2023 Medicare Advantage Special Needs Plan (SNP) Comparison Chart for Alameda County

~ Rev 10/31/22 ~

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 a referral to see a specialist. The Medicare HMO will *not* pay for services received outside the plan's network unless it is urgent or emergency care. See our 2023 HMO Comparison Chart for more information and details: www.lashicap.org/hicap.

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. 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 need a nursing home level of care. 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.*** Seven are for people with Medicare and full Medi-Cal (duals, with no share of cost). These are called **D-SNPS** and they have no premiums or co-payments. Another Special Needs Plan is for people with specific chronic or disabling conditions, such as diabetes, dementia, or cardiovascular disorders. It is called a **C-SNP** and certain cost-sharing applies. In 2023, there are nine C-SNPs in Alameda County. The third type of Special Needs Plan is for people in institutions like a nursing home or for people who need a nursing home level of care at home. It is called an **I-SNP** and certain cost-sharing applies. In 2023, there are four I-SNPs in Alameda County.

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 guaranteed 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 a quarterly basis. The change will become effective on 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 and highlights the areas where the Medicare Advantage plans may differ in benefits. **For more detailed information about coverage and cost-sharing, contact the plans directly.** For preventive care benefits covered by Medicare, please see the back of this chart. Also, on the last page is an explanation of the Star Ratings provided by Medicare.

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

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

SHIP State Health Insurance Assistance Program

Navigating Medicare

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2023 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Aetna Medicare** **833-859-6031 (Sales & Marketing)** **866-409-1221 (Member Services)** www.aetnamedicare.com	**Align Senior Care** **844-305-3879 (Sales &Marketing)** **844-305-3879 (Member Services)** www.alignseniorcare.com
Plan Name/Type	**Aetna Medicare Preferred Plan** **D-SNP (H4982-008)** **For FULL DUALS**	**Align Connect** **C-SNP (H3274-003)** **For People with Diagnosis of Dementia**
Star Rating	★★★	**Plan too new to be measured**
Annual OOP Max	**$8,300**	**$3,500*** ***$226** annual deductible applies to certain services
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$0** per day; Unlimited number of days	**$150** copay/day for days 1-10; **$0** for days 11-150
Outpatient Hospital	**$0** per ambulatory surgical center visit**;** **$0** per outpatient hospital visit	**20%** coinsurance for ambulatory surgical ctr visit; **20%** coinsurance for outpatient hospital services
Skilled Nursing Facility	**$0** per day; 100 days per benefit period	**$0** for days 1-20; **$100** copay/day for days 21-100
Ambulance	**$0** copay per trip by ground or air	**$125** copay per trip by ground; **20%** coinsurance per trip by air
Emergency & Urgent Care	**$0** copay per emergency room or urgent care visit; Worldwide coverage	**$90** copay per ER visit; **$40** per urgent care visit; waived if admitted to hospital within 3 days
Lab Tests, Procedures, and Radiation Therapy	**$0** copay per service	**$0** co-pay for lab services and x-rays; **20%** coinsurance for diagnostic tests, procedures, diagnostic and therapeutic radiology
Renal Dialysis	**$0** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$0** copay for individual or group therapy session	**$20** copay for individual therapy session; **$10** copay for group therapy session
Eyewear	**$400** annual allowance for eyeglasses or contact lenses, through EyeMed	**$130** annual allowance for eyeglasses/frames or contact lenses
Eye Exams	**$0** copay per Medicare-covered exam; **$0** copay for 1 annual routine exam	**20%** coinsurance per Medicare-covered exam; **$0** copay for one annual routine exam
Hearing Aids	**$2,500** annual allowance; through NationsHearing	**$1,000** annual allowance; limited to 2 aids/year
Hearing Exams	**$0** copay per Medicare-covered exam; **$0** copay for one annual routine exam	**20%** coinsurance per Medicare-covered exam; **$0** copay for one annual routine exam
Dental	**$0** copay for limited preventive and comprehensive services; through Liberty Dental network	**$0** copay for 2 exams, cleanings, and X-rays/year; **$500** annual allowance for comprehensive services
Chiropractic	**$0** copay per Medicare covered visit; **$0** copay/visit for unlimited routine visits per year, through American Specialty Health	**20%** coinsurance per Medicare-covered visit; **$30** copay/visit for 12 routine visits per year
Podiatry	**$0** copay per Medicare covered visit; **$0** copay/visit for 12 routine visits per year	**20%** coinsurance per Medicare-covered visit; **$0** copay for 4 routine visits per year
Prescription Drugs (Outpatient)	**$0** deductible: **$0** copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail order Preferred Generic: **$2** / **$6** / **$6** Generic: **$15** / **$45** / **$45** Preferred Brand: **$45** / **$135** / **$135** Non-Preferred Brand: **$95** / **$285** / **$285** Specialty co-insurance: **25%** / **N/A** / **N/A** **$0** deductible for Tier 1; **$505** deductible for Tiers 2-5; after total yearly drug costs reach **$4,660**, you pay **25%** for generic and 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 visits per year through American Specialty Health **Fall Prevention: $150** annual allowance for approved home safety devices **Flex Card: $100** quarterly allowance for healthy foods at approved locations and/or utilities **Meals:** 42 home-delivered meals over a 21-day period following hospital or skilled nursing facility stay **Over the Counter: $150** quarterly allowance for items from plan's OTC catalog **Transportation: $0** copay/trip for 40 one-way trips each year to plan-approved locations, within 60 miles **Wellness: $0** for Silver Sneakers gym membership	**Acupuncture: $30** copay/visit for 12 visits per year **Companion Care: 30 hours/year** for assistance with errands, housekeeping, and companionship, for those with dementia **Over the Counter (OTC): $175** quarterly allowance for items from plan's OTC catalog
Medical Groups and Hospitals	**Medical Groups:** Brown and Toland **Hospitals:** Alameda, Alta Bates/Summit (Berk/Oak), Eden (C.Valley), St. Rose (Hayward), Stanford Valley Care (Pleas/ Liv), Washington Hospital (Fremont)	**Medical Groups:** **Hospitals:**

