

2023 Medicare Advantage Plan HMO Comparison Chart for Alameda County

~Rev. 11/04/22 ~

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

Medicare HMOs are one type of Medicare Advantage (MA) plan. When joining a Medicare HMO, beneficiaries do not give up their Medicare coverage; rather they agree to receive it through the plan's network of providers. A member must choose a Primary Care Physician and receive referrals to see specialists. The HMO will *not* pay for services received outside the plan's network unless it is urgent or emergency care. In those circumstances, members should notify their plans 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 2023, there are 30 Medicare HMOs in Alameda County, and they are listed in this chart. Three of these 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. In 2023, there are five Medicare PPOs in Alameda County. See our 2023 PPO Comparison Chart for more information and details: www.lashicap.org/hicap.

Medicare Special Needs Plans are another type of Medicare Advantage plan. They are designed for people on Medicare and Medi-Cal (duals), those with certain chronic conditions, or those who 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. In 2023, there are 20 Special Needs Plans in Alameda County. See our **2023 Special Needs Plan Comparison Chart** for more information and details: www.lashicap.org/hicap.

Enrollment:

In the fall of 2022, 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, 2023.** In 2023, 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.

IMPORTANT NOTE: Beginning in 2023, no Medicare Advantage or Prescription Drug Plan can charge more than a \$35 copay per month for insulin and any drug deductibles do not apply.

ABOUT THIS CHART

This Comparison Chart is a summary 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



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2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Aetna Medicare 855-859-6031 (Sales & Marketing) 833-570-6670 (Member Services) www.aetnamedicare.com	Aetna Medicare 855-859-6031 (Sales & Marketing) 833-570-6670 (Member Services) www.aetnamedicare.com			
Plan Name/Type	Aetna Medicare Plus Plan (HMO) (H4982-005)	Aetna Medicare Eagle Plan (HMO) (H4982-013)			
Star Rating	★★★	★★★			
Annual OOP Max	\$3,900	\$4,200			
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 1-7; \$0 per day for days 8 and beyond	\$50 co-pay/day for days 1-3; \$0 for days 4-90; \$0 for days 91 and beyond (unlimited)			
Outpatient Hospital	\$0 copay for ambulatory surgical center visit; \$150 copay for outpatient hospital facility visit	\$0 copay for ambulatory surgical center visit; \$50 copay for outpatient hospital facility visit			
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$75 per day for days 21-100	\$0 copay/day for days 1-20; \$196 per day for days 21-100			
Ambulance	\$225 copay per ground or air ambulance trip	\$275 copay per ground or air ambulance trip			
Emergency & Urgent Care	\$110 copay per emergency room visit; \$15 per urgent care visit; Copays apply worldwide; copays waived for ER care if admitted to hospital	\$110 copay per emergency room visit; \$10 copay per urgent care visit in U.S.; \$110 per emergency or urgent care visit worldwide; copays waived for ER care if admitted to hospital			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$0 copay for diagnostic radiology; \$60 copay for therapeutic radiology	\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$100 copay for diagnostic radiology; \$60 copay for therapeutic radiology			
Renal Dialysis	20% co-insurance per treatment	20% co-insurance per treatment			
Outpatient Mental Health Visits	\$25 copay per individual or group therapy session	\$25 copay per individual or group therapy session			
Eyewear	\$200 annual reimbursement allowance for eyeglasses or contacts	\$250 annual reimbursement allowance for eyeglasses or contacts			
Eye Exams	\$0 copay for diagnostic exams; \$0 copay for one annual routine exam	\$0 copay per Medicare-covered vision services; \$0 copay for one annual routine exam			
Hearing Aids	\$1,250 annual hearing aid allowance per ear; purchased through NationsHearing	\$2,500 annual hearing aid allowance per ear; purchased through NationsHearing			
Hearing Exams	\$0 copay for diagnostic hearing exam; \$0 copay for one annual routine exam	\$0 copay for diagnostic hearing exam; \$0 copay for one annual routine exam			
Dental	Up to \$1,000 annual reimbursement for covered preventive and comprehensive services; any licensed dental provider	Up to \$1,500 annual reimbursement for covered preventive and comprehensive services; any licensed dental provider			
Chiropractic	\$0 copay for Medicare covered visits; \$0 copay for unlimited routine visits; Must use American Specialty Health provider	\$0 copay for Medicare covered visits; \$0 copay for unlimited routine chiropractic visits; Must use American Specialty Health provider			
Podiatry	\$15 copay per Medicare-covered visit	\$10 copay per Medicare-covered visit			
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 day retail	100 day mail	THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE. YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.
	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	
	\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.				
Other Benefits/Options	Acupuncture: \$0 copay for unlimited acupuncture treatments within American Specialty Health network Over the Counter: \$105 quarterly allowance for plan-approved items at CVS retail or by mail order Transportation: \$0 copay for 12 one-way trips each year to plan approved locations, via SafeRide Wellness: \$0 copay for basic Silver Sneakers membership; at-home fitness kit			Acupuncture: \$0 copay for unlimited acupuncture treatments with American Specialty Health network Over the Counter: \$105 quarterly allowance for plan-approved items at CVS retail or by mail order Transportation: \$0 copay for 12 one-way trips each year to plan approved locations, via SafeRide Wellness: \$0 copay for basic Silver Sneakers membership; at-home fitness kit	
Medical Groups and Hospitals	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)			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)	

2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Aetna Medicare 855-859-6031 (Sales & Marketing) 833-570-6670 (Member Services) www.aetnamedicare.com	Blue Shield of California 800-488-8000 (Sales & Marketing) 800-776-4466 (Member Services) www.blueshieldca.com/medicare						
Plan Name/Type	Aetna Medicare Select Plan (HMO (H0523-068))	Blue Shield Inspire (HMO) (H0504-041)						
Star Rating	★ ★ ★ 1/2	★ ★ ★ ★						
Annual OOP Max	\$3,900	\$4,400						
Monthly Premium	\$0	\$0						
Doctor Visits	\$0 copay for Primary Care Physician; \$0 for Specialist	\$0 copay for Primary Care Physician; \$15 for Specialist						
Inpatient Hospital	\$250 copay/day for days 1-7; \$0 per day for days 8 and beyond	\$250 copay/day for days 1-5; \$0 per day for days 6 and beyond						
Outpatient Hospital	\$0 copay for ambulatory surgical center visit; \$150 copay for outpatient hospital facility visit	\$50 copay per ambulatory surgical center visit; \$200 per outpatient hospital facility visit						
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$75 per day for days 21-100	\$0 copay/day for days 1-20; \$145 per day for days 21-100						
Ambulance	\$225 copay per ground or air ambulance trip	\$260 copay per ground or air ambulance trip						
Emergency & Urgent Care	\$110 copay per emergency room visit; \$0 per urgent care visit in U.S.; \$110 per emergency or urgent care visit worldwide; copays waived for ER care if admitted to hospital	\$110 copay per emergency room visit; \$15 per urgent care visit; \$110 per emergency or urgent care visit worldwide; copays waived if admitted to hospital within 1 day						
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$0 copay for diagnostic radiology; \$60 copay for therapeutic radiology	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$70 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	\$25 copay per individual or group therapy session	\$30 copay for individual or group therapy session						
Eyewear	\$250 annual reimbursement allowance for eyeglasses or contacts	\$0 co-pay for eyeglass lenses; \$200 annual allowance for contact lenses; \$200 frame allowance every 2 yrs						
Eye Exams	\$0 copay for diagnostic exams; \$0 copay for one annual routine exam	\$15 copay for diagnostic exams; \$0 copay for one annual routine exam						
Hearing Aids	\$1,250 annual hearing aid allowance per ear; purchased through NationsHearing	\$499 - \$699 copay per aid (depending on type); limited to 2 hearing aids per year						
Hearing Exams	\$0 copay for diagnostic hearing exam; \$0 copay for one annual routine exam	\$0-\$15 copay for diagnostic hearing exam; \$0-\$15 copay for one annual routine exam						
Dental	\$1,500 annual allowance for covered preventive and comprehensive services; any licensed dental provider	\$0 copay for cleaning, x-rays, fluoride treatments and oral exams every six months; See optional supplemental plans below						
Chiropractic	\$0 copay for Medicare covered visits; \$0 copay for unlimited routine visits; Must use American Specialty Health provider	\$15 copay for Medicare-covered visits; \$0 copay/visit for 12 routine visits per year						
Podiatry	\$15 copay per Medicare-covered visit	\$15 copay per Medicare-covered visit; \$1,000 annual allowance for routine foot care						
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	90 days retail	90 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$0	\$0	\$0	Generic	\$5	\$7.50	\$7.50
	Preferred Brand	\$42	\$126	\$126	Preferred Brand	\$40	\$100	\$100
	Non-Preferred Brand	\$99	\$297	\$297	Non-Preferred Brand	\$95	\$237.50	\$237.50
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A
	\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.				\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. 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	Acupuncture: \$0 copay for unlimited acupuncture treatments within American Specialty Health network Over the Counter: \$105 quarterly allowance for plan-approved items at CVS retail or by mail order Transportation: \$0 copay for 12 one-way trips each year to plan approved locations, via SafeRide Wellness: \$0 copay for basic Silver Sneakers membership; at-home fitness kit				Acupuncture: \$0 copay/visit for 12 visits/year Dental HMO at \$12.50/month: \$1,000 each year Dental PPO at \$42.30/month: \$1,500 each year Mobility: \$0 copay for annual AAA Membership for members with qualifying chronic illnesses Over the Counter: \$100 quarterly allowance for covered items from OTC catalogue Transportation: \$0 copay for 20 one-way trips per year to plan approved locations Wellness: \$0 for basic Silver Sneakers membership			
Medical Groups and Hospitals	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)				Medical Groups: Brown & Toland, Hill Physicians East Bay Hospitals: Alameda, Alta Bates/Summit Medical Center (Berk/Oak), Eden (Castro Valley), San Leandro, and Washington (Fremont)			

