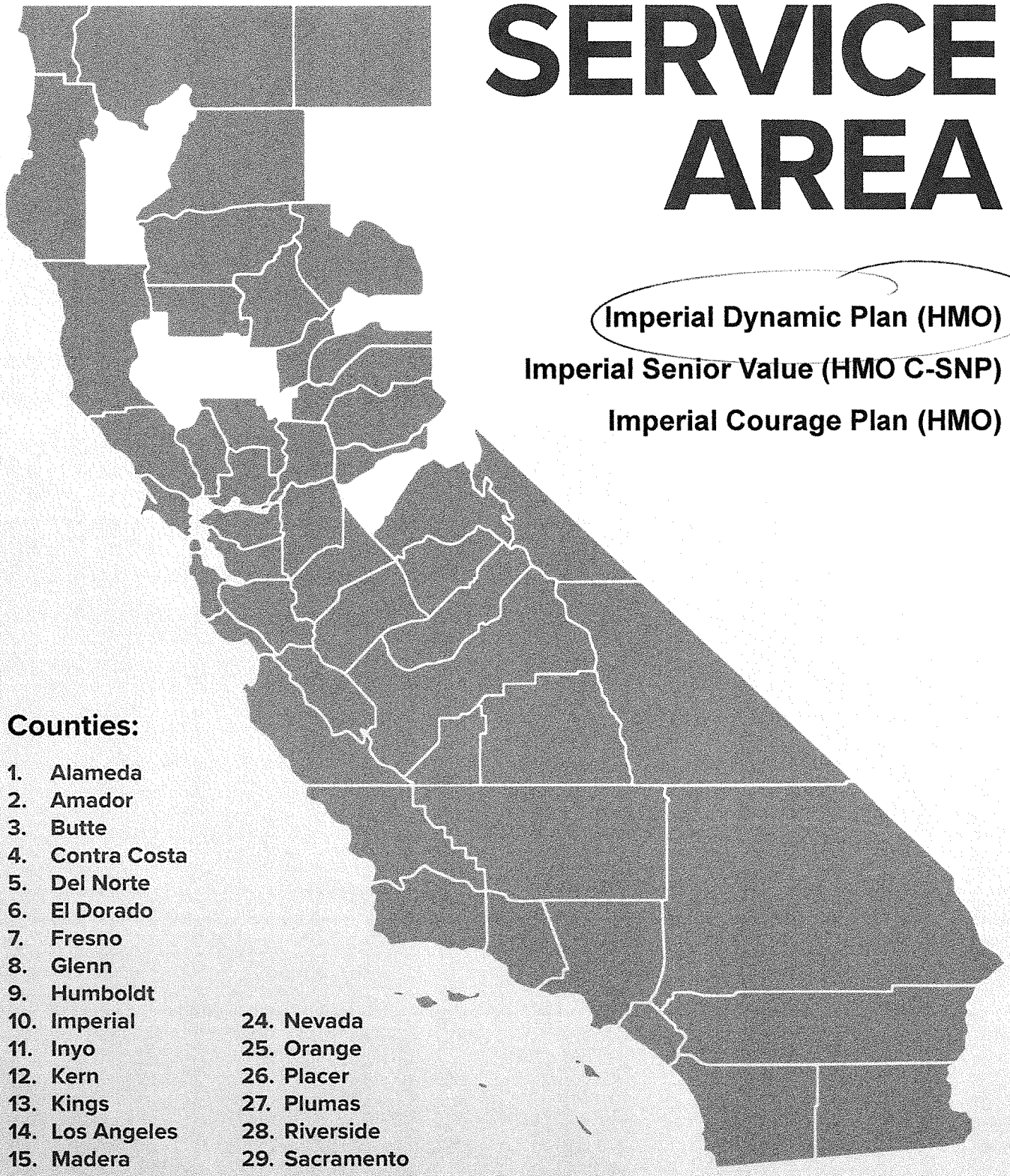
BENEFIT HIGHLIGHTS

Imperial Senior Value (HMO C-SNP) 005

Imperial Dynamic Plan (HMO) 012

Imperial Courage Plan (HMO) 016

SERVICE AREA



Imperial Dynamic Plan (HMO)