2023 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Align Senior Care** **844-305-3879 (Sales &Marketing)** **844-305-3879 (Member Services)** www.alignseniorcare.com	**Align Senior Care** **844-305-3879 (Sales &Marketing)** **844-305-3879 (Member Services)** www.alignseniorcare.com
Plan Name/Type	**Align Kidney Care** **C-SNP (H3274-004)** **For People with ESRD/Dialysis**	**Align Premier** **I-SNP (H3274-001)** **For People Needing** **Nursing Home Level of Care**
Star Rating	**Plan too new to be measured**	**Plan too new to be measured**
Annual OOP Max	**$8,300*** ***$226** annual deductible applies to certain services	**$7,550*** ***$226** annual deductible applies to certain services
Monthly Premium	**$38.90**	**$38.90**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Nephrologist visits; **20%** coinsurance for Specialist	**$0** for Primary Care Physician; **20%** coinsurance for Specialist
Inpatient Hospital	**$1,600** deductible; **$0** copay/day for days 1-60; **$400** copay/day for days 61-90; **$800** copay/day for days 91-150	**$1,600** deductible; **$0** copay/day for days 1-60; **$400** copay/day for days 61-90; **$800** copay/day for days 91-150
Outpatient Hospital	**20%** coinsurance per ambulatory surgical center or outpatient hospital visit	**20%** coinsurance per ambulatory surgical center or outpatient hospital visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$200** copay/day for days 21-100	**$0** copay/day for days 1-20; **$200** copay/day for days 21-100
Ambulance	**20%** coinsurance per trip by ground or air	**20%** coinsurance per trip by ground or air
Emergency & Urgent Care	**$90** copay per ER visit; **$25** per urgent care visit; waived if admitted to hospital within 3 days	**$90** copay per ER visit; **$55** per urgent care visit; waived if admitted to hospital within 3 days
Lab Tests, Procedures, and Radiation Therapy	**$0** co-pay for lab services and x-rays; **20%** coinsurance for diagnostic tests, procedures, diagnostic and therapeutic radiology	**$0** copay for lab services and x-rays; **20%** coinsurance for diagnostic tests, procedures, diagnostic and therapeutic radiology
Renal Dialysis	**20%** coinsurance per treatment	**20%** coinsurance per treatment
Outpatient Mental Health Visits	**20%** coinsurance for individual or group therapy session	**20%** coinsurance for individual or group therapy session
Eyewear	**$150** annual allowance for eyeglasses/frames or contact lenses	**$130** annual allowance for eyeglasses/frames or contact lenses
Eye Exams	**20%** coinsurance per Medicare-covered exam; **$0** copay for one annual routine exam	**20%** coinsurance per Medicare-covered exam; **$0** copay for one annual routine exam
Hearing Aids	**$3,000** allowance every two years	**$1,500** annual allowance
Hearing Exams	**20%** coinsurance per Medicare-covered exam; **$0** copay for one routine exam every two years	**20%** coinsurance per Medicare-covered exam **$0** copay for one annual routine exam
Dental	**$0** copay for 2 exams, cleanings, and X-rays/year; **$800** annual allowance for comprehensive svcs	**$0** copay for 2 exams, cleanings, and X-rays/year; **$1,000** annual allowance for comprehensive svcs
Chiropractic	**20%** coinsurance for Medicare-covered visit	**20%** coinsurance for Medicare-covered visit
Podiatry	**20%** coinsurance for Medicare-covered visit; **$0** copay/visit for 6 routine visits per year	**20%** coinsurance for Medicare-covered visit; **$0** copay/visit for 4 routine visits per year
Prescription Drugs (Outpatient)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail order Preferred Generic: **$2** / **$6** / **$6** Generic: **$15** / **$45** / **$45** Preferred Brand: **$45** / **$135** / **$135** Non-Preferred Brand: **$95** / **$285** / **$285** Specialty co-insurance: **25%** / **N/A** / **N/A** **$0** deductible for Tier 1; **$505** deductible for Tiers 2-5; after total yearly drug costs reach **$4,660**, you pay **25%** for generic and 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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail order Preferred Generic: **25%** / **25%** / **25%** Generic: **25%** / **25%** / **25%** Preferred Brand: **25%** / **25%** / **25%** Non-Preferred Brand: **25%** / **25%** / **25%** Specialty co-insurance: **25%** / **25%** / **25%** **$505** deductible for all drug tiers; after total yearly drug costs reach **$4,660**, you pay **25%** for generic and 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	**Meals: $0** copay for up to 2 meals/day for 7 days following discharge from hospital or SNF; **$0** copay for 2 meals/day for up to 60 days for those with ESRD **Over the Counter (OTC): $600** annual allowance for items from plan's OTC catalog **Transportation: $0** copay for up to 80 trips per year to plan-approved locations within 75 miles **Wellness: $0** copay for online fitness services	**Companion Care: 30 hours/year** for assistance with errands, housekeeping, and companionship, for those with certain qualifying conditions **Over the Counter: $100** quarterly allowance for items from plan's OTC catalog
Medical Groups and Hospitals	**Medical Groups:** **Hospitals:**	**Medical Groups:** **Hospitals:**

