

2022 Medicare Advantage Plan HMO/PPO Comparison Chart for Alameda County

~ Rev 11/10/21 ~

Medicare Advantage Plans contract with the Centers for Medicare and Medicaid Services (CMS) to provide all the benefits covered by Medicare and some additional benefits. In exchange, CMS (Medicare) pays the plan a fixed fee per member, per month. This amount varies by region and is also adjusted for the individual member's age, gender and health condition. **To enroll in a Medicare Advantage plan, a person must have both Medicare Parts A & B. The person must also live within the plan's service area.** Medicare Advantage plans must accept anybody on Medicare, including those who are under age 65 on Medicare through disability, regardless of their health condition. In 2021, for the first time, people with ESRD can also enroll in Medicare Advantage plans.

Medicare HMOs are one type of Medicare Advantage (MA) plan. When joining a Medicare HMO, beneficiaries do not give up their Medicare coverage; rather they agree to receive it through the plan's network of providers. A member must choose a Primary Care Physician and receive a referral to see a specialist. The Medicare HMO will *not* pay for services received outside the plan's network unless it is urgent or emergency care. In those circumstances, the member should notify the plan as soon as possible. The cost-sharing varies from plan to plan. Premiums, co-payments, and extra benefits can differ. The Annual Out of Pocket Maximum listed for each plan applies to all cost-sharing *except* plan premiums and prescription drug co-pays. In 2022, two Medicare HMO plans in Alameda County do not include the Medicare Part D prescription drug benefit. When people join an HMO *without* drug coverage, they are opting out of Part D. *Enrolling in a stand-alone Part D plan will automatically trigger disenrollment from the Medicare Advantage Plan.*

A Medicare PPO is another type of Medicare Advantage (MA) plan. A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses such as deductibles and co-insurance will apply.

Medicare Special Needs Plans are another type of Medicare Advantage plan. They are designed for people on Medicare and Medi-Cal (duals), those with certain chronic conditions, or those who reside in nursing homes. They all must include Part D prescription drug coverage and they have a responsibility to coordinate benefits and care for their members. See our **2022 Special Needs Plan Comparison Chart** for more information and details.

Enrollment:

In the fall of 2021, Medicare beneficiaries can enroll, disenroll or change plans during the **Medicare Annual Enrollment Period, from October 15 through December 7. Changes take effect on January 1, 2022.** In 2022, members have one more opportunity to make a change: they can leave their MA plan and change back to Original Medicare during the **Medicare Advantage Open Enrollment Period, from Jan 1 through March 31.** This right only applies to those who begin the year enrolled in a Medicare Advantage plan. They can leave their MA plan and enroll in a stand-alone Part D plan or they can change to another Medicare Advantage plan. If someone returns to Original Medicare during this period, they will have through March 31 to join a stand-alone Medicare Prescription Drug Plan. There are no corresponding guarantee issue rights to get a Medigap plan without a health screening although people can apply for a Medigap at any time but must answer health screening questions.

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

ABOUT THIS CHART

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

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

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



SHIP
State Health Insurance
Assistance Program

Navigating Medicare

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2022 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<p><i>Please contact the Plan for more information or call 1-800-Medicare</i></p>	<p align="center">Aetna Medicare 855-335-1407 (Sales & Marketing) 833-859-6031 (Member Services) www.aetnamedicare.com</p>				<p align="center">Aetna Medicare 855-335-1407 (Sales & Marketing) 833-859-6031 (Member Services) www.aetnamedicare.com</p>																											
<p>Plan Name</p>	<p align="center">Aetna Medicare Plus Plan (HMO) (H4982-005-0)</p>				<p align="center">Aetna Medicare Eagle Plan (HMO) (H4982-013-0)</p>																											
<p>Star Rating</p>	<p align="center">★★★</p>				<p align="center">★★★</p>																											
<p>Annual OOP Max</p>	<p align="center">\$3,900</p>				<p align="center">\$4,200</p>																											
<p>Monthly Premium</p>	<p align="center">\$0</p>				<p align="center">\$0</p>																											
<p>Doctor Visits</p>	<p align="center">\$0 copay for Primary Care Physician; \$15 for Specialist</p>				<p align="center">\$0 copay for Primary Care Physician; \$10 for Specialist</p>																											
<p>Inpatient Hospital</p>	<p align="center">\$250 copay/day for days 1-7; \$0 per day for days 8 and beyond</p>				<p align="center">\$50 co-pay/day for days 1-3; \$0 for days 4-90; \$0 for days 91 and beyond (unlimited)</p>																											
<p>Outpatient Hospital</p>	<p align="center">\$0 copay for ambulatory surgical center visit; \$150 copay for outpatient hospital facility visit</p>				<p align="center">\$0 copay for ambulatory surgical center visit; \$50 copay for outpatient hospital facility visit</p>																											
<p>Skilled Nursing Facility</p>	<p align="center">\$0 copay/day for days 1-20; \$75 per day for days 21-100</p>				<p align="center">\$0 copay/day for days 1-20; \$188 per day for days 21-100</p>																											
<p>Ambulance</p>	<p align="center">\$225 copay per ground or air ambulance trip</p>				<p align="center">\$275 copay per ground or air ambulance trip</p>																											
<p>Emergency & Urgent Care</p>	<p align="center">\$90 copay per emergency room visit; \$15 per urgent care visit; \$90 per emergency or urgent care visit worldwide; copays waived for ER care if admitted to hospital</p>				<p align="center">\$90 copay per emergency room visit; \$10 copay per urgent care visit; \$90 per emergency or urgent care visit worldwide; copays waived for ER care if admitted to hospital</p>																											
<p>Lab Tests, Procedures, and Radiation Therapy</p>	<p align="center">\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$0 co-pay for diagnostic radiology; \$60 copay for therapeutic radiology</p>				<p align="center">\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$100 co-pay for diagnostic radiology; \$60 copay for therapeutic radiology</p>																											
<p>Renal Dialysis</p>	<p align="center">20% co-insurance per treatment</p>				<p align="center">20% co-insurance per treatment</p>																											
<p>Outpatient Mental Health Visits</p>	<p align="center">\$25 copay per individual or group therapy session</p>				<p align="center">\$25 copay per individual or group therapy session</p>																											
<p>Eyewear</p>	<p align="center">\$200 annual reimbursement allowance for eyeglasses or contacts</p>				<p align="center">\$250 annual reimbursement allowance for eyeglasses or contacts</p>																											
<p>Eye Exams</p>	<p align="center">\$0 copay per Medicare-covered vision services; \$0 copay for one routine exam per year</p>				<p align="center">\$0 copay per Medicare-covered vision services; \$0 copay for one routine exam per year</p>																											
<p>Hearing Aids</p>	<p align="center">\$1,250 annual hearing aid allowance per ear; purchased through NationsHearing</p>				<p align="center">\$2,500 annual hearing aid allowance per ear; purchased through NationsHearing</p>																											
<p>Hearing Exams</p>	<p align="center">\$0 copay for diagnostic hearing exam; \$0 copay for one annual routine exam</p>				<p align="center">\$0 copay for diagnostic hearing exam; \$0 copay for one annual routine exam</p>																											
<p>Dental</p>	<p align="center">Up to \$1,000 annual reimbursement for covered preventive and comprehensive services; any licensed dentist that is a Medicare provider</p>				<p align="center">Up to \$2,000 annual reimbursement for covered preventive and comprehensive services; any licensed dentist that is a Medicare provider</p>																											
<p>Chiropractic</p>	<p align="center">\$0 copay for Medicare covered visits; \$0 copay for routine chiropractic visits (unlimited); must use American Specialty Health provider</p>				<p align="center">\$0 copay for Medicare covered visits; \$0 copay for routine chiropractic visits (unlimited); must use American Specialty Health provider</p>																											
<p>Podiatry</p>	<p align="center">\$15 copay per Medicare-covered visit</p>				<p align="center">\$10 copay per Medicare-covered visit</p>																											
<p>Prescription Drugs (Outpatient)</p>	<table border="1"> <tr> <td><i>Cost-sharing shown is for network pharmacies</i></td> <td>30 days</td> <td>100 day retail</td> <td>100 day mail</td> </tr> <tr> <td>Preferred Generic</td> <td>\$0</td> <td>\$0</td> <td>\$0</td> </tr> <tr> <td>Generic</td> <td>\$0</td> <td>\$0</td> <td>\$0</td> </tr> <tr> <td>Preferred Brand</td> <td>\$42</td> <td>\$126</td> <td>\$126</td> </tr> <tr> <td>Non-Preferred Brand</td> <td>\$99</td> <td>\$297</td> <td>\$297</td> </tr> <tr> <td>Specialty co-insurance</td> <td>33%</td> <td>N/A</td> <td>N/A</td> </tr> </table> <p>\$0 deductible; after total yearly drug costs reach \$4,430, you pay \$0 for Tier 1 and 2 drugs and no more than 25% of the plan's cost for brand name drugs until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and the greater of \$9.85 or 5% for brands.</p>				<i>Cost-sharing shown is for network pharmacies</i>	30 days	100 day retail	100 day mail	Preferred Generic	\$0	\$0	\$0	Generic	\$0	\$0	\$0	Preferred Brand	\$42	\$126	\$126	Non-Preferred Brand	\$99	\$297	\$297	Specialty co-insurance	33%	N/A	N/A	<p align="center">THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.</p> <p align="center">YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.</p>			
<i>Cost-sharing shown is for network pharmacies</i>	30 days	100 day retail	100 day mail																													
Preferred Generic	\$0	\$0	\$0																													
Generic	\$0	\$0	\$0																													
Preferred Brand	\$42	\$126	\$126																													
Non-Preferred Brand	\$99	\$297	\$297																													
Specialty co-insurance	33%	N/A	N/A																													
<p>Other Benefits/Options</p>	<p>Acupuncture: \$0 copay for unlimited acupuncture treatments within American Specialty Health network Over the Counter: \$75 quarterly allowance for items in Health Solutions catalog Transportation: \$0 copay for 12 one-way trips each year to plan approved locations Wellness: \$0 co-pay for basic Silver Sneakers membership</p>				<p>Acupuncture: \$0 copay for unlimited acupuncture treatments with American Specialty Health network Over the Counter: \$105 quarterly allowance for items in Health Solutions catalog Transportation: \$0 copay for 12 one-way trips each year to plan approved locations Wellness: \$0 co-pay for basic Silver Sneakers membership</p>																											
<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Brown and Toland Hospitals: Alta Bates/Summit Medical Center (Berkeley/Oakland), St. Rose (Hayward) Stanford Valley Care (Pleasanton and Livermore), and Washington Hospital (Fremont)</p>				<p>Medical Groups: Brown and Toland Hospitals: Alta Bates/Summit Medical Center (Berkeley/Oakland), St. Rose (Hayward) Stanford Valley Care (Pleasanton and Livermore), and Washington Hospital (Fremont)</p>																											