Imperial Senior Value (HMO C-SNP)

Imperial Courage Plan (HMO)

Counties:

1. Alameda
2. Amador
3. Butte
4. Contra Costa
5. Del Norte
6. El Dorado
7. Fresno
8. Glenn
9. Humboldt
10. Imperial
11. Inyo
12. Kern
13. Kings
14. Los Angeles
15. Madera
16. Marin
17. Mariposa
18. Mendocino
19. Merced
20. Modoc
21. Mono
22. Monterey
23. Napa
24. Nevada
25. Orange
26. Placer
27. Plumas
28. Riverside
29. Sacramento
30. San Benito
31. San Bernardino
32. San Diego
33. San Francisco
34. San Joaquin
35. San Luis Obispo
36. San Mateo
37. Santa Barbara
38. Santa Clara
39. Santa Cruz
40. Shasta
41. Siskiyou
42. Solano
43. Sonoma
44. Stanislaus
45. Tehama
46. Tulare
47. Tuolumne
48. Ventura
49. Yolo
50. Yuba

Imperial Dynamic Plan (HMO) 012

Premiums and Benefits	Imperial Dynamic Plan (HMO)
Premiums How much do I need to pay monthly?	• Part C Premium: You pay $0 per month • Part D Premium: You pay $0 per month • Imperial Dynamic Plan pays $35 of your Part B Premium. You must continue to pay your Medicare Part B premium
Deductible How much do I need to pay before the plan pays?	• This plan does not have a deductible for Part C or D benefits
Maximum Out-of-Pocket costs What's the limit on how much I will pay?	• The most you will pay each year for Part C services in this plan is $296
Inpatient Hospital – Acute [1,2] How long will my plan cover? How much do I pay?	• You pay $0 per day for days 1 – 90 • You pay a $0 copay for each Lifetime Reserve Day.
Outpatient Hospital Services [1,2]	• You pay $100 per visit
Ambulatory Surgery Center[1,2]	• You pay $100 for each Medicare-covered ambulatory surgical center visit
Doctor visits How much do I pay to visit a primary care physician or specialist?	• Primary care physician visit: You pay $0 • Specialist visit[1,2]: You pay $0 • You have the option of getting certain services by telehealth using phone or video
Preventive Service How much do I pay for Preventive Care?	• You pay $0 for glaucoma screening[1], diabetes self-management training[1], digital rectal exams and EKGs following a welcome visit

Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.

Premiums and Benefits	Imperial Dynamic Plan (HMO)
Emergency Services How much do I pay for Emergency Care?	• You pay $125 per visit • If you are admitted to the hospital within 48 hours, you don't have to pay your share of the cost for emergency care
Urgently Needed Services How much do I pay for Urgently Needed Services?	• You pay $0

Diagnostic Services / Labs / Imaging[1,2]
How much do I pay for Diagnostic Services?
	• You pay $0 for:
	  • Lab services
	  • Diagnostic tests
	  • Diagnostic radiology services (e.g., MRI)
	  • X-rays
	• You pay 20% of the total cost for therapeutic radiology services

Outpatient Substance Abuse[1,2]	• You pay 20% of the total cost for each Outpatient Substance Abuse visit in an individual or group setting
	• You pay $0 for each home health visit

Mental Health Specialty Services[1,2]
How much do I pay for inpatient or outpatient services?
	• Inpatient stays:
	  • You pay $0 per day for days 1 – 90
	  • You pay a $0 copay for each Lifetime Reserve Day.
	• Outpatient services: You pay $0 for each Medicare-covered individual or group therapy outpatient mental health visit (non-physician)
	• You pay $0 for each Medicare-covered psychiatric individual or group therapy session