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Please contact the Plan for more information or call 1-800-Medicare	**Align Senior Care** **844-305-3879 (Sales &Marketing)** **844-305-3879 (Member Services)** www.alignseniorcare.com	**Alignment Health Plan** **888-979-2247 (Sales &Marketing)** **866-634-2247 (Member Services)** www.alignmenthealthplan.com
Plan Name/Type	**Align Thrive** **I-SNP (H3274-002) For People Who Need Nursing Home Level of Care**	**Alignment Health Heart & Diabetes** **C-SNP (H3815-010) For People with Cardiovascular Disorders and/or Diabetes**
Star Rating	**Plan too new to be measured**	★★★★
Annual OOP Max	**$3,500*** ***$226** annual deductible applies to certain services	**$1,000**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** copay for PCP; **$0** copay for Specialist	**$0** copay for PCP;**$0** copay for Specialist
Inpatient Hospital	**$150** copay/day for days 1-10; **$0** copay for days 11-150	**$0** copay for unlimited days per admission
Outpatient Hospital	**20%** coinsurance per ambulatory surgical center or outpatient hospital visit	**$0** copay per ambulatory surgical center or outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$100** copay/day for days 21-100	**$0** copay for days 1-31; **$50** copay/day for days 32-100
Ambulance	**$125** copay per trip by ground; **20%** coinsurance per trip by air	**$100** copay per trip by ground or air
Emergency & Urgent Care	**$90** copay per ER visit; **$40** per urgent care visit; waived if admitted to hospital within 3 days	**$70** copay per ER visit; waived if admitted to hospital within 24 hours; **$0** per urgent care visit; Worldwide Coverage; **$0** copay; limit **$25,000**/year
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services and x-rays; **20%** coinsurance for diagnostic tests, procedures, diagnostic and therapeutic radiology	**$0** copay for lab services, x-rays, diagnostic tests, procedures, and diagnostic radiology; **20%** coinsurance for therapeutic radiology
Renal Dialysis	**20%** coinsurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$20** copay per individual therapy session; **$10** per group therapy session	**$0** copay per individual or group therapy session
Eyewear	**$130** annual allowance for eyeglasses/frames or contact lenses	**$200** annual allowance for eyeglasses/frames or contact lenses
Eye Exams	**20%** coinsurance 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	**$1,000** annual allowance; limited to 2 aids/year	Not covered
Hearing Exams	**20%** coinsurance per Medicare-covered exam **$0** copay for one annual routine exam	**$0** co-pay per Medicare-covered exam **$0** for one annual routine exam
Dental	**$0** copay for 2 exams, cleanings, and X-rays/year; **$1,000** annual allowance for comprehensive services	**$0** copay for 2 exams, 2 cleanings & fluoride treatments per year; **$0** for x-rays every 3 years; **$15-$425** copays for certain comprehensive services
Chiropractic	**20%** coinsurance for Medicare-covered visit; **$30** copay per visit for 12 routine visits/year	**$0** copay per Medicare covered visit; routine visits not covered
Podiatry	**20%** coinsurance for Medicare-covered visit; **$0** copay/visit for 4 routine visits per year	**$0** copay per Medicare covered visit; **$0** copay for 12 routine visits each year
Prescription Drugs (Outpatient)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail order Preferred Generic: **$2** / **$6** / **$2** Generic: **$15** / **$45** / **$45** Preferred Brand: **$45** / **$135** / **$135** Non-Preferred Brand: **$95** / **$285** / **$285** Specialty co-insurance: **25%** / **N/A** / **N/A** **$0** deductible for Tier 1; **$505** deductible for Tiers 2-5; after total yearly drug costs reach **$4,660**, you pay **25%** for generic and 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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 day mail order Preferred Generic: **$0** / **$0** / **$0** Generic: **$0** / **$0** / **$0** Preferred Brand: **$40** / **$120** / **$120** Non-Preferred Brand: **$100** / **$300** / **$300** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; after total yearly drug costs reach **$4,660**, you pay **25%** for generic and 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: $30** copay/visit for 12 visits per year **Companion Care: 30 hours/year** for assistance with errands, housekeeping, and companionship, for those with certain specified conditions **Over the Counter: $150** quarterly allowance for items from plan's OTC catalog	**Acupuncture: $0** co-pay for 40 routine visits/year **Groceries: $20** monthly allowance for those with qualifying chronic conditions **Over the Counter (OTC): $135** quarterly allowance **Pet Services: $0** copay for 7 boarding days or 14 walks/year for those with qualifying chronic condition **Transportation**: **$0** copay for 50 one-way trips/year to plan-approved locations within 35 miles **Wellness: $0** for basic gym membership **Enhanced Dental Option: $27** monthly premium; **$1,500** limit per year with varying coinsurance
Medical Groups and Hospitals	**Medical Groups:** **Hospitals:**	**Medical Groups:** Brown & Toland, California IPA, Imperial Health Plan **Hospitals**: Alameda, Alta Bates/Summit (Berk/Oak) Eden (C. Valley), Highland (Oakland), St. Rose, (Hayward), and Stanford Valley Care (Pleas/Liv)