2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<p><i>Please contact the Plan for more information or call 1-800-Medicare</i></p>	<p>Alignment Health Plan 888-979-2247 (Sales & Marketing) 866-634-2247 (Member Services)</p>							
<p>Plan Name/Type</p>	<p>Alignment Health CalPlus + Veterans (HMO) (H3815-036)</p>				<p>Alignment Health Harmony (HMO) (H3815-031)</p>			
<p>Star Rating</p>	<p>★★★★</p>				<p>★★★★</p>			
<p>Annual OOP Max</p>	<p>\$5,900</p>				<p>\$2,900</p>			
<p>Monthly Premium</p>	<p>\$0</p>				<p>\$0</p>			
<p>Doctor Visits</p>	<p>\$0 for Primary Care Physician; \$0 for Specialist</p>				<p>\$0 for Primary Care Physician; \$0 for Specialist</p>			
<p>Inpatient Hospital</p>	<p>\$1,600 deductible; \$0 copay for days 1-60; \$400 copay/day for days 61-90; \$800 copay/day for days 91-150</p>				<p>\$0 copay/day for days 1-4; \$100 copay/day for days 5-10; \$0 copay/day for days 10-90 and beyond</p>			
<p>Outpatient Hospital</p>	<p>\$0 copay for ambulatory surgical center; \$0 copay for outpatient hospital facility</p>				<p>\$100 copay for ambulatory surgical center visit; \$200 copay for outpatient hospital facility visit</p>			
<p>Skilled Nursing Facility</p>	<p>\$0 copay/day for days 1-20; \$200/day for days 21-100</p>				<p>\$0 copay/day for days 1-20; \$100 copay/day for days 21-100</p>			
<p>Ambulance</p>	<p>20% co-insurance per ground ambulance trip; 20% coinsurance per air ambulance trip</p>				<p>\$175 copay per ground or air ambulance trip; Waived if admitted to hospital</p>			
<p>Emergency & Urgent Care</p>	<p>20% coinsurance for ER and urgent care visits; ER copay waived if admitted within 3 days; \$75 copay for ER/urgent care worldwide; \$10,000 annual limit</p>				<p>\$85 copay for ER visit; \$0 for urgent care visit; copays not waived if admitted; \$0 copay for ER/urgent care worldwide with \$25,000 annual limit</p>			
<p>Lab Tests, Procedures, and Radiation Therapy</p>	<p>\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology</p>				<p>\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology</p>			
<p>Renal Dialysis</p>	<p>20% co-insurance per treatment</p>				<p>\$30 copay per treatment</p>			
<p>Outpatient Mental Health Visits</p>	<p>20% co-insurance per individual or group therapy session</p>				<p>\$40 copay per individual or group therapy session</p>			
<p>Eyewear</p>	<p>\$0 copay with Flex allowance; see Other Benefits</p>				<p>\$150 annual allowance for eyeglasses or contacts</p>			
<p>Eye Exams</p>	<p>\$0 copay for diagnostic exam; \$0 copay for one annual routine exam</p>				<p>\$0 copay for diagnostic exam; \$0 copay for one annual routine exam</p>			
<p>Hearing Aids</p>	<p>\$0 copay with Flex allowance; see Other Benefits</p>				<p>\$0 copay with Flex allowance; see Other Benefits</p>			
<p>Hearing Exams</p>	<p>\$0 copay for diagnostic exam; \$0 copay for one annual routine exam</p>				<p>\$0 copay for diagnostic exam; \$0 copay for one annual routine exam</p>			
<p>Dental</p>	<p>\$0 copay for certain preventive and comprehensive services with Flex allowance; see Other Benefits</p>				<p>\$0 copay for certain preventive and comprehensive services with Flex allowance; see Other Benefits</p>			
<p>Chiropractic</p>	<p>\$0 copay per Medicare-covered visit; \$0 copay for routine visits with Flex Allowance; See Other Benefits/Options</p>				<p>\$0 copay per Medicare-covered visit; \$0 copay for routine visits with Flex Allowance; See Other Benefits/Options</p>			
<p>Podiatry</p>	<p>\$0 copay for Medicare-covered services</p>				<p>\$5 copay for Medicare-covered services; \$5 copay for unlimited routine visits each year</p>			
<p>Prescription Drugs (Part D)</p>	<p><i>Cost-sharing shown is for preferred pharmacies</i></p>	<p>30 days</p>	<p>100 days retail</p>	<p>100 days mail</p>	<p><i>Cost-sharing shown is for preferred pharmacies</i></p>	<p>30 days</p>	<p>100 days retail</p>	<p>100 days mail</p>
	<p>Preferred Generic</p>	<p>\$0</p>	<p>\$0</p>	<p>\$0</p>	<p>Preferred Generic</p>	<p>\$0</p>	<p>\$0</p>	<p>\$0</p>
	<p>Generic</p>	<p>\$20</p>	<p>\$60</p>	<p>\$60</p>	<p>Generic</p>	<p>\$3</p>	<p>\$9</p>	<p>\$9</p>
	<p>Preferred Brand</p>	<p>25%</p>	<p>25%</p>	<p>25%</p>	<p>Preferred Brand</p>	<p>\$40</p>	<p>\$120</p>	<p>\$120</p>
	<p>Non-Preferred Brand</p>	<p>25%</p>	<p>25%</p>	<p>25%</p>	<p>Non-Preferred Brand</p>	<p>\$93</p>	<p>\$279</p>	<p>\$279</p>
	<p>Specialty co-insurance</p>	<p>25%</p>	<p>25%</p>	<p>25%</p>	<p>Specialty co-insurance</p>	<p>33%</p>	<p>N/A</p>	<p>N/A</p>
<p>\$505 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.</p>		<p>\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.</p>						
<p>Other Benefits/Options</p>	<p>Acupuncture: \$0 co-pay for unlimited routine visits covered with Flex Allowance Caregiver Support: \$600 annual allowance Flex Allowance: \$600 annual allowance for dental, vision, hearing, acupuncture, and chiropractic needs Groceries: \$150 monthly allowance for those with qualifying chronic conditions Meals: \$0 copay for up to 2 meals/day for 14 days for those with qualifying chronic conditions Over the Counter: \$10 quarterly allowance for covered items from OTC catalogue Transportation: \$0 copay for 20 one-way trips per year to plan approved locations within 50 miles Wellness: \$0 copay for basic gym membership</p>				<p>Acupuncture: \$0 co-pay/visit with Flex Allowance Flex Allowance: \$500 annual allowance for dental, vision, hearing, acupuncture, and chiropractic needs Groceries: \$50 monthly allowance for those with qualifying chronic conditions Over the Counter: \$100 quarterly allowance Pet Services: \$0 copay for 7 boarding days or 14 walks per year if diagnosed with chronic condition Transportation: \$0 copay for 8 one-way trips to plan approved locations within 20 miles Wellness: \$0 copay for basic gym membership Optional supplemental package: Enhanced Dental Option at \$27/month for certain comprehensive services, with 0-70% co-insurance, up to \$1,500/year</p>			
<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Alignment Health Plan Network; Brown & Toland, Nivano IPA Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv)</p>				<p>Medical Groups: Alignment Health Plan Network; Brown & Toland Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv)</p>			