2022 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	<p align="center">Anthem Blue Cross 800-619-6164 (Sales & Marketing) 888-230-7338 (Member Services) www.anthem.com</p>							
Plan Name	<p align="center">Anthem MediBlue Plus (HMO) (H0544-097-0)</p>				<p align="center">Anthem MediBlue Select (HMO) (H0544-098-0)</p>			
Star Rating	★★★1/2				★★★1/2			
Annual OOP Max	\$4,900				\$7,550			
Monthly Premium	\$49				\$0			
Doctor Visits	\$0 for Primary Care Physician; \$15 for Specialist				\$15 for Primary Care Physician; \$45 for Specialist			
Inpatient Hospital	\$265 copay for days 1-7; \$0 copay/day for days 8 and beyond				\$325 copay for days 1-6; \$0 copay/day for days 7 and beyond			
Outpatient Hospital	\$200 copay for ambulatory surgical center visit; \$265 for outpatient hospital facility visit				\$275 copay for ambulatory surgical center visit; \$325 for outpatient hospital facility visit			
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$188 per day for days 21-100				\$0 copay/day for days 1-20; \$188 per day for days 21-100			
Ambulance	\$250 copay per ground ambulance trip; 20% coinsurance per air ambulance trip				\$250 copay per ground ambulance trip; 20% coinsurance per air ambulance trip			
Emergency & Urgent Care	\$90 copay for ER visit; \$35 for urgent care visit; Waived if admitted to hospital within 24 hours; \$100,000 annual limit for ER/urgent care worldwide				\$90 copay for ER visit; \$35 for urgent care visit; Waived if admitted to hospital within 24 hours; \$100,000 annual limit for ER/urgent care worldwide			
Lab Tests, Procedures, and Radiation Therapy	\$0-\$10 copay for lab services; \$0-\$50 for diagnostic tests & procedures; \$10 for x-rays; \$150 for diagnostic radiology services; 20% coinsurance for therapeutic radiology				\$0-\$10 copay for lab services; \$0-\$75 for diagnostic tests & procedures; \$10 for x-rays; \$150 for diagnostic radiology services; 20% coinsurance for therapeutic radiology			
Renal Dialysis	20% co-insurance per treatment				20% co-insurance per treatment			
Outpatient Mental Health Visits	\$40 copay per individual or group therapy session				\$40 copay per individual or group therapy session			
Eyewear	\$100 annual allowance with \$0 copay				\$100 annual allowance with \$0 copay			
Eye Exams	\$15 copay for diagnostic exam; \$0 copay for one annual routine exam				\$45 copay for diagnostic exam; \$0 copay for one annual routine exam			
Hearing Aids	\$3,000 annual allowance with \$0 copay				\$3,000 annual allowance with \$0 copay			
Hearing Exams	\$15 copay for Medicare-covered hearing exam; \$0 copay for one annual routine exam				\$45 copay for Medicare-covered hearing exam; \$0 copay for one annual routine exam			
Dental	\$15 copay for Medicare covered services; \$0 copay for 1 oral exam and 1 cleaning per year				\$45 copay for Medicare covered services; \$0 copay for 1 oral exam and 1 cleaning per year			
Chiropractic	\$20 copay per Medicare-covered visit				\$20 copay per Medicare-covered visit			
Podiatry	\$0-\$15 copay for Medicare-covered services; \$0 copay for unlimited routine visits each year				\$0-\$45 copay for Medicare-covered services; \$0 copay for 24 routine visits each year			
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for network pharmacies</i>	30 days	90 days retail	90 days mail	<i>Cost-sharing shown is for network pharmacies</i>	30 days	90 days retail	90 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$8	\$24	\$0	Generic	\$10	\$30	\$0
	Preferred Brand	\$42	\$126	\$126	Preferred Brand	\$42	\$126	\$84
	Non-Preferred Brand	\$95	\$285	\$285	Non-Preferred Brand	\$95	\$285	\$190
	Specialty co-insurance	33%	33%	N/A	Specialty co-insurance	33%	33%	N/A
Other Benefits/Options	<p>\$0 deductible; after total yearly drug costs reach \$4,430, you pay no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and the greater of \$9.85 or 5% for brands.</p> <p>Acupuncture: \$0 co-pay/visit for 24 visits per year</p> <p>Medicare Community Resource Support: Referrals and coordination for community services</p> <p>Over the Counter: \$50 allowance per quarter for covered items</p> <p>Wellness: \$0 for basic Silver Sneakers membership</p> <p>Optional supplemental packages:</p> <p>1: Preventive Dental at \$12 per month: up to \$500/year \$0 co-pays for basic preventive services</p> <p>2: Dental & Vision at \$32 per month: up to \$1,000/year for dental and \$150/year for eyewear</p> <p>3: Enhanced Dental & Vision at \$48 per month: up to \$2,000/year for dental and \$200/year for eyewear</p>				<p>\$0 deductible; after total yearly drug costs reach \$4,430, you pay no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and the greater of \$9.85 or 5% for brands.</p> <p>Acupuncture: \$0 co-pay/visit for 12 visits per year</p> <p>Medicare Community Resource Support: Referrals and coordination for community services</p> <p>Over the Counter: \$25 allowance per quarter for covered items</p> <p>Wellness: \$0 for basic Silver Sneakers membership</p> <p>Optional supplemental packages:</p> <p>1: Preventive Dental at \$12 per month: up to \$500/year; \$0 co-pays for basic preventive services</p> <p>2: Dental & Vision at \$32 per month: up to \$1,000/year for dental and \$150/year for eyewear</p> <p>3: Enhanced Dental & Vision at \$48 per month: up to \$2,000/year for dental and \$200/year for eyewear</p>			
	<p>Medical Groups: Brown & Toland Hospitals: Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), St. Rose, (Hayward), Stanford Valley Care (Pleasanton & Livermore), Washington (Fremont)</p>				<p>Medical Groups: Brown & Toland Hospitals: Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), St. Rose, (Hayward), Stanford Valley Care (Pleasanton & Livermore), Washington (Fremont)</p>			