2023 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Anthem Blue Cross** **844-309-6996 (Sales & Marketing)** **800-499-2793 (Member Services)** www.shop.anthem.com/medicare/ca	**Brand New Day** **866-255-4795 (Sales &Marketing)** **866-255-4795 (Member Services)** www.bndhmo.com
Plan Name/Type	**Anthem MediBlue Dual Advantage D-SNP (H0544-125) For FULL DUALS**	**Brand New Day Dual Access D-SNP (H0838-024) For FULL DUALS**
Star Rating	★★★	★★★
Annual OOP Max	**$7,500**	**$8,300**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$0** per day for days 1 - 150	**$0** per stay
Outpatient Hospital	**$0** per ambulatory surgical center visit; **$0** per outpatient hospital visit	**$0** per ambulatory surgical center visit**;** **$0** per outpatient hospital visit
Skilled Nursing Facility	**$0** copay per day for days 1 - 100	**$0** copay per day for days 1 - 100
Ambulance	**$0** copay per trip by ground or air	**$0** copay per trip by ground or air
Emergency & Urgent Care	**$0** copay per ER or urgent care visit; Worldwide coverage; **$0** copay; **$100,000** limit/year	**$0** copay per ER or urgent care visit; Worldwide coverage; **$90** copay for emergency or urgent care visit; **$50,000** limit
Lab Tests, Procedures, and Radiation Therapy	**$0** copay per service	**$0** copay per service
Renal Dialysis	**$0** co-insurance per treatment	**$0** coinsurance per treatment
Outpatient Mental Health Visits	**$0** copay for individual or group therapy session	**$0** copay for individual or group therapy session
Eyewear	**$300** annual allowance for eyeglasses or contact lenses	**$300** annual allowance for eyeglasses or contact lenses
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	**$3,000** annual allowance	**$149** allowance per aid for 2 aids every 3 years
Hearing Exams	**$0** co-pay per Medicare-covered exam; **$0** copay for one annual routine exam	**$0** co-pay per Medicare-covered exam; **$0** copay for one annual routine exam
Dental	**$0** copay for 2 exams, 2 cleanings, 1 fluoride treatment and 1 x-ray per year; **$1,000** annual allowance for certain comprehensive services	**$0** copay for certain preventative and comprehensive services
Chiropractic	**$0** co-pay per Medicare covered visit; **$0** copay/visit for 12 routine visits per year	**$0** co-pay per Medicare covered visit; **$0** copay/visit for 30 visits per year (combined with
Podiatry	**$0** co-pay per Medicare covered visit; **$0** copay/visit for unlimited routine visits per year	**$0** co-pay per Medicare covered visit; Routine care not covered
Prescription Drugs (Outpatient)	**$0** deductible; **$0** copay for 30, 60, or 100 day supply of all covered drugs	**$0** deductible: Depending on your income, you pay the following: **Generics: $0 or $1.45** **All Other Drugs: $0 or $4.30** After annual drug costs (paid by you, the plan, and by Extra Help from Medicare) reach **$7,400**, 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 per visit for unlimited visits per year **Community Resource Support:** Referrals and coordination for community services **Meals: $0** copay for 2 meals per day for 5 days following inpatient hospital or SNF stay **Over the Counter (OTC): $100** quarterly allowance for plan approved items **Transportation: $0** copay/trip for 48 trips per year to plan-approved locations within 60 miles **Wellness: $0** for Silver Sneakers gym membership	**Acupuncture: $0** copay/visit for 30 visits per year (combined with chiropractic) **Groceries: $50** monthly allowance for health foods at approved grocery stores, for those with qualifying chronic conditions **Meals: $0** copay per meal for 14 meals/month for 12 months for those with qualifying chronic conditions **Over the Counter (OTC): $180** quarterly allowance for plan approved items **Transportation: $0** copay/trip for 48 trips per year to plan approved locations within 50 miles **Wellness: $0** for Silver Sneakers gym membership
Medical Groups and Hospitals	**Medical Groups:** Bay Valley, Brown & Toland, Hill Physicians, Imperial Health, Nivano Physicians **Hospitals**: Alta Bates/Summit (Berk/Oak) Eden (C. Valley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), & Washington (Fremont)	**Medical Groups:** Alameda Health System; Hill Physicians East Bay **Hospitals:** Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), San Leandro, Washington (Fremont)

2023 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**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	**Brand New Day Embrace Care C-SNP (H0838-039)** **For People with Cardiovascular Disease, Chronic Heart Failure, or Diabetes**	**Brand New Day Embrace Choice C-SNP (H0838-040)** **For People with Cardiovascular Disease, Chronic Heart Failure, or Diabetes**
Star Rating	★★★	★★★
Annual OOP Max	**$1,999**	**$8,300**
Monthly Premium	**$0**	**$38.90**
Doctor Visits	**$0** for Primary Care Physician; **$0-10** for Specialist	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$175** per day for days 1-6; **$0** per day for days 7-90	**$0** per stay
Outpatient Hospital	**$0 - $75** per ambulatory surgical center visit**;** **$0 - $100** per outpatient hospital visit	**$0** per ambulatory surgical center visit**;** **$0** per outpatient hospital visit
Skilled Nursing Facility	**$0** for days 1-20; **$200** copay per day for days 21-100	**$0** per day for days 1 - 100
Ambulance	**$0 - $100** copay per trip by ground or air	**20%** coinsurance per trip by ground or air
Emergency & Urgent Care	**$0 - $125** per ER visit; waived if admitted to hospital within 72 hours; **$0** for urgent care; Worldwide coverage; **$125** copay per emergency or urgent care visit; **$50,000** limit	**$95** copay per ER visit; waived if admitted to hospital within 72 hours; **$0** for urgent care; Worldwide coverage; **$95** copay per emergency or urgent care visit; **$50,000** limit
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, x-rays, diagnostic tests, procedures, and diagnostic radiology; **20%** coinsurance for therapeutic radiology	**$0** copay for lab services; **20%** coinsurance for x-rays, diagnostic tests, procedures, and diagnostic and therapeutic radiology
Renal Dialysis	**20%** coinsurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$10** copay for individual therapy session; **20%** coinsurance per group therapy session	**$40** copay for individual or group therapy session
Eyewear	**$300** annual allowance for eyeglasses or contacts	**$300** annual allowance for eyeglasses or contacts
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	**$699-$999** allowance per aid for 2 aids per year	**$149** allowance per aid for 2 aids every 3 years
Hearing 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
Dental	**$0** copay for certain preventative services; **$0-$1,110** for certain comprehensive services	**$0** copay for certain preventative services; **$0 - $350** copay for certain comprehensive services
Chiropractic	**$0** co-pay per Medicare covered visit**; $0** copay/visit for 12 visits per year (combined with acupuncture)	**$0** co-pay per Medicare covered visit**; $0** copay/visit for 12 visits per year (combined with acupuncture)
Podiatry	**$0** co-pay per Medicare covered visit; Routine care not covered	**$0** co-pay per Medicare covered visit; Routine care not covered
Prescription Drugs (Outpatient)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail order Preferred Generic: **$0** / **$0** / **$0** Generic: **$9** / **$27** / **$18** Preferred Brand: **$47** / **$101** / **$94** Non-Preferred Brand: **$90** / **$270** / **$180** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; 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 generics and brands until out-of-pocket drug expenses reach **$7,400**. After that, you pay the greater of **$4.14** or **5%** for generics and the greater of **$10.35** or **5%** for brands.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail order 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** **$0** deductible: after total yearly drug costs reach **$4,660**, you pay **25%** for generics and **25%** for brands 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/visit for 12 visits per year (combined with chiropractic) **Meals: $0** copay per meal for 14 meals/week for 12 weeks for people with qualifying chronic conditions **Over the Counter (OTC): $40** allowance every month for plan approved items **Transportation: $0** copay/trip for 48 trips per year to plan approved locations within 50 miles **Wellness: $0** for Silver Sneakers gym membership	**Acupuncture: $0** copay/visit for 12 visits per year (combined with chiropractic) **Cost-Sharing Waived:** most co-insurance and copays are waived for those with full Medi-Cal/Extra Help **Groceries: $50** monthly allowance for certain healthy foods, for those with qualifying conditions **Meals: $0** copay per meal for 14 meals/week for 12 weeks for people with qualifying chronic conditions **Over the Counter (OTC): $185** quarterly allowance for plan approved items **Transportation: $0** copay/trip for 48 trips per year to plan approved locations within 50 miles **Wellness: $0** for Silver Sneakers gym membership
Medical Groups and Hospitals	**Medical Groups:** Alameda Health System; Hill Physicians East Bay **Hospitals:** Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), San Leandro, Washington (Fremont)	**Medical Groups:** Alameda Health System; Hill Physicians East Bay **Hospitals:** Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), San Leandro, Washington (Fremont)