2023 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">Alignment Health Plan 888-979-2247 (Sales & Marketing) 866-634-2247 (Member Services) www.alignmenthealthplan.com</p>																																	
<p>Plan Name/Type</p>	<p align="center">Alignment Health My Choice CalPlus (HMO) (H3815-007)</p>		<p align="center">Alignment Health Premium (HMO) (H3815-037)</p>																															
<p>Star Rating</p>	<p align="center">★★★★</p>		<p align="center">★★★★</p>																															
<p>Annual OOP Max</p>	<p align="center">\$3,000</p>		<p align="center">\$4,900</p>																															
<p>Monthly Premium</p>	<p align="center">\$0</p>		<p align="center">\$69</p>																															
<p>Doctor Visits</p>	<p>\$0 for Primary Care Physician; \$0 for Specialist</p>		<p>\$5 for Primary Care Physician; \$20 for Specialist</p>																															
<p>Inpatient Hospital</p>	<p>\$0 copay for days 1-4; \$100 copay/day for days 5-10; \$0 copay for days 11 and beyond; unlimited</p>		<p>\$225 copay for days 1-5; \$0 copay/day for days 6 and beyond; unlimited</p>																															
<p>Outpatient Hospital</p>	<p>\$100 copay for ambulatory surgical center; \$200 copay for outpatient hospital facility</p>		<p>\$0 copay for ambulatory surgical center visit; \$325 for outpatient hospital facility visit</p>																															
<p>Skilled Nursing Facility</p>	<p>\$0 copay/day for days 1-20; \$50 copay/day for days 21-100</p>		<p>\$0 copay/day for days 1-20; \$160 per day for days 21-57; \$0 for days 58-100</p>																															
<p>Ambulance</p>	<p>\$175 copay per trip by ground or air; waived if admitted</p>		<p>\$250 copay per trip by ground or air; waived if admitted</p>																															
<p>Emergency & Urgent Care</p>	<p>\$85 copay for ER visit; \$0 for urgent care visit; ER copay waived if admitted to hospital within 48 hours; \$12,000 annual limit for ER/urgent care worldwide</p>		<p>\$90 copay for ER visit; \$0 for urgent care visit; copays not waived if admitted; \$7,500 annual limit for ER/urgent care worldwide</p>																															
<p>Lab Tests, Procedures, and Radiation Therapy</p>	<p>\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology</p>		<p>\$0 copay for lab services, diagnostic tests & procedures; \$15 for x-rays; \$150 for diagnostic radiology; 20% coinsurance 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>\$0 copay per individual or group therapy session</p>		<p>\$40 copay per individual or group therapy session</p>																															
<p>Eyewear</p>	<p>\$100 annual allowance for eyeglasses or contacts</p>		<p>\$150 allowance for eyeglasses or contacts every 2 yrs</p>																															
<p>Eye Exams</p>	<p>\$0 copay for diagnostic exam; \$0 copay for one annual routine exam</p>		<p>\$0 copay for diagnostic exam; \$0 copay for one annual routine exam</p>																															
<p>Hearing Aids</p>	<p>\$1,000 allowance with \$0 copay; every 2 years</p>		<p>Not covered</p>																															
<p>Hearing Exams</p>	<p>\$0 copay for diagnostic exam; \$0 copay for one annual routine exam</p>		<p>\$0 copay for diagnostic exam; \$0 copay for one annual routine exam</p>																															
<p>Dental</p>	<p>\$0 copay for basic preventive services; \$20-\$425 copays for certain comprehensive services</p>		<p>\$0 copay for basic preventive services; \$20-\$425 copays for certain comprehensive services</p>																															
<p>Chiropractic</p>	<p>\$0 copay per Medicare-covered visit; \$0 copay for 40 routine visits per year, combined with acupuncture; \$10 coverage limit/visit</p>		<p>\$0 copay per Medicare-covered visit</p>																															
<p>Podiatry</p>	<p>\$5 copay for Medicare-covered services; \$5 copay for unlimited routine visits each year</p>		<p>\$0 copay for Medicare-covered services</p>																															
<p>Prescription Drugs (Part D)</p>	<table border="1"> <thead> <tr> <th></th> <th><i>Cost-sharing shown is for preferred pharmacies</i></th> <th>30 days</th> <th>100 days retail</th> <th>100 days mail</th> </tr> </thead> <tbody> <tr> <td>Preferred Generic</td> <td>\$0</td> <td>\$0</td> <td>\$0</td> <td>\$0</td> </tr> <tr> <td>Generic</td> <td>\$3</td> <td>\$9</td> <td>\$9</td> <td>\$0</td> </tr> <tr> <td>Preferred Brand</td> <td>\$40</td> <td>\$120</td> <td>\$120</td> <td>\$120</td> </tr> <tr> <td>Non-Preferred Brand</td> <td>\$100</td> <td>\$300</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> <td>N/A</td> </tr> </tbody> </table> <p>\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands. \$7,400 annual out of pocket max</p>					<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail	Preferred Generic	\$0	\$0	\$0	\$0	Generic	\$3	\$9	\$9	\$0	Preferred Brand	\$40	\$120	\$120	\$120	Non-Preferred Brand	\$100	\$300	\$300	\$300	Specialty co-insurance	33%	N/A	N/A	N/A
	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail																														
Preferred Generic	\$0	\$0	\$0	\$0																														
Generic	\$3	\$9	\$9	\$0																														
Preferred Brand	\$40	\$120	\$120	\$120																														
Non-Preferred Brand	\$100	\$300	\$300	\$300																														
Specialty co-insurance	33%	N/A	N/A	N/A																														
<p>Other Benefits/Options</p>	<p>Acupuncture: \$0 co-pay for 40 visits per year, combined with chiropractic; \$10 coverage limit/visit Caregiver Support: \$600 annual allowance Groceries: \$20 monthly allowance for those with qualifying chronic conditions Meals: \$0 copay for up to 2 meals/day for 14 days for those with qualifying chronic conditions Over the Counter: \$60 quarterly allowance Pet Services: \$0 copay for 7 boarding days or 14 walks per year with qualifying chronic condition Transportation: \$0 copay for 12 one-way trips per year to plan approved locations within 20 miles Wellness: \$0 copay for basic gym membership</p>		<p>Over the Counter: \$60 quarterly allowance for covered items Wellness: \$0 copay for basic gym membership Optional supplemental package: -Enhanced Dental Option at \$27/month for certain comprehensive services, with 0-70% co-insurance, up to \$1,500/year</p>																															
<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Alignment Health Plan Network; Brown & Toland, Nivano IPA Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv)</p>		<p>Medical Groups: Alignment Health Plan Network; Brown & Toland, Nivano IPA Hospitals: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose, (Hay), San Leandro, Stanford Valley Care (Pleas/Liv)</p>																															

2023 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">Anthem Blue Cross 800-619-6164 (Sales & Marketing) 888-230-7338 (Member Services) www.anthem.com</p>							
<p>Plan Name/Type</p>	<p align="center">Anthem MediBlue Coordination Plus (HMO) (H0544-099)</p>				<p align="center">Anthem MediBlue Select (HMO) (H0544-098)</p>			
<p>Star Rating</p>	<p align="center">★★★</p>				<p align="center">★★★</p>			
<p>Annual OOP Max</p>	<p align="center">\$7,550</p>				<p align="center">\$7,550</p>			
<p>Monthly Premium</p>	<p align="center">\$19.70</p>				<p align="center">\$0</p>			
<p>Doctor Visits</p>	<p align="center">20% co-insurance for Primary Care Physician; 20% co-insurance for Specialist</p>				<p align="center">\$15 for Primary Care Physician; \$45 for Specialist</p>			
<p>Inpatient Hospital</p>	<p align="center">\$1,600 deductible for days 1-60; \$400 copay/day for days 61-90; \$800 copay/day for days 91-150</p>				<p align="center">\$325 copay for days 1-6; \$0 copay/day for days 7 and beyond</p>			
<p>Outpatient Hospital</p>	<p align="center">20% co-insurance for ambulatory surgical center; 20% co-insurance for outpatient hospital facility</p>				<p align="center">\$275 copay for ambulatory surgical center visit; \$325 for outpatient hospital facility visit</p>			
<p>Skilled Nursing Facility</p>	<p align="center">\$0 copay/day for days 1-20; \$200/day for days 21-100</p>				<p align="center">\$0 copay/day for days 1-20; \$196 per day for days 21-100</p>			
<p>Ambulance</p>	<p align="center">20% co-insurance per ground ambulance trip; 20% coinsurance per air ambulance trip</p>				<p align="center">\$250 copay per ground ambulance trip; 20% coinsurance per air ambulance trip</p>			
<p>Emergency & Urgent Care</p>	<p align="center">\$90 copay for ER visit; \$60 for urgent care visit; ER copay waived if admitted to hospital within 24 hours; \$100,000 annual limit for ER/urgent care worldwide</p>				<p align="center">\$90 copay for ER visit; \$35 for urgent care visit; ER copay waived if admitted to hospital within 24 hours; \$100,000 annual limit for ER/urgent care worldwide</p>			
<p>Lab Tests, Procedures, and Radiation Therapy</p>	<p align="center">20% co-insurance for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology</p>				<p align="center">\$10 copay for lab services; \$50-75 for diagnostic tests & procedures; \$10 for x-rays; \$150 for diagnostic radiology; 20% coinsurance 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">20% co-insurance per individual or group therapy session</p>				<p align="center">\$40 copay per individual or group therapy session</p>			
<p>Eyewear</p>	<p align="center">\$300 annual allowance for eyeglasses or contacts</p>				<p align="center">\$100 annual allowance for eyeglasses or contacts</p>			
<p>Eye Exams</p>	<p align="center">20% co-insurance for diagnostic exam; \$0 copay for one annual routine exam</p>				<p align="center">\$45 copay for diagnostic exam; \$0 copay for one annual routine exam</p>			
<p>Hearing Aids</p>	<p align="center">\$3,000 annual allowance with \$0 copay</p>				<p align="center">\$3,000 annual allowance with \$0 copay</p>			
<p>Hearing Exams</p>	<p align="center">20% co-insurance for diagnostic exam; \$0 copay for one annual routine exam</p>				<p align="center">\$45 copay for diagnostic exam; \$0 copay for one annual routine exam</p>			
<p>Dental</p>	<p align="center">20% co-insurance for Medicare covered services; \$0 copay for basic preventive services; \$1,500 annual allowance for covered comprehensive svcs</p>				<p align="center">\$45 copay for Medicare covered services; \$0 copay for 1 oral exam and 1 cleaning per year</p>			
<p>Chiropractic</p>	<p align="center">\$20 copay per Medicare-covered visit; \$0 copay for 12 routine visits per year</p>				<p align="center">\$20 copay per Medicare-covered visit</p>			
<p>Podiatry</p>	<p align="center">20% coinsurance for Medicare-covered services; \$0 copay for unlimited routine visits each year</p>				<p align="center">\$0-45 copay for Medicare-covered services; \$0 copay for 24 routine visits each year</p>			
<p>Prescription Drugs (Part D)</p>	<p><i>Cost-sharing shown is for preferred pharmacies</i></p>	<p>30 days</p>	<p>90 days retail</p>	<p>90 days mail</p>	<p><i>Cost-sharing shown is for preferred pharmacies</i></p>	<p>30 days</p>	<p>90 days retail</p>	<p>90 days mail</p>
	<p>Preferred Generic</p>	<p>\$0</p>	<p>\$0</p>	<p>\$0</p>	<p>Preferred Generic</p>	<p>\$0</p>	<p>\$0</p>	<p>\$0</p>
	<p>Generic</p>	<p>\$13</p>	<p>\$39</p>	<p>\$0</p>	<p>Generic</p>	<p>\$10</p>	<p>\$30</p>	<p>\$0</p>
	<p>Preferred Brand</p>	<p>\$47</p>	<p>\$141</p>	<p>\$141</p>	<p>Preferred Brand</p>	<p>\$42</p>	<p>\$126</p>	<p>\$84</p>
	<p>Non-Preferred Brand</p>	<p>\$95</p>	<p>\$285</p>	<p>\$285</p>	<p>Non-Preferred Brand</p>	<p>\$95</p>	<p>\$285</p>	<p>\$190</p>
	<p>Specialty co-insurance</p>	<p>33%</p>	<p>N/A</p>	<p>N/A</p>	<p>Specialty co-insurance</p>	<p>33%</p>	<p>N/A</p>	<p>N/A</p>
<p>\$505 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.</p>		<p>\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.</p>						
<p>Other Benefits/Options</p>	<p>Acupuncture: \$0 co-pay/visit for unlimited visits Cost-Sharing Waived: most co-insurance and copays are waived for those w/full Medi-Cal/LIS Flex Accounts: \$50 monthly allowances for groceries and utilities if diagnosed with chronic condition; \$500 annual allowances for assistive devices and dental/vision/hearing needs Meals: \$0 copay for up to 2 meals/day for 5 days following discharge from hospital or SNF Over the Counter: \$100 allowance per quarter for covered items Transportation: \$0 copay for 60 one-way trips per year to plan approved locations Wellness: \$0 for basic Silver Sneakers membership</p>				<p>Acupuncture: \$0 co-pay/visit for 12 visits per year Over the Counter: \$25 allowance per quarter for covered items Wellness: \$0 for basic Silver Sneakers membership Optional supplemental packages: 1: Preventive Dental at \$12 per month: up to \$500/year; \$0 co-pays for basic preventive services 2: Dental & Vision at \$31 per month: up to \$1,000/year for dental and \$150/year for eyewear 3: Enhanced Dental & Vision at \$48 per month: up to \$2,000/year for dental and \$200/year for eyewear</p>			
<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Allied Pacific IPA, Brown & Toland, Imperial Health Northern CA Hospitals: Eden (Castro Valley), St. Rose, (Hayward), Stanford Valley Care (Pleasanton & Livermore), Washington (Fremont)</p>				<p>Medical Groups: Allied Pacific IPA, Brown & Toland, Imperial Health Northern CA Hospitals: Eden (Castro Valley), St. Rose, (Hayward), Stanford Valley Care (Pleasanton & Livermore), Washington (Fremont)</p>			

