# 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: <u>www.lashicap.org/hicap</u>.

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: <a href="https://www.lashicap.org/hicap">www.lashicap.org/hicap</a>.

**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., employersponsored 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 <u>www.lashicap.org/hicap</u>.

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



Navigating Medicare

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2024 MED	ICARE SNP COMPARISON CHART FOR	R ALAMEDA COUNTY: D-SNPs
Please contact the Plan for more information or call 1-800-Medicare	Aetna Medicare 833-859-6031 (Sales & Marketing) 866-409-1221 (Member Services) www.aetnamedicare.com	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	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist
Inpatient Hospital	<b>\$0</b> per day; Unlimited number of days	<b>\$0</b> per day for days 1 - 150
Outpatient Hospital	<b>\$0</b> per ambulatory surgical center visit; <b>\$0</b> per outpatient hospital visit	<b>\$0</b> per ambulatory surgical center visit; <b>\$0</b> per outpatient hospital visit
Skilled Nursing Facility	<b>\$0</b> per day; 100 days per benefit period	<b>\$0</b> copay per day for days 1 - 100
Ambulance	<b>\$0</b> copay per trip by ground or air	<b>\$0</b> copay per trip by ground or air
Emergency & Urgent Care	\$0 copay per emergency room or urgent care visit; Worldwide coverage	<b>\$0</b> copay per ER or urgent care visit; Worldwide coverage; <b>\$0</b> copay; <b>\$100,000</b> limit/year
Lab Tests, Procedures, and Radiation Therapy	<b>\$0</b> copay per service	<b>\$0</b> copay per service
Renal Dialysis	<b>\$0</b> co-insurance per treatment	<b>\$0</b> co-insurance per treatment
Outpatient Mental Health Visits	<b>\$0</b> copay for individual or group therapy session	<b>\$0</b> copay for individual or group therapy session
Eyewear	\$400 annual allowance for eyewear, through EyeMed provider	\$300 annual allowance for eyewear
Eye Exams	<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> copay for 1 annual routine exam	<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> copay for one annual routine exam
Hearing Aids	<b>\$2,500</b> annual allowance per ear;	\$3,000 annual allowance
-	through NationsHearing provider <b>\$0</b> copay per Medicare-covered exam;	<b>\$0</b> co-pay per Medicare-covered exam;
Hearing Exams	<b>\$0</b> copay for one annual routine 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	<ul> <li>\$0 copay per Medicare covered visit;</li> <li>\$0 copay for unlimited routine visits per year, through American Specialty Health</li> </ul>	<b>\$0</b> co-pay per Medicare covered visit; <b>\$0</b> copay for 12 routine visits per year
Podiatry	<b>\$0</b> copay per Medicare covered visit;	<b>\$0</b> co-pay per Medicare covered visit;
Prescription Drugs (Outpatient)	<ul> <li>\$0 copay/visit for 12 routine visits per year</li> <li>\$0 deductible:</li> <li>\$0 copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit</li> </ul>	<ul> <li>\$0 copay for unlimited routine visits per year</li> <li>\$0 deductible; \$0 copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit</li> </ul>
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 (CastroValley), 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

2024 MED	ICARE SNP COMPARISON CHART FO	R ALAMEDA COUNTY: D-SNPs
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) <u>www.bndhmo.com</u>	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	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist	\$0 copay for Primary Care Physician; \$0 for Specialist
Inpatient Hospital	<b>\$0</b> per stay	<b>\$0</b> 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	<b>\$0</b> copay per day for days 1 - 100	<b>\$0</b> copay for days 1 - 100
Ambulance	<b>\$0</b> copay per trip by ground or air	<b>\$0</b> 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	<b>\$0</b> copay per service	<b>\$0</b> copay per service
Renal Dialysis	<b>\$0</b> coinsurance per treatment	\$0 copay per treatment
Outpatient Mental Health Visits	<b>\$0</b> copay for individual or group therapy session	<b>\$0</b> copay per individual or group therapy session
Eyewear	\$300 annual allowance for eyewear	<b>\$260</b> annual allowance for eyewear
Eye Exams	<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> copay for one annual routine exam	<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> co-pay for routine exams
Hearing Aids	<b>\$149</b> allowance per aid for 2 aids every 3 years	\$2,500 annual allowance
Hearing Exams	<ul> <li>\$0 co-pay per Medicare-covered exam;</li> <li>\$0 copay for one annual routine exam</li> </ul>	<ul><li>\$0 copay for Medicare-covered exam;</li><li>\$0 copay for routine exams</li></ul>
Dental	<ul> <li>\$0 copay for Medicare covered visit;</li> <li>\$0 copay for certain preventative and comprehensive services</li> </ul>	<ul> <li>\$0 copay for Medicare covered visit;</li> <li>\$0 co-pay for preventive services; \$500/year;</li> <li>\$0 co-pay for comprehensive services; \$1,000/year</li> </ul>
Chiropractic	<ul> <li>\$0 co-pay per Medicare covered visit;</li> <li>\$0 copay for 30 routine visits per year, combined with acupuncture</li> </ul>	<b>\$0</b> co-pay per Medicare-covered visit
Podiatry	<b>\$0</b> co-pay per Medicare covered visit	<ul><li>\$0 copay per Medicare-covered visit;</li><li>\$0 copay for 6 routine visits per year</li></ul>
Prescription Drugs (Outpatient)	<b>\$0</b> deductible; <b>\$0</b> copay for 30, 60, or 100 day supply of all covered drugs; specialty drugs have 30 day limit	<b>\$0</b> deductible: Depending on your income, you pay the following: <b>Generics: \$0</b> to \$4.50 <b>Brand Name Drugs: \$0</b> to \$11.20 After annual drug costs reach <b>\$8,000</b> , you pay <b>\$0</b> .
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