Premiums and Benefits	Imperial Dynamic Plan (HMO)
Skilled Nursing Facility[1,2] How much do I pay for Skilled Nursing Facility stay?	We cover up to 100 days in a SNF per benefit period: • You pay $0 per day for days 1 – 20 • You pay $100 per day for days 21 – 50 • You pay $200 per day for days 51 – 100

Cardiac Rehabilitation Services / Occupational / Physical/Speech / Language Therapy[2]
How much do I pay for Outpatient Rehab and therapy?
	• You pay $0 for:
	  • Cardiac (heart) rehab services
	  • Occupational therapy
	  • Physical therapy
	  • Speech and language therapy

Ambulance Services[1] How much do I pay for Ambulance services?	• You pay $150 per one-way trip by ground • You pay 20% of the total cost per trip by air • Prior authorization required for non-emergency trips • If you are admitted to the hospital within 48 hours, you don't have to pay your share of the cost for emergency care
Durable Medical Equipment (DME) / Prosthetics / Diabetic Supplies[1]	• You pay 20% of the total cost per item for Durable Medical Equipment (DME)[1], such as oxygen or a wheelchair • You pay 20% of the total cost per item on prosthetics[1] such as braces, artificial limbs • You pay $0 for diabetic monitoring supplies[1]
Medicare Part B Rx Drugs and Home Infusion Drugs[1] How much do I pay for Part B Drugs?	• You pay $0 for Part B insulins • You pay 20% of the total cost for all other Part B drugs including chemotherapy drugs

 Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.

Part D Prescription Drugs	Imperial Dynamic Plan (HMO)	
Part D Premium	You pay $0 per month	
Out-of-Pocket Cost Threshold What's the limit on how much I will pay?	Your yearly limit for Part D in this plan is $2,100	
Deductible Stage	No deductible (Your coverage begins on the effective date of your enrollment)	
Initial Coverage Stage	**You pay the following costs until your yearly out-of-pocket drug costs reach $2,100**	
	Retail 30 Day Supply	**Mail Order 100 Day Supply**
Tier 1 – Preferred Generic	$0.00	$0.00
Tier 2 – Generic	$6.00	$5.00
Tier 3 – Preferred Brand	$45.00/ Select Insulins: $0	$90.00/ Select Insulins: $0
Tier 4 – Non-Preferred	$90.00/ Select Insulins: $0	$180.00/ Select Insulins: $0
Tier 5 – Specialty Tier	33%	Mail order supply not available for Tier 5
Catastrophic Coverage Stage	**Once your yearly out-of-pocket drug costs reach $2,100. You pay $0 for covered prescription drugs for the remainder of the plan year.**	

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.

Supplemental Benefits	Imperial Dynamic Plan (HMO)
Dental Services How much do I pay for dental services?	• Medicare-covered Dental services: You pay $0 • Preventive dental services: You pay $0 for routine office visits. Office visits include exam, cleaning, fluoride treatment and dental X-ray. Your plan covers up to $500 in routine dental services per year • You pay $0 for restorative services; prosthodontics, other oral/ maxillofacial surgery, other services. Your plan covers up to $4000 every year

Vision Services
How much do I pay for Vision Services? What's my Eyewear Allowance per year?
	• You pay $0 for Medicare-covered vision services
	• You pay $0 for routine eye exams
	• You pay $0 every year for either:
	  • One pair of eyeglasses (lenses and frames)
	  • One pair of contact lenses
	• The plan covers up to $500 every year for eyewear

Hearing Services[1,2]
How much do I pay for Hearing Services or Hearing Aids?
	• You pay $0 for:
	  • Covered diagnostic and routine exams
	  • The plan covers up to $250
	• Hearing aid allowance: You pay $0. The plan covers up to $500 per calendar year

Transportation Services[1,2] How much do I pay for Transportation services?	• You pay $0 for 100 one-way trips to plan approved locations
Meal Benefit[1]	• There is $0 copayment for up to 7 delivered meals following a surgery or hospital stay. • The plan covers up to $105 per benefit period.
SSBCI Qualified Food and Produce/Grocery *You must qualify by having one or more of the chronic conditions listed on the last page of this document.	• $45 Per Quarter

Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.