Please contact the Plan for more information or call 1-800-Medicare	**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	**Brand New Day Select Care II I-SNP (H0838-043)** **For People Who Need Nursing Home Level of Care**	**Brand New Day Select Choice II I-SNP (H0838-045)** **For People Who Need Nursing Home Level of Care**
Star Rating	★★★	★★★
Annual OOP Max	**$3,450**	**$7,500**
Monthly Premium	**$0**	**$38.90**
Doctor Visits	**$0** copay for Primary Care Physician; **$10** copay for Specialist	**20%** co-insurance for Primary Care Physician; **20%** co-insurance for Specialist
Inpatient Hospital	**$150** copay/day for days 1-6; **$0** for days 7-150	**$1,600** deductible; **$0** copay/day for days 1-60; **$400**/day for days 61-90; **$800**/day for days 91-150
Outpatient Hospital	**$0-75** copay per ambulatory surgical center visit**;** **$0-$150** copay per outpatient hospital visit	**20%** co-insurance per ambulatory surgical center visit or outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay for days 1-20 **$200** copay per day for days 21-100	**$0** copay for days 1-20; **$200** copay/day for days 21-100
Ambulance	**$0-$85** copay per trip by ground or air	**20%** coinsurance per trip by ground or air
Emergency & Urgent Care	**$0-$120** per emergency room visit; waived if admitted to hospital within 72 hours; **$0** for urgent care; Worldwide coverage; **$120** copay per emergency or urgent care visit; **$50,000** limit	**$90** copay per ER visit; waived if admitted to hospital within 72 hours; **$0** for urgent care; Worldwide coverage; **$90** copay per emergency or urgent care visit; **$50,000** limit
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, x-rays, diagnostic tests, procedures, and diagnostic and therapeutic radiology	**$0** copay for lab services; **20%** co-insurance for diagnostic tests and procedures, x-rays, and diagnostic and therapeutic radiology
Renal Dialysis	**$0** copay per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$10** copay per individual session; **20%** coinsurance per group therapy session	**20%** co-insurance per individual or group therapy session
Eyewear	**$300** annual allowance for eyeglasses or contacts	**$300** annual allowance for eyeglasses or contacts
Eye 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
Hearing Aids	**$699-$999** allowance per aid for 2 aids per year	**$149** allowance per aid for 2 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 preventative services; **$0 - $1,110** copays for certain comprehensive services	**$0** copay for certain preventative services; **$0 - $350** copay for certain comprehensive services
Chiropractic	**$0** copay for Medicare covered visit; Routine care not covered	**$0** copay for Medicare covered visit; Routine care not covered
Podiatry	**$0** co-pay per Medicare covered visit; Routine care not covered	**$0** co-pay per Medicare covered visit; Routine care not covered
Prescription Drugs (Outpatient)	*Cost-sharing shown is for network pharmacies* / 30 days / 90 days retail / 90 days mail order Preferred Generic: **$0** / **$0** / **$0** Generic: **$12** / **$36** / **$24** Preferred Brand: **$47** / **$141** / **$94** Non-Preferred Brand: **$100** / **$300** / **$200** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; 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 generics and brands until out-of-pocket drug expenses reach **$7,400**. After that, you pay the greater of **$4.14** or **5%** for generics and the greater of **$10.35** or **5%** for brands.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail order 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** **$0** deductible for Tier 1; **$505** deductible for Tiers 2 - 5: after total yearly drug costs reach **$4,660**, you pay **25%** for generics and **25%** for brands 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	**Over the Counter (OTC): $65** allowance every 6 months for plan approved items **Transportation: $0** copay/trip for 24 trips per year to plan approved locations within 50 miles	**Cost-Sharing Waived:** most co-insurance and copays are waived for those with full Medi-Cal/LIS **Over the Counter (OTC): $465** quarterly allowance for plan approved items **Transportation: $0** copay/trip for 48 trips per year to plan approved locations within 50 miles
Medical Groups and Hospitals	**Medical Groups:** Alameda Health System; Hill Physicians East Bay **Hospitals:** Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), San Leandro, Washington (Fremont)	**Medical Groups:** Alameda Health System; Hill Physicians East Bay **Hospitals:** Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oakland), San Leandro, Washington (Fremont)