	ARE SIVE COWFARISON CHART FOR ALAN
Please contact the	Kaiser Permanente
Plan for more	1-800-777-1238 (Sales & Marketing)
information or call	1-800-443-0815 (Member Services)
1-800-Medicare	www.healthy.kaiserpermanente.org
	Kaiser Medicare Medi-Cal Plan North
Plan Name/Type	/ <b>D-SNP</b> (H8794-004)
	For FULL DUALS
Star Rating	****
Annual OOP Max	\$3,400
Monthly Premium	\$0 
Doctor Visits	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist
Inpatient Hospital	<b>\$0</b> per day;
inpatient nospital	Unlimited days per benefit period <b>\$0</b> copay per ambulatory surgical center visit;
Outpatient Hospital	<b>\$0</b> copay per autotration surgical center visit;
Skilled Nursing	<b>\$0</b> copay per day;
Facility	100 days per benefit period
Ambulance	<b>\$0</b> copay per trip by ground or air
Emergency &	<b>\$0</b> copay per emergency room or urgent care visit;
Urgent Care	Worldwide coverage
Lab Tests,	<b>60</b>
Procedures, and Radiation Therapy	<b>\$0</b> copay per service
Renal Dialysis	<b>\$0</b> copay per treatment
Outpatient Mental	
Health Visits	<b>\$0</b> copay per individual or group therapy session
Evewear	\$350 annual allowance
	for eyewear <b>\$0</b> copay per Medicare-covered exam;
Eye Exams	<b>\$0</b> copay for routine exams
Hearing Aids	Not Covered
Hearing Exams	<b>\$0</b> co-pay per Medicare-covered exam
	<b>\$0</b> copay for Medicare covered visit;
Dental	<b>\$0</b> co-pay for certain preventive and comprehensive services; with Delta Care USA
Chiropractic	<b>\$0</b> co-pay per Medicare covered visit
Podiatry	<b>\$0</b> co-pay per Medicare covered visit
Prescription Drugs (Outpatient)	<b>\$0</b> deductible: Depending on your income, you pay the following: <b>Generics: \$0</b> to <b>\$4.50</b> <b>Brand Name Drugs: \$0</b> to <b>\$11.20</b> After annual drug costs (paid by you, the plan, and by Extra Help from Medicare) reach <b>\$8,000</b> , you pay <b>\$0</b> .
Supplemental Benefits and Optional Plans	<b>Over the Counter (OTC): \$250</b> quarterly allowance for items in OTC catalogue; each order must be at least <b>\$25 Wellness: \$0</b> 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 MED	ICARE SNP COMPAR	ISON	CHART	FOR	ALAMEDA COUNTY	: C-SN	Ps		
Please contact the	Align Seni	ior Ca	ire		Align Sen	ior Ca	re		
Plan for more	844-305-3879 (Sa			1 <b>0</b> )	844-305-3879 (Sales & Marketing)				
information or call	844-305-3879 (Member Services)								
1-800-Medicare	www.alignsen	844-305-3879 (Member Services) www.alignseniorcare.com							
	Align Kidı				Align Mem	•			
Plan Name/Type	C-SNP (H				C-SNP (H				
	For People with				For People with Dia			entia	
Star Rating	Not Enough Da		ilable		Not Enough Da		lable		
Annual OOP Max	\$8,8	50			\$3,5	00			
<b>Monthly Premium</b>	\$41 / Medical De	ductible	e = \$240		<b>\$0</b> / Medical Dec	luctible	= \$240		
Doctor Visits	\$0 for Primary Care Physic			ologist	<b>\$0</b> for Primary Care Phys	sician: <b>S</b> (	for Spec	ialist	
	visits; 20% coinsura			(0	\$\$10111111111 Suite 1119		ior spee	iuno i	
Inpatient Hospital	\$1,632 deductible; \$0 co \$408 copay/day f			-60;	\$150 copay/day for days 1	-10· <b>\$0</b> f	or days 1	1-150	
inpatient nospitai	\$816 copay/day f				\$100 copuj/duj 101 duj5 1	10,001	or days r	1 100	
Outpatient	20% coinsurance per ambu			nter or	20% coinsurance for amb	ulatory si	urgical ct	r visit:	
Hospital	outpatient ho		0		20% coinsurance for outp				
Skilled Nursing	<b>\$0</b> copay/day for	or days 1	-20;			(1)			
Facility	\$204 copay/day f				<b>\$0</b> for days 1-20; <b>\$100</b> coj	pay/day f	or days 2	1-100	
Ambulance	20% coinsurance per t	trin by m	round or a	ir	\$125 copay per t				
	2070 consurance per l	rıh oğ Bi	ound of a		20% coinsurance	<u> </u>		_	
Emergency &	\$90 copay per ER visit; \$2				<b>\$90</b> copay per ER visit; <b>\$</b>	40 per ur	gent care	visit;	
Urgent Care	copays waived if admitted	to hospit	al within ?	3 days	copays waived if admitted	to hospit	al within	3 days	