2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Brand New Day 866-255-4795 (Sales & Marketing) 866-255-4795 (Member Services) www.bndhmo.com	Brand New Day 866-255-4795 (Sales & Marketing) 866-255-4795 (Member Services) www.bndhmo.com						
Plan Name/Type	Classic Care I (HMO) (H0838-050)	Classic Care II (HMO) (H0838-051)						
Star Rating	★★★	★★★						
Annual OOP Max	\$3,650	\$1,500						
Monthly Premium	\$0	\$0						
Doctor Visits	\$0 copay for Primary Care Physician; \$0 for Specialist	\$0 copay for Primary Care Physician; \$10 for Specialist						
Inpatient Hospital	\$0 per day stay	\$150 copay/day for days 1-6; \$0 per day for days 7 and beyond						
Outpatient Hospital	\$0 copay per ambulatory surgical center visit; \$0 copay per outpatient hospital facility visit	\$0-\$150 copay for ambulatory surgical center visit; \$0-\$150 copay per outpatient hospital facility visit						
Skilled Nursing Facility	\$0 copay per stay	\$0 copay/day for days 1-20; \$200 per day for days 21-100						
Ambulance	\$0 copay per ground or air ambulance trip	\$0-\$200 copay per ground or air ambulance trip						
Emergency & Urgent Care	\$0 copay per emergency room visit; \$0 per urgent care visit; \$50,000 max worldwide with \$100 copay/visit	\$0-\$100 copay per emergency room visit; \$0 per urgent care visit; \$50,000 max worldwide with \$100 copay/visit						
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$0 copay for diagnostic radiology; 20% co-insurance for therapeutic radiology	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$0-\$50 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	\$0 copay for individual or group therapy session	\$10 copay for individual or group therapy session						
Eyewear	\$300 annual eyewear allowance	\$300 annual eyewear allowance						
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam						
Hearing Aids	\$149 copay per aid for basic model; limited to 2 hearing aids every 3 years	\$699 copay per aid for basic model; \$999 for prime model; limited to 2 hearing aids every 3 years						
Hearing Exams	\$0 copay for Medicare-covered exam; \$0 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; \$0 - \$350 copay for certain comprehensive services	\$0 copay for preventive and diagnostic services; \$0 - \$1,110 copay for certain comprehensive services						
Chiropractic	\$0 copay per Medicare-covered visit; \$0 copay/visit for 30 routine visits per year	\$0 copay/visit for up to 12 routine visits per year, combined with routine acupuncture						
Podiatry	20% coinsurance per Medicare-covered visit	\$0 copay per Medicare-covered visit						
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	90 days retail	90 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	90 days retail	100 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$0	\$0	\$0	Generic	\$12	\$36	\$24
	Preferred Brand	15%	15%	15%	Preferred Brand	\$47	\$121	\$94
	Non-Preferred Brand	15%	15%	15%	Non-Preferred Brand	\$100	\$300	\$200
	Specialty co-insurance	33%	33%	33%	Specialty co-insurance	32%	32%	32%
	\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.				\$50 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and \$10.35 or 5% for brands.			
Other Benefits/Options	Acupuncture: \$0 copay/visit for 30 visits/year, combined with routine chiropractic visits Food Allowance: Up to \$50/month for those with qualifying chronic conditions Meals: \$0 copay/meal for 14 meals each month for 12 months, for those with qualifying chronic conditions Over the Counter: \$210 quarterly allowance for plan approved items, via catalogue, retail, or online Transportation: \$0 copay for 48 one-way trips per year to plan approved locations Wellness: \$0 for basic Silver Sneakers membership				Acupuncture: \$0 copay/visit for up to 12 visits/year, combined with routine chiropractic visits Meals: \$0 copay for up to 15 meals/week for 6 weeks for those with qualifying chronic conditions; \$5 copay for up to 30 additional meals Over the Counter: \$40 quarterly allowance for plan approved items via catalogue, retail, or online Transportation: \$0 copay for 24 one-way trips per year to plan approved locations Wellness: \$0 for basic Silver Sneakers membership			
Medical Groups and Hospitals	Medical Groups: Alameda Health System, Hill Physician East Bay, John Muir Physicians Alameda Hospitals: Alameda, Alta Bates/Summit Medical Center (Berkley/Oakland), Eden (Castro Valley), San Leandro, and Washington (Fremont)				Medical Groups: Alameda Health System, Hill Physicians East Bay; John Muir Physicians Alameda Hospitals: Alameda, Alta Bates/Summit Medical Center (Berkley/Oakland), Eden (Castro Valley), San Leandro, and Washington (Fremont)			

