2023 Medicare Advantage Plan HMO Comparison Chart for Alameda County

~Rev. 12/02/22 ~

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 Cart 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

SHIP State Health Insurance Assistance Program

Navigating Medicare

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2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**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)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 day retail / 100 day mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$0** / **$0** / **$0** Preferred Brand: **$42** / **$126** / **$126** Non-Preferred Brand: **$99** / **$297** / **$297** Specialty co-insurance: **33%** / **N/A** / **N/A** **$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.	**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	**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

Please contact the Plan for more information or call 1-800-Medicare	**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 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)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$0** / **$0** / **$0** Preferred Brand: **$42** / **$126** / **$126** Non-Preferred Brand: **$99** / **$297** / **$297** Specialty co-insurance: **33%** / **N/A** / **N/A** **$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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$5** / **$7.50** / **$7.50** Preferred Brand: **$40** / **$100** / **$100** Non-Preferred Brand: **$95** / **$237.50** / **$237.50** Specialty co-insurance: **33%** / **N/A** / **N/A** **$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

Please contact the Plan for more information or call 1-800-Medicare	**Alignment Health Plan** **888-979-2247 (Sales & Marketing)** **866-634-2247 (Member Services)** www.alignmenthealthplan.com	
Plan Name/Type	**Alignment Health CalPlus + Veterans (HMO) (H3815-036)**	**Alignment Health Harmony (HMO) (H3815-031)**
Star Rating	★★★★	★★★★
Annual OOP Max	**$5,900**	**$2,900**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$1,600** deductible; **$0** copay for days 1-60; **$400** copay/day for days 61-90; **$800** copay/day for days 91-150	**$0** copay/day for days 1-4; **$100** copay/day for days 5-10; **$0** copay/day for days 10-90 and beyond
Outpatient Hospital	**$0** copay for ambulatory surgical center; **$0** copay for outpatient hospital facility	**$100** copay for ambulatory surgical center visit; **$200** copay for outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$200**/day for days 21-100	**$0** copay/day for days 1-20; **$100** copay/day for days 21-100
Ambulance	**20%** co-insurance per ground ambulance trip; **20%** coinsurance per air ambulance trip	**$175** copay per ground or air ambulance trip; Waived if admitted to hospital
Emergency & Urgent Care	**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	**$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
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; **20%** coinsurance for therapeutic radiology	**$0** copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; **20%** coinsurance for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**$30** copay per treatment
Outpatient Mental Health Visits	**20%** co-insurance per individual or group therapy session	**$40** copay per individual or group therapy session
Eyewear	**$0** copay with Flex allowance; see Other Benefits	**$150** annual allowance for eyeglasses or contacts
Eye Exams	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam
Hearing Aids	**$0** copay with Flex allowance; see Other Benefits	**$0** copay with Flex allowance; see Other Benefits
Hearing Exams	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam
Dental	**$0** copay for certain preventive and comprehensive services with Flex allowance; see Other Benefits	**$0** copay for certain preventive and comprehensive services with Flex allowance; see Other Benefits
Chiropractic	**$0** copay per Medicare-covered visit; **$0** copay per routine visit with Flex Allowance; see Other Benefits	**$0** copay per Medicare-covered visit; **$0** copay per routine visit with Flex Allowance; see Other Benefits
Podiatry	**$0** copay for Medicare-covered services	**$5** copay for Medicare-covered services**;** **$5** copay for unlimited routine visits each year
Prescription Drugs (Part D)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$20** / **$60** / **$60** Preferred Brand: **25%** / **25%** / **25%** Non-Preferred Brand: **25%** / **25%** / **25%** Specialty co-insurance: **25%** / **25%** / **25%** **$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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$3** / **$9** / **$9** Preferred Brand: **$40** / **$120** / **$120** Non-Preferred Brand: **$93** / **$279** / **$279** Specialty co-insurance: **33%** / **N/A** / **N/A** **$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	**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	**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
Medical Groups and Hospitals	**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)	**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)

