

2024 Medicare Advantage Special Needs Plan (SNP) ~ FINAL ~ Comparison Chart 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 a referral to see a specialist. The Medicare HMO will *not* pay for services received outside the plan's network unless it is urgent or emergency care. See our 2024 HMO Comparison Chart for more information and details: www.lashicap.org/hicap.

A Medicare PPO is another type of Medicare Advantage (MA) plan. A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses such as deductibles and co-insurance will apply. See our 2024 PPO Comparison Chart for more information and details: www.lashicap.org/hicap.

Medicare Special Needs Plans are another type of Medicare Advantage plan. They are designed for people on Medicare and Medi-Cal (duals), those with certain chronic conditions, or those who need a nursing home level of care. They all must include Part D prescription drug coverage and they have a responsibility to coordinate benefits and care for their members. **In 2024, there are 17 Special Needs Plans in Alameda County.** Five are for people with Medicare and full Medi-Cal (duals, with no share of cost). These are called **D-SNPs** and they have no premiums or co-payments. Another Special Needs Plan is for people with specific chronic or disabling conditions, such as diabetes, dementia, or cardiovascular disorders. It is called a **C-SNP** and certain cost-sharing applies. In 2024, there are ten C-SNPs in Alameda County. The third type of Special Needs Plan is for people in institutions like a nursing home or for people who need a nursing home level of care at home. It is called an **I-SNP** and certain cost-sharing applies. In 2024, there are two I-SNPs in Alameda County.

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 become effective on the first of the following month, except in the last quarter of the year (October through December), when it becomes effective on January 1.

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

ABOUT THIS CHART

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

The information in this chart applies to the individual plans under Medicare only. Group coverage (i.e., employer-sponsored plans) may be very different and should be evaluated and compared to the individual plans. Converting to 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
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Navigating Medicare

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2024 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY: D-SNPs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Aetna Medicare 833-859-6031 (Sales & Marketing) 866-409-1221 (Member Services) www.aetnamedicare.com	Anthem Blue Cross 844-309-6996 (Sales & Marketing) 833-707-3130 (Member Services) www.shop.anthem.com/medicare/ca
Plan Name/Type	Aetna Medicare Preferred Plan D-SNP (H4982-008) For FULL DUALS	Anthem Dual Advantage D-SNP (H4471-007) For FULL DUALS
Star Rating	★★★	Plan to new to be measured
Annual OOP Max	\$8,850	\$8,850
Monthly Premium	\$0	\$0
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist	\$0 for Primary Care Physician; \$0 for Specialist
Inpatient Hospital	\$0 per day; Unlimited number of days	\$0 per day for days 1 - 150
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit
Skilled Nursing Facility	\$0 per day; 100 days per benefit period	\$0 copay per day for days 1 - 100
Ambulance	\$0 copay per trip by ground or air	\$0 copay per trip by ground or air
Emergency & Urgent Care	\$0 copay per emergency room or urgent care visit; Worldwide coverage	\$0 copay per ER or urgent care visit; Worldwide coverage; \$0 copay; \$100,000 limit/year
Lab Tests, Procedures, and Radiation Therapy	\$0 copay per service	\$0 copay per service
Renal Dialysis	\$0 co-insurance per treatment	\$0 co-insurance per treatment
Outpatient Mental Health Visits	\$0 copay for individual or group therapy session	\$0 copay for individual or group therapy session
Eyewear	\$400 annual allowance for eyewear, through EyeMed provider	\$300 annual allowance for eyewear
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for 1 annual routine exam	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam
Hearing Aids	\$2,500 annual allowance per ear; through NationsHearing provider	\$3,000 annual allowance
Hearing Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 co-pay per Medicare-covered exam; \$0 copay for one annual routine exam
Dental	\$0 copay for certain preventive and comprehensive services; through Liberty Dental network	\$0 copay for Medicare covered visit; \$1,400 annual allowance for certain preventive and comprehensive services
Chiropractic	\$0 copay per Medicare covered visit; \$0 copay for unlimited routine visits per year, through American Specialty Health	\$0 co-pay per Medicare covered visit; \$0 copay for 12 routine visits per year
Podiatry	\$0 copay per Medicare covered visit; \$0 copay/visit for 12 routine visits per year	\$0 co-pay per Medicare covered visit; \$0 copay for unlimited routine visits per year
Prescription Drugs (Outpatient)	\$0 deductible; \$0 copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit	\$0 deductible; \$0 copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for unlimited routine visits/year through American Specialty Health Fall Prevention: \$150 annual allowance for approved home safety devices Extra Benefits Card: \$50 monthly allowance for healthy foods and \$50 monthly allowance for certain OTC items, through NationsBenefits Meals: 42 home-delivered meals over a 21-day period following hospital or skilled nursing facility stay Transportation: \$0 copay/trip for 40 one-way trips each year to plan-approved locations, within 60 miles Wellness: \$0 for Silver Sneakers gym membership	Acupuncture: \$0 copay per visit for unlimited routine visits per year Community Resource Support: Referrals and coordination for community services Meals: \$0 copay for 2 meals per day for 5 days following inpatient hospital or SNF stay Options Allowance: \$70 monthly allowance for assistive devices, eligible food items, OTC products, and utilities Transportation: \$0 copay/trip for 48 trips per year to plan-approved locations within 60 miles Wellness: \$0 for Silver Sneakers gym membership; one fitness tracker every other year
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 (Castro Valley), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleas/Liv), and Washington Hospital (Frem)	Medical Groups: Bay Valley, Brown & Toland, Hill Physicians, Imperial Health Holdings Hospitals: Alta Bates/Summit (Berk/Oak), Eden (C. Valley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), & Washington (Fremont)