2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Central Health Medicare Plan 866-314-2427 (Sales & Marketing) 866-314-2427 (Member Services) www.centralhealthplan.com	Central Health Medicare Plan 866-314-2427 (Sales & Marketing) 866-314-2427 (Member Services) www.centralhealthplan.com		
Plan Name/Type	Central Health Premier Plan I (HMO) (H5649-020)	Central Health Premier Plan II (HMO) (H5649-021)		
Star Rating	★★★1/2	★★★1/2		
Annual OOP Max	\$899	\$6,700		
Monthly Premium	\$0	\$34.50		
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist	\$0 for Primary Care Physician; \$0 for Specialist		
Inpatient Hospital	\$0 per stay; unlimited days	\$1,600 for days 1-60; \$400/day for days 60-90; \$800/day for days 91-150		
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$0 copay per outpatient hospital facility visit	\$0 per ambulatory surgical center visit; 20% coinsurance per outpatient hospital facility visit		
Skilled Nursing Facility	\$0 copay per day for days 1-20; \$200/day for days 21-100	\$0 copay per day for days 1-20; \$200/day for days 21-100		
Ambulance	\$0-\$40 copay per one-way trip by ground; 20% coinsurance per trip by air	20% coinsurance per each trip by ground; 20% coinsurance per trip by air		
Emergency & Urgent Care	\$0-\$50 copay per emergency room visit; \$0 for urgent care; ER copay waived if admitted to hospital within 72 hours; \$100,000 max worldwide with \$0 copay/ER and \$25/urgent care	20% of cost per emergency room visit; 20% of cost per urgent care visit; ER copay waived if admitted to hospital within 72 hours; \$100,000 max worldwide with \$0 copays		
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance for therapeutic radiology	20% coinsurance 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	\$0 copay per individual or group therapy session	20% coinsurance per individual or group therapy session		
Eyewear	\$0 copay for eyeglasses or contact lenses; \$300 annual allowance	\$0 copay for eyeglasses or contact lenses; \$300 annual allowance		
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 copay per Medicare-covered exam; 20% coinsurance for one annual routine exam		
Hearing Aids	\$2,000 annual allowance though NationsHearing	\$3,000 annual allowance though NationsHearing		
Hearing Exams	\$0 copay for Medicare-covered exam; \$0 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; \$0 - \$295 copay for certain comprehensive services	\$0 copay for certain preventive services; \$0 - \$295 copay for certain comprehensive services		
Chiropractic	\$0 copay per Medicare-covered visit; Routine visits not covered	\$0 copay per Medicare-covered visit; Routine visits not covered		
Podiatry	\$0 co-pay per Medicare-covered visit; Routine visits not covered	\$0 co-pay per Medicare-covered visit; Routine visits not covered		
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>		
	30 days	90 days	90 days mail	
	Preferred Generic	\$0	\$0	\$0
	Generic	\$0	\$0	\$0
	Preferred Brand	\$35	\$105	\$70
	Non-Preferred Brand	\$75	\$225	\$150
	Specialty co-insurance	33%	N/A	N/A
	\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.	\$104 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.		
Other Benefits/Options	Acupuncture: \$0 co-pay for unlimited visits/year Flex Allowance: \$325 quarterly allowance for OTC items, Herbal Catalogue items, & fitness fees Groceries: \$25 monthly allowance for those with qualifying chronic conditions Meals: \$0 copay/meal for 2 meals/day for 14 days for those with qualifying chronic conditions Transportation: \$0 co-pay for 48 one-way trips to plan approved locations within 50 miles Wellness: \$0 for basic Silver Sneakers membership	Acupuncture: \$0 co-pay for unlimited visits/year Cost-Sharing Waived: most co-insurance and copays are waived for those with full Medi-Cal/LIS Flex Allowance: \$325 quarterly allowance for OTC items, Herbal Catalogue items, & fitness fees Groceries: \$25 monthly allowance for those with qualifying chronic conditions Meals: \$0 copay/meal for 2 meals/day for 14 days for those with qualifying chronic conditions Transportation: \$0 co-pay for 48 one-way trips to plan approved locations within 50 miles Wellness: \$0 for basic Silver Sneakers membership		
Medical Groups and Hospitals	Medical Groups: Hill Physicians East Bay Hospitals: Fremont Hospital	Medical Groups: Hill Physicians East Bay Hospitals: Fremont Hospital		

2023 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">Essence Healthcare (formerly Stanford Healthcare Advantage) 855-921-3777 (Sales & Marketing) 855-996-8422 (Member Services) www.essencehealthcare.com</p>							
<p>Plan Name/Type</p>	<p align="center">Essence Advantage Gold (HMO) (H2986-007)</p>				<p align="center">Essence Advantage Platinum (HMO) (H2986-004)</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">\$57</p>				<p align="center">\$87</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 align="center">\$315 copay/day for days 1-7; \$0 for days 8 & beyond</p>				<p align="center">\$300 copay/day for days 1-7; \$0 for days 8 & beyond</p>			
<p>Outpatient Hospital</p>	<p align="center">20% co-insurance per ambulatory surgical center and outpatient hospital visit</p>				<p align="center">\$240 copay per ambulatory surgical center and outpatient hospital visit</p>			
<p>Skilled Nursing Facility</p>	<p align="center">\$0 copay/day for days 1-20; \$150 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">\$210 copay per ground or air ambulance trip</p>				<p align="center">\$200 copay per ground or air ambulance trip</p>			
<p>Emergency & Urgent Care</p>	<p align="center">\$110 copay for emergency room visit; waived if admitted to hospital within 24 hours; \$35 for urgent care visit; \$110 copay for emergency/urgent care outside the U.S.; Worldwide coverage (unlimited)</p>				<p align="center">\$110 per emergency room visit; waived if admitted to hospital within 24 hours; \$35 per urgent care visit; \$110 copay for emergency/urgent care outside the U.S.; Worldwide coverage (unlimited)</p>			
<p>Lab Tests, Procedures, and Radiation Therapy</p>	<p align="center">\$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 align="center">\$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>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">\$30 copay per individual session; \$20 per group therapy session</p>				<p align="center">\$20 copay per individual session; \$10 per group therapy session</p>			
<p>Eyewear</p>	<p align="center">See Optional Benefit Package below</p>				<p align="center">See Optional Benefit Package below</p>			
<p>Eye Exams</p>	<p align="center">\$5-\$35 copay per Medicare-covered exam; Routine exams not covered; See Optional Benefit Packages below</p>				<p align="center">\$0-\$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 align="center">\$0 copay per Medicare-covered exam;</p>				<p align="center">\$0 copay per Medicare-covered exam</p>			
<p>Dental</p>	<p align="center">\$35 copay per Medicare covered visit; See Optional Benefit Packages below</p>				<p align="center">\$20 copay per Medicare covered visit; See Optional Benefit Packages below</p>			
<p>Chiropractic</p>	<p align="center">\$20 copay per Medicare covered visit; Routine care not covered</p>				<p align="center">\$20 copay per Medicare covered visit; Routine care not covered</p>			
<p>Podiatry</p>	<p align="center">\$35 copay per Medicare-covered visit; Routine foot care not covered</p>				<p align="center">\$20 copay per Medicare covered visit; Routine foot care not covered</p>			
<p>Prescription Drugs (Part D)</p>	<p><i>Cost-sharing shown is for preferred pharmacies</i></p>	<p>30 days</p>	<p>90 days retail</p>	<p>90 days mail</p>	<p><i>Cost-sharing shown is for preferred pharmacies</i></p>	<p>30 days</p>	<p>90 days retail</p>	<p>90 days mail</p>
	<p>Preferred Generic</p>	<p>\$5</p>	<p>\$15</p>	<p>\$10</p>	<p>Preferred Generic</p>	<p>\$5</p>	<p>\$15</p>	<p>\$10</p>
	<p>Generic</p>	<p>\$15</p>	<p>\$45</p>	<p>\$30</p>	<p>Generic</p>	<p>\$15</p>	<p>\$45</p>	<p>\$30</p>
	<p>Preferred Brand</p>	<p>\$47</p>	<p>\$141</p>	<p>\$94</p>	<p>Preferred Brand</p>	<p>\$47</p>	<p>\$141</p>	<p>\$94</p>
	<p>Non-Preferred Brand</p>	<p>\$100</p>	<p>\$300</p>	<p>\$200</p>	<p>Non-Preferred Brand</p>	<p>\$100</p>	<p>\$300</p>	<p>\$200</p>
	<p>Specialty co-insurance</p>	<p>33%</p>	<p>N/A</p>	<p>N/A</p>	<p>Specialty co-insurance</p>	<p>33%</p>	<p>N/A</p>	<p>N/A</p>
<p>\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics & the greater of \$10.35 or 5% for brands.</p>	<p>\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.</p>							
<p>Other Benefits/Options</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 qualifying 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 qualifying chronic cond. Over the Counter: \$50 quarterly credit w/Flex Card 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>Optional Dental/Vision Plan 1 at \$20/month: \$25 copay for one routine annual eye exam; \$25 copay for eyeglass lenses every 2 years; \$150 allowance for frames or contact lenses every 2 years with \$25 copay; Delta Care USA with \$0 copay for certain preventive services; \$0-\$445 copays for various comprehensive services; Contact plan for details; available with either Gold or Platinum plan.</p>							
<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Affinity East Bay, 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: Affinity East Bay, 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>			