Lab Tests,	\$0 co-pay for lab set				<b>\$0</b> co-pay for lab se				
Procedures, and	20% coinsurance for diag			lures,	20% coinsurance for diag			dures,	
Radiation Therapy	diagnostic and thera	adiology		diagnostic and there	apeutic ra	adiology			
Renal Dialysis	20% coinsurance	e per trea	itment		20% co-insuranc	e per trea	atment		
Outpatient Mental	20% coinsurance				\$20 copay for individ			n;	
Health Visits	group therap	by sessio	n		<b>\$10</b> copay for group therapy session				
Eyewear	\$150 annual				\$300 annual allowance				
Lycwear	for eyeglasses/frame				for eyeglasses/frames or contact lenses				
Eye Exams	20% coinsurance per Me \$0 copay for one and			am;	20% coinsurance per Medicare-covered exam; \$0 copay for one annual routine exam				
Hearing Aids	\$3,000 allowance				\$1,500 annual allowance; limited to 2 aids/year				
	20% coinsurance per Me		•	am:	20% coinsurance per Medicare-covered exam;				
Hearing Exams	\$0 copay for one routine				<b>\$0</b> copay for one annual routine exam				
	20% coinsurance per M				20% coinsurance per Medicare covered visit;				
Dental	\$1,000 annual allowar			с	\$3,000 annual allowance for certain basic				
	and comprehe through Liberty I				and comprehensive services, through Liberty Dental network				
<u></u>					<b>20%</b> coinsurance per Medicare-covered visit;				
Chiropractic	<b>20%</b> coinsurance for M	edicare-	covered vi	sıt	<b>\$30</b> copay for 12 routine visits per year				
Podiatry	20% coinsurance for M			,	20% coinsurance per M	edicare-	covered v	isit;	
Toulatiy	<b>\$0</b> copay/visit for 6 ro	-		1	<b>\$0</b> copay for 4 routine visits per year				
	Cost-sharing shown is for	30 dave	90 davs	90 days	Cost-sharing shown is for	30 days	90 dave	90 days	
	preferred pharmacies	days retail	days retail	mail	preferred pharmacies	retail	days retail	mail	
	Preferred Generic	\$2	\$6	\$6	Preferred Generic	\$0	\$0	\$0	
	Generic	\$15	\$45	\$45	Generic	\$10	\$30	\$30	
Prescription Drugs	Preferred Brand	\$45	\$135	\$135	Preferred Brand	\$45	\$135	\$135	
(Outpatient)	Non-Preferred Brand	\$95	\$285	\$285	Non-Preferred Brand	\$95	\$285	\$285	
	Specialty co-insurance <b>\$0</b> deductible for Tier 1; <b>\$5</b> 4	25%	N/A	N/A	Specialty co-insurance	25%	N/A	N/A	
	5; after total yearly drug cos				<b>\$0</b> deductible for Tiers 1&2; 3-5; after total yearly drug c				
	25% for generics and brand				pay 25% for generics and bi			2	
	drug expenses reach \$8,000.	. After the	hat, you pa	ay <b>\$0</b> .	drug expenses reach \$8,000.				
					Acupuncture: \$30 copay pe	r visit fo	r 12 routi	ne	
	Meals: \$0 copay for up to 2	meals/d	av for 7 da	avs	visits per year	/1 visit 10	1 12 1041	lite	
	following discharge from ho				Companion Care: 60 hours	<b>s/year</b> fo	r assistan	ce with	
G	for 2 meals/day for up to 60	days for	those wit	h	errands, housekeeping, and o				
Supplemental Benefits and	ESRD				Memory Fitness: \$0 copay				
	<b>Over the Counter: \$600</b> and from plan's OTC catalog	inuar and	Jwance Ioi	nems	BrainHQ; <b>\$0</b> copay for 2 ser <b>Over the Counter: \$325</b> qu				
<b>Optional Plans</b>	Transportation: \$0 copay 8	80 trips r	ber year to	plan-	OTC items, <b>\$50</b> of which ma	-			
	approved locations within 7	•••	ĩ		incontinence supplies; unuse	2 2			
	Wellness: \$0 copay for onli	ne fitnes	s services		Transportation: \$0 copay/t		one-way	y trips	
					per year to plan-approved lo	cations			
Medical Groups	Medical Groups: Certain i	ndepend	ent physic	ians	Medical Groups: Certain in	ndepende	nt physic	ians	
	-		Medical Groups: Certain independent physicians Hospitals: Alta Bates/Summit (Berk/Oak), Eden						
and Hospitals	Hospitals: Alta Bates/Summ			Oak), Ed	en				
(may not be full list; check with plan)	Hospitals: Alta Bates/Summ Medical Center (Castro Vall		k∕Oak), Ed	en	Hospitals: Alta Bates/Sumn Medical Center (Castro Vall		Oak), Ed	len	