2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Alignment Health Plan** **888-979-2247 (Sales & Marketing)** **866-634-2247 (Member Services)** www.alignmenthealthplan.com	
Plan Name/Type	**Alignment Health My Choice CalPlus (HMO) (H3815-007)**	**Alignment Health Premium (HMO) (H3815-037)**
Star Rating	★★★★	★★★★
Annual OOP Max	**$3,000**	**$4,900**
Monthly Premium	**$0**	**$69**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**$5** for Primary Care Physician; **$20** for Specialist
Inpatient Hospital	**$0** copay for days 1-4; **$100** copay/day for days 5-10; **$0** copay for days 11 and beyond; unlimited	**$225** copay for days 1-5; **$0** copay/day for days 6 and beyond; unlimited
Outpatient Hospital	**$100** copay for ambulatory surgical center; **$200** copay for outpatient hospital facility	**$0** copay for ambulatory surgical center visit; **$325** for outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$50** copay/day for days 21-100	**$0** copay/day for days 1-20; **$160** per day for days 21-57; **$0** for days 58-100
Ambulance	**$175** copay per trip by ground or air; waived if admitted	**$250** copay per trip by ground or air; waived if admitted
Emergency & Urgent Care	**$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	**$90** copay for ER visit; **$0** for urgent care visit; copays not waived if admitted; **$7,500** annual limit for ER/urgent care worldwide
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; **20%** coinsurance for therapeutic radiology	**$0** copay for lab services, diagnostic tests & procedures; **$15** for x-rays; **$150** for diagnostic radiology; **20%** coinsurance for 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	**$40** copay per individual or group therapy session
Eyewear	**$100** annual allowance for eyeglasses or contacts	**$150** allowance for eyeglasses or contacts every 2 yrs
Eye Exams	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam
Hearing Aids	**$1,000** allowance with **$0** copay; every 2 years	Not covered
Hearing Exams	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam
Dental	**$0** copay for basic preventive services; **$20-$425** copays for certain comprehensive services	**$0** copay for basic preventive services; **$20-$425** copays for certain comprehensive services
Chiropractic	**$0** copay per Medicare-covered visit; **$0** copay for 40 routine visits per year, combined with acupuncture; **$10** coverage limit/visit	**$0** copay per Medicare-covered visit
Podiatry	**$5** copay for Medicare-covered services; **$5** copay for unlimited routine visits each year	**$0** copay for Medicare-covered services
Prescription Drugs (Part D)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$3** / **$9** / **$9** 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 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	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail 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 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
Other Benefits/Options	**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	**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
Medical Groups and Hospitals	**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)	**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)