2023 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Central Health Medicare** **1-866-314-2427 (Sales & Marketing)** **1-866-314-2427 (Member Services)** www.centralhealthplan.com	**Kaiser Permanente** **1-800-777-1238 (Sales & Marketing)** **1-800-443-0815 (Member Services)** www.healthy.kaiserpermanente.org
Plan Name/Type	**Central Health Focus Plan** **C-SNP (H5649-006)** **For People with Cardiovascular Disease, Chronic Heart Failure, or Diabetes**	**Kaiser Medicare Medi-Cal Plan** **D-SNP (H0524-030)** **For FULL DUALS**
Star Rating	★★★1/2	★★★★★
Annual OOP Max	**$1,800**	**$3,400**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** copay for Primary Care Physician; **$0** copay for Specialist	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$0** per stay	**$0** per day; Unlimited days per benefit period
Outpatient Hospital	**$0** copay per ambulatory surgical center visit; **$0** copay per outpatient hospital visit	**$0** copay per ambulatory surgical center visit; **$0** copay per outpatient hospital visit
Skilled Nursing Facility	**$0** copay for days 1-20; **$200** copay/day for days 21-100	**$0** copay per day; 100 days per benefit period
Ambulance	**$0** copay per trip by ground; **20%** coinsurance per trip by air	**$0** copay per trip by ground or air
Emergency & Urgent Care	**$100** copay per ER visit; waived if admitted to hospital within 72 hours; **$0** copay for urgent care; Worldwide coverage; **$50** copay per emergency or urgent care visit; **$100,000** limit	**$0** copay per emergency room or urgent care visit; Worldwide coverage
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, x-rays, diagnostic tests, procedures, and diagnostic radiology; **20%** coinsurance for therapeutic radiology	**$0** copay per service
Renal Dialysis	**20%** co-insurance per treatment	**$0** copay per treatment
Outpatient Mental Health Visits	**$0** copay for individual or group therapy session	**$0** copay per individual or group therapy session
Eyewear	**$150** annual allowance for eyeglasses or contacts	**$350** annual allowance for eyeglasses or contact lenses
Eye Exams	**$0** copay for Medicare-covered exam; **$0** copay for one annual routine exam	**$0** copay per Medicare-covered exam; **$0** copay for routine exams
Hearing Aids	**$2,000** annual allowance, through NationsHearing	Not Covered
Hearing Exams	**$0** copay for Medicare-covered exam; **$0** copay for one annual routine exam	**$0** co-pay per Medicare-covered exam; Routine exams not covered
Dental	**$0** copay for certain preventative services; **$0 - $295** copay for certain comprehensive services	**$0** co-pay for certain preventive and comprehensive services; with Delta Care USA
Chiropractic	**$0** copay for Medicare covered visit; Routine care not covered	**$0** co-pay per Medicare covered visit; Routine care not covered
Podiatry	**$0** co-pay per Medicare covered visit; Routine care not covered	**$0** co-pay per Medicare covered visit; Routine foot care not covered
Prescription Drugs (Outpatient)	*Cost-sharing shown is for network pharmacies* / 30 days / 90 days retail / 90 days mail order 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 any generics and **25%** of the plan's cost for brands 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: Depending on your income, you pay the following: **Generic: $0** or **$1.45** **All Other Drugs: $0** or **$4.30** After annual drug costs (paid by you, the plan, and by Extra Help from Medicare) reach **$7,400**, you pay the greater of **$4.15** or **5%** for generics and the greater of **$10.35** or **5%** for brands.
Other Benefits/Options	**Flex Allowance: $300** quarterly allowance for OTC items, herbal catalog items, & fitness fees **Groceries: $50** monthly allowance for certain healthy foods, for those with qualifying conditions **Meals: $0** co-pay for 2 meals/day for 2 weeks following surgery or hospital stay; can be used up to 4 times/year **Transportation: $0** copay/trip for 48 trips per year to plan approved locations within 50 miles **Wellness: $0** for Silver Sneakers gym membership	**Meals: $0** copay for up to two home-delivered meals per day for four weeks, following inpatient hospital stay due to congestive heart failure; once per calendar year **Over the Counter (OTC): $100** quarterly allowance for items in OTC catalogue; each order must be at least **$25** **Wellness: $0** copay for Silver&Fit gym membership
Medical Groups and Hospitals	**Medical Groups:** Hill Physicians East Bay **Hospitals:** Fremont Hospital	**Medical Groups:** Kaiser Permanente **Hospitals:** Kaiser Oakland, San Leandro, Fremont