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

2024 MEDI	CARE SNP COMPARI	SON (	ЛАК	I FOR A	LAMEDA COUNTY:	C-SNI	- 5			
Please contact the	Alignment H	lealth	l Plan	1	Alignment H	lealth	Plan			
Plan for more	888-979-2247 (Sa				888-979-2247 (Sales & Marketing)					
information or call	866-634-2247 (N	866-634-2247 (Member Services)								
1-800-Medicare	www.alignmenth	www.alignmenthealthplan.com								
	www.angninenu				_					
	Alignment Health l	Heart	& Di	iabetes	Alignment Health Heart & Diabete					
Plan Name/Type	C-SNP (H3815-010) For People with			CalPlus C-SN						
	Cardiovascular Disord				For People with Cardi			sorders		
	Calulovasculai Disolt	icis ai		Jabetes	and/or D	iabete	S			
Star Rating	***	***	**							
Annual OOP Max	\$79	0			\$8,8	50				
Monthly Premium	\$0				\$8.5					
Doctor Visits	\$0 copay for PCP; \$0	copay fo	or Specia	alist	\$0 copay for PCP; \$0	copay fe	or Specia	list		
Inpatient Hospital	\$0 copay for unlimited				\$1,632 deductible; \$0 co \$408 copay/day t	pay/day	for days			
	\$0 copay per ambulato	• •			\$816 copay/day f \$816 copay/day f 20% coinsurance per ambi	for days	91-150	enter or		
Outpatient Hospital Skilled Nursing	outpatient hospita \$0 copay for	al facilit	y visit		outpatient hospit	al facili	y visit			
Facility	\$0 copay for \$50 copay/day for				<b>\$0</b> copay/day f <b>\$204</b> copay/day f					
Ambulance	\$100 copay per trip	by grou	ind or ai	ir	20% coinsurance per	trip by g	round or	air		
Emergency &	\$70 copay per ER visit; waiv	ved if ad	lmitted t	o hospital	20% coinsurance per ER vi	isit; wai	ved if ad	mitted to		
Urgent Care	within 48 hours; <b>\$0</b> pe Worldwide Coverage; <b>\$0</b> c				hospital within 72 hours; Worldwide Coverage; <b>\$75</b>					
Lab Tests,	\$0 copay for lab s	ervices,	x-rays,		20% coinsurance for lab					
Procedures, and	diagnostic tests, procedures,				x-rays, diagnostic tests, pr					
Radiation Therapy	20% coinsurance for the	ierapeut	ic radio	logy	radiology; 20% coinsurance	e for the	rapeutic	radiology		
Renal Dialysis	20% co-insurance	e per tre	atment		20% co-insuranc	e per tre	atment			
Outpatient Mental Health Visits	<b>\$0</b> copay per in group therap				<b>20%</b> coinsurance group therap					
Eyewear	\$200 annual allowa	nce for	evewea	r	<b>\$500</b> annual allowance for eyewear every two years					
	\$0 copay per Medica				\$0 copay per Medicare-covered exam;					
Eye Exams	\$0 copay for one and				\$0 copay for one an					
Hearing Aids	Not cov	reed			\$2,000 allowance	every tv	vo years			
Hearing Exams	\$0 co-pay per Medic			ım	<b>\$0</b> co-pay per Medic			n;		
IItai ing Exams	\$0 for one annua				\$0 for one annual routine exam 20% coinsurance per Medicare covered visit;					
Dental	20% coinsurance per M \$0 copay certain prev \$15-\$425 copays for certain	ventive	services	;	\$0 copay certain preventive services; \$0 copay for certain comprehensive services; \$500 quarterly limit					
Chiropractic	\$0 copay per Medic				<b>\$0</b> copay per Medicare covered visit; <b>\$0</b> copay for 12					
Chilopractic					routine visits per year, combined with acupuncture					
Podiatry	<b>\$0</b> copay per Medic				<b>\$0</b> copay per Medicare covered visit					
5	\$0 copay for 12 routi	ne visits	100	100		30	100	100		
	Cost-sharing shown is for	days	days	days	Cost-sharing shown is for	days	days	days		
	preferred pharmacies	retail	retail	mail	preferred pharmacies	retail	retail	mail		
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	25%	25%	25%		
Duese wintion Duuge	Generic	\$5	\$15	\$12.50	Generic	25%	25%	25%		
Prescription Drugs (Outpatient)	Preferred Brand Non-Preferred Brand	\$30 \$75	\$90 \$125	\$75 \$187.50	Preferred Brand Non-Preferred Brand	25% 25%	25% 25%	25% 25%		
(Outpatient)	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	25%	N/A	N/A		
	\$0 deductible; after total year	rly drug		each	<b>\$545</b> deductible; after total yearly drug costs reach					
	\$5,030, you pay 25% for gen				\$5,030, you pay 25% for ge					
	drugs until out-of-pocket dru After that, you pay <b>\$0</b> .	g expen	ses reac	h <b>\$8,000.</b>	drugs until out-of-pocket dru After that, you pay <b>\$0</b> .	ig exper	ises reac	n <b>\$8,000.</b>		
	Essentials Allowance: \$200	quarter	lv allow	ance for						
	groceries, gas, utilities, and h				Acupuncture: \$0 co-pay for		tine visit	ts per		
	qualifying chronic conditions				year, combined with chiropr Essentials Allowance: \$500		ly allow:	ance for		
	Over the Counter (OTC): S				groceries, gas, utilities, and l					
	<b>Pest Control: \$0</b> copay for a service for those with qualify		qualifying chronic conditions, combined with OTC							
Supplemental	Pet Services: \$0 copay for 7				Over the Counter (OTC):					
Benefits and	walks/year for those with qua	alifying	chronic	condition	<b>Pest Control: \$0</b> copay for service for those with qualify					
<b>Optional Plans</b>	Transportation: \$0 copay for			rips/year	Pet Services: \$0 copay for 7					
	to plan-approved locations w Wellness: \$0 for basic gym i				walks/year for those with qu	alifying	chronic	condition		
				mium:	Transportation: \$0 copay f	or unlin	nited one	-way		
	Enhanced Dental Option: \$27 monthly premium; \$1,500 limit per year with 0%-50% coinsurance for				trips/year to plan-approved locations within 50 miles					
	certain diagnostic and compr				Wellness: \$0 for basic gym					
Medical Groups	Medical Groups: Brown &				Medical Groups: Brown &					
and Hospitals	Hospitals: Alameda, Alta Ba				Hospitals: Alameda, Alta B Eden (Castro Valley), Highl					
(may not be full list; check with plan)	Eden (Castro Valley), Highla (Hayward), Stanford Valley									
L CHECK WITH DIADT	(Hayward), Stanford Valley Care (Pleas/Liv) (Hayward), Stanford Valley Care (Pleas/Liv)									