2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Anthem Blue Cross** **800-619-6164 (Sales & Marketing)** **888-230-7338 (Member Services)** www.anthem.com	
Plan Name/Type	**Anthem MediBlue Coordination Plus (HMO) (H0544-099)**	**Anthem MediBlue Select (HMO) (H0544-098)**
Star Rating	★★★	★★★
Annual OOP Max	**$7,550**	**$7,550**
Monthly Premium	**$19.70**	**$0**
Doctor Visits	**20%** co-insurance for Primary Care Physician; **20%** co-insurance for Specialist	**$15** for Primary Care Physician; **$45** for Specialist
Inpatient Hospital	**$1,600** deductible for days 1-60; **$400** copay/day for days 61-90; **$800** copay/day for days 91-150	**$325** copay for days 1-6; **$0** copay/day for days 7 and beyond
Outpatient Hospital	**20%** co-insurance for ambulatory surgical center; **20%** co-insurance for outpatient hospital facility	**$275** copay for ambulatory surgical center visit; **$325** for outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$200**/day for days 21-100	**$0** copay/day for days 1-20; **$196** per day for days 21-100
Ambulance	**20%** co-insurance per ground ambulance trip; **20%** coinsurance per air ambulance trip	**$250** copay per ground ambulance trip; **20%** coinsurance per air ambulance trip
Emergency & Urgent Care	**$90** copay for ER visit; **$60** for urgent care visit; ER copay waived if admitted to hospital within 24 hours; **$100,000** annual limit for ER/urgent care worldwide	**$90** copay for ER visit; **$35** for urgent care visit; ER copay waived if admitted to hospital within 24 hours; **$100,000** annual limit for ER/urgent care worldwide
Lab Tests, Procedures, and Radiation Therapy	**20%** co-insurance for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; **20%** coinsurance for therapeutic radiology	**$10** copay for lab services; **$50-75** for diagnostic tests & procedures; **$10** for x-rays; **$150** for diagnostic radiology; **20%** coinsurance for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**20%** co-insurance per individual or group therapy session	**$40** copay per individual or group therapy session
Eyewear	**$300** annual allowance for eyeglasses or contacts	**$100** annual allowance for eyeglasses or contacts
Eye Exams	**20%** co-insurance for diagnostic exam; **$0** copay for one annual routine exam	**$45** copay for diagnostic exam; **$0** copay for one annual routine exam
Hearing Aids	**$3,000** annual allowance with **$0** copay	**$3,000** annual allowance with **$0** copay
Hearing Exams	**20%** co-insurance for diagnostic exam; **$0** copay for one annual routine exam	**$45** copay for diagnostic exam; **$0** copay for one annual routine exam
Dental	**20%** co-insurance for Medicare covered services; **$0** copay for basic preventive services; **$1,500** annual allowance for covered comprehensive svcs	**$45** copay for Medicare covered services**;** **$0** copay for 1 oral exam and 1 cleaning per year
Chiropractic	**$20** copay per Medicare-covered visit; **$0** copay for 12 routine visits per year	**$20** copay per Medicare-covered visit
Podiatry	**20%** coinsurance for Medicare-covered services; **$0** copay for unlimited routine visits each year	**$0-45** copay for Medicare-covered services**;** **$0** copay for 24 routine visits each year
Prescription Drugs (Part D)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$13** / **$39** / **$0** Preferred Brand: **$47** / **$141** / **$141** Non-Preferred Brand: **$95** / **$285** / **$285** Specialty co-insurance: **33%** / **N/A** / **N/A** **$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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$10** / **$30** / **$0** Preferred Brand: **$42** / **$126** / **$84** Non-Preferred Brand: **$95** / **$285** / **$190** Specialty co-insurance: **33%** / **N/A** / **N/A** **$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	**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	**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
Medical Groups and Hospitals	**Medical Groups:** Imperial Health Holdings **Hospitals**: Eden (Castro Valley), St. Rose, (Hayward), Stanford Valley Care (Pleasanton & Livermore), Washington (Fremont)	**Medical Groups:** Imperial Health Holdings **Hospitals**: Eden (Castro Valley), St. Rose, (Hayward), Stanford Valley Care (Pleasanton & Livermore), Washington (Fremont)