2023 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Imperial Health Plan of CA** **1-800-838-5197 (Sales & Marketing)** **1-800-838-8271 (Member Services)** **www.imperialhealthplan.com**	**Imperial Health Plan of CA** **1-800-838-5197(Sales & Marketing)** **1-800-838-8271 (Member Services)** **www.imperialhealthplan.com**
Plan Name/Type	**Imperial Dual Plan** **D-SNP (H5496-011)** **For FULL DUALS**	**Imperial Senior Value** **C-SNP (H5496-005)** **For People with Cardiovascular Disease, Heart Failure, or Diabetes**
Star Rating	**★★1/2**	**★★1/2**
Annual OOP Max	**$2,999**	**$2,999**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** copay for Primary Care Physician; **$0** for Specialist	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$0** co-pay/day for days 1 - 150	**$0** per day for days 1-90; **$670**/day for days 91-150
Outpatient Hospital	**$0** per ambulatory surgical center visit**;** **$0** per outpatient hospital visit	**$0** per ambulatory surgical center visit**;** **$0** per outpatient hospital visit
Skilled Nursing Facility	**$0** copay for days 1 - 100	**$0** copay for days 1-20; **$164.50**/day for days 21-100
Ambulance	**$0** copay per trip by ground or air	**$125** copay per trip by ground **20%** co-insurance per trip by air
Emergency & Urgent Care	**$0** copay per emergency room or urgent care visit	**$0** copay per emergency room or urgent care visit; Worldwide coverage: **$0** copay and **$50,000** limit
Lab Tests, Procedures, and Radiation Therapy	**$0** copay per service	**$0** copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; **20%** co-insurance for therapeutic radiology
Renal Dialysis	**$0** copay per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$0** copay per individual or group therapy session	**20%** co-insurance per individual or group therapy session
Eyewear	**$0** copay for one pair eyeglasses or contacts; **$260** annual allowance	**$0** copay for one pair eyeglasses or contacts; **$250** annual allowance
Eye Exams	**$0** copay per Medicare-covered exam; **$0** co-pay for routine exams	**$0** copay per Medicare-covered exam; **$0** copay for routine exams
Hearing Aids	**$0** copay; **$2,500** annual allowance	**20%** co-insurance; **$1,250** annual allowance
Hearing Exams	**$0** copay for Medicare-covered exam; **$0** copay for routine exams	**20**% co-insurance for Medicare-covered exam; **20%** for routine exams; plan covers **$250**/year
Dental	**$0** co-pay for preventive services; **$500** annual allowance; **$0** co-pay for comprehensive services; **$2,000** annual allowance	**$0** co-pay for preventive services; plan covers **$500**/year; **$0** co-pay for comprehensive services; plan covers **$2,000**/year; through Liberty Dental
Chiropractic	**$0** co-pay per Medicare-covered visit; Routine care not covered	**$0** copay per Medicare-covered visit; Routine care not covered
Podiatry	**$0** copay per Medicare-covered visit; **$0** copay for 6 routine visits per year	**$0** copay per Medicare-covered visit; **$0** copay for 6 routine visits per year
Prescription Drugs (Outpatient)	**$0** deductible: Depending on your income, you pay the following: **Generic: $0** or **$1.45** **All Other Drugs: $0** or **$4.30** After annual drug costs (paid by you, the plan, and by Extra Help from Medicare) reach **$7,660**, you pay the greater of **$4.15** or **5%** for generics and the greater of **$10.35** or **5%** for brands.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail order Preferred Generic: **$0** / **$0** / **$0** Generic: **$5** / **$12** / **$10** Preferred Brand: **$45** / **$110** / **$90** Non-Preferred Brand: **$90** / **$225** / **$180** 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.
Other Benefits/Options	**Groceries: $30** quarterly allowance on pre-paid card, for those with qualifying chronic conditions **Meals: $0** co-pay for up to 7 home-delivered meals following surgery or hospital stay; **$105** allowance per benefit period **Over the Counter (OTC): $120** quarterly allowance for items in plan's OTC mail order catalog **Transportation: $0** co-pay for unlimited round trips to plan approved locations **Wellness: $0** for Silver&Fit gym membership	**Caregiver Support: $0** copay for up to 48 hours/year for in-home support services **Meals: $0** co-pay for up to 7 home-delivered meals following surgery or hospital stay; **$105** allowance per benefit period **Over the Counter (OTC): $120** quarterly allowance for items in plan's OTC mail order catalog **Transportation: $0** co-pay for unlimited round trips to plan approved locations **Wellness: $0** for Silver&Fit gym membership
Medical Groups and Hospitals	**Medical Groups:** Brown & Toland, Imperial Health, Nivano Physicians **Hospitals:** Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), St. Rose (Hayward), and Washington (Fremont)	**Medical Groups:** Brown & Toland, Imperial Health, Nivano Physicians **Hospitals:** Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), St. Rose (Hayward), and Washington (Fremont)