2024 MEI	DICARE SNP COMPAR	RISON	CHAF	RT FOR	ALAMEDA COUNTY:	C-SN	Ps		
Please contact the Plan for more information or call 1-800-Medicare	Brand New Day 866-255-4795 (Sales & Marketing) 866-255-4795 (Member Services) www.bndhmo.com				Brand New Day 866-255-4795 (Sales &Marketing) 866-255-4795 (Member Services) www.bndhmo.com				
Plan Name/Type	Brand New Day C-SNP (He For People with Cardio Chronic Heart Failure	0838-0 ovascu	39) 11ar Dis		Brand New Day E C-SNP (H0 For People with Cardi Chronic Heart Fail	838-04 iovascu	l0) 11ar Di	isease,	
Star Rating	**1	/2			**1				
Annual OOP Max	\$3,0				\$8,85				
Monthly Premium	\$0				\$41				
Doctor Visits	\$0 for Primary Care Physic	1an; <b>\$0-</b>	10 for Sp	pecialist	\$0 for PCP; 40% coinsu \$1,632 deductible; \$0 cop		-		
Inpatient Hospital	<b>\$0</b> copay for day 1; <b>\$225</b> <b>\$0</b> per day for	days 10	)-90		<b>\$408</b> copay/day fo <b>\$816</b> copay/day fo	or days 6 or days 9	1-90; 1-150		
Outpatient Hospital	<b>\$0 - \$100</b> per ambulatory <b>\$0 - \$150</b> per outpat	ient hos		/	20% coinsurance per ambu outpatient hospita	l facility	visit	enter or	
Skilled Nursing Facility	\$0 for day \$204 copay per day	for day			<b>\$0</b> copay for c <b>\$204</b> copay/day fo				
Ambulance	<b>\$0 - \$150</b> copay per <b>20%</b> coinsurance				20% coinsurance per tr	rip by gr	ound or	air	
Emergency & Urgent Care	<b>\$0 - \$125</b> per ER visit; waiv within 72 hours; <b>\$0</b> Worldwide coverage: <b>\$12</b> or urgent care visi	ed if ad for urg 5 copay	mitted to ent care; per eme		\$100 copay per ER visit; hospital within 72 hours Worldwide coverage: \$100 or urgent care visit	; <b>\$0</b> for copay j	urgent c	are;	
Lab Tests, Procedures, and Radiation Therapy	<b>\$0</b> copay for lab services, x- procedures; <b>\$50</b> copay for <b>20%</b> coinsurance for th	r diagno	ostic radio	ology;	<b>\$0</b> copay for lab services; <b>2</b> rays, diagnostic tests, proce radiology; <b>20%</b> coinsurance	dures; \$	) for dia	gnostic	
Renal Dialysis	20% coinsurance	e per trea	atment		20% co-insurance	per trea	tment		
Outpatient Mental Health Visits	\$10 copay for individu 20% coinsurance per g				<b>\$40</b> copay for individual or group therapy session				
Eyewear	\$300 annual allowa		-		\$300 annual allowance for eyewear				
Eye Exams	<b>\$0</b> copay per Medica <b>\$0</b> copay for one and				<b>\$0</b> copay per Medicare covered exam; <b>\$0</b> for one annual routine exam				
Hearing Aids	\$699-\$999 copay per aid for	2 aids p	er year		<b>\$149</b> allowance per aid for 2 aids every 3 years				
Hearing Exams	<b>\$0</b> copay per Medica <b>\$0</b> copay for one and				<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> copay for one annual routine exam				
Dental	\$0 copay for Medica \$0 copay for certain pr \$0-\$2,160 copays for certa	re cover eventati	red visit; ive servic	es;	<ul> <li>\$0 copay for Medicare covered visit;</li> <li>\$0-\$17 copay for certain preventative services;</li> <li>\$0 - \$350 copay for certain comprehensive services</li> </ul>				
Chiropractic	<b>\$0</b> co-pay per Medicare cover routine visits/year, combi		· ·	2	<b>\$0</b> co-pay per Medicare covered visit; <b>\$0</b> for 12 routine visits per year, combined with acupuncture				
Podiatry	<b>\$0</b> co-pay per Medic				<b>\$0</b> co-pay per Medic				
	Cost-sharing shown is for preferred pharmacies Preferred Generic	30 days retail <b>\$0</b>	100 days retail <b>\$0</b>	100 days mail <b>\$0</b>	Cost-sharing shown is for preferred pharmacies Preferred Generic	30 days retail 25%	100 days retail 25%	100 days mail 25%	
Prescription Drugs (Outpatient)	Generic Preferred Brand Non-Preferred Brand Specialty co-insurance \$0 deductible; after total year \$5,030, you pay \$0 for prefer for generics and brands until expenses reach \$8,000. Afte	l <b>25%</b> rug	Generic25%25%Preferred Brand25%25%Non-Preferred Brand25%25%Specialty co-insurance25%N/A\$0 deductible for Tier 1; \$545 for Tiers 2-6: after tor yearly drug costs reach \$5,030, you pay 25% for generics and 25% for brands until out-of-pocket dru 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				<ul> <li>In-Home Support Services: 20 hours per year for those with qualifying conditions</li> <li>Meals: \$0 copay per meal for 14 meals/month for 12 months for people with qualifying chronic conditions</li> <li>Over the Counter: \$50 monthly allowance for plan approved OTC items</li> <li>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</li> </ul>				