2024 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY: D-SNPs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Brand New Day 866-255-4795 (Sales &Marketing) 866-255-4795 (Member Services) www.bndhmo.com	Imperial Health Plan of CA 1-800-838-5197 (Sales & Marketing) 1-800-838-8271 (Member Services) www.imperialhealthplan.com
Plan Name/Type	Brand New Day Dual Access D-SNP (H0838-024) For FULL DUALS	Imperial Dual Plan D-SNP (H5496-011) For FULL DUALS
Star Rating	★★1/2	★★★
Annual OOP Max	\$8,850	\$2,999
Monthly Premium	\$0	\$0
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist	\$0 copay for Primary Care Physician; \$0 for Specialist
Inpatient Hospital	\$0 per stay	\$0 co-pay/day for days 1 - 150
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit	\$0 per ambulatory surgical center visit; \$0 per outpatient hospital visit
Skilled Nursing Facility	\$0 copay per day for days 1 - 100	\$0 copay for days 1 - 100
Ambulance	\$0 copay per trip by ground or air	\$0 copay per trip by ground or air
Emergency & Urgent Care	\$0 copay per ER or urgent care visit; Worldwide coverage: \$100 copay for emergency or urgent care visit; \$50,000 limit	\$0 copay per emergency room or urgent care visit; Worldwide coverage: \$0 copay; \$50,000 limit
Lab Tests, Procedures, and Radiation Therapy	\$0 copay per service	\$0 copay per service
Renal Dialysis	\$0 coinsurance per treatment	\$0 copay per treatment
Outpatient Mental Health Visits	\$0 copay for individual or group therapy session	\$0 copay per individual or group therapy session
Eyewear	\$300 annual allowance for eyewear	\$260 annual 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 co-pay for routine exams
Hearing Aids	\$149 allowance per aid for 2 aids every 3 years	\$2,500 annual allowance
Hearing Exams	\$0 co-pay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 copay for Medicare-covered exam; \$0 copay for routine exams
Dental	\$0 copay for Medicare covered visit; \$0 copay for certain preventative and comprehensive services	\$0 copay for Medicare covered visit; \$0 co-pay for preventive services; \$500/year; \$0 co-pay for comprehensive services; \$1,000/year
Chiropractic	\$0 co-pay per Medicare covered visit; \$0 copay for 30 routine visits per year, combined with acupuncture	\$0 co-pay per Medicare-covered visit
Podiatry	\$0 co-pay per Medicare covered visit	\$0 copay per Medicare-covered visit; \$0 copay for 6 routine visits per year
Prescription Drugs (Outpatient)	\$0 deductible; \$0 copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit	\$0 deductible: Depending on your income, you pay the following: Generics: \$0 to \$4.50 Brand Name Drugs: \$0 to \$11.20 After annual drug costs reach \$8,000, you pay \$0.
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for 30 routine visits per year, combined with chiropractic Groceries: \$50 monthly allowance for healthy foods for those with qualifying chronic conditions Meals: \$0 copay per meal for 14 meals/month for those with qualifying chronic conditions Over the Counter (OTC): \$33 monthly allowance for plan approved items Scales: \$0 copay for those with qualifying chronic conditions Transportation: \$0 copay/trip for 12 one-way trips per year to plan approved locations within 50 miles Wellness: \$0 for Silver Sneakers gym membership	Groceries: \$105 quarterly allowance for those with qualifying chronic conditions In-Home Support Services: \$0 copay for 60 hours/yr Meals: \$0 co-pay for up to 7 home-delivered meals following surgery or hospital stay; \$105 allowance per benefit period Over the Counter (OTC): \$140 quarterly allowance for items in plan's OTC mail order catalog Transportation: \$0 co-pay for 100 one-way trips to plan approved locations Wellness: \$0 for Silver&Fit gym membership or at-home fitness kit
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Alameda Health System; Hill Physicians East Bay Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (C Valley), Highland (Oak), San Leandro, Washington (Fremont)	Medical Groups: Brown & Toland, Imperial Health Holdings, Nivano Physicians Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), St. Rose (Hayward), and Washington (Fremont)

2024 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY: D-SNPs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Kaiser Permanente 1-800-777-1238 (Sales & Marketing) 1-800-443-0815 (Member Services) www.healthy.kaiserpermanente.org
Plan Name/Type	Kaiser Medicare Medi-Cal Plan North / D-SNP (H8794-004) For FULL DUALS
Star Rating	★★★★
Annual OOP Max	\$3,400
Monthly Premium	\$0
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist
Inpatient Hospital	\$0 per day; Unlimited days per benefit period
Outpatient Hospital	\$0 copay per ambulatory surgical center visit; \$0 copay per outpatient hospital visit
Skilled Nursing Facility	\$0 copay per day; 100 days per benefit period
Ambulance	\$0 copay per trip by ground or air
Emergency & Urgent Care	\$0 copay per emergency room or urgent care visit; Worldwide coverage
Lab Tests, Procedures, and Radiation Therapy	\$0 copay per service
Renal Dialysis	\$0 copay per treatment
Outpatient Mental Health Visits	\$0 copay per individual or group therapy session
Eyewear	\$350 annual allowance for eyewear
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for routine exams
Hearing Aids	Not Covered
Hearing Exams	\$0 co-pay per Medicare-covered exam
Dental	\$0 copay for Medicare covered visit; \$0 co-pay for certain preventive and comprehensive services; with Delta Care USA
Chiropractic	\$0 co-pay per Medicare covered visit
Podiatry	\$0 co-pay per Medicare covered visit
Prescription Drugs (Outpatient)	\$0 deductible: Depending on your income, you pay the following: Generics: \$0 to \$4.50 Brand Name Drugs: \$0 to \$11.20 After annual drug costs (paid by you, the plan, and by Extra Help from Medicare) reach \$8,000 , you pay \$0 .
Supplemental Benefits and Optional Plans	Over the Counter (OTC): \$250 quarterly allowance for items in OTC catalogue; each order must be at least \$25 Wellness: \$0 copay for Silver&Fit gym membership
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Kaiser Permanente Hospitals: Kaiser Oakland, San Leandro, Fremont

2024 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY: C-SNPs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Align Senior Care 844-305-3879 (Sales &Marketing) 844-305-3879 (Member Services) www.alignseniorcare.com	Align Senior Care 844-305-3879 (Sales &Marketing) 844-305-3879 (Member Services) www.alignseniorcare.com																								
Plan Name/Type	Align Kidney Care C-SNP (H3274-004) For People with ESRD/Dialysis	Align Memory Care C-SNP (H3274-003) For People with Diagnosis of Dementia																								
Star Rating	Not Enough Data Available	Not Enough Data Available																								
Annual OOP Max	\$8,850	\$3,500																								
Monthly Premium	\$41 / Medical Deductible = \$240	\$0 / Medical Deductible = \$240																								
Doctor Visits	\$0 for Primary Care Physician; \$0 for Nephrologist visits; 20% coinsurance for Specialist	\$0 for Primary Care Physician; \$0 for Specialist																								
Inpatient Hospital	\$1,632 deductible; \$0 copay/day for days 1-60; \$408 copay/day for days 61-90; \$816 copay/day for days 91-150	\$150 copay/day for days 1-10; \$0 for days 11-150																								
Outpatient Hospital	20% coinsurance per ambulatory surgical center or outpatient hospital visit	20% coinsurance for ambulatory surgical ctr visit; 20% coinsurance for outpatient hospital services																								
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$204 copay/day for days 21-100	\$0 for days 1-20; \$100 copay/day for days 21-100																								
Ambulance	20% coinsurance per trip by ground or air	\$125 copay per trip by ground; 20% coinsurance per trip by air																								
Emergency & Urgent Care	\$90 copay per ER visit; \$25 per urgent care visit; copays waived if admitted to hospital within 3 days	\$90 copay per ER visit; \$40 per urgent care visit; copays waived if admitted to hospital within 3 days																								
Lab Tests, Procedures, and Radiation Therapy	\$0 co-pay for lab services and x-rays; 20% coinsurance for diagnostic tests, procedures, diagnostic and therapeutic radiology	\$0 co-pay for lab services and x-rays; 20% coinsurance for diagnostic tests, procedures, diagnostic and therapeutic radiology																								
Renal Dialysis	20% coinsurance per treatment	20% co-insurance per treatment																								
Outpatient Mental Health Visits	20% coinsurance for individual or group therapy session	\$20 copay for individual therapy session; \$10 copay for group therapy session																								
Eyewear	\$150 annual allowance for eyeglasses/frames or contact lenses	\$300 annual allowance for eyeglasses/frames or contact lenses																								
Eye Exams	20% coinsurance per Medicare-covered exam; \$0 copay for one annual routine exam	20% coinsurance per Medicare-covered exam; \$0 copay for one annual routine exam																								
Hearing Aids	\$3,000 allowance every two years	\$1,500 annual allowance; limited to 2 aids/year																								
Hearing Exams	20% coinsurance per Medicare-covered exam; \$0 copay for one routine exam every two years	20% coinsurance per Medicare-covered exam; \$0 copay for one annual routine exam																								
Dental	20% coinsurance per Medicare covered visit; \$1,000 annual allowance for certain basic and comprehensive svcs, through Liberty Dental network	20% coinsurance per Medicare covered visit; \$3,000 annual allowance for certain basic and comprehensive services, through Liberty Dental network																								
Chiropractic	20% coinsurance for Medicare-covered visit	20% coinsurance per Medicare-covered visit; \$30 copay for 12 routine visits per year																								
Podiatry	20% coinsurance for Medicare-covered visit; \$0 copay/visit for 6 routine visits per year	20% coinsurance per Medicare-covered visit; \$0 copay for 4 routine visits per year																								
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for preferred pharmacies</i>	<table border="1"> <tr> <td></td> <td>30 days retail</td> <td>90 days retail</td> <td>90 days mail</td> </tr> <tr> <td>Preferred Generic</td> <td>\$2</td> <td>\$6</td> <td>\$6</td> </tr> <tr> <td>Generic</td> <td>\$15</td> <td>\$45</td> <td>\$45</td> </tr> <tr> <td>Preferred Brand</td> <td>\$45</td> <td>\$135</td> <td>\$135</td> </tr> <tr> <td>Non-Preferred Brand</td> <td>\$95</td> <td>\$285</td> <td>\$285</td> </tr> <tr> <td>Specialty co-insurance</td> <td>25%</td> <td>N/A</td> <td>N/A</td> </tr> </table>		30 days retail	90 days retail	90 days mail	Preferred Generic	\$2	\$6	\$6	Generic	\$15	\$45	\$45	Preferred Brand	\$45	\$135	\$135	Non-Preferred Brand	\$95	\$285	\$285	Specialty co-insurance	25%	N/A	N/A
		30 days retail	90 days retail	90 days mail																						
	Preferred Generic	\$2	\$6	\$6																						
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	Non-Preferred Brand	\$95	\$285	\$285																						
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Specialty co-insurance	25%	N/A	N/A																							
	\$0 deductible for Tier 1; \$545 deductible for Tiers 2-5; after total yearly drug costs reach \$5,030 , you pay 25% for generics and brands until out-of-pocket drug expenses reach \$8,000 . After that, you pay \$0 .	\$0 deductible for Tiers 1&2; \$400 deductible for Tiers 3-5; after total yearly drug costs reach \$5,030 , you pay 25% for generics and brands until out-of-pocket drug expenses reach \$8,000 . After that, you pay \$0 .																								
Supplemental Benefits and Optional Plans	Meals: \$0 copay for up to 2 meals/day for 7 days following discharge from hospital or SNF; \$0 copay for 2 meals/day for up to 60 days for those with ESRD Over the Counter: \$600 annual allowance for items from plan's OTC catalog Transportation: \$0 copay 80 trips per year to plan-approved locations within 75 miles Wellness: \$0 copay for online fitness services	Acupuncture: \$30 copay per visit for 12 routine visits per year Companion Care: 60 hours/year for assistance with errands, housekeeping, and companionship Memory Fitness: \$0 copay for online subscription to BrainHQ; \$0 copay for 2 sensory kits per year Over the Counter: \$325 quarterly allowance for OTC items, \$50 of which may only be used on incontinence supplies; unused balance carries over Transportation: \$0 copay/trip for 24 one-way trips per year to plan-approved locations																								
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Certain independent physicians Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley)	Medical Groups: Certain independent physicians Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley)																								

2024 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY: C-SNPs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Alignment Health Plan 888-979-2247 (Sales &Marketing) 866-634-2247 (Member Services) www.alignmenthealthplan.com	Alignment Health Plan 888-979-2247 (Sales &Marketing) 866-634-2247 (Member Services) www.alignmenthealthplan.com	
Plan Name/Type	Alignment Health Heart & Diabetes C-SNP (H3815-010) For People with Cardiovascular Disorders and/or Diabetes	Alignment Health Heart & Diabetes CalPlus C-SNP (H3815-039) For People with Cardiovascular Disorders and/or Diabetes	
Star Rating	★★★★	★★★★	
Annual OOP Max	\$790	\$8,850	
Monthly Premium	\$0	\$8.50	
Doctor Visits	\$0 copay for PCP; \$0 copay for Specialist	\$0 copay for PCP; \$0 copay for Specialist	
Inpatient Hospital	\$0 copay for unlimited days per admission	\$1,632 deductible; \$0 copay/day for days 1-60; \$408 copay/day for days 61-90; \$816 copay/day for days 91-150	
Outpatient Hospital	\$0 copay per ambulatory surgical center or outpatient hospital facility visit	20% coinsurance per ambulatory surgical center or outpatient hospital facility visit	
Skilled Nursing Facility	\$0 copay for days 1-31; \$50 copay/day for days 32-100	\$0 copay/day for days 1-20; \$204 copay/day for days 21-100	
Ambulance	\$100 copay per trip by ground or air	20% coinsurance per trip by ground or air	
Emergency & Urgent Care	\$70 copay per ER visit; waived if admitted to hospital within 48 hours; \$0 per urgent care visit; Worldwide Coverage; \$0 copay; limit \$25,000/year	20% coinsurance per ER visit; waived if admitted to hospital within 72 hours; \$0 per urgent care visit; Worldwide Coverage; \$75 copay; limit \$25,000/year	
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, x-rays, diagnostic tests, procedures, and diagnostic radiology; 20% coinsurance for therapeutic radiology	20% coinsurance for lab services; \$0 copay for x-rays, diagnostic tests, procedures and 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	20% coinsurance per individual or group therapy session	
Eyewear	\$200 annual allowance for eyewear	\$500 annual allowance for eyewear every two 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	Not covered	\$2,000 allowance every two years	
Hearing Exams	\$0 co-pay per Medicare-covered exam \$0 for one annual routine exam	\$0 co-pay per Medicare-covered exam; \$0 for one annual routine exam	
Dental	20% coinsurance per Medicare covered visit; \$0 copay certain preventive services; \$15-\$425 copays for certain comprehensive services	20% coinsurance per Medicare covered visit; \$0 copay certain preventive services; \$0 copay for certain comprehensive services; \$500 quarterly limit	
Chiropractic	\$0 copay per Medicare covered visit	\$0 copay per Medicare covered visit; \$0 copay for 12 routine visits per year, combined with acupuncture	
Podiatry	\$0 copay per Medicare covered visit; \$0 copay for 12 routine visits each year	\$0 copay per Medicare covered visit	
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for preferred pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>	
	Preferred Generic	\$0 \$0 \$0	Preferred Generic 25% 25% 25%
	Generic	\$5 \$15 \$12.50	Generic 25% 25% 25%
	Preferred Brand	\$30 \$90 \$75	Preferred Brand 25% 25% 25%
	Non-Preferred Brand	\$75 \$125 \$187.50	Non-Preferred Brand 25% 25% 25%
Specialty co-insurance	33% N/A N/A	Specialty co-insurance 25% N/A N/A	
	\$0 deductible; after total yearly drug costs reach \$5,030, you pay 25% for generic and brand name drugs until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.	\$545 deductible; after total yearly drug costs reach \$5,030, you pay 25% for generic and brand name drugs until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.	
Supplemental Benefits and Optional Plans	Essentials Allowance: \$200 quarterly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions, combined with OTC Over the Counter (OTC): \$200 quarterly allowance Pest Control: \$0 copay for one annual eradication service for those with qualifying chronic conditions Pet Services: \$0 copay for 7 boarding days or 14 walks/year for those with qualifying chronic condition Transportation: \$0 copay for 50 one-way trips/year to plan-approved locations within 35 miles Wellness: \$0 for basic gym membership Enhanced Dental Option: \$27 monthly premium; \$1,500 limit per year with 0%-50% coinsurance for certain diagnostic and comprehensive services	Acupuncture: \$0 co-pay for 12 routine visits per year, combined with chiropractic Essentials Allowance: \$500 quarterly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions, combined with OTC Over the Counter (OTC): \$500 quarterly allowance Pest Control: \$0 copay for one annual eradication service for those with qualifying chronic conditions Pet Services: \$0 copay for 7 boarding days or 14 walks/year for those with qualifying chronic condition Transportation: \$0 copay for unlimited one-way trips/year to plan-approved locations within 50 miles Wellness: \$0 for basic gym membership	
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Brown & Toland Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oak), St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)	Medical Groups: Brown & Toland Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (Castro Valley), Highland (Oak), St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)	

2024 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY: C-SNPs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Brand New Day 866-255-4795 (Sales &Marketing) 866-255-4795 (Member Services) www.bndhmo.com	Brand New Day 866-255-4795 (Sales &Marketing) 866-255-4795 (Member Services) www.bndhmo.com	
Plan Name/Type	Brand New Day Embrace Care C-SNP (H0838-039) For People with Cardiovascular Disease, Chronic Heart Failure, or Diabetes	Brand New Day Embrace Choice C-SNP (H0838-040) For People with Cardiovascular Disease, Chronic Heart Failure, or Diabetes	
Star Rating	★★1/2	★★1/2	
Annual OOP Max	\$3,000	\$8,850	
Monthly Premium	\$0	\$41	
Doctor Visits	\$0 for Primary Care Physician; \$0-10 for Specialist	\$0 for PCP; 40% coinsurance for Specialist	
Inpatient Hospital	\$0 copay for day 1; \$225 per day for days 2-9; \$0 per day for days 10-90	\$1,632 deductible; \$0 copay/day for days 1-60; \$408 copay/day for days 61-90; \$816 copay/day for days 91-150	
Outpatient Hospital	\$0 - \$100 per ambulatory surgical center visit; \$0 - \$150 per outpatient hospital visit	20% coinsurance per ambulatory surgical center or outpatient hospital facility visit	
Skilled Nursing Facility	\$0 for days 1-20; \$204 copay per day for days 21-100	\$0 copay for days 1-20; \$204 copay/day for days 21-100	
Ambulance	\$0 - \$150 copay per trip by ground; 20% coinsurance per trip by air	20% coinsurance per trip by ground or air	
Emergency & Urgent Care	\$0 - \$125 per ER visit; waived if admitted to hospital within 72 hours; \$0 for urgent care; Worldwide coverage: \$125 copay per emergency or urgent care visit; \$50,000 limit	\$100 copay per ER visit; waived if admitted to hospital within 72 hours; \$0 for urgent care; Worldwide coverage: \$100 copay per emergency or urgent care visit; \$50,000 limit	
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, x-rays, diagnostic tests, and procedures; \$50 copay for diagnostic radiology; 20% coinsurance for therapeutic radiology	\$0 copay for lab services; 20% coinsurance for x-rays, diagnostic tests, procedures; \$0 for diagnostic radiology; 20% coinsurance for therapeutic radiology	
Renal Dialysis	20% coinsurance per treatment	20% co-insurance per treatment	
Outpatient Mental Health Visits	\$10 copay for individual therapy session; 20% coinsurance per group therapy session	\$40 copay for individual or group therapy session	
Eyewear	\$300 annual allowance for eyewear	\$300 annual 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 for one annual routine exam	
Hearing Aids	\$699-\$999 copay per aid for 2 aids per year	\$149 allowance per aid for 2 aids every 3 years	
Hearing Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	
Dental	\$0 copay for Medicare covered visit; \$0 copay for certain preventative services; \$0-\$2,160 copays for certain comprehensive svcs	\$0 copay for Medicare covered visit; \$0-\$17 copay for certain preventative services; \$0 - \$350 copay for certain comprehensive services	
Chiropractic	\$0 co-pay per Medicare covered visit; \$0 copay for 12 routine visits/year, combined with acupuncture	\$0 co-pay per Medicare covered visit; \$0 for 12 routine visits per year, combined with acupuncture	
Podiatry	\$0 co-pay per Medicare covered visit	\$0 co-pay per Medicare covered visit	
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for preferred pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>	
	Preferred Generic	\$0 \$0 \$0	Preferred Generic 25% 25% 25%
	Generic	\$9 \$27 \$18	Generic 25% 25% 25%
	Preferred Brand	\$47 \$101 \$94	Preferred Brand 25% 25% 25%
	Non-Preferred Brand	\$90 \$270 \$180	Non-Preferred Brand 25% 25% 25%
Specialty co-insurance	33% N/A N/A	Specialty co-insurance 25% N/A N/A	
	\$0 deductible; after total yearly drug costs reach \$5,030, you pay \$0 for preferred generics and 25% for generics and brands until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.	\$0 deductible for Tier 1; \$545 for Tiers 2-6: after total yearly drug costs reach \$5,030, you pay 25% for generics and 25% for brands until out-of-pocket drug expenses reach \$8,000. After that, you \$0.	
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay for 12 routine visits per year, combined with chiropractic In-Home Support Services: \$0 copay for 20 hours per year for those with qualifying chronic condtns Meals: \$0 copay per meal for 14 meals/week for 12 weeks for people with qualifying chronic conditions Scales: \$0 copay for those with qualifying chronic conditions Over the Counter (OTC): \$44 quarterly allowance for plan approved items Transportation: \$0 copay/trip for 12 trips per year to plan approved locations within 50 miles Wellness: \$0 for Silver Sneakers gym membership	Acupuncture: \$0 copay for 12 routine visits per year, combined with chiropractic Groceries: \$30 monthly allowance for certain healthy foods, for those with qualifying conditions In-Home Support Services: 20 hours per year for those with qualifying chronic conditions Meals: \$0 copay per meal for 14 meals/month for 12 months for people with qualifying chronic conditions Over the Counter: \$50 monthly allowance for plan approved OTC items Scales: \$0 copay for those w/qualify chronic cond Transportation: \$0 copay for 12 one-way trips per year to plan approved locations within 50 miles Wellness: \$0 for Silver Sneakers gym membership	
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Alameda Health System; Hill Physicians East Bay / Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (C Valley), Highland (Oak), San Leandro, Washington (Fremont)	Medical Groups: Alameda Health System; Hill Physicians East Bay / Hospitals: Alameda, Alta Bates/Summit (Berk/Oak) Eden (C Valley), Highland (Oak), San Leandro, Washington (Fremont)	

2024 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY: C-SNPs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Central Health Medicare 1-866-314-2427 (Sales & Marketing) 1-866-314-2427 (Member Services) www.centralhealthplan.com	Imperial Health Plan of CA 1-800-838-8271 (Sales & Marketing) 1-800-838-8271 (Member Services) www.imperialhealthplan.com						
Plan Name/Type	Central Health Focus Plan C-SNP (H5649-006) For People with Cardiovascular Disease, Chronic Heart Failure, or Diabetes	Imperial Senior Value C-SNP (H5496-005) For People with Cardiovascular Disease, Heart Failure, or Diabetes						
Star Rating	★★★1/2	★★★						
Annual OOP Max	\$1,800	\$1,999						
Monthly Premium	\$0	\$0						
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist	\$0 for Primary Care Physician; \$0 for Specialist						
Inpatient Hospital	\$0 per stay	\$150 copay/day for days 1-5; \$0/day for days 6-90; \$670/day for days 91-150						
Outpatient Hospital	\$0 copay per ambulatory surgical center visit; \$0 copay per outpatient hospital visit	\$200 per ambulatory surgical center visit; \$200 per outpatient hospital visit						
Skilled Nursing Facility	\$0 per stay	\$0 copay for days 1-20; \$200/day for days 21-100						
Ambulance	\$0-\$100 copay per trip by ground; 20% coinsurance per trip by air	\$150 copay per trip by ground; 20% co-insurance per trip by air						
Emergency & Urgent Care	\$0-\$125 copay per ER visit; waived if admitted to hospital within 72 hours; \$0 copay for urgent care; Worldwide coverage: \$50 copay for emergency or urgent care visit; \$100,000 limit	\$125 copay per emergency room visit; \$0 for urgent care; Worldwide coverage: \$0 copay; \$50,000 limit						
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, x-rays, diagnostic tests, procedures; \$75 copay for diagnostic radiology; 20% coinsurance for therapeutic radiology	10% coinsurance 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	\$0 copay for individual or group therapy session	20% co-insurance per individual or group therapy session						
Eyewear	\$150 annual allowance for eyewear	\$250 annual allowance for eyewear						
Eye Exams	\$0 copay for Medicare-covered exam; \$0 for one annual routine exam	\$0 copay per Medicare-covered exam; \$0 copay for routine exams						
Hearing Aids	\$2,000 annual allowance, through NationsHearing	\$500 annual allowance						
Hearing Exams	\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam	\$0 copay for Medicare-covered exam; \$0 for routine exams up to \$250/year						
Dental	\$0 copay for Medicare covered visit; \$0-\$41 copay for certain preventative services; \$0-\$2,160 copay for certain comprehensive services	\$0 copay for Medicare covered visit; \$0 co-pay for preventative services; \$500/year; \$0 co-pay for comprehensive services; \$2,000/year						
Chiropractic	\$0 copay for Medicare covered visit	\$0 copay per Medicare-covered visit						
Podiatry	\$0 co-pay per Medicare covered visit	\$0 copay per Medicare-covered visit; \$0 copay for 6 routine visits per year						
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for network pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>						
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$0	\$0	\$0	Generic	\$5	\$15	\$10
	Preferred Brand	\$35	\$105	\$70	Preferred Brand	\$45	\$135	\$90
	Non-Preferred Brand	\$75	\$225	\$150	Non-Preferred Brand	\$90	\$270	\$180
Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A	
	\$0 deductible; after total yearly drug costs reach \$5,030, you pay \$0 for any generics and 25% of the plan's cost for brands until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.			\$0 deductible; after total yearly drug costs reach \$5,030, you pay \$0, \$5, \$10 or \$15 for generics and 25% of the plan's cost for brands until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.				
Supplemental Benefits and Optional Plans	Acupuncture: \$0 copay per visit for unlimited routine visits per year Groceries: \$25 monthly allowance for healthy foods, for those with qualifying conditions Meals: \$0 co-pay for 2 meals/day for 14 days following surgery or hospital stay; up to 4 times/year Over the Counter: \$46 monthly allowance for OTC and Herbal Catalog items Scales: \$0 copay for those with qualifying chronic conditions Transportation: \$0 copay for 24 one-way trips per year to plan approved locations within 50 miles Wellness: \$0 for Silver Sneakers gym membership			In-Home Support Services: \$0 copay 60 hours/year Meals: \$0 co-pay for up to 7 home-delivered meals following surgery or hospital stay; \$105 allowance per benefit period Over the Counter: \$75 quarterly allowance for items in plan's OTC mail order catalog Transportation: \$0 co-pay for 100 one-way trips to plan approved locations Wellness: \$0 for Silver&Fit gym membership or at-home fitness kit				
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 (Castro Valley, Washington (Fremont))			Medical Groups: Brown & Toland, Imperial Health Holdings, Nivano Physicians Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), St. Rose (Hayward), and Washington (Fremont)				

2024 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY: C-SNPs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	SCAN Health Plan 877-870-4867 (Sales & Marketing) 800-559-3500 (Member Services) www.scanhealthplan.com	SCAN Health Plan 877-870-4867 (Sales & Marketing) 800-559-3500 (Member Services) www.scanhealthplan.com
Plan Name/Type	SCAN Balance C-SNP (H5425-076) For People with Diabetes	SCAN Heart First C-SNP (H5425-077) For People with Cardiovascular Disease and/or Congestive Heart Failure
Star Rating	★★★1/2	★★★1/2
Annual OOP Max	\$2,800	\$2,800
Monthly Premium	\$0	\$0
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist	\$0 for Primary Care Physician; \$0 for Specialist
Inpatient Hospital	\$150 copay per day for days 1-7; \$0 for days 8-90 and beyond	\$150 copay per day for days 1-7; \$0 for days 8-90 and beyond
Outpatient Hospital	\$0 per ambulatory surgical center visit; \$0-\$125 copay per outpatient hospital visit	\$0 per ambulatory surgical center visit; \$0-\$125 copay per outpatient hospital visit
Skilled Nursing Facility	\$0 for days 1-20; \$75 copay/day for days 21-100	\$0 for days 1-20; \$75 copay/day for days 21-100
Ambulance	\$90 copay per emergency room visit; Waived if admitted to hospital immediately; \$0 copay per urgent care visit; Worldwide coverage	\$90 copay per emergency room visit; Waived if admitted to hospital immediately; \$0 copay per urgent care visit; Worldwide coverage
Emergency & Urgent Care	\$180 copay per trip by ground or air	\$180 copay per trip by ground or air
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; \$60 copay for therapeutic radiology	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; \$60 copay for therapeutic radiology
Renal Dialysis	20% co-insurance per treatment	20% co-insurance per treatment
Outpatient Mental Health Visits	\$10 copay per individual or group therapy session	\$10 copay per individual or group therapy session
Eyewear	\$235 allowance for lenses/frames every 2 years	\$235 allowance for lenses/frames every 2 years
Eye Exams	\$0 copay per Medicare-covered exam; \$0 copay for 1 annual routine exam	\$0 copay per Medicare-covered exam; \$0 copay for 1 annual routine exam
Hearing Aids	\$450-\$750 copay per aid; 2 aids per year, through TruHearing	\$450-\$750 copay per aid; 2 aids per year, through TruHearing
Hearing Exams	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam
Dental	\$0 copay for Medicare covered visit; \$0 copay per oral exam, cleaning, and x-rays; up to 2 visits each per year; See Optional Benefit Plan below	\$0 copay for Medicare covered visit; \$0 copay per oral exam, cleaning, and x-rays; up to 2 visits each per year; See Optional Benefit Plan below
Chiropractic	\$0 copay per Medicare-covered visit	\$0 copay per Medicare-covered visit
Podiatry	\$0 co-pay per Medicare covered visit	\$0 co-pay per Medicare covered visit
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for preferred pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>
		30 days retail 100 days retail 100 days mail
	Preferred Generic	\$0 \$0 \$0
	Generic	\$0 \$0 \$0
	Preferred Brand	\$40 \$100 \$100
	Non-Preferred Brand	\$90 \$250 \$250
Specialty co-insurance	33% N/A N/A	
	\$0 deductible; after total yearly drug costs reach \$5,030, you pay \$0 for generics and no more than 25% of the plan's cost for brand names until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.	\$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 names until out-of-pocket drug expenses reach \$8,000. After that, you pay \$0.
Supplemental Benefits and Optional Plans	Over the Counter (OTC): \$100 quarterly allowance for items from plan's OTC catalog; balance carried over to next quarter but not next year Transportation: \$0 copay for up to 24 one-way trips per year to plan-approved locations within 75 miles Optional Dental Plan: \$10/month with varying copays for preventive and comprehensive services	Over the Counter (OTC): \$100 quarterly allowance for items from plan's OTC catalog; balance carried over to next quarter but not next year Transportation: \$0 copay for up to 24 one-way trips per year to plan-approved locations within 75 miles Optional Dental Plan: \$10/month with varying copays for preventive and comprehensive services
Medical Groups and Hospitals (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)

2024 MEDICARE SNP COMPARISON CHART FOR ALAMEDA COUNTY: I-SNPs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	Align Senior Care 844-305-3879 (Sales &Marketing) 844-305-3879 (Member Services) www.alignseniorcare.com	Align Senior Care 844-305-3879 (Sales &Marketing) 844-305-3879 (Member Services) www.alignseniorcare.com																								
Plan Name/Type	Align Premier Care I-SNP (H3274-002) - For People Needing Nursing Home Level of Care	Align Senior Care I-SNP (H3274-001) For People Needing Nursing Home Level of Care																								
Star Rating	Not Enough Data Available	Not Enough Data Available																								
Annual OOP Max	\$3,500	\$8,850																								
Monthly Premium	\$0 / Medical Deductible = \$240	\$41 / Medical Deductible = \$240																								
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist	\$0 copay for Primary Care Physician; 20% coinsurance for Specialist																								
Inpatient Hospital	\$150 copay/day for days 1-10; \$0 for days 11-150	\$1,632 deductible; \$0 copay/day for days 1-60; \$408 copay/day for days 61-90; \$816 copay/day for days 91-150																								
Outpatient Hospital	20% coinsurance per ambulatory surgical center or outpatient hospital visit	20% coinsurance per ambulatory surgical center or outpatient hospital facility visit																								
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$100 copay/day for days 21-100	\$0 copay/day for days 1-20; \$204 copay/day for days 21-100																								
Ambulance	\$125 copay per trip by ground; 20% coinsurance per trip by air	20% coinsurance per trip by ground or air																								
Emergency & Urgent Care	\$90 copay per ER visit; \$40 per urgent care visit; copays waived if admitted to hospital within 3 days	\$90 copay per ER visit; \$55 per urgent care visit; copays waived if admitted to hospital within 3 days																								
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services and x-rays; 20% coinsurance for diagnostic tests, procedures, diagnostic and therapeutic radiology	\$0 copay for lab services and x-rays; 20% coinsurance for diagnostic tests, procedures, diagnostic and therapeutic radiology																								
Renal Dialysis	20% coinsurance per treatment	20% coinsurance per treatment																								
Outpatient Mental Health Visits	\$20 copay for individual therapy session; \$10 copay for group therapy session	20% coinsurance per individual or group therapy session																								
Eyewear	\$225 annual allowance for eyewear	\$275 annual allowance for eyewear																								
Eye Exams	20% coinsurance per Medicare-covered exam; \$0 copay for one annual routine exam	20% coinsurance per Medicare-covered exam; \$0 copay for one annual routine exam																								
Hearing Aids	\$1,500 annual allowance; limited to 2 aids/year	\$1,500 annual allowance; limited to 2 aids/year																								
Hearing Exams	20% coinsurance per Medicare-covered exam; \$0 copay for one annual routine exam	20% coinsurance per Medicare-covered exam \$0 copay for one annual routine exam																								
Dental	20% coinsurance per Medicare covered visit; \$1,000 annual allowance for certain basic and comprehensive services, through Liberty Dental	20% coinsurance per Medicare covered visit; \$3,000 annual allowance for certain basic and comprehensive services, through Liberty Dental																								
Chiropractic	20% coinsurance for Medicare-covered visit; \$30 copay for 12 routine visits per year	20% coinsurance for Medicare-covered visit																								
Podiatry	20% coinsurance for Medicare-covered visit; \$0 copay/visit for 4 routine visits per year	20% coinsurance for Medicare-covered visit; \$0 copay/visit for 4 routine visits per year																								
Prescription Drugs (Outpatient)	<i>Cost-sharing shown is for preferred pharmacies</i>	<table border="1"> <tr> <td></td> <td align="center">30 days retail</td> <td align="center">90 days retail</td> <td align="center">90 days mail</td> </tr> <tr> <td>Preferred Generic</td> <td align="center">\$0</td> <td align="center">\$0</td> <td align="center">\$0</td> </tr> <tr> <td>Generic</td> <td align="center">\$10</td> <td align="center">\$30</td> <td align="center">\$30</td> </tr> <tr> <td>Preferred Brand</td> <td align="center">\$45</td> <td align="center">\$145</td> <td align="center">\$145</td> </tr> <tr> <td>Non-Preferred Brand</td> <td align="center">\$95</td> <td align="center">\$285</td> <td align="center">\$285</td> </tr> <tr> <td>Specialty co-insurance</td> <td align="center">25%</td> <td align="center">N/A</td> <td align="center">N/A</td> </tr> </table>		30 days retail	90 days retail	90 days mail	Preferred Generic	\$0	\$0	\$0	Generic	\$10	\$30	\$30	Preferred Brand	\$45	\$145	\$145	Non-Preferred Brand	\$95	\$285	\$285	Specialty co-insurance	25%	N/A	N/A
		30 days retail	90 days retail	90 days mail																						
	Preferred Generic	\$0	\$0	\$0																						
	Generic	\$10	\$30	\$30																						
	Preferred Brand	\$45	\$145	\$145																						
	Non-Preferred Brand	\$95	\$285	\$285																						
	Specialty co-insurance	25%	N/A	N/A																						
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%																							
	\$0 deductible for Tiers 1&2; \$400 deductible for Tiers 3-5; after total yearly drug costs reach \$5,030 , you pay 25% for generic and brand name drugs until out-of-pocket drug expenses reach \$8,000 . After that, you pay \$0 .	\$545 deductible for all drugs; after total yearly drug costs reach \$5,030 , you pay 25% for generic and brand name drugs until out-of-pocket drug expenses reach \$8,000 . After that, you pay \$0 .																								
Supplemental Benefits and Optional Plans	Acupuncture: \$30 copay per visit for 12 routine visits per year Companion Care: 30 hours per year for those with certain qualifying conditions Groceries: \$35 monthly allowance at preferred locations for those w/chronic qualifying conditions Over the Counter: \$225 quarterly allowance for OTC items, \$50 of which may only be used on incontinence supplies; unused balance carries over Transportation: \$0 copay for 24 trips per year to plan-approved locations Wellness: \$0 copay for online fitness services	Companion Care: 30 hours per year for those with certain qualifying conditions Groceries: \$30 monthly allowance at preferred locations for those w/chronic qualifying conditions Memory Fitness: \$0 copay for online subscription to BrainHQ Over the Counter: \$250 quarterly allowance for OTC items, \$50 of which may only be used on incontinence supplies; unused balance carries over Transportation: \$0 copay for 24 trips per year to plan-approved locations																								
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Certain independent physicians Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley)	Medical Groups: Certain independent physicians Hospitals: Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley)																								

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 per 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>