2023 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 800-838-8271 (Sales & Marketing) 800-838-8271 (Member Services) www.imperialhealthplan.com	Imperial Health Plan of California 800-838-8271 (Sales & Marketing) 800-838-8271 (Member Services) www.imperialhealthplan.com						
Plan Name/Type	Imperial Traditional (HMO) (H5496-007)	Imperial Strong (HMO) (H5496-014)						
Star Rating	★★1/2	★★1/2						
Annual OOP Max	\$2,999	\$8,300						
Monthly Premium	\$0	\$0*						
Doctor Visits	\$0 for Primary Care Physician; \$10 for Specialist	20% for Primary Care Physician; 20% for Specialist						
Inpatient Hospital	\$150 copay for days 1-5; \$0 per day for days 6-90; \$670 per day for days 91-150	\$0 copay for days 1-60; \$389 co-pay/day for days 61-90; \$778 per day for days 91-150						
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$0 copay per outpatient hospital facility visit	20% coinsurance per ambulatory surgical center visit; 20% coinsurance per outpatient hospital facility 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; \$200/day for days 21-100						
Ambulance	\$150 copay per one-way trip by ground; 20% coinsurance per each trip by air	20% coinsurance per each trip by ground; 20% coinsurance per each trip by air						
Emergency & Urgent Care	\$100 per emergency room visit; \$20 copay for urgent care; copays waived if admitted to hospital within 48 hours; \$50,000 max worldwide with \$0 copay/ER and \$20/urgent care	20% of cost, up to \$95, per emergency room visit; 20% of cost up to \$60 for urgent care; Costs waived if admitted to hospital within 72 hours						
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance for therapeutic radiology	20% coinsurance 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% coinsurance per individual or group therapy session	20% coinsurance per individual or group therapy session						
Eyewear	\$0 copay for eyeglasses or contact lenses; \$250 annual allowance	\$0 copay for eyeglasses or contact lenses; \$240 annual allowance						
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for routine exams	20% coinsurance per Medicare-covered exam; \$0 copay for routine exams						
Hearing Aids	20% coinsurance for hearing aids; \$2,500 annual allowance	20% coinsurance for hearing aids; \$1,000 annual allowance						
Hearing Exams	20% coinsurance for Medicare-covered exam; 20% coinsurance for routine exams; plan covers up to \$250/year	20% coinsurance for Medicare-covered exams; 20% coinsurance for routine exams; plan covers up to \$250/year						
Dental	\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services up to \$500/year; \$0 co-pay for certain comprehensive services; plan covers up to \$2000/year; Imperial HMO contracted provider	\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services; plan covers up to \$500/year; \$0 co-pay for certain comprehensive services; up to \$2000 per year; Imperial HMO contracted provider						
Chiropractic	\$0 copay 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; Routine visits not covered						
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>						
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	25%	25%	25%
	Generic	\$5	\$10	\$10	Generic	25%	25%	25%
	Preferred Brand	\$45	\$90	\$90	Preferred Brand	25%	25%	25%
	Non-Preferred Brand	\$90	\$180	\$180	Non-Preferred Brand	25%	25%	25%
	Specialty co-insurance	33%	33%	N/A	Specialty co-insurance	25%	25%	25%
	\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands. \$7,400 annual out of pocket max.				\$505 deductible; after deductible, you pay 25% of the plan's cost for all drugs until out-of-pocket drug expenses reach \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands. \$7,400 annual out of pocket max.			
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 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 NOTE: This plan has a \$226 medical deductible in addition to the Part D deductible			
Medical Groups and Hospitals	Medical Groups: Brown & Toland, Imperial Health, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (C. Valley), St. Rose (Hayward) and Washington (Fremont)				Medical Groups: Brown & Toland, Imperial Health, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (C. Valley), St. Rose (Hayward) and Washington (Fremont)			

2023 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 800-838-8271 (Sales & Marketing) 800-838-8271 (Member Services) www.imperialhealthplan.com	Imperial Health Plan of California 800-838-8271 (Sales & Marketing) 800-838-8271 (Member Services) www.imperialhealthplan.com			
Plan Name/Type	Imperial Dynamic (HMO) (H5496-012)	Imperial Courage (HMO) (H5496-016)			
Star Rating	★★1/2	★★1/2			
Annual OOP Max	\$899	\$2,999			
Monthly Premium	\$0	\$0			
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist	20% for Primary Care Physician; 20% for Specialist			
Inpatient Hospital	\$0 copay for days 1-90; \$670 per day for days 91-150	\$150 copay for days 1-5; \$0 co-pay/day for days 61-90; \$670 per day for days 91-150			
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$0 copay per outpatient hospital facility visit	\$0 per ambulatory surgical center visit; \$0 copay per outpatient hospital facility 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; \$164.50/day for days 21-100			
Ambulance	\$125 copay per one-way trip by ground; 20% coinsurance per each trip by air	\$125 copay per one-way trip by ground; 20% coinsurance per each trip by air			
Emergency & Urgent Care	\$100 per emergency room visit; \$0 copay for urgent care; ER copay waived if admitted to hospital within 48 hours; \$50,000 max worldwide with \$0 copay	\$100 per emergency room visit; \$0 copay for urgent care; ER copay waived if admitted to hospital within 48 hours; \$50,000 max worldwide with \$0 copay/ER and \$20 urgent care			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance for therapeutic radiology	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance for therapeutic radiology			
Renal Dialysis	20% co-insurance per treatment	20% co-insurance per treatment			
Outpatient Mental Health Visits	20% coinsurance per individual or group therapy session	20% coinsurance per individual or group therapy session			
Eyewear	\$0 copay for eyeglasses or contact lenses; \$250 annual allowance	\$0 copay for eyeglasses or contact lenses; \$250 annual allowance			
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for routine exams	\$0 copay per Medicare-covered exam; \$0 copay for routine exams			
Hearing Aids	20% coinsurance for hearing aids; \$1,000 annual allowance	20% coinsurance for hearing aids; \$1,250 annual allowance			
Hearing Exams	20% coinsurance for Medicare-covered exam; 20% coinsurance for routine exams; plan covers up to \$250/year	20% coinsurance for Medicare-covered exams; 20% coinsurance for routine exams; plan covers up to \$250/year			
Dental	\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services up to \$500/year ; \$0 co-pay for certain comprehensive services; plan covers up to \$2000/year ; Imperial HMO contracted provider	\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services; plan covers up to \$500/year ; \$0 co-pay for certain comprehensive services; up to \$2000 per year; Imperial HMO contracted provider			
Chiropractic	\$0 copay 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 6 routine visits per year			
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	<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>			
	Preferred Generic		30 days	90 days	100 days mail
	Generic		\$0	\$0	\$0
	Preferred Brand		\$3	\$9	\$5
	Non-Preferred Brand		\$30	\$90	\$75
	Specialty co-insurance		\$75	\$150	\$180
	\$0 deductible; after total yearly drug costs reach \$4,660 , 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 \$7,400 . After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands. \$7,400 annual out of pocket max.				
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 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	Meals: \$0 copay for up to 7 home-delivered meals following a surgery or hospital stay Over the Counter: \$120 quarterly allowance Part B Premium Reduction: \$75 monthly reimbursement Transportation: \$0 co-pay for unlimited round trips to plan approved locations Wellness: \$0 for basic Silver&Fit membership			
Medical Groups and Hospitals	Medical Groups: Brown & Toland, Imperial Health, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (C. Valley), St. Rose (Hayward) and Washington (Fremont)	Medical Groups: Brown & Toland, Imperial Health, Nivano Physicians, Physician Partners IPA Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (C. Valley), St. Rose (Hayward) and Washington (Fremont)			