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Alameda l Physicians East Bay / Hospi Bates/Summit (Berk/Oak) Ed (Oak), San Leandro, Washin	t <b>als:</b> Ala den (C V	ameda, A Valley), H	lta	Wellness: \$0 for Silver Sneakers gym membership           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 **Central Health Medicare Imperial Health Plan of CA** Please contact the Plan for more 1-866-314-2427 (Sales & Marketing) 1-800-838-8271 (Sales & Marketing) information or call 1-866-314-2427 (Member Services) 1-800-838-8271 (Member Services) 1-800-Medicare www.centralhealthplan.com www.imperialhealthplan.com **Central Health Focus Plan** Imperial Senior Value C-SNP (H5649-006) C-SNP (H5496-005) Plan Name/Type For People with Cardiovascular Disease, For People with Cardiovascular Disease, **Chronic Heart Failure, or Diabetes** 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 \$150 copay/day for days 1-5; \$0/day for days 6-90; **Inpatient Hospital** \$0 per stay \$670/day for days 91-150 **\$0** copay per ambulatory surgical center visit; \$200 per ambulatory surgical center visit; **Outpatient Hospital** \$0 copay per outpatient hospital visit \$200 per outpatient hospital visit **Skilled Nursing \$0** copay for days 1-20; \$0 per stay \$200/day for days 21-100 Facility \$150 copay per trip by ground; **\$0-\$100** copay per trip by ground; Ambulance 20% coinsurance per trip by air 20% co-insurance per trip by air \$0-\$125 copay per ER visit; waived if admitted to **Emergency &** hospital within 72 hours; **\$0** copay for urgent care; \$125 copay per emergency room visit; \$0 for urgent Worldwide coverage: \$50 copay for emergency **Urgent** Care care; Worldwide coverage: **\$0** copay; **\$50,000** limit or urgent care visit; \$100,000 limit Lab Tests, \$0 copay for lab services, x-rays, diagnostic tests, 10% coinsurance for lab services, diagnostic tests & Procedures, and procedures; \$75 copay for diagnostic radiology; procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology 20% co-insurance for the rapeutic radiology **Radiation Therapy Renal Dialysis** 20% co-insurance per treatment 20% co-insurance per treatment **Outpatient Mental** 20% co-insurance per individual \$0 copay for individual or group therapy session or group therapy session **Health Visits** Eyewear **\$150** annual allowance for eyewear \$250 annual allowance for eyewear \$0 copay for Medicare-covered exam; **\$0** copay per Medicare-covered exam; **Eve Exams \$0** for one annual routine exam **\$0** copay for routine exams **Hearing Aids** \$2,000 annual allowance, through NationsHearing \$500 annual allowance **\$0** copay for Medicare-covered exam; \$0 copay for Medicare-covered exam; **Hearing Exams** \$0 copay for one annual routine exam \$0 for routine exams up to \$250/year \$0 copay for Medicare covered visit; **\$0** copay for Medicare covered visit; Dental **\$0-\$41** copay for certain preventative services; **\$0** co-pay for preventive services; **\$500**/year; \$0-\$2,160 copay for certain comprehensive services **\$0** co-pay for comprehensive services; **\$2,000**/year Chiropractic \$0 copay for Medicare covered visit \$0 copay per Medicare-covered visit \$0 copay per Medicare-covered visit; \$0 co-pay per Medicare covered visit **Podiatry** \$0 copay for 6 routine visits per year 90 100 30 100 100 30 Cost-sharing shown is for Cost-sharing shown is for days days days days days days network pharmacies preferred pharmacies retail retail mail retail retail mail Preferred Generic Preferred Generic \$0 \$0 **\$0** \$0 **\$0 \$0** Generic \$0 \$0 \$0 Generic \$5 \$15 \$10 **Prescription Drugs** Preferred Brand \$35 \$105 \$70 Preferred Brand \$45 \$135 \$90 Non-Preferred Brand \$75 \$225 \$150 Non-Preferred Brand \$90 \$270 \$180 (Outpatient) Specialty co-insurance 33% Specialty co-insurance 33% N/A N/A N/A N/A \$0 deductible; after total yearly drug costs reach **\$0** deductible; after total yearly drug costs reach \$5,030, you pay \$0 for any generics and 25% of the \$5,030, you pay \$0, \$5, \$10 or \$15 for generics and plan's cost for brands until out-of-pocket drug 25% of the plan's cost for brands until out-of-pocket expenses reach \$8,000. After that, you pay \$0. drug expenses reach \$8,000. After that, you pay \$0. Acupuncture: \$0 copay per visit for unlimited routine visits per year In-Home Support Services: \$0 copay 60 hours/year Groceries: \$25 monthly allowance for healthy Meals: \$0 co-pay for up to 7 home-delivered meals foods, for those with qualifying conditions following surgery or hospital stay; \$105 allowance 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