In-home Support Services	• You pay $0 for up to 60 hours of in-home support services including help with transportation, grocery shopping, medication pickup, care reminders, light house help, and light exercise.
Chiropractic and Acupuncture Treatments	• You pay a $0 copay for 35 visits (combined with Acupuncture Treatments) every year.
Over-the-Counter (OTC)	• $140 allowance every three months through our OTC mail order catalog • Cash, checks, credit cards or money orders are not accepted under this OTC benefit • No roll over
Podiatry Services[2]	• You pay $0 for 6 routine foot care visits per calendar year
Fitness Benefit	• You pay $0 for up to one home fitness kit per year through the Silver&Fit® Program. The Silver&Fit Program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH).
Worldwide Emergency/Urgent Coverage	• Reimbursement up to $100,000 for qualifying expenses with $0 copay • Urgently needed or Emergency services only

Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.

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Section 1 – All fields in this section are required (unless marked optional)

Select the plan you want to join:

☐ Imperial Senior Value (HMO C-SNP) 005 – $0 Part C/D

☒ Imperial Dynamic Plan (HMO) 012 – $0 Part C/D

☐ Imperial Courage Plan (HMO MA-only) 016 – $0 Part C Only

First name:	Last name:	Middle initial: (optional)
Birth date (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	Phone number:
Email Address (optional):		Cell Phone (optional):

Permanent residence street address (Don't enter a P.O. Box. Note: For individuals experiencing homelessness, a P.O. Box may be considered your permanent residence address.):

City:	County: (optional)	State:	ZIP code:

Mailing address, if different from your permanent address (P.O. Box allowed):

Street address:	City:	State:	ZIP code:
Emergency Contact (optional):	Relationship:	Phone Number:	

Your Medicare information:

Medicare number: _ _ _ _ - _ _ _ - _ _ _ _

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Imperial Health Plan?

☐ Yes ☐ No

Name of other coverage:	Member number for this coverage:	Group number for this coverage:

Do you have cardiovascular disorder, chronic heart failure, and/or diabetes? ☐ Yes ☐ No

Are you enrolled in your state Medi-Cal (Medicaid) program? ☐ Yes ☐ No

If "yes," please provide your Medi-Cal (Medicaid) number: _____

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Imperial Health Plan.
- By joining this Medicare Advantage or Medicare Prescription Drug Plan, I acknowledge that Imperial Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA or Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA or Part D plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my Imperial Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Imperial Health Plan. Benefits and services provided by Imperial Health Plan and contained in my Imperial Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Imperial Health Plan will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1) This person is authorized under State law to complete this enrollment, and
  2) Documentation of this authority is available upon request by Medicare.

Signature:	**Today's date:**
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone number:	Relationship to enrollee:

Section 2 – All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Other _____

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Imperial Health Plan at 1-800-838-8271 if you need information in an accessible format other than what's listed above. Our office hours are October 1 through March 31, Monday through Sunday from 8:00 am to 8:00 pm and April 1 through September 30, Monday through Friday from 8:00 am to 8:00 pm except holidays. TTY users can call 711.

Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No

List your Primary Care Physician (PCP), clinic, or health center:

PCP Name: _____ PCP ID Number: _____

Medical Group or IPA: _____

Are you an existing patient of this PCP? ☐ Yes ☐ No

I want to get the following materials via email. Select one or more.

☐ Yes, I would like to receive my new member Enrollment Kit – EOC, Comprehensive Drug Formulary, and Provider/Pharmacy Directory.

Email address: _____

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. Please select a premium payment option. If you don't make a selection, you will receive a bill.**

☒ Get a bill.