2022 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Blue Shield of California 800-488-8000 (Sales & Marketing) 800-776-4466 (Member Services) www.blueshieldca.com/medicare	Brand New Day 866-255-4795 (Sales & Marketing) 866-255-4795 (Member Services) www.bndhmo.com						
Plan Name	Blue Shield Inspire (HMO) (H0504-041-0)	Classic Care II (HMO) (H0838-037-0)						
Star Rating	Not Enough Data Available	★★★1/2						
Annual OOP Max	\$4,200	\$999						
Monthly Premium	\$0	\$0						
Doctor Visits	\$0 copay for Primary Care Physician; \$15 for Specialist	\$0 copay for Primary Care Physician; \$10 for Specialist						
Inpatient Hospital	\$250 copay/day for days 1-5; \$0 per day for days 6 and beyond	\$100 copay/day for days 1-6; \$0 per day for days 7 and beyond						
Outpatient Hospital	\$50 copay per ambulatory surgical center visit; \$200 per outpatient hospital facility visit	\$0-\$75 copay for ambulatory surgical center visit; \$0-\$150 for outpatient hospital facility visit						
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$145 per day for days 21-100	\$0 copay/day for days 1-20; \$185.50 per day for days 21-100						
Ambulance	\$250 copay per ground or air ambulance trip	\$0-\$100 copay per ground ambulance trip						
Emergency & Urgent Care	\$85 copay per emergency room visit; \$15 per urgent care visit; \$85 copay for visits outside U.S.; waived if admitted to hospital within 24 hours	\$0-\$100 copay per emergency room visit; waived if admitted to hospital within 72 hours; \$0 per urgent care visit; Worldwide coverage with \$50,000 limit						
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$70 copay for diagnostic radiology; 20% co-insurance for therapeutic radiology	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$0-\$25 copay for diagnostic radiology; 20% co-insurance for therapeutic radiology						
Renal Dialysis	20% co-insurance per treatment	20% co-insurance per treatment						
Outpatient Mental Health Visits	\$30 copay for individual or group therapy session	\$0 copay for individual session; 20% co-insurance for group therapy session						
Eyewear	\$0 co-pay for eyeglass lenses and up to \$150 reimbursement for contact lenses each year; \$0 co-pay for up to \$150 for frames every 2 years	\$0 co-pay for lenses and frames; \$175 allowance each year; additional \$70 allowance for polycarb and \$89.50 for progressive lenses upgrades						
Eye Exams	\$15 copay per Medicare-covered exam; \$0 copay for one annual routine exam	\$10 copay per Medicare-covered exam; \$0 copay for one annual routine exam						
Hearing Aids	\$499 - \$699 copay per aid (depending on type); limited to 2 hearing aids per year	\$699 - \$999 copay per aid (depending on type); limited to 2 hearing aids per year						
Hearing Exams	\$5-\$15 copay for Medicare-covered exam; \$0-\$15 copay for one annual routine exam	\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam						
Dental	\$0 copay for certain preventive services; see optional supplemental plans below	\$0 copay for preventive and diagnostic services; \$0 - \$1,110 copays for comprehensive services						
Chiropractic	\$15 copay per Medicare-covered visit; \$0 copay/visit for 12 routine visits per year	\$0 copay/visit for up to 30 routine visits per year, combined with routine acupuncture						
Podiatry	\$15 copay per Medicare-covered visit; \$1,000 annual allowance for routine foot care	\$0 copay per Medicare-covered visit						
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for network pharmacies</i>	30 days	90 days retail	90 days mail	<i>Cost-sharing shown is for network pharmacies</i>	30 days	90 days retail	100 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$5	\$7.50	\$7.50	Generic	\$12	\$36	\$24
	Preferred Brand	\$40	\$100	\$100	Preferred Brand	\$47	\$121	\$94
	Non-Preferred Brand	\$95	\$237.50	\$237.50	Non-Preferred Brand	\$100	\$300	\$200
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	32%	N/A	N/A
		\$0 deductible; after total yearly drug costs reach \$4,430, you pay no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and the greater of \$9.85 or 5% for brands.			\$0 deductible for tiers 1&2; \$50 for tiers 2-5; after total yearly drug costs reach \$4,430, you pay no more than 25% of the plan's cost for brand name and 25% for generics until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and \$9.85 or 5% for brands.			
Other Benefits/Options	Acupuncture: \$0 copay/visit for 12 visits/year Dental HMO at \$12.40/month: \$1,000 each year for certain covered services with network dentist; Dental PPO at \$41.90/month: \$1,500 each year for covered services; \$50 deductible for major svcs. Mobility: \$0 copay for annual AAA Membership for members with chronic illnesses Over the Counter: \$90 quarterly allowance for covered items from OTC catalogue Wellness: \$0 for basic Silver Sneakers membership			Acupuncture: \$0 copay/visit for up to 30 visits/year, combined with routine chiropractic Meals: \$0 copay for up to 15 meals/week for 6 weeks for certain chronic conditions; \$5 copay for up to 30 additional meals Over the Counter: \$30 quarterly allowance for covered items from OTC catalogue Transportation: \$0 copay for unlimited one-way trips per year to plan approved locations Wellness: \$0 for basic Silver Sneakers membership				
Medical Groups and Hospitals	Medical Groups: Brown & Toland, Hill Physicians East Bay Hospitals: Alameda, Alta Bates/Summit Medical Center (Berkeley/Oakland), Eden (Castro Valley), San Leandro, Stanford Valley Care (Pleasanton & Livermore), and Washington (Fremont)			Medical Groups: Hill Physicians East Bay; John Muir Physicians Alameda Hospitals: Alameda, Alta Bates/Summit Medical Center (Berkeley/Oakland), Eden (Castro Valley), San Leandro, St. Rose (Hayward), and Washington (Fremont)				