2023 MEDICARE HMO 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	**Classic Care I (HMO) (H0838-050)**	**Classic Care II (HMO) (H0838-051)**
Star Rating	★★★	★★★
Annual OOP Max	**$3,650**	**$1,500**
Monthly Premium	**$38.90**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**$0** for Primary Care Physician; **$10** for Specialist
Inpatient Hospital	**$1,600** for days 1-60; **$400**/day for days 60-90; **$800**/day for days 91-150	**$150** copay/day for days 1-6; **$0** per day for days 7 and beyond
Outpatient Hospital	**20%** coinsurance per ambulatory surgical center and 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 for days 1-20; **$200** per day for days 21-100	**$0** copay for days 1-20; **$200** per day for days 21-100
Ambulance	**20%** coinsurance per trip by ground or air	**$200** copay per trip by ground or air
Emergency & Urgent Care	**$100** copay per emergency room visit; waived if admitted within 3 days; **$0** per urgent care visit; **$50,000** max worldwide with **$100** copay/visit	**$0-$100** copay per emergency room visit; waived if admitted within 3 days; **$0** per urgent care visit; **$50,000** max worldwide with **$100** copay/visit
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, **20%** coinsurance for diagnostic procedures, tests, and x-rays; **20%** co-insurance for diagnostic and 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, combined with routine acupuncture	**$0** copay per Medicare-covered visit; **$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)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$0** / **$0** / **$0** 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 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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$12** / **$36** / **$24** Preferred Brand: **$47** / **$141** / **$94** Non-Preferred Brand: **$100** / **$300** / **$200** Specialty co-insurance: **32%** / **N/A** / **N/A** **$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 **Cost-Sharing Waived:** most co-insurance and copays are waived for those w/full Medi-Cal/LIS **Groceries: $50** monthly allowance at plan-approved stores, for those with qualifying chronic conditions **Meals: $0** copay/meal for 14 meals each month for 12 months, for those with qualifying chronic cond. **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 within 50 miles **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 within 50 miles **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

Please contact the Plan for more information or call 1-800-Medicare	**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 for days 1-20; **$200**/day for days 21-100	**$0** copay 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)	*Cost-sharing shown is for preferred pharmacies* / 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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days / 90 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$0** / **$0** / **$0** Preferred Brand: **15%** / **15%** / **15%** Non-Preferred Brand: **15%** / **15%** / **15%** Specialty co-insurance: **33%** / **N/A** / **N/A** **$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

<table>
<tr><td>Please contact the Plan for more information or call 1-800-Medicare</td><td colspan="2">Essence Healthcare (formerly Stanford Healthcare Advantage)
855-921-3777 (Sales & Marketing)
855-996-8422 (Member Services)
www.essencehealthcare.com</td></tr>
<tr><td>Plan Name/Type</td><td>Essence Advantage Gold (HMO) (H2986-007)</td><td>Essence Advantage Platinum (HMO) (H2986-004)</td></tr>
<tr><td>Star Rating</td><td>★★★1/2</td><td>★★★1/2</td></tr>
<tr><td>Annual OOP Max</td><td>$5,900</td><td>$4,900</td></tr>
<tr><td>Monthly Premium</td><td>$57</td><td>$87</td></tr>
<tr><td>Doctor Visits</td><td>$5 copay for Primary Care Physician;
$35 for Specialist</td><td>$0 copay for Primary Care Physician;
$30 for Specialist</td></tr>
<tr><td>Inpatient Hospital</td><td>$315 copay/day for days 1-7; $0 for days 8 & beyond</td><td>$300 copay/day for days 1-7; $0 for days 8 & beyond</td></tr>
<tr><td>Outpatient Hospital</td><td>20% co-insurance per ambulatory surgical center and outpatient hospital visit</td><td>$240 copay per ambulatory surgical center and outpatient hospital visit</td></tr>
<tr><td>Skilled Nursing Facility</td><td>$0 copay/day for days 1-20;
$150 per day for days 21-100</td><td>$0 copay/day for days 1-20;
$100 per day for days 21-100</td></tr>
<tr><td>Ambulance</td><td>$210 copay per ground or air ambulance trip</td><td>$200 copay per ground or air ambulance trip</td></tr>
<tr><td>Emergency & Urgent Care</td><td>$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)</td><td>$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)</td></tr>
<tr><td>Lab Tests, Procedures, and Radiation Therapy</td><td>$10 copay for lab services;
$45 for diagnostic procedures, tests, and x-rays;
$210 copay for diagnostic radiology;
20% of cost for therapeutic radiology</td><td>$10 copay for lab services;
$25 for diagnostic procedures, tests, and x-rays;
$210 copay for diagnostic radiology;
20% of cost for therapeutic radiology</td></tr>
<tr><td>Renal Dialysis</td><td>20% co-insurance per treatment</td><td>20% co-insurance per treatment</td></tr>
<tr><td>Outpatient Mental Health Visits</td><td>$30 copay per individual session;
$20 per group therapy session</td><td>$20 copay per individual session;
$10 per group therapy session</td></tr>
<tr><td>Eyewear</td><td>See Optional Benefit Package below</td><td>See Optional Benefit Package below</td></tr>
<tr><td>Eye Exams</td><td>$5-$35 copay per Medicare-covered exam;
Routine exams not covered;
See Optional Benefit Packages below</td><td>$0-$30 copay per Medicare-covered exam;
Routine exams not covered;
See Optional Benefit Packages below</td></tr>
<tr><td>Hearing Aids</td><td>Not Covered</td><td>Not Covered</td></tr>
<tr><td>Hearing Exams</td><td>$0 copay per Medicare-covered exam;</td><td>$0 copay per Medicare-covered exam</td></tr>
<tr><td>Dental</td><td>$35 copay per Medicare covered visit;
See Optional Benefit Packages below</td><td>$20 copay per Medicare covered visit;
See Optional Benefit Packages below</td></tr>
<tr><td>Chiropractic</td><td>$20 copay per Medicare covered visit;
Routine care not covered</td><td>$20 copay per Medicare covered visit;
Routine care not covered</td></tr>
<tr><td>Podiatry</td><td>$35 copay per Medicare-covered visit;
Routine foot care not covered</td><td>$20 copay per Medicare covered visit;
Routine foot care not covered</td></tr>
<tr><td>Prescription Drugs (Part D)</td><td>
<table>
<tr><td>Cost-sharing shown is for preferred pharmacies</td><td>30 days</td><td>90 days retail</td><td>90 days mail</td></tr>
<tr><td>Preferred Generic</td><td>$5</td><td>$15</td><td>$10</td></tr>
<tr><td>Generic</td><td>$15</td><td>$45</td><td>$30</td></tr>
<tr><td>Preferred Brand</td><td>$47</td><td>$141</td><td>$94</td></tr>
<tr><td>Non-Preferred Brand</td><td>$100</td><td>$300</td><td>$200</td></tr>
<tr><td>Specialty co-insurance</td><td>33%</td><td>N/A</td><td>N/A</td></tr>
</table>
$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.</td><td>
<table>
<tr><td>Cost-sharing shown is for preferred pharmacies</td><td>30 days</td><td>90 days retail</td><td>90 days mail</td></tr>
<tr><td>Preferred Generic</td><td>$5</td><td>$15</td><td>$10</td></tr>
<tr><td>Generic</td><td>$15</td><td>$45</td><td>$30</td></tr>
<tr><td>Preferred Brand</td><td>$47</td><td>$141</td><td>$94</td></tr>
<tr><td>Non-Preferred Brand</td><td>$100</td><td>$300</td><td>$200</td></tr>
<tr><td>Specialty co-insurance</td><td>33%</td><td>N/A</td><td>N/A</td></tr>
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<tr><td>Other Benefits/Options</td><td>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</td><td>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</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Medical Groups and Hospitals</td><td>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)</td><td>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)</td></tr>
</table>

2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**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)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$5** / **$10** / **$10** Preferred Brand: **$45** / **$90** / **$90** Non-Preferred Brand: **$90** / **$180** / **$180** Specialty co-insurance: **33%** / **33%** / **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. **$7,400** annual out of pocket max.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days / 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%** / **25%** / **25%** **$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 Holdings, 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 Holdings, 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

Please contact the Plan for more information or call 1-800-Medicare	**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)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$3** / **$9** / **$5** Preferred Brand: **$30** / **$90** / **$75** Non-Preferred Brand: **$75** / **$150** / **$180** Specialty co-insurance: **33%** / **33%** / **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. **$7,400** annual out of pocket max.	**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	**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 Holdings, 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 Holdings, 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

Please contact the Plan for more information or call 1-800-Medicare	**Kaiser Permanente** **800-777-1238 (Sales & Marketing)** **800-443-0815 (Member Services)** www.medicare.kaiserpermanente.org	
Plan Name/Type	**Kaiser Permanente Senior Advantage Basic Alameda (HMO) (H0524-059)**	**Kaiser Permanente Senior Advantage (HMO) (H0524-032)**
Star Rating	★★★★★	★★★★★
Annual OOP Max	**$6,000**	**$3,900**
Monthly Premium	**$0**	**$70**
Doctor Visits	**$5** copay for Primary Care Physician; **$15** for Specialist	**$0** copay for Primary Care Physician; **$10** for Specialist
Inpatient Hospital	**$265** copay/day for days 1-5; **$0** per day for days 6 and beyond	**$195** copay/day for days 1-5; **$0** per day for days 6 and beyond
Outpatient Hospital	**$250** per ambulatory surgical center visit**;** **$0-$250** copay per outpatient hospital facility visit	**$180** per ambulatory surgical center visit**;** **$0-$180** copay per outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$100** per day for days 21-100	**$0** copay/day for days 1-20; **$100** per day for days 21-100
Ambulance	**$200** copay per air or ground ambulance trip	**$200** copay per air or ground ambulance trip
Emergency & Urgent Care	**$110** for emergency room visit; **$5** for urgent care visit; Worldwide coverage	**$110** for emergency room visit; **$0** for urgent care visit; Worldwide coverage
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab, diagnostic tests & procedures; **$5** copay for x-rays; **$215** copay for diagnostic radiology; **$0** for therapeutic radiology	**$0** copay for lab, diagnostic tests, procedures, x-rays; **$195** copay for diagnostic radiology; **$0** for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$2** copay per individual session; **$5** per group therapy session	**$0** copay per individual session; **$0** per group therapy session
Eyewear	**$150** allowance for eyewear every 2 years; See Optional Benefits Plan below	**$150** allowance for eyewear every 2 years; See Optional Benefits Plan below
Eye Exams	**$5-$15** copay per Medicare-covered exam; **$5** per routine exam	**$0-$10** copay per Medicare-covered exam; **$0** per routine exam
Hearing Aids	**$1,250** allowance per aid, every 3 years	**$1,250** allowance per aid, every 3 years
Hearing Exams	**$15** copay per Medicare-covered exam; **$0** copay for routine exam	**$10** copay per Medicare-covered exam; **$0** copay for routine exam
Dental	**$0** copay for certain preventive and diagnostic services; See Optional Benefits Plan below for additional dental benefits	**$0** copay for certain preventive and diagnostic services; See Optional Benefits Plan below for additional dental benefits
Chiropractic	**$5** copay per Medicare covered visit; Routine care not covered	**$0** copay per Medicare covered visit; Routine care not covered
Podiatry	**$15** copay per Medicare covered visit; Routine foot care not covered	**$10** copay per Medicare covered visit; Routine foot care not covered
Prescription Drugs (Part D)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 day retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$12** / **$36** / **$24** Preferred Brand: **$45** / **$135** / **$90** Non-Preferred Brand: **$100** / **$300** / **$200** Specialty co-insurance: **33%** / **33%** / **33%** **$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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$5** / **$15** / **$10** Preferred Brand: **$45** / **$135** / **$90** Non-Preferred Brand: **$100** / **$300** / **$200** Specialty co-insurance: **33%** / **33%** / **33%** **$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.
Other Benefits/Options	**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 **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	**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 **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
Medical Groups and Hospitals	**Medical Groups:** Kaiser Permanente **Hospitals:** Kaiser Oakland, San Leandro, Fremont	**Medical Groups:** Kaiser Permanente **Hospitals:** Kaiser Oakland, San Leandro, Fremont

2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for outline of coverage & provider information or call 1-800-Medicare	**United Health Care** **844-723-6473 (Sales and Marketing)** **877-596-3258 (Member Services)** www.aarpmedicareplans.com	
Plan Name/Type	**UnitedHealthcare Canopy Health (HMO-POS) (H0543-188)**	**AARP Medicare Advantage Focus (HMO-POS) (H0543-235)**
Star Rating	★★★★	★★★★
Annual OOP Max	**$3,400**	**$6,700**
Monthly Premium	**$57**	**$25**
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** for days 8 and beyond (unlimited)	**$300** copay/day for days 1-7; **$0** for days 8 and beyond (unlimited)
Outpatient Hospital	**$75** copay for ambulatory surgical center visit**;** **$200** copay for outpatient hospital visit	**$200** copay for ambulatory surgical center visit**;** **$250** copay for outpatient hospital visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$196** per day for days 21-38; **$0** for 39-100	**$0** copay for days 1-20; **$196** copay/day for days 21-55; **$0** for 56-100
Emergency & Urgent Care	**$90** copay per emergency room visit; waived if admitted to hospital within 24 hours; **$40** per urgent care visit; **$0** copay for worldwide coverage	**$90** copay per emergency room visit; waived if admitted to hospital within 24 hours; **$40** per urgent care visit; **$0** copay for worldwide coverage
Ambulance	**$265** copay per trip by ground or air	**$250** copay per trip by ground or air
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab, diagnostic tests, and procedures; **$15** copay per x-ray; **$105** copay for diagnostic radiology; **$60** copay for therapeutic radiology	**$0** copay for lab, diagnostic tests and procedures; **$15** copay per x-ray; **$60** 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 for individual therapy session; **$15** copay for group therapy session	**$25** copay for individual therapy session; **$15** copay for group therapy session
Eyewear	**$0** copay for standard lenses**,** with **$100** annual allowance toward frames or contact lenses; through United Healthcare Vision	**$0** copay for standard lenses**,** with **$100** annual allowance toward frames or contact lenses; through United Healthcare Vision
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	**$175 - $1,225** copay per aid; up to 2 aids each year; through United Healthcare Hearing	**$175 - $1,225** copay per aid; up to 2 aids each year; through United Healthcare Hearing
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** 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	**$0** copay for certain preventive services; can use out of network dentists but higher copays may apply See Optional Benefit Plan below
Chiropractic	**$15** copay for Medicare-covered visit; Routine care not covered	**$10** copay for Medicare-covered visit; Routine care not covered
Podiatry	**$15** copay per Medicare-covered visit; **$15** copay/visit for 6 routine visits per year	**$10** copay per Medicare-covered visit; **$10** copay/visit for 6 routine visits per year
Prescription Drugs (Part D)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$12** / **$36** / **$0** Preferred Brand: **$47** / **$141** / **$131** Non-Preferred Brand: **$100** / **$300** / **$290** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; after total yearly drug costs reach **$4,660**, you pay you pay **$0** for preferred generics and no more than **25%** of the plan's cost for brand name drugs and **25%** for generics until out-of-pocket drug expenses reach **$7,400.** 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 Preferred Generic: **$0** / **$0** / **$0** Generic: **$12** / **$36** / **$0** Preferred Brand: **$47** / **$141** / **$131** Non-Preferred Brand: **$100** / **$300** / **$290** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; after total yearly drug costs reach **$4,660**, you pay you pay **$0** for preferred generics and no more than **25%** of the plan's cost for brand name drugs and **25%** for generics until out-of-pocket drug expenses reach **$7,400.** 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: $40** allowance per quarter for items from network retail location or OTC catalog **Transportation: $0** copay for 24 one-way trips per year to plan-approved, medically related locations **Wellness: $0** for Renew Active Fitness membership	**Over the Counter: $40** allowance per quarter for items from network retail location or OTC catalog **Wellness: $0** for Renew Active Fitness membership **Optional Dental Platinum Rider at $52/month:** includes certain preventive and comprehensive benefits with varied cost-sharing
Medical Groups and Hospitals	**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)	**Medical Groups:** Brown and Toland East Bay; Hill Physicians East Bay **Hospitals:** St. Rose (Hayward)

2023 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for outline of coverage & provider information or call 1-800-Medicare	**United Health Care** **844-723-6473 (Sales and Marketing)** **877-596-3258 (Member Services)** www.aarpmedicareplans.com	
Plan Name/Type	**United Health Care Advantage Assure (HMO) (H0543-183)**	**AARP SecureHorizons Plan 1 (HMO-POS) (H0543-070)**
Star Rating	★★★★	★★★★
Annual OOP Max	**$8,300**	**$6,700**
Monthly Premium	**$27.50**	**$118**
Doctor Visits	**20%** coinsurance for Primary Care Physician; **20%** coinsurance for Specialist	**$0** copay for Primary Care Physician; **$10** for Specialist
Inpatient Hospital	**$1,600** copay per stay; unlimited days	**$390** copay/day for days 1-5; **$0** for days 6 and beyond (unlimited)
Outpatient Hospital	**20%** coinsurance for ambulatory surgical center visit**;** **20%** coinsurance for outpatient hospital visit	**$370** copay for ambulatory surgical center visit**;** **$370** copay for 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; **$196** per day for days 21-55; **$0** for 56-100
Emergency & Urgent Care	**$90** copay for emergency room visit; waived if admitted to hospital within 24 hours; **$40** per urgent care visit; **$0** copay for worldwide coverage	**$90** copay for emergency room visit; waived if admitted to hospital within 24 hours; **$40** per urgent care visit; **$0** copay for worldwide coverage
Ambulance	**20%** coinsurance per trip by ground or air	**$250** copay per trip by ground or air
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab, diagnostic tests and procedures; **20%** coinsurance for x-rays, diagnostic radiology, and therapeutic radiology	**$0** copay for lab, diagnostic tests, and procedures; **$15** copay per x-ray; **$105** 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	**20%** coinsurance for individual therapy session; **20%** coinsurance for group therapy session	**$25** copay for individual therapy session; **$15** copay for group therapy session
Eyewear	**$0** copay for standard lenses**,** with **$100** annual allowance for frames or contact lenses; through United Healthcare Vision	**$0** copay for standard lenses**,** with **$100** annual allowance for frames or contact lenses; through United Healthcare Vision
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	Plan pays up to **$2,500** per year for 2 aids/year; through United Healthcare Hearing	**$175 - $1,225** copay per aid; up to 2 aids each year; through United Healthcare Hearing
Hearing Exams	**20%** coinsurance 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	Not Covered	See Optional Benefits Plan below
Chiropractic	**20%** coinsurance for Medicare-covered visit; Routine care not covered	**$10** copay for Medicare-covered visit; Routine care not covered
Podiatry	**$0** co-pay per Medicare-covered visit; **$0** co-pay per routine visit, up to 4 per year	**$10** copay per Medicare-covered visit; **$10** copay/visit for 6 routine visits per year
Prescription Drugs (Part D)	*Cost-sharing shown is for preferred pharmacies* / 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** **$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.	*Cost-sharing shown is for preferred pharmacies* / 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** **$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.
Other Benefits/Options	**Cost-Sharing Waived:** most co-insurance and copays are waived for those with full Medi-Cal/LIS **Transportation: $0** copay for 36 one-way trips per year to plan-approved, medically related locations	**Optional Dental Platinum Rider at:** **$56/month:** includes certain preventive and comprehensive benefits with varied cost-sharing
Medical Groups and Hospitals	**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)	**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)

2023 MEDICARE HMO 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	**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)	*Cost-sharing shown is for preferred pharmacies* / 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

Please contact the Plan for more information or call 1-800-Medicare	**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)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$5** / **$15** / **$0** Preferred Brand: **$37** / **$111** / **$74** Non-Preferred Brand: **$90** / **$270** / **$180** Specialty co-insurance: **29%** / **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.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$5** / **$15** / **$0** Preferred Brand: **$37** / **$111** / **$74** 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 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