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. *The Social Security/RRB deduction may take at least two months to begin after approval by Social Security or the Railroad Retirement Board (RRB). Until Social Security approves the deduction, you will continue to receive paper statements.*

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay Imperial Health Plan the Part D-IRMAA.

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name:	Relationship to Enrollee:
Signature:	National producer number (NPN):

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Imperial Health Plan is an (HMO) (HMO SNP) with a Medicare Contract. Enrollment in Imperial Health Plan depends on contract renewal. Imperial Health Plan of California (HMO) (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-838-8271 (TTY: 711). Imperial Health Plan of California (HMO) (HMO SNP) cumple con las leyes federales de derechos civiles aplicables y no discrimina por cuestiones de raza, color, nacionalidad, edad, discapacidad o género. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-838-8271 (TTY: 711).

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Attestation of Eligibility for an Enrollment Period		
Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. **Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.**		
☐	I am new to Medicare.	
☐	I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).	
☐	I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date)	Date
☐	I recently was released from incarceration. I was released on (insert date)	Date
☐	I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date)	Date
☐	I recently obtained lawful presence status in the United States. I got this status on (insert date)	Date
☐	I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date)	Date
☐	I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date)	Date
☐	I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).	
☐	I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move	Date

	into/out of the facility on (insert date)	
☐	I recently left a PACE program on (insert date)	Date
☐	I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date)	Date
☐	I am leaving employer or union coverage on (insert date)	Date
☐	I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.	
☐	My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.	
☐	I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date)	Date
☐	I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)	Date
☐	I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.	
☐	I am enrolling during the Annual Enrollment Period (AEP) from October 15 through December 7.	
☐	(C-SNP Only) I have a qualifying chronic condition that makes me eligible for enrollment in a Chronic Condition Special Needs Plan.	
If none of these statements applies to you or you're not sure, please contact Imperial Health Plan of California, Inc. (HMO) (HMO SNP) at 1-800-838-5914, TTY:711, to see if you are eligible to enroll. We are open October 1 - March 31: Monday - Sunday from 8:00 am PST. - 8:00 pm PST and April 1 - September 30: Monday - Friday from 8:00 am PST. - 8:00 pm PST. except holidays.		

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Scope of Appointment Confirmation (SOA)

The Centers for Medicare and Medicaid Services (CMS) requires licensed sales agents to document the scope a marketing appointment* between the agent and the Medicare beneficiary (or their authorized representative) prior to any individual face-to-face or telephonic sales meeting. All information provided on this form is confidential. A separate form should be completed for each Medicare eligible beneficiary or his/her authorized representative. A new scope of appointment (SOA) is required if the beneficiary (or their authorized representative) requests information regarding a different plan type than previously agreed upon.

Please initial below beside the type of product(s) you want the agent to discuss.

Medicare Advantage Plans (Part C)	
☐	**Medicare Health Maintenance Organization (HMO):** A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan network (except in emergencies).
☐	**Medicare Special Needs Plan (C-SNP):** A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment, or automatically enroll you in the plan(s) discussed.

Beneficiary or Authorized Representative Signature and Signature Date	
Signature:	Signature Date:
If you are the authorized representative, please sign above and print below	
Representative's Name:	Your Relationship to the Beneficiary:

To be completed by Agent	
Agent Name: Alan Kip Meredith	Agent Phone: 805 548-8672
Agent Signature: A. Meredith	FMO:
Beneficiary Name:	Beneficiary Phone:
Beneficiary Address:	Beneficiary MBI:
Initial Method of Contact:	
Plan(s) the agent represented during this meeting: MAPD	Date Appointment Completed:
If applicable, provide the explanation why the SOA was not signed prior to meeting: (walk-in, unplanned attendee etc.)	

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Please Return this HRA in the self-addressed envelope provided.