2023 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**SCAN Health Plan** **877-870-4867 (Sales & Marketing)** **800-559-3500 (Member Services)** www.scanhealthplan.com	**SCAN Health Plan** **877-870-4867 (Sales & Marketing)** **800-559-3500 (Member Services)** www.scanhealthplan.com
Plan Name/Type	**SCAN Balance** **C-SNP (H5425-076)** **For People with Diabetes**	**SCAN Heart First** **C-SNP (H5425-077)** **For People with Cardiosvascular Disease and/or Congestive Heart Failure**
Star Rating	**★★★★1/2**	**★★★★1/2**
Annual OOP Max	**$4,000**	**$4,000**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$10** for Specialist	**$0** for Primary Care Physician; **$10** for Specialist
Inpatient Hospital	**$250** copay per day for days 1-6; **$0** for days 7-90 and beyond	**$250** copay per day for days 1-6; **$0** for days 7-90 and beyond
Outpatient Hospital	**$0** per ambulatory surgical center visit**;** **$10-$125** copay per outpatient hospital visit	**$0** per ambulatory surgical center visit**;** **$10-$125** copay per outpatient hospital visit
Skilled Nursing Facility	**$0** for days 1-20; **$75** copay/day for days 21-100	**$0** for days 1-20; **$75** copay/day for days 21-100
Emergency & Urgent Care	**$90** copay per emergency room visit; Waived if immediately admitted to hospital; **$10** copay per urgent care visit; Worldwide coverage	**$90** copay per emergency room visit; Waived if immediately admitted to hospital; **$10** copay per urgent care visit; Worldwide coverage
Ambulance	**$180** copay per trip by ground or air	**$180** copay per trip by ground or air
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; **$60** copay for therapeutic radiology	**$0** copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; **$60** copay for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$10** copay per individual or group therapy session	**$10** copay per individual or group therapy session
Eyewear	**$235** allowance for lenses/frames every 2 years	**$235** allowance for lenses/frames every 2 years
Eye Exams	**$0** copay per Medicare-covered exam; **$0** copay for 1 annual routine exam	**$0** copay per Medicare-covered exam; **$0** copay for 1 annual routine exam
Hearing Aids	**$450-$750** copay per aid; 2 aids per year, through TruHearing Advanced	**$450-$750** copay per aid; 2 aids per year, through TruHearing Advanced
Hearing 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
Dental	**$0** copay per oral exam, cleaning, and x-rays; up to 2 visits each per year; See Optional Benefit Plan below	**$0** copay per oral exam, cleaning, and x-rays; up to 2 visits each per year; See Optional Benefit Plan below
Chiropractic	**$0** copay per Medicare-covered visit; Routine care not covered	**$0** copay per Medicare-covered visit; Routine care not covered
Podiatry	**$10** co-pay per Medicare covered visit; **$0** copay/visit for 6 routine visits per year	**$10** co-pay per Medicare covered visit; **$0** copay/visit for 6 routine visits per year
Prescription Drugs (Outpatient)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail order Preferred Generic: **$0** / **$0** / **$0** Generic: **$0** / **$0** / **$0** Preferred Brand: **$40** / **$100** / **$100** Non-Preferred Brand: **$90** / **$250** / **$250** 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 names 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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail order Preferred Generic: **$0** / **$0** / **$0** Generic: **$0** / **$0** / **$0** Preferred Brand: **$40** / **$100** / **$100** Non-Preferred Brand: **$90** / **$250** / **$250** 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 names 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	**Over the Counter (OTC):** $100 quarterly allowance for items from plan's OTC catalog **Transportation: $0** copay for up to 24 one-way trips per year to plan-approved locations within 75 miles **Optional Dental Plan: $10**/month with varying copays for preventive and comprehensive services	**Over the Counter (OTC):** $100 quarterly allowance for items from plan's OTC catalog **Transportation: $0** copay for up to 24 one-way trips per year to plan-approved locations within 75 miles **Optional Dental Plan: $10**/month with varying copays for preventive and comprehensive services
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 SNP COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**United Health Care** **1-844-560-4944 (Sales and Marketing)** **1-800-933-4017 (Member Services)** www.uhc.com	**Wellcare by Health Net of CA** **1-844-917-0175 (Sales/Marketing)** **1-800-431-9007 (Member Services)** www.wellcarenow.com
Plan Name/Type	**UHC Dual Complete** **D-SNP (H1375-001)** **For FULL DUALS**	**Wellcare Dual Liberty Amber** **D-SNP (H3561-001)** **For FULL DUALS**
Star Rating	★★1/2	★★★
Annual OOP Max	**$8,300**	**$8,300**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** copay for Primary Care Physician; **$0** for Specialist	**$0** copay for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$0** copay per stay for unlimited days	**$0** for days 1-150
Outpatient Hospital	**$0** copay per ambulatory surgical center visit; **$0** copay per outpatient hospital visit	**$0** copay per ambulatory surgical center visit**;** **$0** copay per outpatient hospital visit
Skilled Nursing Facility	**$0** co-pay for days 1-100	**$0** copay for days 1-100
Emergency & Urgent Care	**$0** copay per emergency room or urgent care visit; Worldwide coverage	**$0** copay per trip by ground or air
Ambulance	**$0** copay per trip by ground or air	**$0** copay per emergency room or urgent care visit; Worldwide coverage: **$95** copay/visit; **$50,000** coverage limit
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, diagnostic tests & procedures, x-rays, diagnostic and therapeutic radiology	**$0** copay for lab services, diagnostic tests & procedures, x-rays, diagnostic and therapeutic radiology
Renal Dialysis	**$0** copay per treatment	**$0** copay per treatment
Outpatient Mental Health Visits	**$0** copay per individual or group therapy session	**$0** copay per individual or group therapy session
Eyewear	**$400** allowance for frames or contact lenses every 2 years; eyeglass lenses covered in full	**$400** annual allowance for eyeglasses/contact lenses
Eye Exams	**$0** copay per Medicare-covered exam; **$0** copay for one annual routine exam	**$0** copay for Medicare-covered exam; **$0** copay for one annual routine exam
Hearing Aids	**$3,600** allowance for 2 aids per year; through United Healthcare Hearing	**$1,000** allowance for two aids per year
Hearing 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
Dental	**$0** copay for certain preventive and comprehensive services; **$2,000** combined annual limit; can use out-of-network dentists but higher copays may apply	**$0** copay for limited services
Chiropractic	**$0** copay per Medicare covered visit; Routine care not covered	**$0** copay for Medicare-covered visit; **$0** copay/visit for 24 routine visits per year
Podiatry	**$0** co-pay per Medicare-covered visit; Routine care not covered	**$0** copay for Medicare-covered visit; **$0** copay/visit for 12 routine visits per year
Prescription Drugs (Outpatient)	**$0** copay for all covered drugs; Specialty (Tier 5) drugs limited to 30-day supply	**$0** copay for all covered drugs; Specialty (Tier 5) drugs limited to 30-day supply
Other Benefits/Options	**Over the Counter (OTC): $80** monthly allowance for plan-approved items from catalog; can be used for plan-covered groceries and certain utility bills **Transportation: $0** copay/trip for 72 one-way trips per year to plan approved locations **Wellness**: **$0** for Renew Active gym membership	**Acupuncture: $0** copay/visit for 24 visits per year **Caregiver Support: $0** copay for 12 visits/year for in-home support services; each visit limit 4 hours **Groceries: $25** monthly allowance for plan approved products **Meals: $0** copay for 3 home-delivered meals per day for up to 14 days following inpatient hospital stay **Over the Counter (OTC): $220** quarterly allowance for plan-approved items from CVS retail locations or mail order items from plan catalog **Transportation: $0** co-pay for 48 one-way trips per year to plan-approved locations **Utility Flex Card: $75** per month for certain home utility costs; for those with qualifying conditions **Wellness: $0** for gym membership at participating locations
Medical Groups and Hospitals	**Medical Groups:** Brown & Toland, Hill Physicians East Bay, PAMF/Sutter East Bay **Hospitals:** Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oakland), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv), and Washington (Fremont)	**Medical Groups:** Brown and Toland**;** Hill Physicians East Bay **Hospitals:** Alameda, Alta Bates/Summit (Berk/Oak), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv) and Washington (Fremont)

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
- 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