Transportation: \$0 copay for 24 one-way trips per

year to plan approved locations within 50 miles Wellness: \$0 for Silver Sneakers gym membership

Medical Groups: Hill Physicians East Bay

(Castro Valley, Washington (Fremont)

Hospitals: Alta Bates/Summit (Berk/Oak), Eden

Scales: \$0 copay for those with qualifying

and Herbal Catalog items

chronic conditions

Supplemental

**Optional Plans** 

Medical Groups and

(may not be full list;

check with plan)

**Benefits** and

Hospitals

per benefit period

home fitness kit

plan approved locations

Holdings, Nivano Physicians

and Washington (Fremont)

Over the Counter: \$75 quarterly allowance for

Transportation: \$0 co-pay for 100 one-way trips to

Wellness: \$0 for Silver&Fit gym membership or at-

Medical Groups: Brown & Toland, Imperial Health

Medical Center (Castro Valley), St. Rose (Hayward),

Hospitals: Alta Bates/Summit (Berk/Oak), Eden

items in plan's OTC mail order catalog

2024 MEI	DICARE SNP COMPAR	RISON	CHA	RT FOF	R ALAMEDA COUNTY	: C-S	NPs		
Please contact the Plan for more information or call 1-800-Medicare	SCAN Hea 877-870-4867 (Sal 800-559-3500 (M www.scanheal	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)				SCAN Heart First C-SNP (H5425-077) For People with Cardiosvascular Disease and/or Congestive Heart Failure				
Star Rating	***				***				
Annual OOP Max	\$2,80	0			\$2,80	)0			
Monthly Premium	\$0 \$0 for Primary Ca	re Phys	ician:		\$0 \$0 for Primary Ca	are Phys	ician:		
Doctor Visits	\$0 for Triniary Ca \$0 for Spe \$150 copay per day	cialist	-		\$0 for Trinary Ca \$0 for Spe \$150 copay per da	cialist	-		
Inpatient Hospital Outpatient	\$0 for days 8-90 \$0 per ambulatory sur	and be	yond	·	\$0 for days 8-90 \$0 per ambulatory sur	and bey	ond		
Hospital	\$0-\$125 copay per outp	atient h		/	\$0-\$125 copay per outp	batient h			
Skilled Nursing Facility	<b>\$0</b> for days <b>\$75</b> copay/day for		1-100		<b>\$0</b> for day <b>\$75</b> copay/day fo		1-100		
Ambulance	<b>\$90</b> copay per emergency admitted to hospital imme urgent care visit; Wor	diately	; <b>\$0</b> copa	ay per	<b>\$90</b> copay per emergency admitted to hospital imme urgent care visit; Wo	ediately;	\$0 copa	y per	
Emergency & Urgent Care	\$180 copay per trip	by grou	nd or air	r	\$180 copay per trip	by grou	nd or air		
Lab Tests, Procedures, and Radiation Therapy	<b>\$0</b> copay for lab service procedures, x-rays, and c <b>\$60</b> copay for therap	liagnost	ic radio	logy;	<b>\$0</b> copay for lab service procedures, x-rays, and <b>\$60</b> copay for thera	liagnosti	ic radiolo		
Renal Dialysis	20% co-insurance	per trea	atment		20% co-insurance	e per trea	tment		
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	<b>\$235</b> allowance for lenses/frames every 2 years				
Eye Exams	<b>\$0</b> copay per Medicar <b>\$0</b> copay for 1 annu				<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> copay for 1 annual routine exam				
Hearing Aids	\$450-\$750 copay per a through Tru	id; 2 aio Hearing	ds per ye g	ear,	\$450-\$750 copay per aid; 2 aids per year, through TruHearing				
Hearing Exams	\$0 copay per Medicar \$0 copay for one ann	ual rout	ine exar	n	\$0 copay per Medicare-covered exam; \$0 copay for one annual routine exam				
Dental	\$0 copay for Medicar \$0 copay per oral exam, up to 2 visits ea See Optional Bene	cleaning ch per y	g, and x- vear;		<ul> <li>\$0 copay for Medicare covered visit;</li> <li>\$0 copay per oral exam, cleaning, and x-rays; up to 2 visits each per year;</li> <li>See Optional Benefit Plan below</li> </ul>				
Chiropractic	<b>\$0</b> copay per Medica	are-cove	ered visi	t	<b>\$0</b> copay per Medicare-covered visit				
Podiatry	\$0 co-pay per Medic	are cov	ered visi	it	<b>\$0</b> co-pay per Medicare covered visit				
	Cost-sharing shown is for preferred pharmacies	30 days	100 days	100 days	Cost-sharing shown is for preferred pharmacies	30 days	100 days	100 days	
	Preferred Generic Generic Preferred Brand	retail \$0 \$0 \$40	retail \$0 \$0 \$100	mail \$0 \$0 \$100	Preferred Generic Generic Preferred Brand	retail \$0 \$0 \$40	retail \$0 \$0 \$100	mail \$0 \$0 \$100	
Prescription Drugs	Non-Preferred Brand	\$ <del>9</del> 0	\$250	\$250	Non-Preferred Brand	\$40 \$90	\$100	\$250	
(Outpatient)	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A	
	\$0 deductible; after total year \$5,030, you pay \$0 for gener 25% of the plan's cost for br pocket drug expenses reach \$	ics and and nar	no more nes until	e than l out-of-	<b>\$0</b> deductible; after total yea <b>\$5,030</b> , you pay <b>\$0</b> for gener <b>25%</b> of the plan's cost for be pocket drug expenses reach \$	rics and i rand nam	no more nes until	than out-of-	
	pay \$0.	100	out cul	11.00000	pay \$0.	100	unt au 1- 11		
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 <b>Transportation:</b> \$0 copay for up to 24 one-way trips per year to plan-approved locations within 75 miles <b>Optional Dental Plan:</b> \$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 & Hospitals: Alameda, San Le (Hayward)				Medical Groups: Brown & Toland Hospitals: Alameda, San Leandro, St. Rose (Hayward)				

2024 MEDI	CARE SNP COMPAR	ISON	CHAR	T FOR	ALAMEDA COUNTY	: I-SN	Ps			
Please contact the Plan for more information or call 1-800-Medicare	Align Senior Care 844-305-3879 (Sales & Marketing) 844-305-3879 (Member Services) www.alignseniorcare.com				844-305-3879 (Member Services www.alignseniorcare.com					
Plan Name/Type	Align Prei I-SNP (H3274-0 Needing Nursing H	Align Senior Care I-SNP (H3274-001) For People Needing Nursing Home Level of Care								
Star Rating	Not Enough D		ailable		Not Enough I		ailable			
Annual OOP Max	\$3,5				\$8,					
Monthly Premium	<b>\$0</b> / Medical De			40	\$41 / Medical D					
Doctor Visits	\$0 for Primary C \$0 for Sp				\$0 copay for Prima 20% coinsuran			1;		
Inpatient Hospital	\$150 copay/day \$0 for day	for day	's 1-10;		\$1,632 deductible; \$0 c \$408 copay/day \$816 copay/day	opay/day for days	for days 61-90;	; 1-60;		
<b>Outpatient Hospital</b>	20% coinsurance per amb			center or	20% coinsurance per am	oulatory	surgical o	center or		
	outpatient h				outpatient hosp					
Skilled Nursing Facility	\$0 copay/day t \$100 copay/day \$125 copay per	for days	\$ 21-100		<b>\$0</b> copay/day <b>\$204</b> copay/day	for days	21-100			
Ambulance	20% coinsurance				20% coinsurance per	trip by g	ground of	r air		
Emergency & Urgent Care	<b>\$90</b> copay per ER visit; <b>\$</b> copays waived if admitted	640 per u	urgent ca		<b>\$90</b> copay per ER visit; copays waived if admitted					
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab se 20% coinsurance for diag diagnostic and the	gnostic t	ests, pro	cedures,	\$0 copay for lab so 20% coinsurance for dia diagnostic and the	gnostic t	ests, proc	edures,		
Renal Dialysis	20% coinsurance	e per tro	eatment		20% coinsuran	ce per tre	atment			
Outpatient Mental Health Visits	\$20 copay for individ \$10 copay for grou				20% coinsurance per individual or group therapy session					
Eyewear	\$225 annual allow	r	\$275 annual allowance for eyewear							
Eye Exams	20% coinsurance per M				<b>20%</b> coinsurance per Medicare-covered exam;					
-	\$0 copay for one an				<b>\$0</b> copay for one annual routine exam					
Hearing Aids	\$1,500 annual allowance	,		-	\$1,500 annual allowance; limited to 2 aids/year					
Hearing Exams	20% coinsurance per M \$0 copay for one ar	nual ro	utine exa	m	20% coinsurance per Medicare-covered exam \$0 copay for one annual routine exam					
Dental	20% coinsurance per N \$1,000 annual allowanc comprehensive services,	e for ce	rtain bas	ic and	20% coinsurance per Medicare covered visit; \$3,000 annual allowance for certain basic and comprehensive services, through Liberty Dental					
Chiropractic	20% coinsurance for M \$30 copay for 12 rot	ledicare utine vis	-covered sits per ye	l visit; ear	20% coinsurance for Medicare-covered visit					
Podiatry	20% coinsurance for N \$0 copay/visit for 4 ro				<b>20%</b> coinsurance for Medicare-covered visit; <b>\$0</b> copay/visit for 4 routine visits per year					
	Cost-sharing shown is for preferred pharmacies Preferred Generic Generic	30 days retail <b>\$0</b> <b>\$10</b>	90 days retail <b>\$0</b> <b>\$30</b>	90 days mail \$0 \$30	Cost-sharing shown is for preferred pharmacies Preferred Generic Generic	30 days	90 days retail 25% 25%	90 days mail 25% 25%		
Dueserin Harry D	Preferred Brand	\$45	\$145	\$145	Preferred Brand	25%	25%	25%		
Prescription Drugs (Outpatient)	Non-Preferred Brand	\$95	\$285	\$285	Non-Preferred Brand	25%	25%	25%		
(Ծաւթձնեն)	Specialty co-insurance <b>\$0</b> deductible for Tiers 1& Tiers 3-5; after total yearly	drug co	osts reach	n <b>\$5,030</b> ,	Specialty co-insurance         25%         25%           \$545 deductible for all drugs; after total yearly drug costs reach \$5,030, you pay 25% for generic and					
	you pay <b>25%</b> for generic a until out-of-pocket drug ex After that, you pay <b>\$0</b> .	penses	reach \$8	,000.	brand name drugs until our reach <b>\$8,000.</b> After that, y	of-pock	et drug e			
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				Instructure in the sum of the sum					
Medical Groups and Hospitals (may not be full list; check with plan)	Medical Groups: Certain Hospitals: Alta Bates/Sum Medical Center (Castro Va	nmit (Be		·	Medical Groups: Certain Hospitals: Alta Bates/Sun Medical Center (Castro Va	ımit (Beı				
			10-							

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

# 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 innetwork 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: <u>www.medicare.gov/medicare-and-you</u>.

#### **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: <a href="https://www.cms.gov/files/document/101323-fact-sheet-2024-medicare-advantage-and-part-d-ratings.pdf">https://www.cms.gov/files/document/101323-fact-sheet-2024-medicare-advantage-and-part-d-ratings.pdf</a>