Health Risk Assessment (HRA)

Date:		Member ID:		Plan Start Date:	
First Name:		Last Name:		Date of Birth:	
Gender:		Phone Number:		Email:	

Section 1: About You (Personal Characteristics)

1 What is your race and/or ethnicity? *Select all that apply and enter details in the space provided.*

- ☐ **American Indian/Alaskan Native** *(for example, Navajo Nation, Nome Eskimo Community, etc.)*
- ☐ **Asian** *(for example, Chinese, Filipino, Indian, Vietnamese, etc.)*
- ☐ **Black/African American** *(for example, African American, Haitian, Ethiopian, etc.)*
- ☐ **Hispanic or Latino** *(for example, Mexican, Salvadoran, Puerto Rican, Cuban, etc.)*
- ☐ **Middle Eastern or North African** *(for example, Lebanese, Iranian, Egyptian, Syrian, etc.)*
- ☐ **Native Hawaiian/ Pacific Islander** *(for example, Native Hawaiian, Samoan, Fijian, etc.)*
- ☐ **White** *(for example, English, German, Irish, Italian, Polish, etc.)*
- ☐ **Other Group**, please write in:

Section 2: Health Conditions

2 Have you ever had any of these health problems? (Check all that apply)

☐ Asthma	☐ Diabetes	☐ Stroke (incl. Brain Bleed)
☐ Depression, Bi-polar, or Schizophrenia	☐ Bladder or Bowel Problems	☐ Vision or Eye Problems
☐ Cancer (including Leukemia)	☐ Hearing Loss	☐ Seizures
☐ COPD or lung disease	☐ Severe Obesity	☐ Blood Vessel Disease
☐ Pneumonia or other lung infections	☐ High Blood Pressure	☐ Drug or Alcohol Problems
☐ Dementia or Memory Loss	☐ Foot Problems	☐ Past Organ Transplant(s):
☐ Liver Disease (End-Stage)	☐ Kidney Disease (Stage 5)	Which organ? _____
☐ Rheumatoid Arthritis, Joint Problems	☐ HIV or AIDS	Transplant Date: _____
☐ Paralysis (Quadriplegia)	☐ Heart Disease, Heart Failure	☐ Other: _____
☐ Trouble moving one side of the body	☐ Irregular Heartbeat	☐ None

Section 3: Your Health & Doctor Visits (Preventive Care)

3	How would you rate your current health? ☐ Excellent ☐ Fair ☐ Very Good ☐ Poor ☐ Good	4	Do you use tobacco products? ☐ Yes, cigarettes or cigars ☐ Yes, vape pens ☐ None
5	When was your last check-up?	6	When was your last mammogram?
7	When was your last blood test?	8	When was your last colon cancer screening?
9	Do you regularly do any kind of physical activity or exercise? ☐ Yes ☐ No	10	Have you been offered a palliative care visit to help manage chronic conditions? ☐ Yes ☐ No
11	Overall, how comfortable are you with performing these activities of daily living?		

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	Eating ☐ Can do independently ☐ Need Assistance		Brushing hair, brushing teeth, shaving, clipping nails, etc.? ☐ Can do independently ☐ Need Assistance
	Dressing and Undressing ☐ Can do independently ☐ Need Assistance		Getting in and out of bed and moving around freely? ☐ Can do independently ☐ Need Assistance
	Using the toilet ☐ Can do independently ☐ Need Assistance		Bathing or showering completely ☐ Can do independently ☐ Need Assistance
12	If you have diabetes or a heart condition, are you taking a statin (cholesterol medicine)? ☐ Yes ☐ No	13	When was your last dilated retinal (eye) exam? Exam Date: _____ Location: _____ Was retinopathy found? ☐ Yes ☐ No
14	What was the A1c level from your last blood test? Test Date: _____ Level: _____	15	When was your last kidney (urine or eGFR) test? Test Date: _____ Results (if known): _____
16	When was your last blood pressure reading? Reading Date: _____ BP levels: ____/____ Location of Reading: ☐ Home ☐ Doctor's Office	17	Have you received any of the following vaccines this year? **Flu** ☐ Yes ☐ No **Pneumonia** ☐ Yes ☐ No **COVID** ☐ Yes ☐ No **Others** ☐ Yes ☐ No
18	If you do not get vaccinated regularly, why?	19	If you received other vaccine(s) this year, which did you receive?
20	How would you describe your eating habits? ☐ Healthy and balanced ☐ Somewhat healthy ☐ Unhealthy or not regular meals	21	Do you currently drink alcohol or use recreational drugs or substances? ☐ Yes, regularly ☐ Yes, occasionally ☐ No or prefer not to say
22	How many times have you been admitted to a hospital in the past 12 months? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ More than 5 times	23	How many times have you gone to the emergency room (ER) in the past 12 months? ☐ 0 ☐ 1-3 ☐ 4-7 ☐ More than 7 times
24	Have you had any stays at a Skilled Nursing Facility (SNF) or Acute Rehab Facility in the past 12 months? ☐ Yes ☐ No		
Section 4: Moving and Balance (Risk of Falling)			
25	Have you fallen in the past year? ☐ Yes ☐ No	26	Do you feel unsteady while walking or standing? ☐ Yes ☐ No
27	Do you need help walking or standing? ☐ Yes ☐ No	28	Has your doctor conducted a timed walk test that lasted 12 seconds or more? ☐ Yes ☐ No
29	Do you have trouble seeing clearly? ☐ Yes ☐ No	30	Have you had a vision test in the past year? ☐ Yes ☐ No
Section 5: Medicines, Allergies, & Pain			
31	Do you take prescription medicines? ☐ Yes ☐ No If yes, how many? _____ List all known medications: _____		
32	Do any medicines make you dizzy, sleepy, or confused? ☐ Yes ☐ No	33	Do you currently have pain or discomfort? ☐ No ☐ Yes. If yes, where? _____ What is the level of pain on a scale from 0 – 10? _____ *(0 = No Pain, 10 = Worst Ever)* _____

34	Do you have any known allergies? ☐ Yes ☐ No If yes, list the allergens: _____	35	Do you get extra help from Medicare to pay for your medications? ☐ Yes ☐ No

Section 6: Support & Social Life

36	Do you feel safe at home? ☐ Yes ☐ No	37	Do you have a caregiver helping you now? ☐ Yes ☐ No If yes, how many days each week? _____
38	Do you have family members or others who are willing and able to help you when you need it? ☐ Yes ☐ No		
39	Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No		
40	How often do you speak with or see close friends/family? ☐ Less than once a week ☐ 1–2 times a week ☐ 3–5 times a week ☐ More than 5 times a week		

Section 7: Housing & Transportation

41	What is your housing situation today? ☐ I have a steady place to live ☐ I have a place to live today, but I am worried about losing it in the future ☐ I do not have a steady place to live *(I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)*
42	In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? *(check all that apply)* ☐ Yes, it has kept me from medical appointments or getting medications ☐ Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need ☐ No

Section 8: Food & Utilities

43	Within the past 12 months, you worried that your food would run out before you got money to buy more. ☐ Often true ☐ Sometimes true ☐ Never true
44	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? ☐ Yes ☐ No ☐ Already shut off

Section 9: Mood and Emotional Health

45 In the past two weeks, how often have you been bothered by any of the following problems?

Check one box for each statement:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	0	1	2	3
Lost interest or joy in things:	☐	☐	☐	☐
Feeling down, depressed, or hopeless:	☐	☐	☐	☐

Please Return this HRA in the self-addressed envelope provided.

IMPORTANT INFORMATION:

2025 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Imperial Health Plan of California, Inc. - H5496

For 2025, Imperial Health Plan of California, Inc. - H5496 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★½☆
Health Services Rating:	★★★½☆
Drug Services Rating:	★★★½☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online
Compare Star Ratings for this and other plans online at **Medicare.gov/plan-compare.**

Questions about this plan?
Contact Imperial Health Plan of California, Inc. 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time at 800-838-5914 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Pacific time. Current members please call 800-838-8271 (toll-free) or 711 (TTY).