2023 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/Type</p>	<p align="center">Kaiser Permanente Senior Advantage Basic Alameda (HMO) (H0524-059)</p>				<p align="center">Kaiser Permanente Senior Advantage (HMO) (H0524-032)</p>			
<p>Star Rating</p>	<p align="center">★★★★★</p>				<p align="center">★★★★★</p>			
<p>Annual OOP Max</p>	<p align="center">\$6,000</p>				<p align="center">\$3,900</p>			
<p>Monthly Premium</p>	<p align="center">\$0</p>				<p align="center">\$70</p>			
<p>Doctor Visits</p>	<p align="center">\$5 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">\$265 copay/day for days 1-5; \$0 per day for days 6 and beyond</p>				<p align="center">\$195 copay/day for days 1-5; \$0 per day for days 6 and beyond</p>			
<p>Outpatient Hospital</p>	<p align="center">\$250 per ambulatory surgical center visit; \$0-\$250 copay per outpatient hospital facility visit</p>				<p align="center">\$180 per ambulatory surgical center visit; \$0-\$180 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">\$110 for emergency room visit; \$5 for urgent care visit; Worldwide coverage</p>				<p align="center">\$110 for emergency room visit; \$0 for urgent care visit; Worldwide coverage</p>			
<p>Lab Tests, Procedures, and Radiation Therapy</p>	<p align="center">\$0 copay for lab, diagnostic tests & procedures; \$5 copay for x-rays; \$215 copay for diagnostic radiology; \$0 for therapeutic radiology</p>				<p align="center">\$0 copay for lab, diagnostic tests, procedures, x-rays; \$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">\$2 copay per individual session; \$5 per group therapy session</p>				<p align="center">\$0 copay per individual session; \$0 per group therapy session</p>			
<p>Eyewear</p>	<p align="center">\$150 allowance for eyewear every 2 years; See Optional Benefits Plan below</p>				<p align="center">\$150 allowance for eyewear every 2 years; See Optional Benefits Plan below</p>			
<p>Eye Exams</p>	<p align="center">\$5-\$15 copay per Medicare-covered exam; \$5 per routine exam</p>				<p align="center">\$0-\$10 copay per Medicare-covered exam; \$0 per routine exam</p>			
<p>Hearing Aids</p>	<p align="center">\$1,250 allowance per aid, every 3 years</p>				<p align="center">\$1,250 allowance per aid, every 3 years</p>			
<p>Hearing Exams</p>	<p align="center">\$15 copay per Medicare-covered exam; \$0 copay for routine exam</p>				<p align="center">\$10 copay per Medicare-covered exam; \$0 copay for routine exam</p>			
<p>Dental</p>	<p align="center">\$0 copay for certain preventive and diagnostic services; See Optional Benefits Plan below for additional dental benefits</p>				<p align="center">\$0 copay for certain preventive and diagnostic services; See Optional Benefits Plan below for additional dental benefits</p>			
<p>Chiropractic</p>	<p align="center">\$5 copay per Medicare covered visit; Routine care not covered</p>				<p align="center">\$0 copay per Medicare covered visit; Routine care not covered</p>			
<p>Podiatry</p>	<p align="center">\$15 copay per Medicare covered visit; Routine foot care not covered</p>				<p align="center">\$10 copay per Medicare covered visit; Routine foot care not covered</p>			
<p>Prescription Drugs (Part D)</p>	<p><i>Cost-sharing shown is for preferred pharmacies</i></p>	<p>30 days</p>	<p>100 day retail</p>	<p>100 days mail</p>	<p><i>Cost-sharing shown is for preferred pharmacies</i></p>	<p>30 days</p>	<p>100 days retail</p>	<p>100 days mail</p>
	<p>Preferred Generic</p>	<p>\$0</p>	<p>\$0</p>	<p>\$0</p>	<p>Preferred Generic</p>	<p>\$0</p>	<p>\$0</p>	<p>\$0</p>
	<p>Generic</p>	<p>\$12</p>	<p>\$36</p>	<p>\$24</p>	<p>Generic</p>	<p>\$5</p>	<p>\$15</p>	<p>\$10</p>
	<p>Preferred Brand</p>	<p>\$45</p>	<p>\$135</p>	<p>\$90</p>	<p>Preferred Brand</p>	<p>\$45</p>	<p>\$135</p>	<p>\$90</p>
	<p>Non-Preferred Brand</p>	<p>\$100</p>	<p>\$300</p>	<p>\$200</p>	<p>Non-Preferred Brand</p>	<p>\$100</p>	<p>\$300</p>	<p>\$200</p>
	<p>Specialty co-insurance</p>	<p>33%</p>	<p>33%</p>	<p>33%</p>	<p>Specialty co-insurance</p>	<p>33%</p>	<p>33%</p>	<p>33%</p>
<p>\$0 deductible; after total yearly drug costs reach \$4,660, you pay \$0 copay for preferred generic, \$12 for generic and 25% for brand name and specialty drugs until out-of-pocket drug expenses reach \$7,400. After that, you pay \$0 for generics and \$12 for brands.</p>				<p>\$0 deductible; after total yearly drug costs reach \$4,660, you pay \$0 copay for preferred generic, \$5 for generic and 25% for brand name and specialty drugs until out-of-pocket drug expenses reach \$7,400. After that, you pay \$0 for generics and \$12 for brands.</p>				
<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 Over the Counter: \$60 quarterly allowance for items from OTC catalogue; each order \$25 minimum Wellness: \$0 for Silver&Fit gym membership</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 Over the Counter: \$60 quarterly allowance for items from OTC catalogue; each order \$25 minimum Wellness: \$0 for Silver&Fit gym membership</p>			
	<p>Optional Benefit Plan: Advantage Plus at \$14/month: -Dental: Copays vary depending upon the service; Delta Care USA HMO network -Vision: \$0 copay for eyewear with \$290 allowance (in addition to \$150 allowance above) every two years</p>				<p>Optional Benefit Plan: Advantage Plus at \$14/month: -Dental: Copays vary depending upon the service; Delta Care USA HMO network -Vision: \$0 copay for eyewear with \$290 allowance (in addition to \$150 allowance 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>			

2023 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/Type</p>	<p align="center">UnitedHealthcare Canopy Health (HMO-POS) (H0543-188)</p>	<p align="center">AARP Medicare Advantage Focus (HMO-POS) (H0543-235)</p>																																																
<p>Star Rating</p>	<p align="center">★★★★</p>	<p align="center">★★★★</p>																																																
<p>Annual OOP Max</p>	<p align="center">\$3,400</p>	<p align="center">\$6,700</p>																																																
<p>Monthly Premium</p>	<p align="center">\$57</p>	<p align="center">\$25</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 for days 8 and beyond (unlimited)</p>	<p align="center">\$300 copay/day for days 1-7; \$0 for days 8 and beyond (unlimited)</p>																																																
<p>Outpatient Hospital</p>	<p align="center">\$75 copay for ambulatory surgical center visit; \$200 copay for outpatient hospital visit</p>	<p align="center">\$200 copay for ambulatory surgical center visit; \$250 copay for outpatient hospital visit</p>																																																
<p>Skilled Nursing Facility</p>	<p align="center">\$0 copay/day for days 1-20; \$196 per day for days 21-38; \$0 for 39-100</p>	<p align="center">\$0 copay for days 1-20; \$196 copay/day for days 21-55; \$0 for 56-100</p>																																																
<p>Emergency & Urgent Care</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 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">\$265 copay per trip by ground or air</p>	<p align="center">\$250 copay per trip by ground or air</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; \$60 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>																																																
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<p>Eyewear</p>	<p align="center">\$0 copay for standard lenses, with \$100 annual allowance toward frames or contact lenses; through United Healthcare Vision</p>	<p align="center">\$0 copay for standard lenses, with \$100 annual allowance toward frames or contact lenses; through United Healthcare Vision</p>																																																
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<p>Hearing Aids</p>	<p align="center">\$175 - \$1,225 copay per aid; up to 2 aids each year; through United Healthcare Hearing</p>	<p align="center">\$175 - \$1,225 copay per aid; up to 2 aids each year; through United Healthcare Hearing</p>																																																
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<p>Dental</p>	<p align="center">\$0 copays for certain preventive and comprehensive services; \$1,000 combined limit; can use out of network dentists but higher copays may apply See Optional Benefit Plan below</p>	<p align="center">\$0 copay for certain preventive services; can use out of network dentists but higher copays may apply See Optional Benefit Plan below</p>																																																
<p>Chiropractic</p>	<p align="center">\$15 copay for Medicare-covered visit; Routine care not covered</p>	<p align="center">\$10 copay for Medicare-covered visit; Routine care not covered</p>																																																
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<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Canopy Health Hill Physicians East Bay, Canopy Health John Muir Physicians, and Canopy Health Meritage Medical Network Hospitals: Alameda, Highland (Oakland), San Leandro, and Washington (Fremont)</p>	<p>Medical Groups: Brown and Toland East Bay; Hill Physicians East Bay Hospitals: St. Rose (Hayward)</p>																																																

2023 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/Type</p>	<p align="center">United Health Care Advantage Assure (HMO) (H0543-183)</p>				<p align="center">AARP SecureHorizons Plan 1 (HMO-POS) (H0543-070)</p>																																																			
<p>Star Rating</p>	<p align="center">★★★★</p>				<p align="center">★★★★</p>																																																			
<p>Annual OOP Max</p>	<p align="center">\$8,300</p>				<p align="center">\$6,700</p>																																																			
<p>Monthly Premium</p>	<p align="center">\$27.50</p>				<p align="center">\$118</p>																																																			
<p>Doctor Visits</p>	<p align="center">20% coinsurance for Primary Care Physician; 20% coinsurance for Specialist</p>				<p align="center">\$0 copay for Primary Care Physician; \$10 for Specialist</p>																																																			
<p>Inpatient Hospital</p>	<p align="center">\$1,600 copay per stay; unlimited days</p>				<p align="center">\$390 copay/day for days 1-5; \$0 for days 6 and beyond (unlimited)</p>																																																			
<p>Outpatient Hospital</p>	<p align="center">20% coinsurance for ambulatory surgical center visit; 20% coinsurance for outpatient hospital visit</p>				<p align="center">\$370 copay for ambulatory surgical center visit; \$370 copay for outpatient hospital visit</p>																																																			
<p>Skilled Nursing Facility</p>	<p align="center">\$0 copay/day for days 1-20; \$200 copay/day for days 21-100</p>				<p align="center">\$0 copay/day for days 1-20; \$196 per day for days 21-55; \$0 for 56-100</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 for emergency room visit; waived if admitted to hospital within 24 hours; \$40 per urgent care visit; \$0 copay for worldwide coverage</p>																																																			
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<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">Plan pays up to \$2,500 per year for 2 aids/year; through United Healthcare Hearing</p>				<p align="center">\$175 - \$1,225 copay per aid; up to 2 aids each year; through United Healthcare Hearing</p>																																																			
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<p>Podiatry</p>	<p align="center">\$0 co-pay per Medicare-covered visit; \$0 co-pay per routine visit, up to 4 per year</p>				<p align="center">\$10 copay per Medicare-covered visit; \$10 copay/visit for 6 routine visits per year</p>																																																			
<p>Prescription Drugs (Part D)</p>	<table border="1"> <thead> <tr> <th><i>Cost-sharing shown is for preferred pharmacies</i></th> <th>30 days</th> <th>100 days retail</th> <th>100 days mail</th> </tr> </thead> <tbody> <tr> <td>Preferred Generic</td> <td>25%</td> <td>25%</td> <td>25%</td> </tr> <tr> <td>Generic</td> <td>25%</td> <td>25%</td> <td>25%</td> </tr> <tr> <td>Preferred Brand</td> <td>25%</td> <td>25%</td> <td>25%</td> </tr> <tr> <td>Non-Preferred Brand</td> <td>25%</td> <td>25%</td> <td>25%</td> </tr> <tr> <td>Specialty co-insurance</td> <td>25%</td> <td>N/A</td> <td>N/A</td> </tr> </tbody> </table> <p>\$505 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.</p>				<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail	Preferred Generic	25%	25%	25%	Generic	25%	25%	25%	Preferred Brand	25%	25%	25%	Non-Preferred Brand	25%	25%	25%	Specialty co-insurance	25%	N/A	N/A	<table border="1"> <thead> <tr> <th><i>Cost-sharing shown is for preferred pharmacies</i></th> <th>30 days</th> <th>100 days retail</th> <th>100 days mail</th> </tr> </thead> <tbody> <tr> <td>Preferred Generic</td> <td>\$3</td> <td>\$9</td> <td>\$0</td> </tr> <tr> <td>Generic</td> <td>\$12</td> <td>\$36</td> <td>\$0</td> </tr> <tr> <td>Preferred Brand</td> <td>\$47</td> <td>\$141</td> <td>\$131</td> </tr> <tr> <td>Non-Preferred Brand</td> <td>\$100</td> <td>\$300</td> <td>\$290</td> </tr> <tr> <td>Specialty co-insurance</td> <td>27%</td> <td>N/A</td> <td>N/A</td> </tr> </tbody> </table> <p>\$0 deductible for Tiers 1-2; \$350 for Tiers 3, 4, & 5; after total yearly drug costs reach \$4,660, you pay \$0 for preferred generics and no more than 25% of the plan's cost for brand name and 25% for generics until out-of-pocket drug expenses reach \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.</p>				<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail	Preferred Generic	\$3	\$9	\$0	Generic	\$12	\$36	\$0	Preferred Brand	\$47	\$141	\$131	Non-Preferred Brand	\$100	\$300	\$290	Specialty co-insurance	27%	N/A	N/A
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<p>Other Benefits/Options</p>	<p>Cost-Sharing Waived: most co-insurance and copays are waived for those with full Medi-Cal/LIS</p> <p>Transportation: \$0 copay for 36 one-way trips per year to plan-approved, medically related locations</p>				<p>Optional Dental Platinum Rider at: \$56/month: includes certain preventive and comprehensive benefits with varied cost-sharing</p>																																																			
<p>Medical Groups and Hospitals</p>	<p>Medical Groups: Affinity East Bay, PAMF, 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: Affinity East Bay, PAMF, 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>																																																			