2022 MEDICARE HMO/PPO COMPARISON CHART FOR ALAMEDA COUNTY

<p><i>Please contact the Plan for more information or call 1-800-Medicare</i></p>	<p align="center">Essence Healthcare (formerly Stanford Healthcare Advantage) 855-921-3777 (Sales & Marketing) 855-996-8422 (Member Services) www.stanfordhealthcareadvantage.org</p>																																																			
<p>Plan Name</p>	<p align="center">Essence Advantage Gold (HMO) (H2986-007-0)</p>		<p align="center">Essence Advantage Platinum (HMO) (H2986-004-0)</p>																																																	
<p>Star Rating</p>	<p align="center">★★★★1/2</p>		<p align="center">★★★★1/2</p>																																																	
<p>Annual OOP Max</p>	<p align="center">\$5,900</p>		<p align="center">\$4,900</p>																																																	
<p>Monthly Premium</p>	<p align="center">\$59</p>		<p align="center">\$89</p>																																																	
<p>Doctor Visits</p>	<p align="center">\$5 copay for Primary Care Physician; \$35 for Specialist</p>		<p align="center">\$0 copay for Primary Care Physician; \$30 for Specialist</p>																																																	
<p>Inpatient Hospital</p>	<p>\$315 copay/day for days 1-7; \$0 for days 8 & beyond</p>		<p>\$300 copay/day for days 1-7; \$0 for days 8 & beyond</p>																																																	
<p>Outpatient Hospital</p>	<p>20% co-insurance per ambulatory surgical center and outpatient hospital visit</p>		<p>\$240 copay per ambulatory surgical center and outpatient hospital visit</p>																																																	
<p>Skilled Nursing Facility</p>	<p>\$0 copay/day for days 1-20; \$150 per day for days 21-100</p>		<p>\$0 copay/day for days 1-20; \$100 per day for days 21-100</p>																																																	
<p>Ambulance</p>	<p>\$210 copay per ground or air ambulance trip</p>		<p>\$200 copay per ground or air ambulance trip</p>																																																	
<p>Emergency & Urgent Care</p>	<p>\$90 copay for emergency room visit; waived if admitted to hospital within 24 hours; \$35 for urgent care visit; \$90 copay for emergency/urgent care outside the U.S.; Worldwide coverage (unlimited)</p>		<p>\$90 per emergency room visit; waived if admitted to hospital within 24 hours; \$35 per urgent care visit; \$90 copay for emergency/urgent care outside the U.S.; Worldwide coverage (unlimited)</p>																																																	
<p>Lab Tests, Procedures, and Radiation Therapy</p>	<p>\$10 copay for lab services; \$25 for diagnostic procedures, tests, and x-rays; \$210 copay for diagnostic radiology; 20% of cost for therapeutic radiology</p>		<p>\$10 copay for lab services; \$45 for diagnostic procedures, tests, and x-rays; \$210 copay for diagnostic radiology; 20% of cost for therapeutic radiology</p>																																																	
<p>Renal Dialysis</p>	<p>20% co-insurance per treatment</p>		<p>20% co-insurance per treatment</p>																																																	
<p>Outpatient Mental Health Visits</p>	<p>\$30 copay per individual session; \$20 per group therapy session</p>		<p>\$20 copay per individual session; \$10 per group therapy session</p>																																																	
<p>Eyewear</p>	<p>See Optional Benefit Package below</p>		<p>See Optional Benefit Package below</p>																																																	
<p>Eye Exams</p>	<p>\$5-\$35 copay per Medicare-covered exam; Routine exams not covered; See Optional Benefit Packages below</p>		<p>\$10-\$30 copay per Medicare-covered exam; Routine exams not covered; See Optional Benefit Packages below</p>																																																	
<p>Hearing Aids</p>	<p align="center">Not Covered</p>		<p align="center">Not Covered</p>																																																	
<p>Hearing Exams</p>	<p>\$0 copay per Medicare-covered exam;</p>		<p>\$0 copay per Medicare-covered exam</p>																																																	
<p>Dental</p>	<p>\$35 copay per Medicare covered visit; See Optional Benefit Packages below</p>		<p>\$30 copay per Medicare covered visit; See Optional Benefit Packages below</p>																																																	
<p>Chiropractic</p>	<p>\$20 copay per Medicare covered visit; Routine care not covered</p>		<p>\$20 copay per Medicare covered visit; Routine care not covered</p>																																																	
<p>Podiatry</p>	<p>\$35 copay per Medicare-covered visit; Routine foot care not covered</p>		<p>\$30 copay per Medicare covered visit; Routine foot care not covered</p>																																																	
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<i>Cost-sharing shown is for network pharmacies</i>	30 days	90 days retail	90 days mail	<i>Cost-sharing shown is for network pharmacies</i>	30 days	90 days retail	90 days mail																																													
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Specialty co-insurance	28%	N/A	N/A	Specialty co-insurance	33%	33%	33%																																													
<p>Other Benefits/Options</p>	<p>Optional Dental/Vision Plan 1 at \$20/month: \$25 copay for one routine annual eye exam; \$150 allowance for eyewear every 2 years; Delta Dental HMO with \$0-\$445 copays; Contact plan for details Optional Dental Plan/Vision Plan 2 at \$38/month: \$25 copay for one routine annual vision exam; \$275 allowance for eyewear every two years; Delta Dental HMO/PPO with \$0 co-pay for preventive dental services; 0-60% co-insurance for comprehensive services; \$1,500 max allowance per year; Contact plan for details</p> <p>Meals: \$0 copay for up to 2 meals/day for 28 days following surgery or inpatient hospital stay; \$0 copay for up to 2 meals/day for 14 days for chronic condition Transportation: \$0 co-pay for 24 trips per year to plan approved locations, using network provider</p>		<p>Acupuncture: \$10 co-pay per visit up to 15/year Meals: \$0 copay for up to 2 meals/day for 28 days following surgery or inpatient hospital stay; \$0 copay for 2 meals/day for 14 day for chronic condition Over the Counter: \$50 quarterly credit Transportation: \$0 co-pay for 24 trips per year to plan approved locations, using network provider Wellness: \$0 for basic Silver&Fit membership</p>																																																	
<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Sutter East Bay, PAMF, Stanford Affiliates / Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), Stanford Palo Alto, and Stanford Valley Care (Pleas/Livermore)</p>		<p>Medical Groups: Sutter East Bay, PAMF, Stanford Affiliates / Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (C. Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), Stanford Palo Alto, and Stanford Valley Care (Pleas/Livermore)</p>																																																	

2022 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Imperial Health Plan of California 800-838-5197 (Sales & Marketing) 800-838-8271 (Member Services) www.imperialhealthplan.com	Imperial Health Plan of California 800-838-5197 (Sales & Marketing) 800-838-8271 (Member Services) www.imperialhealthplan.com	
Plan Name	Imperial Traditional (HMO) (H5496-007-0)	Imperial Strong (HMO) (H5496-014-0)	
Star Rating	★ ★ 1/2	★ ★ 1/2	
Annual OOP Max	\$2,999	\$7,550	
Monthly Premium	\$0	\$0	
Doctor Visits	\$5 for Primary Care Physician; \$10 for Specialist	20% for Primary Care Physician; 20% for Specialist	
Inpatient Hospital	\$150 co-pay for days 1-5; \$0 per day for days 6-90; \$670 per day for days 91-150	\$0 co-pay for days 1-60; \$371 co-pay/day for days 61-90; \$742 per day for days 91-150	
Outpatient Hospital	\$0 co-pay per outpatient hospital facility; \$0 per ambulatory surgical center visit	20% coinsurance per outpatient hospital facility; 20% coinsurance per ambulatory surgical center visit	
Skilled Nursing Facility	\$0 copay per day for days 1-20; \$164.50/day for days 21-100	\$0 copay per day for days 1-20; \$185.50/day for days 21-100	
Ambulance	\$150 co-pay per each ground trip; 20% co-insurance per each air ambulance trip	20% co-insurance per each ground trip; 20% co-insurance per each air ambulance trip	
Emergency & Urgent Care	\$100 per emergency room visit; \$20 copay for urgent care; copays waived if admitted to hospital within 48 hours; up to \$50,000 max worldwide	20% of cost, up to \$90, per emergency room visit; 20% of cost up to \$65 for urgent care; Costs waived if admitted to hospital within 72 hours	
Lab Tests, Procedures, and Radiation Therapy	\$0 co-pay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance for therapeutic radiology	20% co-insurance for lab services, diagnostic tests & procedures, x-rays, diagnostic radiology and therapeutic radiology	
Renal Dialysis	20% co-insurance per treatment	20% co-insurance per treatment	
Outpatient Mental Health Visits	20% co-insurance per individual or group therapy session	20% co-insurance per individual or group therapy session	
Eyewear	\$0 co-pay for contact lenses; \$0 co-pay for eyeglasses; \$250 annual allowance	\$0 co-pay for contact lenses; \$0 co-pay for eyeglasses; \$240 annual allowance	
Eye Exams	\$0 co-pay per Medicare-covered vision services; \$0 co-pay for routine exams	\$0 co-pay per Medicare-covered vision services; \$0 co-pay for routine exams	
Hearing Aids	20% co-insurance for hearing aids; \$1,250 annual allowance	20% co-insurance for hearing aids; \$1,000 annual allowance	
Hearing Exams	20% coinsurance for Medicare-covered exam; 20% co-insurance for routine exams; plan covers up to \$250/year	20% coinsurance for Medicare-covered exams; 20% co-insurance for routine exams; plan covers up to \$250/year	
Dental	\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services; plan covers up to \$500/year; \$0 co-pay for certain restorative services; plan covers up to \$2000 per year; Liberty Dental Plan	\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services; plan covers up to \$500/year; \$0 co-pay for certain restorative service; plan covers up to \$2000 per year; Liberty Dental Plan	
Chiropractic	\$0 co-pay per Medicare-covered visit; Routine visits not covered	20% co-insurance per Medicare-covered visit; Routine visits not covered	
Podiatry	\$0 co-pay per Medicare-covered visit; \$0 co-pay for 6 routine visits per year	\$0 co-pay per Medicare-covered visit; \$0 co-pay for up to 6 routine visits per year	
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for network pharmacies</i>	<i>Cost-sharing shown is for network pharmacies</i>	
	30 days	30 days	
	90 days	90 days	
	90 days mail	90 days mail	
	Preferred Generic	\$0	\$0
	Generic	\$5	\$10
Preferred Brand	\$45	\$90	
Non-Preferred Brand	\$90	\$180	
Specialty co-insurance	33%	33%	
	N/A		
	\$0 deductible; after total yearly drug costs reach \$4,430, you pay \$0 for generics and no more than 25% of the plan's cost for brand name drugs until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and the greater of \$9.85 or 5% for brands.	\$480 deductible; after deductible, you pay 25% of the plan's cost for all drugs until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and the greater of \$9.85 or 5% for brands.	
Other Benefits/Options	Meals: \$0 copay for up to 7 home-delivered meals following a surgery or hospital stay Over the Counter: \$120 quarterly allowance for OTC items in OTC mail order catalogue Transportation: \$0 co-pay for unlimited round trips to plan approved locations Wellness: \$0 for basic Silver&Fit membership	Part B Premium Reduction: \$85 monthly reimbursement	
Medical Groups and Hospitals	Medical Groups: Brown & Toland, Imperial Health, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak) and Eden Medical Center (Castro Valley)	Medical Groups: Brown & Toland, Imperial Health, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak) and Eden Medical Center (Castro Valley)	

2022 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<p><i>Please contact the Plan for more information or call 1-800-Medicare</i></p>	<p align="center">Kaiser Permanente 800-777-1238 (Sales & Marketing) 800-443-0815 (Member Services) www.medicare.kaiserpermanente.org</p>																																																							
<p>Plan Name</p>	<p align="center">Kaiser Permanente Senior Advantage Basic Alameda (HMO) (H0524-059-0)</p>				<p align="center">Kaiser Permanente Senior Advantage (HMO) (H0524-032-0)</p>																																																			
<p>Star Rating</p>	<p align="center">★★★★★</p>				<p align="center">★★★★★</p>																																																			
<p>Annual OOP Max</p>	<p align="center">\$6,700</p>				<p align="center">\$4,900</p>																																																			
<p>Monthly Premium</p>	<p align="center">\$19</p>				<p align="center">\$79</p>																																																			
<p>Doctor Visits</p>	<p align="center">\$15 copay for Primary Care Physician; \$25 for Specialist</p>				<p align="center">\$5 copay for Primary Care Physician; \$15 for Specialist</p>																																																			
<p>Inpatient Hospital</p>	<p align="center">\$290 copay/day for days 1-5; \$0 per day for days 6 and beyond</p>				<p align="center">\$225 copay/day for days 1-5; \$0 per day for days 6 and beyond</p>																																																			
<p>Outpatient Hospital</p>	<p align="center">\$270 per ambulatory surgical center visit; \$0-\$270 copay per outpatient hospital facility visit;</p>				<p align="center">\$200 per ambulatory surgical center visit; \$0-\$200 copay per outpatient hospital facility visit;</p>																																																			
<p>Skilled Nursing Facility</p>	<p align="center">\$0 copay/day for days 1-20; \$100 per day for days 21-100</p>				<p align="center">\$0 copay/day for days 1-20; \$100 per day for days 21-100</p>																																																			
<p>Ambulance</p>	<p align="center">\$200 copay per air or ground ambulance trip</p>				<p align="center">\$200 copay per air or ground ambulance trip</p>																																																			
<p>Emergency & Urgent Care</p>	<p align="center">\$90 for emergency room visit; \$15 for urgent care visit; Worldwide coverage</p>				<p align="center">\$90 for emergency room visit; \$5 for urgent care visit; Worldwide coverage</p>																																																			
<p>Lab Tests, Procedures, and Radiation Therapy</p>	<p align="center">\$0-\$5 copay for lab, diagnostic tests & procedures; \$20 copay for x-ray; \$215 copay for diagnostic radiology; \$0 for therapeutic radiology</p>				<p align="center">\$0-\$5 copay for lab, diagnostic tests & procedures; \$5 copay for x-ray; \$195 copay for diagnostic radiology; \$0 for therapeutic radiology</p>																																																			
<p>Renal Dialysis</p>	<p align="center">20% co-insurance per treatment</p>				<p align="center">20% co-insurance per treatment</p>																																																			
<p>Outpatient Mental Health Visits</p>	<p align="center">\$15 copay per individual session; \$7 per group therapy session</p>				<p align="center">\$5 copay per individual session; \$2 per group therapy session</p>																																																			
<p>Eyewear</p>	<p align="center">\$40 allowance for eyewear every 2 years; See Optional Benefits Plan below</p>				<p align="center">\$40 allowance for eyewear every 2 years; See Optional Benefits Plan below</p>																																																			
<p>Eye Exams</p>	<p align="center">\$15-\$25 copay per Medicare-covered exam; \$15 per routine exam</p>				<p align="center">\$5-\$15 copay per Medicare-covered exam; \$5 per routine exam</p>																																																			
<p>Hearing Aids</p>	<p align="center">Not Covered See Optional Benefits Plan below</p>				<p align="center">Not Covered See Optional Benefit Plan below</p>																																																			
<p>Hearing Exams</p>	<p align="center">\$25 copay per Medicare-covered exam; Routine exams not covered</p>				<p align="center">\$15 copay per Medicare-covered exam; Routine exams not covered</p>																																																			
<p>Dental</p>	<p align="center">\$0 copay for certain preventive and comprehensive services; See Optional Benefits Plan below for additional dental benefits</p>				<p align="center">\$0 copay for certain preventive and comprehensive services; See Optional Benefits Plan below for additional dental benefits</p>																																																			
<p>Chiropractic</p>	<p align="center">\$15 copay per Medicare covered visit; Routine care not covered</p>				<p align="center">\$5 copay per Medicare covered visit; Routine care not covered</p>																																																			
<p>Podiatry</p>	<p align="center">\$25 copay per Medicare covered visit; Routine foot care not covered</p>				<p align="center">\$15 copay per Medicare covered visit; Routine foot care not covered</p>																																																			
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<p>Other Benefits/Options</p>	<p>Meals: \$0 copay for home-delivered meals after hospitalization due to congestive heart failure, two per day for four weeks, once per year Medical Financial Assistance Program: available to eligible members; contact plan for details Wellness: \$0 for Silver&Fit gym membership</p> <p>Optional Benefit Plan: Advantage Plus at \$16/month: -Dental: Copays vary depending upon the service; Delta Care USA HMO network -Hearing: \$350 allowance for 1 aid every 3 years -Vision: \$0 copay for eyewear with \$280 limit (in addition to \$40 limit above) every two years</p>				<p>Meals: \$0 copay for home-delivered meals after hospitalization due to congestive heart failure, two per day for four weeks, once per year Medical Financial Assistance Program: available to eligible members; contact plan for details Wellness: \$0 for Silver&Fit gym membership</p> <p>Optional Benefit Plan: Advantage Plus at \$16/month: -Dental: Copays vary depending upon the service; Delta Care USA HMO network -Hearing: \$350 allowance for 1 aid every 3 years -Vision: \$0 copay for eyewear with \$280 limit (in addition to \$40 limit above) every two years</p>																																																			
<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Kaiser Permanente Hospitals: Kaiser Oakland, San Leandro, Fremont</p>				<p>Medical Groups: Kaiser Permanente Hospitals: Kaiser Oakland, San Leandro, Fremont</p>																																																			

2022 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<p><i>Please contact the Plan for outline of coverage & provider information or call 1-800-Medicare</i></p>	<p align="center">United Health Care 844-723-6473 (Sales and Marketing) 877-596-3258 (Member Services) www.aarpmedicareplans.com</p>																																																	
<p>Plan Name</p>	<p align="center">AARP SecureHorizons Plan 1 (HMO) (H0543-070-0)</p>	<p align="center">UnitedHealthcare Canopy Health (HMO) (H0543-188-0)</p>																																																
<p>Star Rating</p>	<p align="center">★★★★</p>	<p align="center">★★★★</p>																																																
<p>Annual OOP Max</p>	<p align="center">\$6,700</p>	<p align="center">\$4,900</p>																																																
<p>Monthly Premium</p>	<p align="center">\$110</p>	<p align="center">\$69</p>																																																
<p>Doctor Visits</p>	<p align="center">\$0 copay for Primary Care Physician; \$10 for Specialist</p>	<p align="center">\$0 copay for Primary Care Physician; \$15 for Specialist</p>																																																
<p>Inpatient Hospital</p>	<p align="center">\$390 copay/day for days 1-5; \$0 for days 6 and beyond (unlimited)</p>	<p align="center">\$250 copay/day for days 1-7; \$0 for days 8 and beyond (unlimited)</p>																																																
<p>Outpatient Hospital</p>	<p align="center">\$370 copay for ambulatory surgical center visit; \$370 copay for outpatient hospital visit</p>	<p align="center">\$150 copay for ambulatory surgical center visit; \$210 copay for outpatient hospital visit</p>																																																
<p>Skilled Nursing Facility</p>	<p align="center">\$0 copay/day for days 1-20; \$188 per day for days 21-56; \$0 for 57-100</p>	<p align="center">\$0 copay/day for days 1-20; \$184 per day for days 21-47; \$0 for 48-100</p>																																																
<p>Emergency & Urgent Care</p>	<p align="center">\$90 copay for emergency room visit; waived if admitted to hospital within 24 hours; \$40 per urgent care visit; \$0 copay for worldwide coverage</p>	<p align="center">\$90 copay per emergency room visit; waived if admitted to hospital within 24 hours; \$40 per urgent care visit; \$0 copay for worldwide coverage</p>																																																
<p>Ambulance</p>	<p align="center">\$260 copay per ground or air ambulance trip</p>	<p align="center">\$265 copay per ground or air ambulance trip</p>																																																
<p>Lab Tests, Procedures, and Radiation Therapy</p>	<p align="center">\$0 copay for lab, diagnostic tests and procedures; \$15 copay per x-ray; \$105 copay for diagnostic radiology; \$60 copay for therapeutic radiology</p>	<p align="center">\$0 copay for lab, diagnostic tests and procedures; \$15 copay per x-ray; \$105 copay for diagnostic radiology; \$60 copay for therapeutic radiology</p>																																																
<p>Renal Dialysis</p>	<p align="center">20% co-insurance per treatment</p>	<p align="center">20% co-insurance per treatment</p>																																																
<p>Outpatient Mental Health Visits</p>	<p align="center">\$25 copay for individual therapy session; \$15 copay for group therapy session</p>	<p align="center">\$25 copay for individual therapy session; \$15 copay for group therapy session</p>																																																
<p>Eyewear</p>	<p align="center">\$0 copay for standard lenses, with \$100 allowance for frames or contact lenses every two years; through United Healthcare Vision</p>	<p align="center">\$0 copay for standard lenses, with \$100 allowance toward frames or contact lenses every two years; through United Healthcare Vision</p>																																																
<p>Eye Exams</p>	<p align="center">\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam</p>	<p align="center">\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam</p>																																																
<p>Hearing Aids</p>	<p align="center">\$375 - \$1,425 copay per aid; up to 2 aids each year; through United Healthcare Hearing</p>	<p align="center">\$375 - \$1,425 copay per aid; up to 2 aids each year; through United Healthcare Hearing;</p>																																																
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<p>Dental</p>	<p align="center">20% co-insurance for each Medicare-covered visit; See Optional Benefits Plan below</p>	<p align="center">20% co-insurance for each Medicare-covered visit; See Optional Benefit Plan below</p>																																																
<p>Chiropractic</p>	<p align="center">\$10 copay for Medicare-covered visit; Routine care not covered</p>	<p align="center">\$15 copay for Medicare-covered visit; Routine care not covered</p>																																																
<p>Podiatry</p>	<p align="center">\$10 co-pay per Medicare-covered visit; \$10 co-pay per routine visit, up to 6 per year</p>	<p align="center">\$15 co-pay per Medicare-covered visit; \$15 co-pay per routine visit, up to 6 visits per year</p>																																																
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Specialty co-insurance	33%	N/A	N/A																																															
<p>Other Benefits/Options</p>	<p>Optional Dental Platinum Rider at: \$45/month: includes certain preventive and comprehensive benefits with varied cost-sharing</p>	<p>Over the Counter: \$40 allowance per quarter for items from Over-the-Counter catalog Transportation: \$0 copay for 24 one-way trips per year to plan-approved locations Wellness: \$0 for Renew Active Fitness membership Optional Dental Platinum Rider at \$45/month: includes certain preventive and comprehensive benefits with varied cost-sharing</p>																																																
<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Affinity East Bay, Brown & Toland, Hill Physicians East Bay, and Sutter East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), and Washington (Fremont)</p>	<p>Medical Groups: Canopy Health Hill Physicians East Bay, Canopy Health John Muir Physicians, and Canopy Health Meritage Medical Network Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (C. Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), UCSF, and Washington (Frem)</p>																																																

2022 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	SCAN Health Plan 877-870-4867 (Sales & Marketing) 800-559-3500 (Member Services) www.scanhealthplan.com	Wellcare by Health Net 866-277-6583 (Sales & Marketing) 800-275-4737 (Member Services) www.wellcarenow.com																								
Plan Name	SCAN Classic (HMO) (H05425-075-0)	Wellcare Patriot Giveback (HMO) (H0562-044-0)																								
Star Rating	★★★★1/2	★★★★																								
Annual OOP Max	\$4,000	\$3,400																								
Monthly Premium	\$0	\$0																								
Doctor Visits	\$0 copay for Primary Care Physician; \$10 for Specialist	\$5 copay for Primary Care Physician; \$10 for Specialist																								
Inpatient Hospital	\$250 copay/day for days 1-6; \$0 per day for days 7 and beyond; unlimited	\$200 copay/day for days 1-5; \$0 per day for days 6 and beyond																								
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$10-\$125 copay per outpatient hospital facility visit	\$50 per ambulatory surgical center visit; \$200 copay per outpatient hospital facility visit																								
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$75 for days 21-100	\$0 copay/day for days 1-20; \$75 for days 21-100																								
Ambulance	\$180 copay per one-way trip by ground or air	\$125 copay per one-way trip by ground or air																								
Emergency & Urgent Care	\$90 copay per ER visit; waived if admitted to hospital immediately; \$10 per urgent care visit; Worldwide coverage.	\$120 copay per ER visit; \$10 per urgent care visit; waived if admitted to hospital within 24 hours; \$50,000 plan limit for ER & urgent care worldwide																								
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic procedures, tests, x-rays and diagnostic radiology; \$60 copay for therapeutic radiology services	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$200 co-pay for diagnostic radiology; 20% co-insurance for therapeutic radiology services																								
Renal Dialysis	20% co-insurance per treatment	20% co-insurance per treatment																								
Outpatient Mental Health Visits	\$10 copay for individual or group therapy session	\$25 copay for individual or group therapy session																								
Eyewear	\$130 allowance for routine eyewear every 2 years	\$100 allowance for routine eyewear each year																								
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0-\$10 copay per Medicare-covered exam; \$0 copay for one annual routine exam																								
Hearing Aids	\$450 - \$750 copay per aid; up to 2 aids each year; through plan-contracted provider	Not Covered																								
Hearing Exams	\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam	\$10 copay for Medicare-covered exam; \$0 copay for one annual routine exam																								
Dental	\$10 co-pay per Medicare-covered visit; \$0 co-pay for certain preventive services; See Optional Benefits Plan below	\$10 co-pay per Medicare-covered visit; See Optional Benefits Plan below																								
Chiropractic	\$0 copay per Medicare covered visit; Routine visits not covered	\$10 copay per Medicare covered visit; \$10 copay for 36 routine visits per year																								
Podiatry	\$10 copay per Medicare-covered visit; Routine visits not covered	\$10 copay per Medicare-covered visit; \$10 co-pay/visit, for 12 routine visits per year																								
Prescription Drugs (Outpatient)	<table border="1"> <tr> <td><i>Cost-sharing shown is for network pharmacies</i></td> <td>30 days</td> <td>100 days retail</td> <td>100 days mail</td> </tr> <tr> <td>Preferred Generic</td> <td>\$0</td> <td>\$9</td> <td>\$9</td> </tr> <tr> <td>Generic</td> <td>\$0</td> <td>\$36</td> <td>\$36</td> </tr> <tr> <td>Preferred Brand</td> <td>\$37</td> <td>\$141</td> <td>\$141</td> </tr> <tr> <td>Non-Preferred Brand</td> <td>\$90</td> <td>\$300</td> <td>\$300</td> </tr> <tr> <td>Specialty co-insurance</td> <td>33%</td> <td>N/A</td> <td>N/A</td> </tr> </table> <p>\$0 deductible; after total yearly drug costs reach \$4,430, you pay \$0 or \$10 for drugs in Tiers 1 & 2 and no more than 25% of the plan's cost for brand name drugs until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and the greater of \$9.85 or 5% for brands.</p>	<i>Cost-sharing shown is for network pharmacies</i>	30 days	100 days retail	100 days mail	Preferred Generic	\$0	\$9	\$9	Generic	\$0	\$36	\$36	Preferred Brand	\$37	\$141	\$141	Non-Preferred Brand	\$90	\$300	\$300	Specialty co-insurance	33%	N/A	N/A	<p>THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.</p> <p>YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.</p>
<i>Cost-sharing shown is for network pharmacies</i>	30 days	100 days retail	100 days mail																							
Preferred Generic	\$0	\$9	\$9																							
Generic	\$0	\$36	\$36																							
Preferred Brand	\$37	\$141	\$141																							
Non-Preferred Brand	\$90	\$300	\$300																							
Specialty co-insurance	33%	N/A	N/A																							
Other Benefits/Options	<p>Over the Counter: \$100 quarterly allowance; balance carries over to next quarter but not calendar year</p> <p>Transportation: \$0 copay for 24 one-way trips per year to plan-approved locations</p> <p>Optional Dental Package: \$10/month; \$1,000/year for covered preventive and comprehensive services</p>	<p>Acupuncture: \$5-\$10 copay/visit for 36 routine visits per year</p> <p>Part B Premium Reduction: \$25 monthly reimbursement</p> <p>Routine Physical: \$0 copay for one annual exam</p> <p>Tobacco Cessation Counseling: \$0 copay/visit for 5 visits per year</p> <p>Wellness: \$0 for Peerfit Move gym membership</p> <p>Optional Dental Package: \$10/month; \$1,000/year for basic preventive services; varying copays for certain comprehensive services</p>																								
Medical Groups and Hospitals	<p>Medical Groups: Brown & Toland</p> <p>Hospitals: Alameda, San Leandro, St. Rose (Hayward)</p>	<p>Medical Groups: Brown & Toland, Hill Physicians East Bay, Sutter East Bay</p> <p>Hospitals: Alameda, Alta Bates/Summit (Berkeley/Oak), Eden (Castro Valley), St. Rose (Hayward), Stanford Valley Care (Pleasanton/Livermore), and Washington (Fremont)</p>																								

2022 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Wellcare by Health Net 866-277-6583 (Sales & Marketing) 800-275-4737 (Member Services) www.wellcarenow.com							
Plan Name	Wellcare Premium Ultra (HMO) (H0562-009-0)		Wellcare No Premium (HMO) (H0562-113-0)					
Star Rating	★★★★		★★★★					
Annual OOP Max	\$6,700		\$5,500					
Monthly Premium	\$121		\$0					
Doctor Visits	\$10 copay for Primary Care Physician; \$10 for Specialist		\$0 copay for Primary Care Physician; \$15 for Specialist					
Inpatient Hospital	\$335 copay/day for days 1-4; \$0 per day for days 5 and beyond		\$275 copay/day for days 1-7; \$0 per day for days 8 and beyond					
Outpatient Hospital	\$100 per ambulatory surgical center visit; \$325 copay per outpatient hospital facility visit		\$200 per ambulatory surgical center visit; \$250 copay per outpatient hospital facility visit					
Skilled Nursing Facility	\$0 copay for days 1-20; \$150 per day for days 21-100		\$0 copay for days 1-20; \$140 per day for days 21-100					
Ambulance	\$165 copay per one-way ground or air ambulance trip		\$310 copay per one-way ground or air ambulance trip					
Emergency & Urgent Care	\$90 copay per emergency room visit; \$15 per urgent care visit; waived if admitted to hospital within 24 hours; \$50,000 plan limit for worldwide coverage		\$90 copay per emergency room visit; \$20 per urgent care visit; waived if admitted to hospital within 24 hours; \$50,000 plan limit for worldwide coverage					
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$325 copay per diagnostic service; 20% co-insurance for therapeutic radiology		\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$60 copay per diagnostic service; 20% co-insurance for therapeutic radiology					
Renal Dialysis	20% co-insurance per treatment		20% co-insurance per treatment					
Outpatient Mental Health Visits	\$25 copay for individual or group therapy session		\$25 copay for individual or group therapy session					
Eyewear	Routine eyewear available for additional premium; See Optional Benefit Plan below		\$200 allowance for routine eyewear each year					
Eye Exams	\$0-\$15 copay per Medicare-covered exam; \$0 copay for one annual routine exam		\$15 copay per Medicare-covered exam; \$0 copay for one annual routine exam					
Hearing Aids	Not Covered		\$1,500 allowance for up to two hearing aids each year					
Hearing Exams	\$15 copay for Medicare-covered exam; \$0 copay for one annual routine exam		\$0-\$25 copay for Medicare-covered exam; \$0 copay for one annual routine exam					
Dental	\$15 copay for Medicare covered visit; See Optional Benefit Plan below		\$0 copay for Medicare covered visit; \$0 copays for certain preventive services; varying copays for comprehensive services					
Chiropractic	\$15 copay per Medicare covered visit; See Optional Benefit Plans below		\$15 copay per Medicare covered visit; \$15 copay for 24 routine visits per year					
Podiatry	\$10 copay per Medicare-covered visit; \$15 co-pay per visit for 6 routine visits per year		\$15 copay per Medicare-covered visit; \$25 co-pay per visit for 12 routine visits per year					
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for network pharmacies</i>	30 days	90 days retail	90 days mail	<i>Cost-sharing shown is for network pharmacies</i>	30 days	90 days retail	90 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$5	\$15	\$0	Generic	\$5	\$15	\$0
	Preferred Brand	\$37	\$111	\$74	Preferred Brand	\$37	\$111	\$74
	Non-Preferred Brand	\$90	\$270	\$180	Non-Preferred Brand	\$90	\$270	\$180
	Specialty co-insurance	33%	33%	N/A	Specialty co-insurance	33%	33%	N/A
	\$0 deductible; after total yearly drug costs reach \$4,430, you pay no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and the greater of \$9.85 or 5% for brands.				\$0 deductible; after total yearly drug costs reach \$4,430, you pay no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generics and the greater of \$9.85 or 5% for brands.			
Other Benefits/Options	Routine Physical: \$0 copay for one annual exam Tobacco Cessation Counseling: \$0 copay/visit for 5 visits per year Wellness: \$0 for Peerfit Move gym membership Wellcare Premium Ultra at \$25 per month: - Dental: \$0 co-pay for certain preventive services and varying copays for comprehensive services - Acupuncture and Chiropractic: \$10 co-pay per visit, up to 30 combined visits per year; - Eyewear: \$250 annual allowance				Acupuncture: \$0 copay for 24 routine visits per year Over the Counter: \$50 allowance per quarter for covered items available at participating locations or from plan catalog Routine Physical: \$0 copay for one annual exam Tobacco Cessation Counseling: \$0 copay/visit for 5 visits per year Transportation: \$0 copay per trip for up to 24 one-way trips per year to plan-approved locations Wellness: \$0 for Peerfit Move gym membership			
Medical Groups and Hospitals	Medical Groups: Brown & Toland, Hill Physicians East Bay, Sutter East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), St. Rose (Hayward), Stanford Valley Care (Pleas/Liv), and Washington (Fremont)				Medical Groups: Brown and Toland Hospitals: Alameda, San Leandro, St. Rose (Hayward), and Stanford Valley Care (Pleasanton/Livermore)			

2022 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Aetna Medicare 855-335-1407 (Sales & Marketing) 833-859-6031 (Member Services) www.aetnamedicare.com	Blue Shield of California 800-488-2000 (Sales & Marketing) 800-776-4466 (Member Services) www.blueshieldca.com/medicare		
Plan Name	Aetna Medicare Elite Plan (PPO)* (H5521-293-0)	Blue Shield Inspire (PPO)* (H4937-001-0)		
Star Rating	★★★★1/2	Not enough data available		
Annual OOP Max	\$6,700 / \$11,300*	\$6,700 / \$10,000*		
Monthly Premium	\$0	\$99		
Doctor Visits	\$0 copay for PCP; \$25 for Specialist in network 45% co-insurance out of network	\$10 copay for PCP; \$35 for Specialist in network 40% co-insurance out of network		
Inpatient Hospital	\$325 copay per day for days 1-4; \$0 per day for days 5 and beyond (unlimited) in network; 45% co-insurance out of network	\$175 copay per day for days 1-7; \$0 for days 8 and over; 40% co-insurance out of network		
Outpatient Hospital	\$295 copay for ambulatory surgical center visit; \$295 for outpatient hospital facility visit; 45% co-insurance out of network	\$100 copay for ambulatory surgical center visit; \$250 for outpatient hospital facility visit; 40% co-insurance out of network		
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$175 per day for days 21-100; 45% co-insurance out of network	\$0 copay/day for days 1-20; \$178 per day for days 21-100; 40% co-insurance out of network		
Ambulance	\$285 copay per ground or air ambulance trip	\$225 copay per ground or air ambulance trip		
Emergency & Urgent Care	\$90 copay per ER visit; \$40 per urgent care visit; \$90 per emergency or urgent care visit worldwide; co-pays waived for ER only if admitted to hospital	\$90 copay/emergency room visit; \$30 per urgent care visit; \$90 per emergency or urgent care visit worldwide; Waived if admitted to hospital in 24 hours		
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests, procedures, x-rays and diagnostic radiology; 20% for therapeutic radiology 45% co-insurance out of network	\$40 copay for lab services, diagnostic tests, procedures, and x-rays; \$100 for diagnostic radiology; 20% co-insurance for therapeutic radiology; 40% co-insurance out of network		
Renal Dialysis	20% co-insurance per treatment in network 50% co-insurance per treatment out of network	0-20% co-insurance per treatment in network 40% co-insurance per treatment out of network		
Outpatient Mental Health Visits	\$40 copay per individual or group therapy session in network; 45% co-insurance out of network	\$20 copay per visit per individual or group therapy session in network; 40% co-insurance out of network		
Eyewear	\$250 annual reimbursement for eyeglasses or contacts	\$20 copay for lenses per year; \$20 for frames every 2 years, in network; \$35 reimbursement for lenses every year; \$30 for frames every 2 years; out of network		
Eye Exams	\$0 copay for one annual routine exam in network 45% co-insurance out of network	\$20 co-pay for one annual routine exam in network; \$30 reimbursement out of network		
Hearing Aids	\$1,250 annual allowance per ear; purchased through NationsHearing	Not Covered		
Hearing Exams	\$0 copay for one annual routine exam; 45% co-insurance out of network	\$0 copay for one annual routine exam; 40% co-insurance out of network		
Dental	Up to \$1,000 annual reimbursement for covered preventive and comprehensive services; Any licensed dentist that is a Medicare provider	Optional Dental Package: Dental PPO at \$41.90 per month; up to \$1,500 annually for covered preventive and comprehensive services, after \$50 deductible		
Chiropractic	\$20 copay for Medicare covered visit; 45% out of network; Routine chiropractic visits not covered	\$0 copay/visit for 12 routine visits per year 40% co-insurance out of network		
Podiatry	\$40 copay per Medicare-covered visit; Routine podiatry services not covered	\$35 copay per Medicare-covered visit; 40% co-insurance out of network		
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for network pharmacies</i>	<i>Cost-sharing shown is for network pharmacies</i>		
		30 days	100 days retail	100 days mail
	Preferred Generic	\$0	\$0	\$0
	Generic	\$0	\$0	\$0
	Preferred Brand	\$47	\$141	\$141
	Non-Preferred Brand	\$100	\$300	\$300
	Specialty co-insurance	33%	N/A	N/A
	\$0 deductible; after total yearly drug costs reach \$4,430, you pay \$0 for Tier 1 and 2 drugs and no more than 25% of the plan's cost for brand name drugs until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generic & greater of \$9.85 or 5% for brand.	\$400 deductible (for Tiers 3, 4, and 5); after total yearly drug costs reach \$4,430, you pay \$0 for preferred generic and no more than 25% of the plan's cost for brand name drugs and 25% for generics until out-of-pocket drug expenses reach \$7,050. After that, you pay the greater of \$3.95 or 5% for generic & greater of \$9.85 or 5% for brand.		
Other Benefits/Options	Meals: Up to 14 home-delivered meals after an inpatient hospital or skilled nursing facility stay OTC: \$45 quarterly allowance for items in Health Solutions catalogue Wellness: \$0 for basic Silver Sneakers membership	Acupuncture: \$0 copay/visit for up to 12 visits/year Mobility: \$0 copay for annual AAA Membership for members with chronic illnesses; Over the Counter: \$80 quarterly allowance for items in OTC catalogue; Wellness: \$0 for basic Silver Sneakers membership		
Medical Groups and Hospitals	Medical Groups: Brown and Toland; Certain Independent Physicians / Hospitals: Alta Bates/Summit (Berk/Oak), St. Rose (Hay), Stanford Valley Care (Pleas/Liv), and Washington (Fremont) *\$750 annual deductible and higher cost-sharing apply to out of network services.	Medical Groups: Brown & Toland, Hill Physicians East Bay; John Muir Alameda Network; PAMF Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden, San Leandro, and Washington (Fremont) *\$750 annual deductible and higher cost-sharing apply to out of network services.		

Medicare Coverage for Preventive Care Benefits

To help people with Medicare stay healthy, Medicare covers certain screening tests, supplies, and teaching services. People with Original Medicare can receive most of these preventive benefits without having to pay coinsurance or the Part B deductible (\$203 in 2021). Medicare Advantage plans also cannot charge cost sharing (meaning no deductible, no copayment or coinsurance) for most in-network preventive benefits. These preventive benefits available at no cost include:

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

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

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

For more information on preventive care coverage, you can refer to the Medicare and You 2022 Handbook. Call 1-800-Medicare to request a copy or visit: www.medicare.gov/medicare-and-you.

Star Ratings:

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

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

This information is gathered from several different sources. In some cases it is based on member surveys, information from clinicians, or information from plans. In other cases, it is based on results from Medicare’s regular monitoring activities. (Explanation is from <https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx>)