2024 Medicare Advantage Plan
HMO Comparison Chart ~ FINAL~
for Alameda County

~Rev. 11/02/23 ~

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 2024, there are 26 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 2024, there are six Medicare PPOs in Alameda County. See our 2024 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 2024, there are 17 Special Needs Plans in Alameda County. See our **2024 Special Needs Plan Comparison Chart** for more information and details: www.lashicap.org/hicap.

Enrollment:
In the fall of 2023, 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, 2024.** In 2024, members have one more opportunity to make a change: they can leave their MA plan and change back to Original Medicare during the **Medicare Advantage Open Enrollment Period, from Jan 1 through March 31.** This right only applies to those who begin the year enrolled in a Medicare Advantage plan. They can leave their MA plan and enroll in a stand-alone Part D plan, or they can change to another Medicare Advantage plan. If someone returns to Original Medicare during this period, they will have through March 31 to join a stand-alone Medicare Prescription Drug Plan. There are no corresponding guaranteed issue rights to get a Medigap plan without a health screening although people can apply for a Medigap at any time but must answer health screening questions.

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

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

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

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

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

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State Health Insurance Assistance Program
Navigating Medicare

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2024 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Aetna Medicare** **833-859-6031 (Sales & Marketing)** **833-570-6670 (Member Services)** www.aetnamedicare.com	**Aetna Medicare** **833-859-6031 (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; waived if admitted to hospital; **$15** per urgent care visit; **$110** per emergency or urgent care visit worldwide; waived if admitted to hospital	**$110** copay per emergency room visit; waived if admitted to hospital; **$10** per urgent care visit; **$110** per emergency or urgent care visit worldwide; waived 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	**$225** annual reimbursement allowance for eyewear	**$250** annual reimbursement allowance for eyewear
Eye Exams	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam	**$0** copay per diagnostic exam; **$0** copay for one annual routine exam
Hearing Aids	**$1,250** annual hearing aid allowance per ear; purchased through NationsHearing provider	**$1,250** annual hearing aid allowance per ear; purchased through NationsHearing provider
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	**$1,200** annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider	**$1,500** annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider
Chiropractic	**$0** copay for Medicare covered visit; **$0** copay for unlimited routine visits; must use American Specialty Health provider	**$0** copay for Medicare covered visit; **$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: **$47** / **$141** / **$141** Non-Preferred Brand: **$100** / **$300** / **$300** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; **after total yearly drug costs reach $5,030**, 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 **$8,000.** After that, you pay **$0.**	**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.**
Supplemental Benefits and Optional Plans	**Acupuncture: $0** copay for unlimited acupuncture treatments with American Specialty Health provider **Over the Counter: $105** quarterly allowance for plan-approved items **Transportation: $0** copay for 12 one-way trips per year to plan approved locations, via Access2Care **Wellness: $0** copay for basic Silver Sneakers membership; **$600** annual reimbursement allowance for various fitness activities and supplies	**Acupuncture: $0** copay for unlimited acupuncture treatments with American Specialty Health provider **Over the Counter: $105** quarterly allowance for plan-approved items **Transportation: $0** copay for 12 one-way trips per year to plan approved locations, via Access2Care **Wellness: $0** copay for basic Silver Sneakers membership
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Brown and Toland; One Medical **Hospitals**: Alameda, Alta Bates/Summit Med Ctr, (Berk/Oak), Highland (Oak), Eden (CValley), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Hospital (Fremont)	**Medical Groups:** Brown and Toland; One Medical; **Hospitals**: Alameda, Alta Bates/Summit, (Berk/Oak), Highland (Oak), Eden (CValley), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Hospital (Frem)

2024 MEDICARE HMO COMPARISON CHART FOR ALAMEDA COUNTY

Please contact the Plan for more information or call 1-800-Medicare	**Aetna Medicare** **833-859-6031 (Sales & Marketing)** **833-570-6670 (Member Services)** www.aetnamedicare.com	**Aetna Medicare** **833-859-6031 (Sales & Marketing)** **833-570-6670 (Member Services)** www.aetnamedicare.com
Plan Name/Type	**Aetna Medicare Select Plan (HMO (H0523-068)**	**Aetna Medicare Value Plus Plan (HMO-POS) (H0523-076)**
Star Rating	★★1/2	★★1/2
Annual OOP Max	**$2,900**	**$2,900**
Monthly Premium	**$0**	**$13.70**
Doctor Visits	**$0** copay for Primary Care Physician; **$0** for Specialist	**$0** copay for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$250** copay/day for days 1-7; **$0** per day for days 8 and beyond	**$250** copay/day for days 1-7; **$0** per day for days 8 and beyond
Outpatient Hospital	**$0** copay for ambulatory surgical center visit; **$150** copay for outpatient hospital facility visit	**$0** copay per ambulatory surgical center visit; **$150** 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; **$75** per day for days 21-100
Ambulance	**$225** copay per ground or air ambulance trip	**$225** copay per ground or air ambulance trip
Emergency & Urgent Care	**$110** copay per emergency room visit; waived if admitted to hospital; **$0** per urgent care visit; **$110** per emergency or urgent care visit worldwide; ER copay waived if admitted to hospital	**$110** copay per emergency room visit; waived if admitted to hospital**; $0** per urgent care visit; **$110** per emergency or urgent care visit worldwide; ER copay waived 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; **$0** 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 for individual or group therapy session
Eyewear	**$275** annual reimbursement allowance for eyewear	**$325** annual reimbursement allowance for eyewear; must use EyeMed provider
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	**$1,250** annual hearing aid allowance per ear; purchased through NationsHearing provider	**$1,250** annual hearing aid allowance per ear; purchased through NationsHearing provider
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	**$1,600** annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider	**$2,500** annual reimbursement allowance 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	**$15** copay for Medicare-covered visits; **$0** copay/visit for unlimited routine visits; must use American Specialty Health provider
Podiatry	**$0** copay per Medicare-covered visit	**$0** copay per Medicare-covered visit;
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: **$47** / **$141** / **$141** Non-Preferred Brand: **$100** / **$300** / **$300** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; **after total yearly drug costs reach $5,030**, 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 **$8,000.** After that, you pay **$0**.	*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: **$47** / **$141** / **$141** Non-Preferred Brand: **$100** / **$300** / **$300** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; **after total yearly drug costs reach $5,030**, 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 **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**Acupuncture: $0** copay for unlimited acupuncture treatments with American Specialty Health provider **Over the Counter: $105** quarterly allowance for plan-approved items **Transportation: $0** copay for 12 one-way trips each year to plan approved locations, via Access2Care **Wellness: $0** copay for basic Silver Sneakers membership; **$600** annual reimbursement allowance for various fitness activities and supplies	**Acupuncture: $0** copay for unlimited acupuncture treatments with American Specialty Health provider **Groceries: $40** monthly allowance for those with Extra Help, through NationsBenefits card **Over the Counter: $50** monthly allowance for plan-approved items through Nations OTC catalog **Transportation: $0** copay for 12 one-way trips per year to plan approved locations via Access2Care **Wellness: $0** copay for basic Silver Sneakers membership; **$600** annual reimbursement allowance for various fitness activities and supplies
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Brown & Toland, One Medical **Hospitals**: Alameda, Alta Bates/Summit Med Ctr, (Berk/Oak), Highland (Oak), Eden (CValley), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Hospital (Fremont)	**Medical Groups:** Brown & Toland, One Medical **Hospitals**: Alameda, Alta Bates/Summit Med Ctr, (Berk/Oak), Highland (Oak), Eden (CValley), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Hospital (Fremont)

2024 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	**$1,632** deductible; **$0** copay for days 1-60; **$408** copay/day for days 61-90; **$816**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 11-90 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; **$204**/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 or air ambulance trip; Not waived if admitted to hospital	**$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 cost waived if admitted within 72 hrs; **$75** copay for ER/urgent care visit worldwide; **$10,000** annual limit	**$85** copay for ER visit; copay not waived if admitted; **$0** for urgent care visit; **$20** copay for ER/urgent care visit worldwide with **$100,000** 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	See Flex Allowance under Supplemental Benefits	**$150** annual allowance for eyewear
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	See Flex Allowance under Supplemental Benefits	See Flex Allowance under Supplemental Benefits
Hearing Exams	**$0** copay for diagnostic exam	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam
Dental	**$0** copay for certain preventive and comprehensive services	**$0** copay for certain preventive services; **$20-$425** copays for certain comprehensive services
Chiropractic	**$0** copay per Medicare-covered visit	**$0** copay per Medicare-covered visit
Podiatry	**$0** copay for Medicare-covered visit	**$5** copay for Medicare-covered visit
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%** / **N/A** / **N/A** **$545** deductible; **after total yearly drug costs reach $5,030**, you pay no more than **25%** of the plan's cost for brand names and **25%** for generics until out-of-pocket expenses reach **$8,000.** After that, you pay **$0**.	*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 $5,030**, you pay no more than **25%** of the plan's cost for brand names and **25%** for generics until out-of-pocket expenses reach **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**Essentials Allowance: $400** quarterly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions **Flex Allowance: $600** combined annual allowance for dental, vision, hearing, acupuncture, chiropractic, and podiatry services **In-Home Support Services: $0** copay for 12 hours per quarter OR **$300** annual caregiver reimbursement **Meals: $0** copay for up to 2 meals/day for 14 days (2x/year) for those with qualifying chronic conditions **Pet Services: $0** copay for 7 boarding days or 14 walks/year for those w/qualifying chronic conditions **Pest Control: $0** copay for 1 service per year for those with qualifying chronic conditions **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 for unlimited visits **Essentials Allowance: $100** quarterly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions **Flex Allowance: $500** combined annual allowance for dental, vision, hearing, chiropractic, and podiatry **Over the Counter: $100** quarterly allowance **Pet Services: $0** copay for 7 boarding days or 14 walks/year for those w/qualifying chronic conditions **Pest Control: $0** copay for 1 service per year for those with qualifying chronic conditions **Transportation: $0** copay for 28 one-way trips to plan approved locations within 20 miles **Wellness: $0** copay for basic gym membership **Enhanced Dental Option: $27**/month for certain comprehensive services, with **0-50%** co-insurance; **$1,500** limit per year
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Alignment Network, Brown & Toland **Hospitals**: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose (Hay), Stanford Valley Care (Pleas/Liv)	**Medical Groups:** Alignment Network; Brown & Toland **Hospitals**: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose (Hay), Stanford Valley Care (Pleas/Liv)

2024 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 Select (HMO) (H3815-037)**
Star Rating	★★★★	★★★★
Annual OOP Max	**$3,000**	**$3,400**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**$10** for Primary Care Physician; **$35** 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	**$295** copay for days 1-7; **$0** copay/day for days 8 and beyond; unlimited
Outpatient Hospital	**$100** copay for ambulatory surgical center; **$200** copay for outpatient hospital facility	**$35** copay for ambulatory surgical center visit; **$200** 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; **$140** per day for days 21-100
Ambulance	**$175** copay per trip by ground or air; waived if admitted	**$240** copay per trip by ground or air; waived if admitted
Emergency & Urgent Care	**$85** copay for ER visit; waived if admitted to hospital within 48 hours; **$0** for urgent care visit; **$12,000** annual limit for ER/urgent care worldwide	**$90** copay for ER visit; waived if admitted within 24 hours; **$0** for urgent care visit; **$0** copay for ER/urgent care visit 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	**$40** copay per individual or group therapy session	**$35** copay per individual or group therapy session
Eyewear	**$100** annual allowance for eyewear	**$300** allowance for eyewear every 2 years
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	**$1,000** allowance with **$0** copay, every 2 years
Hearing Exams	**$0** copay for diagnostic exam; **$0** copay for one annual routine exam	**$10** copay for diagnostic exam; **$0** copay for one annual routine exam
Dental	**$0** copay for certain preventive services; **$20-$425** copays for certain comprehensive services	**$0** copay for certain preventive services; **$20-$425** copays for certain comprehensive services
Chiropractic	**$0** copay per Medicare-covered visit	**$0** copay per Medicare-covered visit
Podiatry	**$0** copay for Medicare-covered visit; **$0** copay for 12 routine visits each year	**$25** copay for Medicare-covered visit
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 $5,030**, you pay no more than **25%** of the plan's cost for brand names and **25%** for generics until out-of-pocket expenses reach **$8,000.** After that, you pay **$0**.	*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 $5,030**, you pay no more than **25%** of the plan's cost for brand names and **25%** for generics until out-of-pocket expenses reach **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**Acupuncture:** *For those with Extra Help,* **$0** co-pay for 12 visits per year, combined with chiropractic **In-home Support Services: $0** copay for 12 hours per quarter OR **$300** annual caregiver reimbursement **Meals: $0** copay for up to 2 meals/day for 14 days for those with qualifying chronic conditions; *For those with Extra Help,* up to 56 meals per year **Over the Counter: $60** quarterly allowance; *For those with Extra Help,* additional **$240** per quarter **Pet Services: $0** copay for 7 boarding days or 14 walks/year for those w/qualifying chronic conditions **Pest Control: $0** copay for 1 service per year for those with qualifying chronic conditions **Transportation: $0** copay for 12 one-way trips per year to plan approved locations within 20 miles **Wellness: $0** copay for basic gym membership **-Enhanced Dental Option: $27**/month for certain comprehensive services, with **0-50%** co-insurance; **$1,500** limit per year	**Over the Counter: $75** quarterly allowance **Pet Services: $0** copay for 7 boarding days or 14 walks per year for those with qualifying chronic conditions **Pest Control: $0** copay for 1 service per year for those with qualifying chronic conditions **Wellness: $0** copay for basic gym membership at participating fitness centers **-Enhanced Dental Option: $27**/month for certain comprehensive services, with **0-50%** co-insurance; **$1,500** limit per year
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Alignment Network, Brown & Toland **Hospitals**: Alameda; Alta Bates/Summit (Berk/Oak); Eden (C. Valley), Highland (Oak), St. Rose (Hay), Stanford Valley Care (Pleas/Liv)	**Medical Groups:** Brown & Toland **Hospitals**: Alameda; Alta Bates/Summit (Berk/Oak); Highland (Oak), St. Rose, (Hay), Stanford Valley Care (Pleas/Liv)

2024 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)** **833-707-3130 (Member Services)** www.anthem.com	
Plan Name/Type	**Anthem Select (HMO)** **(H0544-098)**	**Anthem Prime (HMO)** **(H4161-005)**
Star Rating	★★★	Plan too new to be measured
Annual OOP Max	**$7,550**	**$1,200**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$15** copay for Primary Care Physician; **$45** copay for Specialist	**$0** copay for Primary Care Physician; **$10** copay for Specialist
Inpatient Hospital	**$325** copay/day for days 1-6; **$0** copay for days 7-90 and beyond	**$250** copay for days 1-5; **$0** copay/day for days 6-90 and beyond
Outpatient Hospital	**$275** copay for ambulatory surgical center visit; **$325** copay for outpatient hospital facility visit	**$150** copay for ambulatory surgical center visit; **$250** for outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay for days 1-20; **$196** per day for days 21-100	**$0** copay/day for days 1-20; **$188** per day for days 21-100
Ambulance	**$250** copay per ground ambulance trip; **20%** coinsurance per air ambulance trip	**$250** copay per ground ambulance trip; **20%** coinsurance per air ambulance trip
Emergency & Urgent Care	**$90** copay for ER visit; waived if admitted to hospital within 24 hours; **$35** for urgent care visit; **$100,000** annual limit for ER/urgent care worldwide	**$90** copay for ER visit; waived if admitted to hospital within 24 hours; **$35** for urgent care visit; **$100,000** annual limit for ER/urgent care worldwide
Lab Tests, Procedures, and Radiation Therapy	**$10** copay for lab services and x-rays; **$50-75** for diagnostic tests & procedures; **$150** for diagnostic radiology; **20%** coinsurance for therapeutic radiology	**$10** copay for lab services and x-rays; **$25-50** for diagnostic tests & procedures; **$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	**$40** copay per individual or group therapy session	**$10** copay per individual or group therapy session
Eyewear	**$100** annual allowance for eyewear	**$100** annual allowance for eyewear
Eye Exams	**$45** copay for diagnostic exam; **$0** copay for one annual routine exam	**$10** 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	**$45** copay for diagnostic exam; **$0** copay for one annual routine exam	**$10** copay for diagnostic exam; **$0** copay for one annual routine exam
Dental	**$45** copay for Medicare covered visit**;** **$0** copay for 1 oral exam and 1 cleaning per year	**$10** copay for Medicare covered visit**;** **$0** copay for 1 oral exam and 1 cleaning per year
Chiropractic	**$15** copay per Medicare-covered visit	**$20** copay per Medicare-covered visit
Podiatry	**$0-45** copay for Medicare-covered visit**;** **$0** copay for 24 routine visits each year	**$0-10** copay for Medicare-covered visit**;** **$0** copay for unlimited 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: **$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 $5,030**, 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 **$8,000.** After that, you pay **$0**.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days retail / 90 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$7** / **$21** / **$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 $5,030**, 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 **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**Acupuncture: $0** co-pay/visit for 12 visits per year **Over the Counter: $25** quarterly allowance **Wellness: $0** for basic Silver Sneakers membership **Optional supplemental packages:** **1: Preventive Dental at $13 per month:** up to **$500**/year; **$0** co-pays for basic preventive services **2: Dental & Vision at $32 per month:** up to **$1,000**/year with **$0** copays for certain preventive services and **20-50%** coinsurance for certain comprehensive services; **$150** annual reimbursement allowance for eyewear **3: Enhanced Dental & Vision at $48 per month:** up to **$2,000**/year with **$0** copays for certain preventive services and **20-50%** coinsurance for certain comprehensive services; **$200** annual reimbursement allowance for eyewear	**Essential Extras: (Choose one): $50** monthly allowance for groceries or **$150** quarterly for utilities if diagnosed with chronic condition; **$500** annual allowance for assistive devices; **$500** annual allowance for dental/vision/hearing needs; or transport for 60 trips/year to plan-approved locations **Over the Counter: $50** quarterly allowance **Wellness: $0** for basic Silver Sneakers membership **Optional supplemental packages:** **1: Preventive Dental at $13 per month:** up to **$500**/year; **$0** co-pays for basic preventive services **2: Dental & Vision at $32 per month:** up to **$1,000**/year with varying copays; **$150** annual reimbursement allowance for eyewear **3: Enhanced Dental & Vision at $48 per month:** up to **$2,000**/year with varying copays; **$200** annual reimbursement allowance for eyewear
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Bay Valley; Brown & Toland; Hill Physicians East Bay; Imperial Health Holdings **Hospitals**: Alta Bates/Summit (Berk/Oak), Eden (CValley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), Washington (Fremont)	**Medical Groups:** Bay Valley; Brown & Toland; Hill Physicians East Bay; Imperial Health Holdings **Hospitals**: Alta Bates/Summit (Berk/Oak), Eden (CValley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), Washington (Fremont)

2024 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	★★1/2	★★1/2
Annual OOP Max	**$2,100**	**$2,499**
Monthly Premium	**$37.60**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**$0** for Primary Care Physician; **$15** for Specialist
Inpatient Hospital	**$50** copay/day for days 1-6; **$0**/day for days 7-150	**$150** copay/day for days 1-6; **$0** per day for days 7-150
Outpatient Hospital	**$0** copay per ambulatory surgical center; **$0-150** copay per outpatient hospital facility visit	**$0-$75** 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	**$0-$200** copay per trip by ground; **20%** coinsurance per trip by ground or air	**$0-250** copay per trip by ground; **20%** co-insurance per trip by air
Emergency & Urgent Care	**$0-100** copay per emergency room visit; waived if admitted within 72 hours; **$0** per urgent care visit; **$50,000** max worldwide with **$100** copay/visit	**$0-$135** copay per emergency room visit; waived if admitted within 72 hours; **$0** per urgent care visit; **$50,000** max worldwide with **$135** 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 therapeutic radiology	**$0** copay for lab, diagnostic procedures, tests, and x-rays; **$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	**$25** copay for individual or group therapy session	**$10** copay for individual therapy session; **20%** co-insurance for group therapy session
Eyewear	**$300** annual allowance for eyewear	**$300** annual eyewear allowance for eyewear
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 Medicare covered visit**;** **$0** copay for certain preventive services; **$0 - $2,160** copay for certain comprehensive services	**$0** copay for Medicare-covered visit; **$0** copay for certain preventive services; **$0 - $2,160** 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	**$0** copay per Medicare-covered visit	**$0** copay per Medicare-covered visit
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: **$47** / **$94** / **$94** Non-Preferred Brand: **$100** / **$200** / **$200** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; **after total yearly drug costs reach $5,030**, 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 **$8,000.** After that, you pay **$0**.	*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 $5,030**, 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 **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**Cost-Sharing Waived: most co-insurance and copays are waived for those w/full Medi-Cal/LIS** **Acupuncture: $0** copay/visit for 30 visits/year, combined with routine chiropractic visits **Flex Allowance: $50** monthly for OTC items via catalogue, retail, or online, **$20** monthly for fitness, and **$100** every 6 months for dental **Groceries: $25** 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. **Transportation: $0** copay for 24 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: $45** quarterly allowance for plan approved items via catalogue, retail, or online **Transportation: $0** copay for 12 one-way trips per year to plan approved locations within 50 miles **Wellness: $0** for basic Silver Sneakers membership
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Alameda Health System, Hill Physicians East Bay; Imperial Health Holdings **Hospitals:** Alameda, Alta Bates/Summit Medical Center (Berk/Oak), Eden (C Valley), Highland (Oak), San Leandro, and Washington (Fremont)	**Medical Groups:** Alameda Health System, Hill Physicians East Bay; Imperial Health Holdings **Hospitals:** Alameda, Alta Bates/Summit Medical Center (Berkley/Oakland), Eden (C Valley), Highland (Oak), San Leandro, and Washington (Fremont)

2024 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	**$3,200**	**$1,199**
Monthly Premium	**$0**	**$41**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**$0** for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$0** copay for days 1-4; **$100** copay/day for days 5-10; **$0** copay for days 11-150	**$0** copay per stay
Outpatient Hospital	**$0-$100** copay per ambulatory surgical center visit**;** **$0-$150** copay per outpatient hospital facility visit	**$0** per ambulatory surgical center visit**;** **$0-$150** copay per outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay for days 1-20; **$204**/day for days 21-100	**$0** copay for days 1-20; **$204**/day for days 21-100
Ambulance	**$0-$150** copay per one-way trip by ground; **20%** coinsurance per trip by air	**$0-$150** copay per one-way trip by ground; **20%** coinsurance per trip by air
Emergency & Urgent Care	**$0-$100** copay per emergency room visit; waived if admitted to hospital within 72 hours; **$0** for urgent care; **$100,000** max worldwide with **$50** copays for ER and urgent care	**$0-$100** copay per emergency room visit; waived if admitted to hospital within 72 hours; **$0** for urgent care; **$100,000** max worldwide with **$0** copays for ER and urgent care
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab services, diagnostic tests & procedures, and x-rays; **$50** for 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	**$40** copay per individual or group therapy session	**$0** copay per individual or group therapy session
Eyewear	**$300** annual allowance for glasses or contacts	**$300** annual allowance for glasses or contacts
Eye Exams	**$0** copay per Medicare-covered exam; **$0** copay for one annual routine exam	**$0** copay per Medicare-covered exam; **$0** copay for one annual routine exam
Hearing Aids	**$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 Medicare covered visit**;** **$0-$41** copay for certain preventive services; **$0 - $2,160** copay for certain comprehensive services	**$0** copay for Medicare covered visit**;** **$0-$41** copay for certain preventive services; **$0 - $2,160** copay for certain comprehensive services
Chiropractic	**$0** copay per Medicare-covered visit	**$0** copay per Medicare-covered visit
Podiatry	**$0** co-pay per Medicare-covered visit	**$0** co-pay per Medicare-covered visit
Prescription Drugs (Part D)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days / 100 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 $5,030**, 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 **$8,000.** After that, you pay **$0**.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 90 days / 100 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 $5,030**, 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 **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**Acupuncture: $0** co-pay for unlimited visits/year **Flex Allowance: $41** monthly allowance for OTC and Herbal Catalogue items, & **$20** monthly allowance for fitness fees **Groceries: $25** monthly allowance for those with qualifying chronic conditions **In-Home Support Services: $0** copay for up to 20 hours per year for qualifying members **Meals: $0** copay/meal for 2 meals/day for 14 days for those with qualifying chronic conditions; 4 times/year **Scales: $0** copay for those w/qualifying chronic cond. **Transportation: $0** co-pay for 24 one-way trips to plan approved locations within 50 miles **Wellness: $0** for basic Silver Sneakers membership	**Cost-Sharing Waived: most co-insurance and copays are waived for those with full Medi-Cal/LIS** **Acupuncture: $0** co-pay for unlimited visits/year **Flex Allowance: $50** monthly allowance for OTC and Herbal Catalogue items; **$20** monthly for fitness fees; **$165** allowance every six months for dental **Groceries: $25** monthly allowance for those with qualifying chronic conditions **In-Home Support Services: $0** copay for up to 20 hours per year for qualifying members **Meals: $0** copay/meal for 2 meals/day for 14 days for those with qualifying chronic conditions; 4 times/year **Scales: $0** copay for those w/qualifying chronic cond. **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 (may not be full list; check with plan)	**Medical Groups:** Hill Physicians East Bay **Hospitals**: Alta Bates/Summit (Berk/Oak), Eden (CValley), Fremont and Washington (Fremont)	**Medical Groups:** Hill Physicians East Bay **Hospitals**: Alta Bates/Summit (Berk/Oak), Eden (CValley), Fremont and Washington (Fremont)

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	★★★	★★★
Annual OOP Max	**$1,349**	**$8,850**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** for Primary Care Physician; **$0** for Specialist	**20%** for Primary Care Physician; **20%** for Specialist
Inpatient Hospital	**$150** copay for days 1-5; **$0** for days 6-90; **$670** per day for days 91-150	**$0** copay for days 1-60; **$400** co-pay/day for days 61-90; **$800** per day for days 91-150
Outpatient Hospital	**$200** per ambulatory surgical center visit**;** **$200** 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; **$200**/day for days 21-100	**$0** copay per day for days 1-20; **$204**/day for days 21-100
Ambulance	**$150** copay per one-way trip by ground; **20%** coinsurance per each trip by air	**20%** coinsurance per one-way trip by ground; **20%** coinsurance per each trip by air
Emergency & Urgent Care	**$125** copay per emergency room visit; waived if admitted to hospital within 72 hours; **$20** copay for urgent care; **$50,000** max worldwide with **$0** copay	**20%** of cost, up to **$100** per emergency room visit; **20%** of cost up to **$55** per urgent care visit; Costs waived if admitted to hospital within 72 hours
Lab Tests, Procedures, and Radiation Therapy	**10%** coinsurance for lab services, diagnostic tests & procedures; **$0** copay for x-rays, & diagnostic radiology; **20%** coinsurance 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	**$250** annual allowance for eyewear	**$240** annual allowance for eyewear
Eye Exams	**$0** copay per Medicare-covered exam; **$0** copay for routine exams	**20%** coinsurance per Medicare-covered exam; **$0** copay for one annual routine exam
Hearing Aids	**$0** copay for hearing aids; **$500** annual allowance	**$0** copay for hearing aids; **$500** annual allowance
Hearing Exams	**$0** copay for Medicare-covered exam; **$0** copay for 1 annual routine exam up to **$250**/year	**20%** coinsurance for Medicare-covered exams; **$0** copay for one annual routine exam 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 up to **$1,000**/year; must use Imperial HMO contracted provider	**$0** co-pay per Medicare-covered visit; **$0** co-pay for preventive services up to **$500**/year; **$0** co-pay for certain comprehensive services up to **$1,000**/year; must use Imperial HMO contracted provider
Chiropractic	**$0** copay per Medicare-covered visit	**20%** co-insurance per Medicare-covered visit
Podiatry	**$0** co-pay per Medicare-covered visit; **$0** co-pay for 6 routine visits per year	**20%** coinsurance per Medicare-covered visit
Prescription Drugs (Part D)	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$5** / **$12** / **$10** Preferred Brand: **$45** / **$110** / **$90** Non-Preferred Brand: **$90** / **$225** / **$180** Specialty co-insurance: **33%** / **33%** / **N/A** **$0** deductible; **after total yearly drug costs reach $5,030**, 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 **$8,000.** After that, you pay **$0**.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 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%** **$545** deductible; after deductible, you pay **25%** of the plan's cost for all drugs until out-of-pocket drug expenses reach **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**In-home Support Services: $0** copay for up to 48 hours per year **Meals: $0** copay for up to 7 home-delivered meals following a surgery or hospital stay, up to **$105**/year **Over the Counter: $75** quarterly allowance for items in OTC mail order catalogue **Transportation: $0** co-pay for 100 one-way trips per year to plan approved locations **Wellness: $0** for basic Silver&Fit membership	**In-home Support Services: $0** copay for up to 48 hours per year **Part B Premium Reduction: $85** monthly reimbursement
Medical Groups and Hospitals (may not be full list; check with plan)	**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)

2024 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	★★★	★★★
Annual OOP Max	**$298**	**$2,999**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** copay for Primary Care Physician; **$0** for Specialist	**$0** copay for Primary Care Physician; **$5** for Specialist
Inpatient Hospital	**$50** copay for days 1-5; **$0** for days 6-90; **$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	**$100** per ambulatory surgical center visit**;** **$100** copay per outpatient hospital facility visit	**$200** per ambulatory surgical center visit**;** **$200** copay per outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay per day for days 1-20; **$200**/day for days 21-100	**$0** copay per day for days 1-20; **$200**/day for days 21-100
Ambulance	**$150** copay per one-way trip by ground; **20%** coinsurance per each trip by air	**$150** copay per one-way trip by ground; **20%** coinsurance per each trip by air
Emergency & Urgent Care	**$125** per emergency room visit; copay waived if admitted to hospital within 48 hours; **$0** copay for urgent care; **$50,000** max worldwide with **$0** copay	**$125** copay per emergency room visit; waived if admitted to hospital within 72 hours; **$20** copay for urgent care; **$50,000** max worldwide with **$0** copay
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	**10%** coinsurance for lab services, diagnostic tests & procedures; **$0** copay for x-rays, & diagnostic radiology; **20%** coinsurance 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	**$250** annual allowance for eyewear	**$250** annual allowance for eyewear
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	**$0** copay for hearing aids; **$500** annual allowance	**$0** copay for hearing aids; **$500** annual allowance
Hearing Exams	**$0** copay for Medicare-covered exam; **$0** copay for 1 annual routine exam up to **$250**/year	**$0** copay for Medicare-covered exam; **$0** copay for 1 annual routine exam 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 up to **$1,000**/year; must use Imperial HMO contracted provider	**$0** co-pay per Medicare-covered visit; **$0** co-pay for preventive services up to **$500**/year; **$0** co-pay for certain comprehensive services up to **$1,000**/year; must use 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 / 100 days / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$3** / **$6** / **$5** Preferred Brand: **$30** / **$90** / **$75** Non-Preferred Brand: **$75** / **$200** / **$180** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; **after total yearly drug costs reach $5,030,** 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 **$8,000.** After that, you pay **$0**.	**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.**
Supplemental Benefits and Optional Plans	**In-home Support Services: $0** copay for up to 48 hours per year **Meals: $0** copay for up to 7 home-delivered meals following a surgery or hospital stay, up to **$105**/year **Over the Counter: $120** quarterly allowance **Transportation: $0** co-pay for 100 one-way trips per year 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, up to **$105**/year **Over the Counter: $75** quarterly allowance **Part B Premium Reduction: $75** monthly reimbursement **Transportation: $0** co-pay for 100 one-way trips per year to plan approved locations **Wellness: $0** for basic Silver&Fit membership
Medical Groups and Hospitals (may not be full list; check with plan)	**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)

2024 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	**$290** copay/day for days 1-5; **$0** per day for days 6 and beyond	**$225** 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	**$190** per ambulatory surgical center visit**;** **$0-$190** 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	**$250** copay per air or ground ambulance trip	**$250** copay per air or ground ambulance trip
Emergency & Urgent Care	**$120** for emergency room visit; **$5** for urgent care visit; Worldwide coverage	**$120** for emergency room visit; **$0** for urgent care visit; Worldwide coverage
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab, diagnostic tests & procedures; **$10** copay for x-rays; **$250** copay for diagnostic radiology; **$10** for therapeutic radiology	**$0** copay for lab, diagnostic tests, procedures, x-rays; **$200** 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	Not covered; See Optional Benefits Plan below	Not covered; 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	Not covered; See Optional Benefits Plan below	Not covered; See Optional Benefits Plan below
Hearing Exams	**$15** copay per Medicare-covered exam	**$10** copay per Medicare-covered exam
Dental	**$5-$15** co-pay per Medicare-covered visit; **$0** copay for certain preventive & diagnostic services; See Optional Benefits Plan below	**$0-$10** co-pay per Medicare-covered visit; **$0** copay for certain preventive & diagnostic services; See Optional Benefits Plan below
Chiropractic	**$5** copay per Medicare covered visit	**$0** copay per Medicare covered visit
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 days mail Preferred Generic: **$4** / **$12** / **$8** Generic: **$18** / **$54** / **$36** Preferred Brand: **$47** / **$141** / **$94** Non-Preferred Brand: **$100** / **$300** / **$200** Specialty co-insurance: **33%** / **33%** / **33%** **$0** deductible; **after total yearly drug costs reach $5,030**, you pay **$4** copay for preferred generic, **$18** for generic and **25%** for brand name and specialty drugs until out-of-pocket drug expenses reach **$8,000.** After that, you pay **$0**.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$7** / **$21** / **$14** Preferred Brand: **$47** / **$141** / **$94** Non-Preferred Brand: **$100** / **$300** / **$200** Specialty co-insurance: **33%** / **33%** / **33%** **$0** deductible; **after total yearly drug costs reach $5,030**, you pay **$0** copay for preferred generic, **$14** for generic and **25%** for brand name and specialty drugs until out-of-pocket drug expenses reach **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**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 **Optional Benefit Plan: Advantage Plus** at **$21/month:** **-Dental:** Copays vary depending upon the service; Must use Delta Care USA HMO network **-Hearing Aids:** $800 allowance per ear every 36 months **-Vision: $0** copay for eyewear with **$300** allowance every two years **-Wellness: $0** for Silver&Fit gym membership	**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 **Optional Benefit Plan: Advantage Plus** at **$21/month:** **-Dental:** Copays vary depending upon the service; Must use Delta Care USA HMO network **-Hearing Aids:** $800 allowance per ear every 36 months **-Vision: $0** copay for eyewear with **$300** allowance every two years **-Wellness: $0** for Silver&Fit gym membership
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Kaiser Permanente **Hospitals:** Kaiser Oakland, San Leandro, Fremont	**Medical Groups:** Kaiser Permanente **Hospitals:** Kaiser Oakland, San Leandro, Fremont

2024 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	**SCAN Health Plan** **877-870-4867 (Sales & Marketing)** **800-559-3500 (Member Services)** www.scanhealthplan.com
Plan Name/Type	**SCAN Classic (HMO)** **(H05425-075)**	**SCAN MyChoice (HMO)** **(H05425-110)**
Star Rating	★★★1/2	★★★1/2
Annual OOP Max	**$2,800**	**$2,800**
Monthly Premium	**$0**	**$0**
Doctor Visits	**$0** copay for Primary Care Physician; **$0** for Specialist	**$0** copay for Primary Care Physician; **$0** for Specialist
Inpatient Hospital	**$150** copay/day for days 1-7; **$0** per day for days 8 and beyond	**$100** copay/day for days 1-5; **$0** per day for days 6 and beyond
Outpatient Hospital	**$0** per ambulatory surgical center visit**;** **$0-$125** copay per outpatient hospital facility visit	**$0** per ambulatory surgical center visit**;** **$0-$125** 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 21-100
Ambulance	**$180** copay per one-way trip by ground or air	**$105** copay per one-way trip by ground or air
Emergency & Urgent Care	**$90** copay per ER visit; waived if admitted to hospital immediately; **$0** per urgent care visit; Worldwide coverage	**$90** copay per ER visit; waived if admitted to hospital immediately; **$0** per urgent care visit; Worldwide coverage
Lab Tests, Procedures, and Radiation Therapy	**$0** copay for lab, diagnostic procedures, tests, x-rays and diagnostic radiology; **$60** copay for therapeutic radiology	**$0** copay for lab, diagnostic procedures, tests, x-rays and diagnostic radiology; **$60** copay for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**20%** co-insurance per treatment
Outpatient Mental Health Visits	**$10** copay for individual or group therapy session	**$10** copay for individual or group therapy session
Eyewear	**$235** allowance for eyewear every 2 years	**$235** allowance for eyewear every 2 years
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	**$450 - $750** copay per aid; up to 2 aids each year; through plan-contracted provider	**$450 - $750** copay per aid; up to 2 aids each year; through plan-contracted provider
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** co-pay per Medicare-covered visit**;** **$0** co-pay for certain preventive services; See Optional Benefits Plan below	**$0** co-pay per Medicare-covered visit**;** **$0** co-pay for certain preventive services
Chiropractic	**$0** copay per Medicare covered visit; Routine visits not covered	**$0** copay per Medicare covered visit; **$0** copay for 30 routine visits per year
Podiatry	**$0** 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 days retail / 100 days mail Preferred Generic: **$0** / **$0** / **$0** Generic: **$0** / **$0** / **$0** Preferred Brand: **$37** / **$91** / **$91** Non-Preferred Brand: **$90** / **$250** / **$250** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; after total yearly drug costs reach **$5,030**, 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 **$8,000.** After that, you pay **$0.**	*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: **$35** / **$85** / **$85** Non-Preferred Brand: **$70** / **$190** / **$190** Specialty co-insurance: **33%** / **N/A** / **N/A** **$0** deductible; after total yearly drug costs reach **$5,030**, 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 **$8,000.** After that, you pay **$0.**
Supplemental Benefits and Optional Plans	**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 within 75 miles **Wellness: $0** for basic membership at participating fitness clubs and studios (call Member Svcs for more info) **Optional Dental Package: $10**/month; **$0-$440** copays for certain diagnostic and comprehensive services	**Acupuncture: $0** copay per visit for 36 routine visits per year **Over the Counter: $75** 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 within 75 miles **Wellness: $0** for basic membership at participating fitness clubs and studios (call Member Svcs for more info)
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Brown & Toland **Hospitals**: Alameda, San Leandro, St. Rose (Hayward)	**Medical Groups:** Brown & Toland **Hospitals**: Alameda, San Leandro, St. Rose (Hayward)

Please contact the Plan for outline of coverage & provider information or call 1-800-Medicare	**United Health Care** **844-723-6473 (Sales and Marketing)** **866-261-7709 (Member Services)** www.aarpmedicareplans.com	
Plan Name/Type	**UHC Canopy Health (HMO-POS) (H0543-188)**	**AARP Medicare Advantage from UHC (HMO-POS) (H0543-235)**
Star Rating	★★★1/2	★★★1/2
Annual OOP Max	**$3,400**	**$6,300**
Monthly Premium	**$46**	**$25**
Doctor Visits	**$0** copay for Primary Care Physician; **$15** for Specialist	**$0** copay for Primary Care Physician; **$10** for Specialist
Inpatient Hospital	**$275** copay/day for days 1-8; **$0** for days 8 and beyond (unlimited)	**$300** copay/day for days 1-7; **$0** for days 8 and beyond (unlimited)
Outpatient Hospital	**$100** copay for ambulatory surgical center visit**;** **$225** copay for outpatient hospital visit	**$225** copay for ambulatory surgical center visit**;** **$275** copay for outpatient hospital visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$203** per day for days 21-100	**$0** copay/day for days 1-20; **$203** per day for days 21-100
Emergency & Urgent Care	**$135** 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	**$290** 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; **$25** copay per x-ray; **$150** 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 with **$100** annual allowance for eyewear; through United Healthcare Vision network	**$0** copay with **$250** annual allowance for eyewear; 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	**$99 - $1,249** copay per aid; up to 2 aids each year; through United Healthcare Hearing network	**$99 - $1,249** copay per aid; up to 2 aids each year; through United Healthcare Hearing network
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; **50%** coinsurance for bridges and dentures; **$750** annual allowance; can use out of network dentists but higher copays may apply	**$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 **$5,030**, 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 **$8,000.** After that, you pay **$0**.	*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 **$5,030**, 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 **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**Over the Counter: $40** quarterly allowance for items from network retail location or OTC catalog **Wellness: $0** for Renew Active gym membership	**Over the Counter: $65** quarterly allowance for items from network retail location or OTC catalog **Wellness: $0** for Renew Active Fitness membership **Optional Platinum Dental Rider at $56/month: $1,500** annual allowance with **$0** copays for certain preventive and comprehensive services; **50%** coinsurance for bridges and dentures; UHC Dental National Medicare Advantage Network; can use out of network dentists but higher copays may apply.
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Canopy Health Hill Physicians East Bay **Hospitals:** Alameda, Highland (Oakland), San Leandro, St. Rose (Hayward), Washington (Fremont)	**Medical Groups:** Affinity East Bay; Brown and Toland East Bay; Hill Physicians East Bay **Hospitals**: Alameda, Highland (Oakland), San Leandro, St. Rose (Hayward), Washington (Fremont)

2024 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)** **866-261-7709 (Member Services)** www.aarpmedicareplans.com	**Blue Shield of California** **888-534-4263 (Sales & Marketing)** **800-776-4466 (Member Services)** www.blueshieldca.com/medicare
Plan Name/Type	**UHC Medicare Advantage CA-001A (HMO) (H0543-183)**	**Blue Shield Inspire (HMO) (H0504-041)**
Star Rating	★★★1/2	★★★1/2
Annual OOP Max	**$8,850**	**$4,400**
Monthly Premium	**$27.80 / Medical Deductible = $240**	**$18.50**
Doctor Visits	**20%** coinsurance for Primary Care Physician; **20%** coinsurance for Specialist	**$0** copay for Primary Care Physician; **$15** for Specialist
Inpatient Hospital	**$1,450** copay per stay; unlimited days	**$250** copay/day for days 1-5; **$0** per day for days 6 and beyond
Outpatient Hospital	**20%** coinsurance for ambulatory surgical center visit**;** **20%** coinsurance for outpatient hospital visit	**$50** copay per ambulatory surgical center visit; **$200** per outpatient hospital facility visit
Skilled Nursing Facility	**$0** copay/day for days 1-20; **$204** copay/day for days 21-100	**$0** copay/day for days 1-20; **$145** per day for days 21-100
Emergency & Urgent Care	**$100** copay for emergency room visit; waived if admitted to hospital within 24 hours; **$40** per urgent care visit; **$0** copay for worldwide coverage	**$120** copay per emergency room visit; **$15** per urgent care visit; **$120** per emergency or urgent care visit worldwide; copays waived if admitted to hospital within 24 hours
Ambulance	**20%** coinsurance per trip by ground or air	**$260** copay per trip by ground; **20%** co-insurance per trip by 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, and x-rays; **$70** copay for diagnostic radiology; **20%** co-insurance for therapeutic radiology
Renal Dialysis	**20%** co-insurance per treatment	**10%** co-insurance per treatment
Outpatient Mental Health Visits	**20%** coinsurance for individual or group therapy session	**$30** copay for individual or group therapy session
Eyewear	**$0** copay with **$100** annual allowance for eyewear; through United Healthcare Vision	**$175** annual allowance for eyewear; **$175** frame allowance every 2 years
Eye Exams	**$0** copay for Medicare-covered exam; **$0** copay for one annual routine exam	**$15** copay for diagnostic exams; **$0** copay for one annual routine exam
Hearing Aids	**$2,500** annual allowance for up to 2 aids each year; through United Healthcare Hearing network	**$499 - $699** copay per aid (depending on type); limited to 2 hearing aids per year
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	**20%** coinsurance per Medicare covered visit; Routine dental not covered	**$10** copay for Medicare covered visit**;** **$0** copay certain preventive svcs every six months
Chiropractic	**20%** coinsurance for Medicare-covered visit	**$15** copay for Medicare-covered visit; **$0** copay/visit for 12 routine visits per year
Podiatry	**$0** co-pay per Medicare-covered visit; **$0** copay/visit for 4 routine visits per year	**$15** copay per Medicare-covered visit; **$15** copay/visit for unlimited 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** **$545** deductible; after total yearly drug costs reach **$5,030**, you pay no more than **25%** of the plan's cost for brand name and **25%** for generics until out-of-pocket expenses reach **$8,000.** After that, you pay **$0**.	*Cost-sharing shown is for preferred pharmacies* / 30 days / 100 days retail / 100 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 $5,030**, you pay no more than **25%** of the plan's cost for brand name drugs and **25%** for generics until OOP expenses reach **$8,000.** After that, you pay **$0**.
Supplemental Benefits and Optional Plans	**Cost-Sharing Waived: most co-insurance and copays are waived for those with full Medi-Cal/LIS** **Over the Counter: $100** quarterly allowance for items from network retail location or OTC catalog **Transportation: $0** copay for 36 one-way trips per year to plan-approved, medically related locations **Wellness: $0** for Renew Active Fitness membership	**Mobility: $0** copay for annual AAA Membership for members with qualifying chronic conditions **Over the Counter: $70** quarterly allowance **Transportation: $0** copay for 12 one-way trips per year to plan approved locations **Wellness: $0** for basic Silver Sneakers membership **Optional Supplemental Plans:** **1: Dental HMO at $15/month: $1,000** annual allowance for specialist services **2: Dental PPO at $45/month: $50** deductible; **$1,500** annual allowance
Medical Groups and Hospitals (may not be full list; check with plan)	**Medical Groups:** Affinity East Bay; Brown & Toland; Hill Physicians East Bay **Hospitals:** St. Rose (Hayward), Washington (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)

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 ($240 in 2024). 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 & Counseling: one screening/year and up to 22 counseling sessions/year
- Pneumococcal Shots: one per lifetime
- Prostate Cancer Screening: one per year for age 50 and over
- RSV (Respiratory Syncytial Virus) Vaccine: one per year
- 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 2024 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/files/document/101323-fact-sheet-2024-medicare-advantage-and-part-d-ratings.pdf