2023 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 844-917-0175 (Sales & Marketing) 866-907-5799 (Member Services) www.wellcarenow.com
Plan Name/Type	SCAN Classic (HMO) (H05425-075)	Wellcare Patriot Giveback (HMO) (H0562-044)
Star Rating	★★★★1/2	★★★
Annual OOP Max	\$4,000	\$4,500
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	\$100 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/day for days 21-80; \$0 for days 81-100
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.	\$110 copay per ER visit; \$10 per urgent care visit; copays waived if admitted to hospital within 24 hours; \$50,000 plan limit for ER & urgent care worldwide; \$110 copays; not waived if admitted
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
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	\$235 allowance for eyewear every 2 years	\$100 annual allowance for eyeglasses or contacts
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	\$0 co-pay for certain preventive services, diagnostic screenings, and x-rays; See Optional Benefits Plan below	See Optional Benefits Plan below
Chiropractic	\$0 copay per Medicare covered visit; Routine visits not covered	\$0 copay per Medicare covered visit; \$0 copay for 36 routine visits per year
Podiatry	\$10 copay per Medicare-covered visit; \$0 copay for 6 routine visits per year	\$10 copay per Medicare-covered visit; \$10 co-pay/visit, for 12 routine visits per year
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days 100 days retail 100 days mail
	Preferred Generic	\$0 \$0 \$0
	Generic	\$0 \$0 \$0
	Preferred Brand	\$37 \$141 \$141
	Non-Preferred Brand	\$90 \$300 \$300
	Specialty co-insurance	33% N/A N/A
	\$0 deductible; after total yearly drug costs reach \$4,660, you pay \$0 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.	THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE. YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.
Other Benefits/Options	Over the Counter: \$100 quarterly allowance; balance carries over to next quarter but not calendar year Transportation: \$0 copay for 24 one-way trips per year to plan-approved locations Wellness: \$0 for basic Silver Sneakers membership; \$0 copay for Fitness Tracker every 2 years Optional Dental Package: \$10/month; \$0-\$440 copays for certain preventive and comprehensive services	Acupuncture: \$0 copay per visit for 36 routine visits per year Part B Premium Reduction: \$25 monthly reimbursement Routine Physical: \$0 copay for one annual exam Tobacco Cessation Counseling: \$0 copay/visit for 5 visits per year Wellness: 32 credits/month for basic gym membership or at-home fitness boxes/videos Optional Dental Package: \$11/month; \$0-\$2,250 copays for certain preventive & comprehensive svcs
Medical Groups and Hospitals	Medical Groups: Brown & Toland Hospitals: Alameda, San Leandro, St. Rose (Hayward)	Medical Groups: Brown & Toland Hospitals: Alameda, San Leandro, St. Rose (Hayward)

2023 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 844-917-0175 (Sales & Marketing) 866-907-5799 (Member Services) www.wellcarenow.com				
Plan Name/Type	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	\$133		\$0		
Doctor Visits	\$10 copay for Primary Care Physician; \$15 for Specialist		\$0 copay for Primary Care Physician; \$15 for Specialist		
Inpatient Hospital	\$325 copay/day for days 1-6; \$0 per day for days 7 and beyond		\$275 copay/day for days 1-7; \$0 per day for days 8 and beyond		
Outpatient Hospital	\$200 per ambulatory surgical center visit; \$350 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 copay/day for days 21-70; \$0 per day for days 71-100		\$0 copay for days 1-20; \$150 per day for days 21-60; \$0 for days 61-100		
Ambulance	\$250 copay per one-way trip by ground or air		\$270 copay per one-way trip by ground or air		
Emergency & Urgent Care	\$95 copay per ER visit; \$15 per urgent care visit; copays waived if admitted to hospital within 24 hours; \$50,000 plan limit for ER coverage worldwide, with \$95 copays, not waived if admitted		\$110 copay per ER visit; \$20 per urgent care visit; copays waived if admitted to hospital within 24 hours; \$50,000 plan limit for ER and urgent care worldwide; with \$110 copays, not waived if admitted		
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$350 copay per diagnostic service; 20% co-insurance for therapeutic radiology		\$0 copay for lab, diagnostic procedures, tests, and x-rays; \$250 co-pay 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	\$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 annual allowance for eyeglasses or contacts		
Eye Exams	\$0-\$15 copay per Medicare-covered exam; \$0 copay for one annual routine exam		\$0-\$15 copay per Medicare-covered exam; \$0 copay for one annual routine exam		
Hearing Aids	Not Covered		\$750 allowance for up to two aids each year		
Hearing Exams	\$15 copay for Medicare-covered exam; \$0 copay for one annual routine exam		\$15 copay for Medicare-covered exam; \$0 copay for one annual routine exam		
Dental	See Optional Benefit Plan below		\$0 copays for certain preventive services; \$0-\$2,250 copays for certain comprehensive services		
Chiropractic	\$15 copay per Medicare covered visit See Optional Benefit Plans below		\$0 copay per Medicare covered visit; \$0 copay for 24 routine visits per year		
Podiatry	\$15 copay per Medicare-covered visit; \$15 co-pay per visit for 6 routine visits per year		\$15 copay per Medicare-covered visit; \$15 copay per visit for 12 routine visits per year		
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>		30 days	90 days retail	90 days mail
	Preferred Generic	\$0	\$0	\$0	\$0
	Generic	\$5	\$15	\$0	\$0
	Preferred Brand	\$37	\$111	\$74	\$74
	Non-Preferred Brand	\$90	\$270	\$180	\$180
	Specialty co-insurance	29%	N/A	N/A	N/A
	\$0 deductible for Tiers 1&2; \$220 deductible for Tiers 3,4, & 5; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 or 5% for brands.		\$0 deductible; after total yearly drug costs reach \$4,660, 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 \$7,400. After that, you pay the greater of \$4.15 or 5% for generics and the greater of \$10.35 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: 32 credits/month for basic gym membership or at-home fitness boxes/videos Wellcare Premium Ultra at \$26 per month: - Dental: \$0 co-pay for certain preventive services and \$0-\$2,250 copays for comprehensive services - Acupuncture and Chiropractic: \$10 co-pay per visit, up to 36 combined visits per year - Eyewear: \$300 annual allowance		Acupuncture: \$0 copay for 24 routine visits per year Over the Counter: \$70 quarterly allowance for plan-approved items at CVS or in 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: 32 credits/month for basic gym membership or at-home fitness boxes/videos		
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), San Leandro, and Stanford Valley Care (Pleas/Livermore)		Medical Groups: Brown and Toland Hospitals: Alameda, San Leandro, St. Rose (Hayward)		

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 (\$226 in 2023). 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 and Boosters
- Depression Screening: one per year
- Diabetes Screening: 2 per year if at risk
- Flu Shot: one per year
- Hepatitis B Shots: as needed depending on health status
- HIV Screening: one per year
- Medical Nutrition Therapy: as needed depending on health status
- Obesity Screening 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
- Shingles Vaccine
- Tobacco-use Cessation Counseling (if not diagnosed with related illness): up to 8 sessions per year
- “Welcome to Medicare” Exam: one in the year following enrollment into Part B

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

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

For more information on preventive care coverage, you can refer to the Medicare and You 2023 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. Detailed information is available here:

<https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings>