

# 2025 Medicare Advantage Plan HMO Comparison Chart ~FINAL~ for Alameda County

~Rev. 11/13/24 ~

Medicare Advantage Plans contract with the Centers for Medicare and Medicaid Services (CMS) to provide all the benefits covered by Medicare and some additional benefits. In exchange, CMS (Medicare) pays the plan a fixed fee per member, per month. This amount varies by region and is also adjusted for the individual member's age, gender and health condition. **To enroll in a Medicare Advantage plan, a person must have both Medicare Parts A & B. The person must also live within the plan's service area.** Medicare Advantage plans must accept anybody on Medicare, including those who are under age 65 on Medicare through disability, regardless of their health condition.

**Medicare HMOs are one type of Medicare Advantage (MA) plan.** When joining a Medicare HMO, beneficiaries do not give up their Medicare coverage; rather they agree to receive it through the plan's network of providers. A member must choose a Primary Care Physician and receive referrals to see specialists. The HMO will normally *not* pay for services received outside the plan's network unless it is urgent or emergency care. In those circumstances, members should notify their plans as soon as possible. *However, if the HMO also has a Point of Service (POS) option, members can go out of network only for certain plan-specified services but will pay higher out of pocket costs for those services.* The cost-sharing varies from plan to plan. Premiums, co-payments, and extra benefits can differ. The Annual Out of Pocket Maximum listed for each plan applies to all cost-sharing *except* plan premiums and prescription drug co-pays. In 2025, there are 24 Medicare HMOs in Alameda County, and they are listed on pages 2-13 of this chart. One of these does not include the Medicare Part D prescription drug benefit. When people join an HMO *without* drug coverage, they opt out of Part D. Enrolling in a stand-alone Part D plan will automatically trigger disenrollment from the Medicare Advantage Plan.

**A Medicare PPO is another type of Medicare Advantage (MA) plan.** A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses such as deductibles and co-insurance will apply. In 2025, there are 4 Medicare PPOs in Alameda County. See our 2025 PPO Comparison Chart for more information and details: [www.lashicap.org/hicap](http://www.lashicap.org/hicap).

**Medicare Special Needs Plans are another type of Medicare Advantage plan.** They are designed for people on Medicare and Medi-Cal (duals), those with certain chronic conditions, or those who reside in nursing homes. They all must include Part D prescription drug coverage and they have a responsibility to coordinate benefits and care for their members. In 2025, there are 19 Special Needs Plans in Alameda County. See our **2025 Special Needs Plan Comparison Chart** for more information and details: [www.lashicap.org/hicap](http://www.lashicap.org/hicap).

## Enrollment:

In the fall of 2024, 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, 2025.** In 2025, 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.

**IMPORTANT NOTE:** In 2025, Medicare Part D out of pocket costs for covered medications under one's plan are capped at \$2,000. Also, plans cannot charge more than a \$35 copay per month for insulin and any drug deductibles do not apply to insulin.

## ABOUT THIS CHART

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

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

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



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**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Aetna Medicare</b> <b>833-859-6031 (Sales &amp; Marketing)</b> <b>833-570-6670 (Member Services)</b> <a href="http://www.aetnamedicare.com">www.aetnamedicare.com</a>							
<b>Plan Name/Type</b>	<b>Aetna Medicare Select HMO-POS (H0523-070)</b>				<b>Aetna Medicare Plus HMO-POS (H4982-007)</b>			
<b>Star Rating</b>	★ ★ ★				★★1/2			
<b>Annual OOP Max</b>	<b>\$2,500</b>				<b>\$3,400</b>			
<b>Monthly Premium</b>	<b>\$0</b>				<b>\$0</b>			
<b>Doctor Visits</b>	\$0 copay for Primary Care Physician; \$0 for Specialist				\$0 copay for Primary Care Physician; \$0 for Specialist			
<b>Inpatient Hospital</b>	\$245 copay/day for days 1-5; \$0 per day for days 6 and beyond				\$150 copay/day for days 1-5; \$0 per day for days 6 and beyond			
<b>Outpatient Hospital</b>	\$0 copay for ambulatory surgical center visit; \$125 copay for outpatient hospital facility visit				\$0 copay for ambulatory surgical center visit; \$125 copay for outpatient hospital facility visit			
<b>Skilled Nursing Facility</b>	\$0 copay/day for days 1-20; \$75 per day for days 21-100				\$0 copay/day for days 1-20; \$75 per day for days 21-100			
<b>Ambulance</b>	\$295 copay per ground or air ambulance trip				\$325 copay per ground trip; 20% per trip by air			
<b>Emergency &amp; Urgent Care</b>	\$140 copay per emergency room visit; waived if admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no annual limit; \$140 copay per ER/urgent care visit; ER copay waived if admitted to hospital; urgent care copays not waived				\$140 copay per emergency room visit; waived if admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no annual limit; \$140 copay per ER/urgent care visit; ER copay waived if admitted to hospital; urgent care copays not waived			
<b>Lab Tests, Procedures, and Radiation Therapy</b>	\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$0 copay for diagnostic radiology; \$60 copay for therapeutic radiology				\$0 copay for lab services, diagnostic tests, procedures, x-rays and diagnostic radiology; \$60 copay for therapeutic radiology			
<b>Renal Dialysis</b>	20% co-insurance per treatment				20% co-insurance per treatment			
<b>Outpatient Mental Health Visits</b>	\$40 copay per individual or group therapy session				\$0 copay per individual or group therapy session			
<b>Eyewear</b>	\$275 annual allowance for eyewear				<b>Not Covered</b>			
<b>Eye Exams</b>	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam				\$0 copay for diagnostic exam; \$0 copay for one annual routine exam			
<b>Hearing Aids</b>	\$1,250 annual hearing aid allowance per ear; purchased through NationsHearing network				\$2,000 annual hearing aid allowance per ear; purchased through NationsHearing network			
<b>Hearing Exams</b>	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam through NationsHearing network				\$0 copay for diagnostic exam; \$0 copay for one annual routine exam through NationsHearing network			
<b>Dental</b>	\$1,000 annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider				\$1,100 annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider			
<b>Chiropractic</b>	\$0 copay for Medicare covered visits; \$0 copay for unlimited routine visits; through American Specialty Health provider				\$0 copay for Medicare covered visits; \$0 copay for unlimited routine visits; through American Specialty Health provider			
<b>Podiatry</b>	\$0 copay per Medicare-covered visit				\$0 copay per Medicare-covered visit			
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 day retail	100 day mail
	Preferred Generic	\$0	\$0	\$6	Preferred Generic	\$0	\$0	\$0
	Generic	\$5	\$15	\$36	Generic	\$0	\$0	\$0
	Preferred Brand	25%	25%	25%	Preferred Brand	24%	24%	24%
	Non-Preferred Brand	35%	35%	35%	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 \$2,000, you pay \$0.				\$590 deductible applies to Tiers 3, 4, and 5; after total yearly drug costs reach \$2,000, you pay \$0.			
<b>Supplemental Benefits and Optional Plans</b>	<b>Acupuncture:</b> \$0 copay for unlimited acupuncture treatments with American Specialty Health provider <b>Over the Counter:</b> \$75 quarterly allowance for plan-approved items <b>Transportation:</b> \$0 copay for 12 one-way trips per year (up to 60 miles each trip) to plan approved locations, via Access2Care <b>Wellness:</b> \$0 copay for basic Silver Sneakers membership or one home fitness kit per year; \$150 per quarter Direct Member reimbursement allowance for various fitness activities and supplies				<b>Acupuncture:</b> \$0 copay for unlimited acupuncture treatments with American Specialty Health <b>Transportation:</b> \$0 copay for 12 one-way trips per year (up to 60 miles each trip) to plan approved locations, via Access2Care <b>Wellness:</b> \$0 copay for basic Silver Sneakers membership or one home fitness kit per year			
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown and Toland; One Medical; <b>Hospitals:</b> Alameda, Highland (Oak), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleasanton), and Washington Hospital (Fremont)				<b>Medical Groups:</b> Brown and Toland; One Medical; <b>Hospitals:</b> Alameda, Highland (Oak), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleasanton), and Washington Hospital (Fremont)			

**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Aetna Medicare</b> <b>833-859-6031 (Sales &amp; Marketing)</b> <b>833-570-6670 (Member Services)</b> <a href="http://www.aetnamedicare.com">www.aetnamedicare.com</a>	<b>Align Senior Care</b> <b>844-305-3879 (Sales &amp; Marketing)</b> <b>844-305-3879 (Member Services)</b> <a href="http://www.alignseniorcare.com">www.alignseniorcare.com</a>
<b>Plan Name/Type</b>	<b>Aetna Medicare Value Plus HMO-POS (H0523-076)</b>	<b>Align Advantage Care HMO (H3274-005)</b>
<b>Star Rating</b>	★ ★ ★	Not enough data available
<b>Annual OOP Max</b>	<b>\$2,500</b>	<b>\$1,900</b>
<b>Monthly Premium</b>	<b>\$5.90</b>	<b>\$0</b>
<b>Doctor Visits</b>	\$0 copay for Primary Care Physician; \$0 for Specialist	\$0 copay for Primary Care Physician; \$0 for Specialist
<b>Inpatient Hospital</b>	\$250 copay/day for days 1-5; \$0 per day for days 6 and beyond	\$0 per stay; \$0 per day for unlimited additional days
<b>Outpatient Hospital</b>	\$0 copay per ambulatory surgical center visit; \$125 per outpatient hospital facility visit	20% coinsurance per ambulatory surgical center visit; \$225 copay per outpatient hospital facility visit
<b>Skilled Nursing Facility</b>	\$0 copay/day for days 1-20; \$75 per day for days 21-100	\$0 copay/day for days 1-100
<b>Ambulance</b>	\$295 copay per ground trip; 20% per trip by air	\$125 copay per trip by ground; 20% coinsurance per trip by air
<b>Emergency &amp; Urgent Care</b>	\$140 copay per emergency room visit; waived if admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no annual limit; <b>\$140 copay</b> per emergency/urgent care visit; ER copay waived if admitted to hospital; urgent care copays not waived	\$90 copay per emergency room visit; \$40 per urgent care visit; waived if admitted to hospital within 3 days; Coverage limited to the U.S. and territories
<b>Lab Tests, Procedures, and Radiation Therapy</b>	\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$0 copay for diagnostic radiology; \$60 copay for therapeutic radiology	\$0 copay for lab services and x-rays; 20% coinsurance for diagnostic tests, procedures, and diagnostic radiology; 20% coinsurance for therapeutic radiology
<b>Renal Dialysis</b>	20% co-insurance per treatment	20% co-insurance per treatment
<b>Outpatient Mental Health Visits</b>	\$40 copay for individual or group therapy session	\$0 copay for individual or group therapy session
<b>Eyewear</b>	\$325 annual allowance for eyewear	\$225 annual allowance for eyewear
<b>Eye Exams</b>	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam	20% coinsurance for diagnostic exam; \$0 copay for one annual routine exam
<b>Hearing Aids</b>	\$1,250 annual hearing aid allowance per ear; purchased through NationsHearing network	<b>Not Covered</b>
<b>Hearing Exams</b>	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam through NationsHearing network	20% coinsurance for diagnostic exam
<b>Dental</b>	\$2,000 annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider	\$0 copay for certain preventive services; \$3,000 annual allowance for comprehensive services; Must use Liberty Dental network
<b>Chiropractic</b>	\$0 copay for Medicare-covered visits; \$0 copay/visit for unlimited routine visits; must use American Specialty Health provider	20% coinsurance for Medicare-covered visits; \$30 copay/visit for 30 routine visits per year; (contact plan for additional details)
<b>Podiatry</b>	\$0 copay per Medicare-covered visit	20% coinsurance per Medicare-covered visit; \$0 copay per routine visit, up to 6 per year
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>
	30 days	30 days
	100 days retail	90 days retail
	100 days mail	90 days mail
	Preferred Generic	Preferred Generic
	Generic	Generic
<b>Supplemental Benefits and Optional Plans</b>	Preferred Brand	Preferred Brand
	Non-Preferred Brand	Non-Preferred Brand
	Specialty co-insurance	Specialty co-insurance
	\$250 deductible applies to Tiers 3, 4, and 5; <b>after total yearly drug costs reach \$2,000, you pay \$0.</b>	\$0 deductible; <b>after total yearly drug costs reach \$2,000, you pay \$0.</b>
	<b>Acupuncture:</b> \$0 copay for unlimited acupuncture treatments with American Specialty Health provider <b>OTC:</b> \$75 quarterly allowance for plan approved items purchased online or in-store at CVS locations; no rollover <b>Transportation:</b> \$0 copay for 12 one-way trips per year to plan approved locations via Access2Care <b>Wellness:</b> \$0 copay for basic Silver Sneakers membership or one home fitness kit per year; <b>\$150</b> per quarter Direct Member reimbursement allowance for various fitness activities and supplies	<b>In-Home Support Services:</b> \$0 copay; limited to 80 hours annually for help with personal needs, light housekeeping, meal prep, etc. <b>Over the Counter:</b> \$405 quarterly allowance for plan-approved items <b>Part B Premium Rebate:</b> \$10/month <b>Transportation:</b> \$0 copay for 24 one-way trips per year to plan approved locations
	<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland, One Medical <b>Hospitals:</b> Alameda, Highland (Oak), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleasanton), and Washington Hospital (Fremont)

**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Alignment Health Plan</b> <b>888-979-2247 (Sales &amp; Marketing)</b> <b>866-634-2247 (Member Services)</b> <a href="http://www.alignmenthealthplan.com">www.alignmenthealthplan.com</a>			
<b>Plan Name/Type</b>	<b>Alignment Health Heroes + HMO (H3815-043)</b>		<b>Alignment Health Harmony HMO (H3815-031)</b>	
<b>Star Rating</b>	★★★★		★★★★	
<b>Annual OOP Max</b>	<b>\$5,900</b>		<b>\$3,400</b>	
<b>Monthly Premium</b>	<b>\$0</b>		<b>\$0</b>	
<b>Doctor Visits</b>	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist		<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist	
<b>Inpatient Hospital</b>	<b>\$1,676</b> deductible per benefit period; <b>\$0</b> copay for days 1-60; <b>\$419</b> copay/day for days 61-90; <b>\$838</b> copay/day for days 91-150		<b>\$100</b> copay/day for days 1-5; <b>\$0</b> copay/day for days 6-90; <b>\$0</b> copay/day for days 90 and beyond	
<b>Outpatient Hospital</b>	<b>\$0</b> copay for ambulatory surgical center; <b>\$0</b> copay for outpatient hospital facility		<b>\$100</b> copay for ambulatory surgical center visit; <b>\$200</b> copay for outpatient hospital facility visit	
<b>Skilled Nursing Facility</b>	<b>\$0</b> copay/day for days 1-20; <b>\$209.50</b> /day for days 21-100		<b>\$0</b> copay/day for days 1-20; <b>\$100</b> copay/day for days 21-100	
<b>Ambulance</b>	<b>20%</b> co-insurance per ground or air ambulance trip; Not waived if admitted to hospital		<b>\$175</b> copay per ground or air ambulance trip; Waived if admitted to hospital	
<b>Emergency &amp; Urgent Care</b>	<b>20%</b> coinsurance for ER and urgent care visits; ER cost waived if admitted to hospital within 3 days; <b>Worldwide coverage: \$75,000</b> annual limit for ER/urgent care with <b>\$10</b> copays		<b>\$100</b> copay for ER visit; copay not waived if admitted to hospital; <b>\$0</b> for urgent care visit; <b>Worldwide coverage: \$100,000</b> annual limit for ER/urgent care with <b>\$20</b> copays	
<b>Lab Tests, Procedures, and Radiation Therapy</b>	<b>\$0</b> copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; <b>20%</b> coinsurance for therapeutic radiology		<b>\$0</b> copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; <b>20%</b> coinsurance for therapeutic radiology	
<b>Renal Dialysis</b>	<b>20%</b> co-insurance per treatment		<b>\$30</b> copay per treatment	
<b>Outpatient Mental Health Visits</b>	<b>20%</b> co-insurance per individual or group therapy session		<b>\$0</b> copay per individual or group therapy session	
<b>Eyewear</b>	<b>\$500</b> allowance for eyewear every 2 years		<b>\$150</b> annual allowance for eyewear	
<b>Eye Exams</b>	<b>\$0</b> copay for diagnostic exam; <b>\$0</b> copay for one annual routine exam		<b>\$0</b> copay for diagnostic exam; <b>\$0</b> copay for one annual routine exam	
<b>Hearing Aids</b>	<b>Not Covered</b>		<b>\$195-\$1,750</b> copay per aid; up to 2 aids per year	
<b>Hearing Exams</b>	<b>\$0</b> copay for diagnostic exam; <b>\$0</b> copay for one annual routine exam		<b>\$0</b> copay for diagnostic exam; <b>\$0</b> copay for one annual routine exam	
<b>Dental</b>	<b>\$0</b> copay for certain preventive and comprehensive services; <b>\$500</b> allowance every 3 months; See enhanced dental plan option below		<b>\$0</b> copay for certain preventive services; <b>\$20-\$570</b> copays for certain comprehensive services	
<b>Chiropractic</b>	<b>\$0</b> copay per Medicare-covered visit		<b>\$0</b> copay per Medicare-covered visit	
<b>Podiatry</b>	<b>\$0</b> copay for Medicare-covered visit		<b>\$5</b> copay for Medicare-covered visit	
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail
	Preferred Generic	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	Generic	<b>\$10</b>	<b>\$30</b>	<b>\$30</b>
	Preferred Brand	<b>25%</b>	<b>25%</b>	<b>25%</b>
	Non-Preferred Brand	<b>25%</b>	<b>25%</b>	<b>25%</b>
	Specialty co-insurance	<b>25%</b>	<b>N/A</b>	<b>N/A</b>
	<b>\$590</b> deductible; <b>after total yearly drug costs reach \$2,000</b> , you pay <b>\$0</b> .			
<b>Supplemental Benefits and Optional Plans</b>	<b>Enhanced Dental Option: \$36/month for 0-50%</b> coinsurance for certain diagnostic and comprehensive services; <b>\$1,500</b> coverage limit per year <b>Essentials Allowance: \$100</b> monthly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions; no rollover <b>In-Home Support Services: \$0</b> copay for 12 hours per quarter OR <b>\$300</b> annual caregiver reimbursement <b>Meals: \$0</b> copay for up to 2 meals/day for 14 days (2x/year) for those with qualifying chronic conditions <b>Pet Services: \$0</b> copay for 7 boarding days or 14 walks/year for those w/qualifying chronic conditions <b>Pest Control: \$0</b> copay for 1 service per year for those with qualifying chronic conditions <b>Transportation: \$0</b> copay for 50 one-way trips per year to plan approved locations within 50 miles <b>Wellness: \$0</b> copay for basic gym membership			
	<b>Acupuncture: \$0</b> co-pay/visit for unlimited visits/yr <b>Enhanced Dental Option: \$36/month for 0-50%</b> coinsurance for certain diagnostic and comprehensive services; <b>\$1,500</b> coverage limit per year <b>Essentials Allowance: \$30</b> monthly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions <b>Over the Counter: \$30</b> monthly allowance <b>Pet Services: \$0</b> copay for 7 boarding days or 14 walks/year for those w/qualifying chronic conditions <b>Pest Control: \$0</b> copay for 1 service per year for those with qualifying chronic conditions <b>Transportation: \$0</b> copay for 28 one-way trips each year to plan approved locations within 20 miles <b>Wellness: \$0</b> copay for basic gym membership			
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland, Nivano IPA <b>Hospitals:</b> Alameda; Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)			
	<b>Medical Groups:</b> Brown & Toland, Nivano IPA <b>Hospitals:</b> Alameda; Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)			



# 2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs

Please contact the Plan for more information or call 1-800-Medicare	<b>Alignment Health Plan</b> <b>888-979-2247 (Sales &amp; Marketing)</b> <b>866-634-2247 (Member Services)</b> <a href="http://www.alignmenthealthplan.com">www.alignmenthealthplan.com</a>			
Plan Name/Type	Alignment Health My Choice CalPlus HMO (H3815-007)		Alignment Health Select HMO (H3815-037)	
Star Rating	★★★★		★★★★	
Annual OOP Max	\$3,499		\$3,400	
Monthly Premium	\$0		\$0	
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist		\$10 for Primary Care Physician; \$35 for Specialist	
Inpatient Hospital	\$0 copay for days 1-4; \$100 copay/day for days 5-10; \$0 copay for days 11 and beyond; unlimited		\$295 copay for days 1-7; \$0 copay/day for days 8 and beyond; unlimited	
Outpatient Hospital	\$100 copay for ambulatory surgical center; \$200 copay for outpatient hospital facility		\$35 copay for ambulatory surgical center visit; \$200 for outpatient hospital facility visit	
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$50 copay/day for days 21-100		\$0 copay/day for days 1-20; \$140 per day for days 21-100	
Ambulance	\$175 copay per trip by ground or air; waived if admitted to hospital		\$240 copay per trip by ground or air; waived if admitted to hospital	
Emergency & Urgent Care	\$85 copay for ER visit; waived if admitted to hospital within 48 hours; \$0 for urgent care visit; <b>Worldwide coverage: \$12,000 annual limit for emergency/urgent care with \$0 copays</b>		\$90 copay for ER visit; waived if admitted within 24 hours; \$0 for urgent care visit; <b>Worldwide coverage: \$25,000 annual limit for emergency/urgent care with \$0 copays</b>	
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology		\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology	
Renal Dialysis	20% coinsurance per treatment		\$30 copay per treatment	
Outpatient Mental Health Visits	\$0 copay per individual or group therapy session		\$20 copay per individual or group therapy session	
Eyewear	\$100 annual allowance for eyewear		\$300 allowance for eyewear every 2 years	
Eye Exams	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam		\$0 copay for diagnostic exam; \$0 copay for one annual routine exam	
Hearing Aids	\$195-\$1,750 copay per aid; up to 2 aids per year		\$195-\$1,750 copay per aid; up to 2 aids per year	
Hearing Exams	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam		\$10 copay for diagnostic exam; \$0 copay for one annual routine exam	
Dental	\$0 copay for certain preventive services; \$20-\$570 copays for certain comprehensive services		\$10-\$30 copays for certain preventive services; \$20-\$570 copays for certain comprehensive services	
Chiropractic	\$0 copay per Medicare-covered visit; <i>For those with Extra Help, \$0 co-pay for 12 visits per year, combined with acupuncture</i>		\$0 copay per Medicare-covered visit	
Podiatry	\$0 copay for Medicare-covered visit		\$25 copay for Medicare-covered visit	
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail
	Preferred Generic	\$0	\$0	\$0
	Generic	\$3	\$9	\$9
	Preferred Brand	\$40	\$120	\$120
	Non-Preferred Brand	\$100	\$300	\$300
	Specialty co-insurance	33%	N/A	N/A
	\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.			
Supplemental Benefits and Optional Plans	<b>Acupuncture:</b> <i>For those with Extra Help, \$0 co-pay for 12 visits per year, combined with chiropractic</i> <b>Enhanced Dental Option:</b> \$36/month for 0-50% coinsurance for certain diagnostic and comprehensive services; \$1,500 coverage limit per year <b>In-home Support Services:</b> \$0 copay for 12 hours per quarter OR \$300 annual caregiver reimbursement <b>Meals:</b> \$0 copay for up to 28 meals over 14 days for those with qualifying chronic conditions; <i>For those with Extra Help, up to 56 meals per year</i> <b>Over the Counter:</b> \$20 monthly allowance; <i>For those with Extra Help, additional \$80 per month</i> <b>Pet Services:</b> \$0 copay for 7 boarding days or 14 walks/year for those w/qualifying chronic conditions <b>Pest Control:</b> \$0 copay for 1 service per year for those with qualifying chronic conditions <b>Transportation:</b> \$0 copay for 12 one-way trips per year to plan approved locations within 20 miles <b>Wellness:</b> \$0 copay for basic gym membership at participating fitness centers			
Medical Groups and Hospitals (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland, Nivano IPA <b>Hospitals:</b> Alameda; Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)			
		<b>Medical Groups:</b> Brown & Toland, Nivano IPA <b>Hospitals:</b> Alameda; Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)		

# 2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs

Please contact the Plan for more information or call 1-800-Medicare	<b>Anthem Blue Cross</b> <b>800-619-6164 (Sales &amp; Marketing)</b> <b>833-707-3130 (Member Services)</b> <a href="http://www.anthem.com">www.anthem.com</a>			
Plan Name/Type	<b>Anthem Select HMO-POS (H0544-098)</b>		<b>Anthem Prime HMO-POS (H4161-005)</b>	
Star Rating	★★★		★★★	
Annual OOP Max	\$7,550		\$1,200	
Monthly Premium	\$0		\$0	
Doctor Visits	\$15 copay for Primary Care Physician; \$45 copay for Specialist		\$0 copay for Primary Care Physician; \$10 copay for Specialist	
Inpatient Hospital	\$315 copay/day for days 1-6; \$0 copay for days 7-90 and beyond		\$250 copay for days 1-5; \$0 copay/day for days 6-90 and beyond	
Outpatient Hospital	\$275 copay for ambulatory surgical center visit; \$315 copay for outpatient hospital facility visit		\$150 copay for ambulatory surgical center visit; \$250 for outpatient hospital facility visit	
Skilled Nursing Facility	\$0 copay for days 1-20; \$196 per day for days 21-100		\$0 copay/day for days 1-20; \$188 per day for days 21-100	
Ambulance	\$250 copay per ground ambulance trip; 20% coinsurance per air ambulance trip		\$250 copay per ground ambulance trip; 20% coinsurance per air ambulance trip	
Emergency & Urgent Care	\$90 copay for ER visit; waived if admitted to hospital within 24 hours; \$35 for urgent care visit; <b>Worldwide coverage: \$100,000 annual limit for emergency/urgent care with \$90 copays per visit</b>		\$90 copay for ER visit; waived if admitted to hospital within 24 hours; \$35 for urgent care visit; <b>Worldwide coverage: \$100,000 annual limit for emergency/urgent care with \$90 copays per visit</b>	
Lab Tests, Procedures, and Radiation Therapy	\$10 copay for lab services and x-rays; \$50-\$75 for diagnostic tests & procedures; \$10-\$150 for diagnostic radiology; 20% coinsurance for therapeutic radiology		\$10 copay for lab services and x-rays; \$25-\$50 for diagnostic tests & procedures; \$10-\$150 for diagnostic radiology; 20% coinsurance for therapeutic radiology	
Renal Dialysis	20% co-insurance per treatment		20% co-insurance per treatment	
Outpatient Mental Health Visits	\$40 copay per individual or group therapy session		\$10 copay per individual or group therapy session	
Eyewear	\$100 annual allowance for eyewear		\$100 annual allowance for eyewear	
Eye Exams	\$45 copay for diagnostic exam; \$0 copay for one annual routine exam		\$10 copay for diagnostic exam; \$0 copay for one annual routine exam	
Hearing Aids	\$3,000 annual allowance with \$0 copay		<b>Not Covered</b>	
Hearing Exams	\$45 copay for diagnostic exam; \$0 copay for one annual routine exam		\$10 copay for diagnostic exam; \$0 copay for one annual routine exam	
Dental	\$45 copay for Medicare covered visit; \$0 copay for 1 oral exam and 1 cleaning per year		\$10 copay for Medicare covered visit; \$0 copay for 1 oral exam and 1 cleaning per year	
Chiropractic	\$15 copay per Medicare-covered visit		\$20 copay per Medicare-covered visit	
Podiatry	\$0-45 copay for Medicare-covered visit; \$0 copay for 24 routine visits each year		\$0-10 copay for Medicare-covered visit; \$0 copay for unlimited routine visits each year	
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	90 days retail	90 days mail
	Preferred Generic	\$0	\$0	\$0
	Generic	\$0	\$0	\$0
	Preferred Brand	15%	15%	15%
	Non-Preferred Brand	30%	30%	30%
	Specialty co-insurance	33%	N/A	N/A
	\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.		\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.	
<b>Supplemental Benefits and Optional Plans</b>	<b>Acupuncture: \$0 co-pay/visit for 12 visits per year</b> <b>Over the Counter: \$25 quarterly allowance</b> <b>Wellness: \$0 for basic Silver Sneakers membership</b> <b>Optional supplemental packages:</b> <b>1: Preventive Dental at \$13 per month:</b> up to \$500/year; \$0 co-pays for basic preventive services <b>2: Dental &amp; Vision at \$33 per month:</b> up to \$1,000/year with \$0 copays for certain preventive services and 20-50% coinsurance for certain comprehensive services; \$150 annual reimbursement allowance for eyewear <b>3: Enhanced Dental &amp; Vision at \$51 per month:</b> up to \$2,000/year with \$0 copays for certain preventive services and 20-50% coinsurance for certain comprehensive services; \$200 annual reimbursement allowance for eyewear		<b>Over the Counter: \$20 quarterly allowance</b> <b>Wellness: \$0 for basic Silver Sneakers membership</b> <b>Optional supplemental packages:</b> <b>1: Preventive Dental at \$13 per month:</b> up to \$500/year; \$0 co-pays for basic preventive services <b>2: Dental &amp; Vision at \$33 per month:</b> dental services up to \$1,000/year with varying copays; \$150 annual reimbursement allowance for eyewear <b>3: Enhanced Dental &amp; Vision at \$51 per month:</b> dental services up to \$2,000/year with varying copays; \$200 annual reimbursement allowance for eyewear	
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland; Hill Physicians East Bay, Imperial Health Holdings <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), Washington (Fremont)		<b>Medical Groups:</b> Brown & Toland; Hill Physicians East Bay, Imperial Health Holdings, Nivano Physicians <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), Washington (Fremont)	

# 2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Blue Shield of CA</b> <b>888-534-4263 (Sales &amp; Marketing)</b> <b>800-776-4466 (Member Services)</b> <a href="http://www.blueshieldca.com/medicare">www.blueshieldca.com/medicare</a>	<b>United Health Care</b> <b>844-723-6473 (Sales and Marketing)</b> <b>866-261-7709 (Member Services)</b> <a href="http://www.aarpmedicareplans.com">www.aarpmedicareplans.com</a>
<b>Plan Name/Type</b>	<b>Blue Shield Inspire (HMO) (H0504-041)</b>	<b>AARP Medicare Advantage from UHC CA-7P HMO-POS (H0543-188)</b>
<b>Star Rating</b>	<b>★★★★1/2</b>	<b>★★★</b>
<b>Annual OOP Max</b>	<b>\$4,300</b>	<b>\$4,900</b>
<b>Monthly Premium</b>	<b>\$39</b>	<b>\$46</b>
<b>Doctor Visits</b>	<b>\$0</b> copay for Primary Care Physician; <b>\$15</b> for Specialist	<b>\$0</b> copay for Primary Care Physician; <b>\$25</b> for Specialist
<b>Inpatient Hospital</b>	<b>\$280</b> copay/day for days 1-5; <b>\$0</b> per day for days 6 and beyond	<b>\$425</b> copay/day for days 1-6; <b>\$0</b> for days 7 and beyond (unlimited)
<b>Outpatient Hospital</b>	<b>\$100</b> copay per ambulatory surgical center visit; <b>\$250</b> per outpatient hospital facility visit	<b>\$375</b> copay for ambulatory surgical center visit; <b>\$425</b> copay for outpatient hospital visit
<b>Skilled Nursing Facility</b>	<b>\$0</b> copay/day for days 1-20; <b>\$200</b> per day for days 21-100	<b>\$0</b> copay/day for days 1-20; <b>\$203</b> per day for days 21-100
<b>Ambulance</b>	<b>\$275</b> copay per trip by ground; <b>20%</b> co-insurance per trip by air	<b>\$290</b> copay per trip by ground or air
<b>Emergency &amp; Urgent Care</b>	<b>\$125</b> copay per emergency room visit; <b>\$15</b> per urgent care visit; <b>Worldwide coverage:</b> no annual limit with <b>\$120</b> copay per emergency or urgent care visit; waived if admitted to hospital within 24 hours	<b>\$125</b> copay per emergency room visit; waived if admitted to hospital within 24 hours; <b>\$55</b> per urgent care visit; <b>Worldwide coverage:</b> no annual limit with <b>\$0</b> copays for emergency/urgent care visits
<b>Lab Tests, Procedures, and Radiation Therapy</b>	<b>\$0</b> copay for lab, diagnostic tests and procedures, and x-rays; <b>\$75</b> copay for diagnostic radiology; <b>20%</b> co-insurance for therapeutic radiology	<b>\$0</b> copay for lab, diagnostic tests, and procedures; <b>\$25</b> copay per x-ray; <b>\$200</b> copay for diagnostic radiology; <b>20%</b> coinsurance for therapeutic radiology
<b>Renal Dialysis</b>	<b>20%</b> co-insurance per treatment	<b>20%</b> co-insurance per treatment
<b>Outpatient Mental Health Visits</b>	<b>\$30</b> copay for individual or group therapy session	<b>\$25</b> copay for individual therapy session; <b>\$15</b> copay for group therapy session
<b>Eyewear</b>	<b>\$195</b> annual allowance for eyewear; <b>\$195</b> allowance for frames every 2 years	<b>\$200</b> annual allowance for eyewear; through United Healthcare Vision network
<b>Eye Exams</b>	<b>\$15</b> copay for diagnostic exams; <b>\$0</b> copay for one annual routine exam	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam
<b>Hearing Aids</b>	<b>\$449 - \$699</b> copay per aid (depending on type); limited to 2 hearing aids per year	<b>\$99 - \$1,249</b> copay per aid; up to 2 aids each year; through United Healthcare Hearing network
<b>Hearing Exams</b>	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam
<b>Dental</b>	<b>\$15</b> copay for Medicare covered visit; <b>\$0</b> copay certain preventive services every six months and 1 full set of x-rays every two years	<b>\$0</b> copays for preventive services; any dental provider; See optional dental plan below
<b>Chiropractic</b>	<b>\$15</b> copay for Medicare-covered visit; <b>\$0</b> copay/visit for 12 routine visits per year	<b>\$15</b> copay for Medicare-covered visit; Routine care not covered
<b>Podiatry</b>	<b>\$15</b> copay per Medicare-covered visit; <b>\$15</b> copay/visit for unlimited routine visits per year	<b>\$25</b> copay per Medicare-covered visit; <b>\$25</b> copay/visit for 6 routine visits per year
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>
	30 days	100 days retail
	100 days mail	100 days mail
	Preferred Generic	<b>\$0</b>
	Generic	<b>\$5</b>
	Preferred Brand	<b>\$40</b>
	Non-Preferred Brand	<b>\$95</b>
	Specialty co-insurance	<b>33%</b>
	<b>\$0</b> deductible; <b>after total yearly drug costs reach \$2,000</b> , you pay <b>\$0</b> .	<b>\$340</b> deductible for Tiers 3, 4, and 5; <b>after total yearly drug costs reach \$2,000</b> , you pay <b>\$0</b> .
<b>Supplemental Benefits and Optional Plans</b>	<b>Over the Counter: \$55</b> quarterly allowance <b>Transportation: \$0</b> copay for 12 one-way trips per year to plan approved locations <b>Wellness: \$0</b> for basic Silver Sneakers membership <b>Optional Supplemental Plans:</b> <b>1: Dental HMO at \$16/month:</b> varying copays for certain preventive and comprehensive services; participating dentists only <b>2: Dental PPO at \$47/month:</b> <b>\$50</b> deductible; varying coinsurance for certain preventive and comprehensive services; <b>\$1,500</b> annual allowance for participating dentists; <b>\$1,000</b> for non-participating	<b>Optional Dental Plan at \$54/month:</b> <b>\$0</b> copays for certain preventive and comprehensive benefits; <b>50%</b> coinsurance for dentures and bridges; <b>\$1,500</b> annual allowance <b>Over the Counter: \$25</b> quarterly allowance for items in-store or online <b>Wellness: \$0</b> for Renew Active gym membership
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland, Hill Physicians East Bay <b>Hospitals:</b> Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oak), San Leandro, St. Rose, and Washington (Fremont)	<b>Medical Groups:</b> Canopy Health, Hill Physicians East Bay <b>Hospitals:</b> Alameda, Highland (Oakland), San Leandro, St. Rose (Hayward), Washington (Fremont)

**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Central Health Medicare Plan</b> <b>866-314-2427 (Sales &amp; Marketing)</b> <b>866-314-2427 (Member Services)</b> <a href="http://www.centralhealthplan.com">www.centralhealthplan.com</a>			
<b>Plan Name/Type</b>	<b>Central Health Premier Plan I (HMO) (H5649-023)</b>		<b>Central Health Classic Care Plan II (HMO) (H5649-028)</b>	
<b>Star Rating</b>	<b>★ ★ 1/2</b>		<b>★ ★ 1/2</b>	
<b>Annual OOP Max</b>	<b>\$2,999</b>		<b>\$2,499</b>	
<b>Monthly Premium</b>	<b>\$0</b>		<b>\$0</b>	
<b>Doctor Visits</b>	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist		<b>\$0</b> for Primary Care Physician; <b>\$10</b> for Specialist	
<b>Inpatient Hospital</b>	<b>\$0</b> copay for days 1-4; <b>\$100</b> copay/day for days 5-10; <b>\$0</b> copay for days 11-90		<b>\$150</b> copay/day for days 1-6; <b>\$0</b> copay for days 7-90	
<b>Outpatient Hospital</b>	<b>\$200</b> copay per ambulatory surgical center visit; <b>\$225</b> copay per outpatient hospital facility visit		<b>\$100</b> per ambulatory surgical center visit; <b>\$250</b> copay per outpatient hospital facility visit	
<b>Skilled Nursing Facility</b>	<b>\$0</b> copay for days 1-20; <b>\$204/day</b> for days 21-100		<b>\$0</b> copay for days 1-20; <b>\$204/day</b> for days 21-100	
<b>Ambulance</b>	<b>\$300</b> copay per one-way trip by ground; <b>20%</b> coinsurance per trip by air		<b>\$250</b> copay per one-way trip by ground; <b>20%</b> coinsurance per trip by air	
<b>Emergency &amp; Urgent Care</b>	<b>\$125</b> copay per emergency room visit; waived if admitted to hospital within 72 hours; <b>\$0</b> for urgent care; <b>Worldwide coverage: \$100,000</b> limit with <b>\$125</b> copays for ER/urgent care		<b>\$140</b> copay per emergency room visit; waived if admitted to hospital within 72 hours; <b>\$0</b> for urgent care; <b>Worldwide coverage: \$50,000</b> limit with <b>\$140</b> copays for ER and urgent care	
<b>Lab Tests, Procedures, and Radiation Therapy</b>	<b>\$0</b> copay for lab services, diagnostic tests & procedures, and x-rays; <b>\$150</b> for diagnostic radiology; <b>20%</b> co-insurance for therapeutic radiology		<b>\$0</b> copay for lab services, diagnostic tests & procedures, x-rays; <b>\$200</b> for diagnostic radiology; <b>20%</b> co-insurance for therapeutic radiology	
<b>Renal Dialysis</b>	<b>20%</b> co-insurance per treatment		<b>20%</b> co-insurance per treatment	
<b>Outpatient Mental Health Visits</b>	<b>\$40</b> copay per individual or group therapy session		<b>\$10</b> copay for individual session; <b>20%</b> coinsurance for group therapy session	
<b>Eyewear</b>	<b>\$300</b> annual allowance for eyewear		<b>\$300</b> annual allowance for eyewear	
<b>Eye Exams</b>	<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> copay for one annual routine exam	
<b>Hearing Aids</b>	<b>\$2,000</b> annual allowance though NationsHearing		<b>\$575 - \$2,099</b> copays for hearing aids, depending on model; up to 2 aids per year	
<b>Hearing Exams</b>	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam		<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam	
<b>Dental</b>	<b>\$0</b> copay for Medicare covered visit; <b>\$0-\$41</b> copays for certain preventive services; <b>\$0 - \$2,160</b> copays for certain comprehensive services		<b>\$0</b> copay for Medicare covered visit; <b>\$0</b> copay for certain preventive services; <b>\$0 - \$2,160</b> copays for certain comprehensive services	
<b>Chiropractic</b>	<b>\$0</b> copay per Medicare-covered visit		<b>\$0</b> copay per Medicare-covered visit; <b>\$0</b> per routine visit, up to 30 per year, combined with acupuncture	
<b>Podiatry</b>	<b>\$0</b> co-pay per Medicare-covered visit		<b>\$0</b> co-pay per Medicare-covered visit	
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	90 days	100 days mail
	Preferred Generic	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	Generic	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	Preferred Brand	<b>\$35</b>	<b>\$105</b>	<b>\$70</b>
	Non-Preferred Brand	<b>\$75</b>	<b>\$225</b>	<b>\$150</b>
	Specialty co-insurance	<b>31%</b>	<b>N/A</b>	<b>N/A</b>
	<b>\$100</b> deductible for Tiers 2-5; <b>after total yearly drug costs reach \$2,000, you pay \$0.</b>			
<b>Supplemental Benefits and Optional Plans</b>	<b>Acupuncture: \$0</b> co-pay for unlimited visits/year <b>Dental Plan Option: \$45/month</b> for certain preventive and comprehensive services with <b>10%</b> to <b>70%</b> coinsurance; <b>\$1,500</b> annual limit <b>Flex Allowance: \$96</b> quarterly allowance for OTC and herbal catalog items including OTC hearing aids & <b>\$20</b> monthly allowance for fitness fees <b>Groceries: \$50</b> monthly allowance for healthy foods for those with qualifying chronic conditions <b>In-Home Support Services: \$0</b> copay for up to 20 hours per year for qualifying members <b>Meals: \$0</b> copay/meal for 2 meals/day for 14 days for those with qualifying chronic conditions; up to 4 times/year <b>Transportation: \$0</b> co-pay for 12 one-way trips to plan approved locations within 50 miles <b>Wellness: \$0</b> for basic Silver Sneakers membership		<b>Acupuncture: \$0</b> co-pay for up to 30 visits/year, combined with chiropractic <b>Dental Plan Option: \$21/month</b> for certain preventive and comprehensive services with <b>10%</b> to <b>70%</b> coinsurance; <b>\$1,500</b> annual limit for non-network providers <b>Flex Allowance: \$129</b> quarterly allowance for OTC and herbal catalog items including OTC hearing aids & <b>\$60</b> monthly allowance for fitness fees <b>Groceries: \$50</b> monthly allowance for healthy foods for those with qualifying chronic conditions <b>Meals: \$0</b> copay/meal for 15 meals/weeks 6 weeks for those with qualifying chronic conditions; up to 30 additional meals with <b>\$5</b> copay per meal <b>Transportation: \$0</b> co-pay for 24 one-way trips to plan approved locations within 50 miles <b>Wellness: \$0</b> for basic Silver Sneakers membership	
	<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)		<b>Medical Groups:</b> Hill Physicians East Bay <b>Hospitals:</b> Eden (Castro Valley) and Washington (Fremont)	



**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for outline of coverage &amp; provider information or call 1-800-Medicare</i>	<b>Chinese Community Health Plan</b> <b>888-681-3888 (Sales and Marketing)</b> <b>888-775-7888 (Member Services)</b>									
Plan Name/Type	<b>CCHP Senior Program HMO (H0571-010)</b>				<b>CCHP Senior Value Program HMO (H0571-011)</b>					
Star Rating	★★1/2				★★1/2					
Annual OOP Max	\$3,000				\$3,500					
Monthly Premium	\$31				\$0					
Doctor Visits	\$0 copay for Primary Care Physician; \$0 for Specialist				\$0 copay for Primary Care Physician; \$15 for Specialist					
Inpatient Hospital	\$200 copay/day for days 1-7; \$0 for days 8-90				\$250 copay/day for days 1-7; \$0 for days 8-90					
Outpatient Hospital	\$300 copay for ambulatory surgical center visit; \$310 copay for outpatient hospital visit				\$300 copay for ambulatory surgical center visit; \$310 copay for outpatient hospital visit					
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$75 per day for days 21-100				\$0 copay/day for days 1-20; \$100 per day for days 21-100					
Emergency & Urgent Care	\$110 copay per emergency room visit; waived if admitted to hospital within 24 hours; \$20 per urgent care visit; <b>Worldwide coverage: \$25,000</b> limit with \$90 copays for ER/urgent care				\$125 copay per emergency room visit; waived if admitted to hospital within 24 hours; \$25 per urgent care visit; <b>Worldwide coverage: \$5,000</b> limit with \$90 copays for ER/urgent care					
Ambulance	\$180 copay per trip by ground or air				\$200 copay per trip by ground or air					
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic tests and procedures and x-rays; \$100 copay for diagnostic radiology; 20% coinsurance for therapeutic radiology				\$0 copay for lab, diagnostic tests and procedures and x-rays; \$150 copay for diagnostic radiology; 20% coinsurance for therapeutic radiology					
Renal Dialysis	20% co-insurance per treatment				20% co-insurance per treatment					
Outpatient Mental Health Visits	\$15 copay per individual or group therapy session				\$20 copay per individual or group therapy session					
Eyewear	\$0 copay with \$150 allowance every 2 years for eyewear; through VSP network provider				\$0 copay with \$100 allowance every 2 years for eyewear; through VSP network provider					
Eye Exams	\$20 copay for Medicare-covered exam; \$20 copay for one annual routine exam				\$35 copay for Medicare-covered exam; \$35 copay for one annual routine exam					
Hearing Aids	\$3,000 annual allowance though NationsHearing				\$3,000 annual allowance though NationsHearing					
Hearing Exams	\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam				\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam					
Dental	\$0 copays for certain preventive services; See Optional Dental plan below				\$0 copays for certain preventive services; See Optional Dental plan below					
Chiropractic	\$15 copay for Medicare-covered visit; Routine care not covered				\$15 copay for Medicare-covered visit; Routine care not covered					
Podiatry	\$15 copay per Medicare-covered visit; Routine care not covered				\$20 copay per Medicare-covered visit; Routine care not covered					
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>		30 days	90 days retail	90 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>		30 days	90 days retail	90 days mail
	Preferred Generic		\$3	\$9	\$6	Preferred Generic		\$0	\$0	\$0
	Generic		\$7	\$21	\$14	Generic		\$3	\$9	\$0
	Preferred Brand		\$30	\$90	\$60	Preferred Brand		\$35	\$105	\$70
	Non-Preferred Brand		\$50	\$150	\$100	Non-Preferred Brand		\$75	\$225	\$150
	Specialty co-insurance		30%	N/A	N/A	Specialty co-insurance		30%	N/A	N/A
	\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.					\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.				
Supplemental Benefits and Optional Plans	Dental Plan Option: \$18.50/month: varying copays for certain preventive and comprehensive services; through DeltaCare USA Dental HMO network Grocery Flex Card: \$20 monthly allowance for healthy foods; can be combined with OTC allowance Over the Counter: \$52 monthly allowance for plan-approved items from network retail location or Nations OTC catalog; can be combined with grocery flex card allowance Transportation: \$0 copay for 24 one-way trips to plan-approved locations				Acupuncture: \$10 copay for 15 routine visits/year Dental Plan Option: \$18.50/month: varying copays for certain preventive and comprehensive services; through DeltaCare USA Dental HMO network Over the Counter: \$65 monthly allowance for plan-approved items from network retail location or Nations OTC catalog Transportation: \$0 copay for 12 one-way trips to plan-approved locations					
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Hill Physicians East Bay, One Medical Hospitals: Alameda, Highland (Oakland), San Leandro				Medical Groups: Hill Physicians East Bay, One Medical Hospitals: Alameda, Highland (Oakland), San Leandro					

# 2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Imperial Health Plan of California</b> <b>800-838-8271 (Sales &amp; Marketing)</b> <b>800-838-8271 (Member Services)</b> <a href="http://www.imperialhealthplan.com">www.imperialhealthplan.com</a>							
<b>Plan Name/Type</b>	<b>Imperial Traditional HMO (H5496-007)</b>				<b>Imperial Giveback HMO (H5496-014)</b>			
<b>Star Rating</b>	★★★1/2				★★★1/2			
<b>Annual OOP Max</b>	<b>\$1,449</b>				<b>\$9,350</b>			
<b>Monthly Premium</b>	<b>\$0</b>				<b>\$0 / \$240 Deductible</b>			
<b>Doctor Visits</b>	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist				<b>20%</b> for Primary Care Physician; <b>20%</b> for Specialist			
<b>Inpatient Hospital</b>	<b>\$0</b> copay for days 1-3; <b>\$150</b> for days 4-5; <b>\$0</b> per day for days 6-90; <b>\$670</b> per day for days 91-150				<b>\$0</b> copay for days 1-60; <b>\$419</b> co-pay/day for days 61-90; <b>\$838</b> per day for days 91-150			
<b>Outpatient Hospital</b>	<b>\$100</b> per ambulatory surgical center visit; <b>\$100</b> copay per outpatient hospital facility visit				<b>20%</b> coinsurance per ambulatory surgical center visit; <b>20%</b> coinsurance per outpatient hospital facility visit			
<b>Skilled Nursing Facility</b>	<b>\$0</b> copay per day for days 1-20; <b>\$100/day</b> for days 21-50; <b>\$200/day</b> for days 51-100				<b>\$0</b> copay per day for days 1-20; <b>\$209.50/day</b> for days 21-100			
<b>Ambulance</b>	<b>\$150</b> copay per one-way trip by ground; <b>20%</b> coinsurance per each trip by air				<b>20%</b> coinsurance per one-way trip by ground; <b>20%</b> coinsurance per each trip by air			
<b>Emergency &amp; Urgent Care</b>	<b>\$125</b> copay per emergency room visit; waived if admitted to hospital within 48 hours; <b>\$0</b> copay for urgent care; <b>Worldwide coverage: \$100,000</b> limit with <b>\$0</b> copay for ER and <b>\$10</b> for urgent care				<b>20%</b> coinsurance, up to <b>\$110</b> per emergency room visit; <b>20%</b> coinsurance up to <b>\$45</b> per urgent care visit; Costs waived if admitted to hospital within 72 hours			
<b>Lab Tests, Procedures, and Radiation Therapy</b>	<b>\$0</b> copay for lab, diagnostic tests and procedures, x-rays, and diagnostic radiology; <b>20%</b> coinsurance for therapeutic radiology				<b>20%</b> coinsurance for lab services, diagnostic tests & procedures, x-rays, diagnostic radiology, and therapeutic radiology			
<b>Renal Dialysis</b>	<b>20%</b> coinsurance per treatment				<b>20%</b> coinsurance per treatment			
<b>Outpatient Mental Health Visits</b>	<b>20%</b> coinsurance per individual or group therapy session				<b>20%</b> coinsurance per individual or group therapy session			
<b>Eyewear</b>	<b>\$500</b> annual allowance for eyewear				<b>\$240</b> annual allowance for eyewear			
<b>Eye Exams</b>	<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> copay for routine exams				<b>20%</b> coinsurance per Medicare-covered exam; <b>\$0</b> copay for one annual routine exam			
<b>Hearing Aids</b>	<b>\$500</b> annual allowance <b>\$0</b> copay				<b>\$500</b> annual allowance <b>\$0</b> copay			
<b>Hearing Exams</b>	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for routine exams; <b>\$250/year</b> limit				<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for exams; <b>\$250/year</b> limit			
<b>Dental</b>	<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for preventive services up to <b>\$500/year</b> ; <b>\$0</b> co-pay for certain comprehensive services up to <b>\$3,000/year</b> ; must use Imperial Traditional contracted provider				<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for preventive services up to <b>\$500/year</b> ; <b>\$0</b> co-pay for certain comprehensive services up to <b>\$2,000/year</b> ; must use Imperial Giveback contracted provider			
<b>Chiropractic</b>	<b>\$0</b> copay per Medicare-covered visit; Routine care not covered				<b>20%</b> co-insurance per Medicare-covered visit; Routine care not covered			
<b>Podiatry</b>	<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for 6 routine visits per year				<b>20%</b> coinsurance per Medicare-covered visit			
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days	100 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days	100 days mail
	Preferred Generic	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	Preferred Generic	<b>25%</b>	<b>25%</b>	<b>25%</b>
	Generic	<b>\$10</b>	<b>\$30</b>	<b>\$10</b>	Generic	<b>25%</b>	<b>25%</b>	<b>25%</b>
	Preferred Brand	<b>\$45</b>	<b>\$135</b>	<b>\$90</b>	Preferred Brand	<b>25%</b>	<b>25%</b>	<b>25%</b>
	Non-Preferred Brand	<b>\$90</b>	<b>\$270</b>	<b>\$180</b>	Non-Preferred Brand	<b>25%</b>	<b>25%</b>	<b>25%</b>
	Specialty co-insurance	<b>33%</b>	<b>N/A</b>	<b>N/A</b>	Specialty co-insurance	<b>25%</b>	<b>25%</b>	<b>25%</b>
	<b>\$0</b> deductible; after total yearly drug costs reach <b>\$2,000</b> , you pay <b>\$0</b> .				<b>\$590</b> deductible; after total yearly drug costs reach <b>\$2,000</b> , you pay <b>\$0</b> .			
<b>Supplemental Benefits and Optional Plans</b>	<b>In-home Support Services:</b> <b>\$0</b> copay for up to 48 hours per year <b>Meals:</b> <b>\$0</b> copay for up to 7 home-delivered meals following a surgery or hospital stay; up to <b>\$105</b> per benefit period <b>Over the Counter:</b> <b>\$95</b> quarterly allowance for items in OTC mail order catalogue; no rollover <b>Transportation:</b> <b>\$0</b> co-pay for 100 one-way trips per year to plan approved locations <b>Wellness:</b> <b>\$0</b> for one home fitness kit per year through Silver&Fit program				<b>In-home Support Services:</b> <b>\$0</b> copay for up to 48 hours per year <b>Over the Counter:</b> <b>\$75</b> quarterly allowance for items in OTC mail order catalogue; no rollover <b>Part B Premium Reduction:</b> <b>\$100</b> monthly reimbursement			
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), San Leandro, and St. Rose (Hayward)				<b>Medical Groups:</b> Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), San Leandro, and St. Rose (Hayward)			

**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Imperial Health Plan of California</b> <b>800-838-8271 (Sales &amp; Marketing)</b> <b>800-838-8271 (Member Services)</b> <a href="http://www.imperialhealthplan.com">www.imperialhealthplan.com</a>				
<b>Plan Name/Type</b>	<b>Imperial Dynamic HMO (H5496-012)</b>			<b>Imperial Courage HMO (H5496-016)</b>	
<b>Star Rating</b>	<b>★★★1/2</b>			<b>★★★1/2</b>	
<b>Annual OOP Max</b>	<b>\$297</b>			<b>\$2,999</b>	
<b>Monthly Premium</b>	<b>\$0</b>			<b>\$0</b>	
<b>Doctor Visits</b>	<b>\$0</b> copay for Primary Care Physician; <b>\$0</b> for Specialist			<b>\$0</b> copay for Primary Care Physician; <b>\$5</b> for Specialist	
<b>Inpatient Hospital</b>	<b>\$0</b> copay for days 1-90; <b>\$670</b> per day for days 91-150			<b>\$150</b> copay for days 1-5; <b>\$0</b> co-pay/day for days 61-90; <b>\$670</b> per day for days 91-150	
<b>Outpatient Hospital</b>	<b>\$100</b> per ambulatory surgical center visit; <b>\$100</b> copay per outpatient hospital facility visit			<b>\$200</b> per ambulatory surgical center visit; <b>\$200</b> copay per outpatient hospital facility visit	
<b>Skilled Nursing Facility</b>	<b>\$0</b> copay per day for days 1-20; <b>\$100/day</b> for days 21-50; <b>\$200/day</b> for days 51-100			<b>\$0</b> copay per day for days 1-20; <b>\$200/day</b> for days 21-100	
<b>Ambulance</b>	<b>\$150</b> copay per one-way trip by ground; <b>20%</b> coinsurance per each trip by air			<b>\$150</b> copay per one-way trip by ground; <b>20%</b> coinsurance per each trip by air	
<b>Emergency &amp; Urgent Care</b>	<b>\$125</b> per emergency room visit; copay waived if admitted to hospital within 48 hours; <b>\$0</b> copay for urgent care; <b>Worldwide coverage: \$100,000</b> limit with <b>\$0</b> copays for emergency and urgent care			<b>\$125</b> copay per emergency room visit; waived if admitted to hospital within 48 hours; <b>\$0</b> copay for urgent care; <b>Worldwide coverage: \$50,000</b> limit with <b>\$0</b> copay for emergency and <b>\$20</b> for urgent care	
<b>Lab Tests, Procedures, and Radiation Therapy</b>	<b>\$0</b> copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; <b>20%</b> co-insurance for therapeutic radiology			<b>\$0</b> copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; <b>20%</b> co-insurance for therapeutic radiology	
<b>Renal Dialysis</b>	<b>20%</b> co-insurance per treatment			<b>20%</b> co-insurance per treatment	
<b>Outpatient Mental Health Visits</b>	<b>20%</b> coinsurance per individual or group therapy session			<b>20%</b> coinsurance per individual or group therapy session	
<b>Eyewear</b>	<b>\$500</b> annual allowance for eyewear			<b>\$250</b> annual allowance for eyewear	
<b>Eye Exams</b>	<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> copay for routine exams			<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> copay for routine exams	
<b>Hearing Aids</b>	<b>\$500</b> annual allowance <b>\$0</b> copay			<b>\$500</b> annual allowance <b>\$0</b> copay	
<b>Hearing Exams</b>	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for routine exams up to <b>\$250/year</b>			<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for routine exams up to <b>\$250/year</b>	
<b>Dental</b>	<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for preventive services up to <b>\$500/year</b> ; <b>\$0</b> co-pay for certain comprehensive services up to <b>\$4,000/year</b> ; must use Imperial Dynamic contracted provider			<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for preventive services up to <b>\$500/year</b> ; <b>\$0</b> co-pay for certain comprehensive services up to <b>\$1,500/year</b> ; must use Imperial Courage contracted provider	
<b>Chiropractic</b>	<b>\$0</b> copay per Medicare-covered visit; Routine visits not covered			<b>\$0</b> copay per Medicare-covered visit; Routine visits not covered	
<b>Podiatry</b>	<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for 6 routine visits per year			<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for 6 routine visits per year	
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days	100 days mail	<b>THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.</b>  <b>YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.</b>
	Preferred Generic	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	
	Generic	<b>\$6</b>	<b>\$18</b>	<b>\$5</b>	
	Preferred Brand	<b>\$45</b>	<b>\$135</b>	<b>\$90</b>	
	Non-Preferred Brand	<b>\$90</b>	<b>\$270</b>	<b>\$180</b>	
	Specialty co-insurance	<b>33%</b>	<b>N/A</b>	<b>N/A</b>	
<b>Supplemental Benefits and Optional Plans</b>	<b>\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.</b>				
	<b>In-home Support Services:</b> <b>\$0</b> copay for up to 48 hours per year <b>Meals:</b> <b>\$0</b> copay for up to 7 home-delivered meals following a surgery or hospital stay, up to <b>\$105</b> per benefit period <b>Over the Counter:</b> <b>\$140</b> quarterly allowance for items in OTC mail order catalogue; no rollover <b>Part B Premium Reduction:</b> <b>\$60</b> monthly reimburs <b>Transportation:</b> <b>\$0</b> co-pay for 100 one-way trips per year to plan approved locations <b>Wellness:</b> <b>\$0</b> for one home fitness kit per year through Silver&Fit program			<b>Meals:</b> <b>\$0</b> copay for up to 7 home-delivered meals following a surgery or hospital stay; up to <b>\$105</b> per benefit period <b>Over the Counter:</b> <b>\$75</b> quarterly allowance for items in OTC mail order catalogue; no rollover <b>Part B Premium Reduction:</b> <b>\$75</b> monthly reimbursement <b>Transportation:</b> <b>\$0</b> co-pay for 100 one-way trips per year to plan approved locations <b>Wellness:</b> <b>\$0</b> for one home fitness kit per year through Silver&Fit program	
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), San Leandro, and St. Rose (Hayward)			<b>Medical Groups:</b> Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), San Leandro, and St. Rose (Hayward)	

# 2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Kaiser Permanente</b> <b>800-777-1238 (Sales &amp; Marketing)</b> <b>800-443-0815 (Member Services)</b> <a href="http://www.medicare.kaiserpermanente.org">www.medicare.kaiserpermanente.org</a>							
Plan Name/Type	<b>Kaiser Permanente Senior Advantage Basic Alameda HMO (H0524-059)</b>				<b>Kaiser Permanente Senior Advantage HMO (H0524-032)</b>			
Star Rating	★★★★1/2				★★★★1/2			
Annual OOP Max	<b>\$6,000</b>				<b>\$3,400</b>			
Monthly Premium	<b>\$0</b>				<b>\$70</b>			
Doctor Visits	\$5 copay for Primary Care Physician; \$10 for Specialist				\$0 copay for Primary Care Physician; \$5 for Specialist			
Inpatient Hospital	\$260 copay/day for days 1-5; \$0 per day for days 6 and beyond				\$225 copay/day for days 1-5; \$0 per day for days 6 and beyond			
Outpatient Hospital	\$225 per ambulatory surgical center visit; \$0-\$225 copay per outpatient hospital facility visit				\$190 per ambulatory surgical center visit; \$0-\$190 copay per outpatient hospital facility visit			
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$100 per day for days 21-100				\$0 copay/day for days 1-20; \$100 per day for days 21-100			
Ambulance	\$250 copay per air or ground ambulance trip				\$250 copay per air or ground ambulance trip			
Emergency & Urgent Care	\$125 for emergency room visit; \$5 for urgent care visit; Worldwide coverage: no limit with \$140 copay for emergency care visit and \$125 for urgent care				\$140 for emergency room visit; \$0 for urgent care visit; Worldwide coverage: no limit with \$140 copay for emergency care visit and \$0 for urgent care			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic tests & procedures, and x-rays; \$200 copay for diagnostic radiology; \$0 for therapeutic radiology				\$0 copay for lab, diagnostic tests, procedures, and x-rays; \$200 copay for diagnostic radiology; \$0 for therapeutic radiology			
Renal Dialysis	20% co-insurance per treatment				20% co-insurance per treatment			
Outpatient Mental Health Visits	\$2 copay per individual session; \$5 per group therapy session				\$0 copay per individual session; \$0 per group therapy session			
Eyewear	<b>Not covered;</b> See Optional Advantage Plus Plan below				<b>Not covered;</b> See Optional Advantage Plus Plan below			
Eye Exams	\$5-\$10 copay per Medicare-covered exam; \$5 per routine exam				\$0-\$5 copay per Medicare-covered exam; \$0 per routine exam			
Hearing Aids	<b>Not covered;</b> See Optional Advantage Plus Plan below				<b>Not covered;</b> See Optional Advantage Plus Plan below			
Hearing Exams	\$10 copay per Medicare-covered exam				\$5 copay per Medicare-covered exam			
Dental	\$10 co-pay per Medicare-covered visit; \$0 copay for certain preventive & diagnostic services; See Optional Advantage Plus Plan below				\$5 co-pay per Medicare-covered visit; \$0 copay for certain preventive & diagnostic services; See Optional Advantage Plus Plan below			
Chiropractic	\$5 copay per Medicare covered visit; Routine visits not covered				\$0 copay per Medicare covered visit; Routine visits not covered			
Podiatry	\$10 copay per Medicare covered visit; Routine visits not covered				\$5 copay per Medicare covered visit; Routine visits not covered			
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 day retail	100 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail
	Preferred Generic	\$4	\$12	\$8	Preferred Generic	\$0	\$0	\$0
	Generic	\$10	\$30	\$20	Generic	\$7	\$21	\$14
	Preferred Brand	\$47	\$141	\$94	Preferred Brand	\$47	\$141	\$94
	Non-Preferred Brand	\$100	\$300	\$200	Non-Preferred Brand	\$100	\$300	\$200
	Specialty co-insurance	33%	33%	33%	Specialty co-insurance	33%	33%	33%
	\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.				\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.			
Supplemental Benefits and Optional Plans	<b>Home Medical Care:</b> home treatment plan as an alternative to hospital care and post-acute services, when found medically appropriate by physician <b>Medical Financial Assistance Program:</b> available to eligible members; contact plan for details <b>Over the Counter:</b> \$60 quarterly allowance for items from OTC catalogue; \$25 minimum order; no rollover <b>Optional Advantage Plus Plan:</b> \$21/month: <b>-Dental:</b> Copays vary depending upon the service; Must use Delta Care USA HMO network <b>-Hearing Aids:</b> \$800 allowance per ear every 36 months; \$0 copay for evaluation and fitting <b>-Vision:</b> \$300 allowance for eyewear every two years <b>-Wellness:</b> \$0 for One Pass gym membership and/or one annual at home fitness kit				<b>Medical Financial Assistance Program:</b> available to eligible members; contact plan for details <b>Over the Counter:</b> \$60 quarterly allowance for items from OTC catalogue; \$25 minimum order; no rollover <b>Optional Advantage Plus Plan:</b> \$21/month: <b>-Dental:</b> Copays vary depending upon the service; Must use Delta Care USA HMO network <b>-Hearing Aids:</b> \$800 allowance per ear every 36 months; \$0 copay for evaluation and fitting <b>-Vision:</b> \$300 allowance for eyewear every two years <b>-Wellness:</b> \$0 for One Pass gym membership and/or one annual at home fitness kit			
Medical Groups and Hospitals (may not be full list; please check with plan)	<b>Medical Groups:</b> Kaiser Permanente <b>Hospitals:</b> Kaiser Oakland, San Leandro, Fremont				<b>Medical Groups:</b> Kaiser Permanente <b>Hospitals:</b> Kaiser Oakland, San Leandro, Fremont			



**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>SCAN Health Plan</b> <b>877-870-4867 (Sales &amp; Marketing)</b> <b>800-559-3500 (Member Services)</b> <a href="http://www.scanhealthplan.com">www.scanhealthplan.com</a>							
<b>Plan Name/Type</b>	<b>SCAN Classic HMO (H05425-075)</b>				<b>SCAN MyChoice HMO (H05425-110)</b>			
<b>Star Rating</b>	★★★★1/2				★★★★1/2			
<b>Annual OOP Max</b>	<b>\$1,500</b>				<b>\$1,500</b>			
<b>Monthly Premium</b>	<b>\$0</b>				<b>\$0</b>			
<b>Doctor Visits</b>	\$0 copay for Primary Care Physician; \$0 for Specialist				\$0 copay for Primary Care Physician; \$0 for Specialist			
<b>Inpatient Hospital</b>	\$100 copay/day for days 1-5; \$0 per day for days 6 and beyond				\$100 copay/day for days 1-5; \$0 per day for days 6 and beyond			
<b>Outpatient Hospital</b>	\$0 per ambulatory surgical center visit; \$0-\$125 copay per outpatient hospital facility visit				\$0 per ambulatory surgical center visit; \$0-\$125 copay per outpatient hospital facility visit			
<b>Skilled Nursing Facility</b>	\$0 copay/day for days 1-20; \$75 per day for days 21-100				\$0 copay/day for days 1-20; \$75 per day for days 21-100			
<b>Ambulance</b>	<b>\$180</b> copay per one-way trip by ground or air				<b>\$105</b> copay per one-way trip by ground or air			
<b>Emergency &amp; Urgent Care</b>	\$90 copay per ER visit; waived if immediately admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no limit with \$90 copay for emergency care visit and \$0 for urgent care				\$90 copay per ER visit; waived if immediately admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no limit with \$90 copay for emergency care visit and \$0 for urgent care			
<b>Lab Tests, Procedures, and Radiation Therapy</b>	\$0 copay for lab, diagnostic procedures, tests, x-rays and diagnostic radiology; \$60 copay for therapeutic radiology				\$0 copay for lab, diagnostic procedures, tests, x-rays and diagnostic radiology; \$60 copay for therapeutic radiology			
<b>Renal Dialysis</b>	<b>20%</b> co-insurance per treatment				<b>20%</b> co-insurance per treatment			
<b>Outpatient Mental Health Visits</b>	\$10 copay for individual or group therapy session				\$10 copay for individual or group therapy session			
<b>Eyewear</b>	<b>\$200</b> annual allowance for eyewear				<b>\$200</b> annual allowance for eyewear			
<b>Eye Exams</b>	\$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			
<b>Hearing Aids</b>	\$550-\$850 copay per aid; up to 2 aids each year; through TruHearing network provider				\$550-\$850 copay per aid; up to 2 aids each year; through TruHearing network provider			
<b>Hearing Exams</b>	\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam				\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam			
<b>Dental</b>	\$0 co-pay per Medicare-covered visit; \$0 co-pay for certain preventive and diagnostic services; See Optional Dental Plan below				\$0 co-pay per Medicare-covered visit; \$0 co-pay for certain preventive and diagnostic services; <b>\$2,000</b> annual limit			
<b>Chiropractic</b>	\$0 copay per Medicare covered visit; \$0 copay for 30 routine visits per year				\$0 copay per Medicare covered visit; \$5 copay for 30 routine visits per year, combined with chiropractic			
<b>Podiatry</b>	\$0 copay per Medicare-covered visit				\$0 copay per Medicare-covered visit			
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>				<i>Cost-sharing shown is for preferred pharmacies</i>			
		30 days	100 days retail	100 days mail		30 days	100 days retail	100 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$0	\$0	\$0	Generic	\$0	\$0	\$0
	Preferred Brand	\$42	\$126	\$126	Preferred Brand	\$35	\$126	\$126
	Non-Preferred Brand	50%	50%	50%	Non-Preferred Brand	50%	50%	50%
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A
	<b>\$0</b> deductible; <b>after total yearly drug costs reach \$2,000</b> , you pay <b>\$0</b> .				<b>\$0</b> deductible; <b>after total yearly drug costs reach \$2,000</b> , you pay <b>\$0</b> .			
<b>Supplemental Benefits and Optional Plans</b>	<b>Acupuncture:</b> \$0 copay per visit for 36 routine visits per year <b>Essential Dental Plan:</b> \$10/month; varying copays for certain diagnostic and comprehensive services <b>In-Home Support Services:</b> 40 hours for personal care following a hospitalization <b>Meals:</b> up to 84 home-delivered meals per year following a hospital stay or due to a chronic condition <b>Over the Counter:</b> \$75 quarterly allowance items in-store at CVS or home delivery; balance carries over to next quarter but not calendar year <b>Transportation:</b> \$0 copay for 24 one-way trips per year to plan-approved locations within 50 miles				<b>Acupuncture:</b> \$0 copay per visit for 30 routine visits per year, combined with chiropractic <b>In-Home Support Services:</b> 40 hours for personal care following a hospitalization <b>Meals:</b> up to 84 home-delivered meals per year following a hospital stay or due to a chronic condition <b>Over the Counter:</b> \$75 quarterly allowance items in-store at CVS or home delivery; balance carries over to next quarter but not calendar year			
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland, Imperial Health Holdings, SCAN Direct Contract <b>Hospitals:</b> Alameda, Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleasanton)				<b>Medical Groups:</b> Brown & Toland, Imperial Health Holdings, SCAN Direct Contract <b>Hospitals:</b> Alameda, Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleasanton)			

## 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 (\$257 in 2025). Medicare Advantage plans also cannot charge cost sharing (meaning no deductible, no copayment or coinsurance) for most in-network preventive benefits. These preventive benefits available at no cost include:

- Abdominal Aortic Aneurysm Screening: one per lifetime
- Alcohol Misuse Screening and Counseling: one screening per year and up to 4 counseling sessions per year
- Annual Wellness Visit: one per year
- Bone Mass Measurement: one every 2 years
- Breast Cancer Screening: one per year
- Cardiovascular (Heart Disease) Screening and Therapy: one screening every 5 years and one counseling session (with primary care physician) per year
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam): one every 2 years or one a year if at high risk
- Colorectal Cancer Screening: frequency varies by type of test
- COVID 19 Vaccine and Boosters
- Depression Screening: one per year
- Diabetes Screening: 2 per year if at risk
- Flu Shot: one per year
- Hepatitis B Shots: as needed depending on health status
- HIV Screening: one per year
- Medical Nutrition Therapy: as needed depending on health status
- Obesity Screening & Counseling: one screening/year and up to 22 counseling sessions/year
- Pneumococcal Shots: one per lifetime
- Prostate Cancer Screening: one per year for age 50 and over
- RSV (Respiratory Syncytial Virus) Vaccine: one per year
- Sexually Transmitted infections (STI) Screening & Counseling: one screening per year and 2 counseling sessions (with primary care physician) per year
- Shingles Vaccine
- Tobacco-use Cessation Counseling (if not diagnosed with related illness): up to 8 sessions per year
- "Welcome to Medicare" Exam: one in the year following enrollment into Part B

The following preventive benefits are subject to cost-sharing under Original Medicare (the Part B deductible and 20% co-insurance). Medicare Advantage plans may charge for these services:

- Barium Enema Screening: one every 4 years for age 50 and over
- Diabetes Self-Management Training Services: as ordered by doctor
- Glaucoma Screening: one per year if at high risk
- Prostate Cancer Screening (digital rectal exam): one per year for age 50 and over
- Tobacco-use Cessation Counseling (if diagnosed with related illness): up to 8 sessions per year

For more information on preventive care coverage, you can refer to the Medicare and You 2024 Handbook. Call 1-800-Medicare to request a copy or visit: [www.medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you).

## Star Ratings

This summary rating gives an overall score of the Medicare Advantage plan's quality and performance on up to 46 unique quality and performance factors that fall into 5 categories:

- Staying healthy: screenings, tests, and vaccines. Includes whether members got various screening tests, vaccines, and other check-ups that help them stay healthy.
- Managing chronic (long-term) conditions. Includes how often members with different conditions got certain tests and treatments that help manage their condition.
- Member experience with the health plan. Includes ratings of member satisfaction with the plan.
- Member complaints and changes in the health plan's performance: Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- Health plan customer service. Includes how well the plan handles member appeals.

This information is gathered from several different sources. In some cases it is based on member surveys, information from clinicians, or information from plans. In other cases, it is based on results from Medicare's regular monitoring activities. Detailed information is available here:

<https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings>

# 2025 Medicare Advantage Plan HMO Comparison Chart ~FINAL~ for Alameda County

~Rev. 11/13/24 ~

Medicare Advantage Plans contract with the Centers for Medicare and Medicaid Services (CMS) to provide all the benefits covered by Medicare and some additional benefits. In exchange, CMS (Medicare) pays the plan a fixed fee per member, per month. This amount varies by region and is also adjusted for the individual member's age, gender and health condition. **To enroll in a Medicare Advantage plan, a person must have both Medicare Parts A & B. The person must also live within the plan's service area.** Medicare Advantage plans must accept anybody on Medicare, including those who are under age 65 on Medicare through disability, regardless of their health condition.

**Medicare HMOs are one type of Medicare Advantage (MA) plan.** When joining a Medicare HMO, beneficiaries do not give up their Medicare coverage; rather they agree to receive it through the plan's network of providers. A member must choose a Primary Care Physician and receive referrals to see specialists. The HMO will normally *not* pay for services received outside the plan's network unless it is urgent or emergency care. In those circumstances, members should notify their plans as soon as possible. *However, if the HMO also has a Point of Service (POS) option, members can go out of network only for certain plan-specified services but will pay higher out of pocket costs for those services.* The cost-sharing varies from plan to plan. Premiums, co-payments, and extra benefits can differ. The Annual Out of Pocket Maximum listed for each plan applies to all cost-sharing *except* plan premiums and prescription drug co-pays. In 2025, there are 24 Medicare HMOs in Alameda County, and they are listed on pages 2-13 of this chart. One of these does not include the Medicare Part D prescription drug benefit. When people join an HMO *without* drug coverage, they opt out of Part D. Enrolling in a stand-alone Part D plan will automatically trigger disenrollment from the Medicare Advantage Plan.

**A Medicare PPO is another type of Medicare Advantage (MA) plan.** A PPO allows members to seek care outside of the plan's network of providers, however higher out-of-pocket expenses such as deductibles and co-insurance will apply. In 2025, there are 4 Medicare PPOs in Alameda County. See our 2025 PPO Comparison Chart for more information and details: [www.lashicap.org/hicap](http://www.lashicap.org/hicap).

**Medicare Special Needs Plans are another type of Medicare Advantage plan.** They are designed for people on Medicare and Medi-Cal (duals), those with certain chronic conditions, or those who reside in nursing homes. They all must include Part D prescription drug coverage and they have a responsibility to coordinate benefits and care for their members. In 2025, there are 19 Special Needs Plans in Alameda County. See our **2025 Special Needs Plan Comparison Chart** for more information and details: [www.lashicap.org/hicap](http://www.lashicap.org/hicap).

## Enrollment:

In the fall of 2024, 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, 2025.** In 2025, 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.

**IMPORTANT NOTE:** In 2025, Medicare Part D out of pocket costs for covered medications under one's plan are capped at \$2,000. Also, plans cannot charge more than a \$35 copay per month for insulin and any drug deductibles do not apply to insulin.

## ABOUT THIS CHART

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

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

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



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Navigating Medicare

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**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Aetna Medicare</b> <b>833-859-6031 (Sales &amp; Marketing)</b> <b>833-570-6670 (Member Services)</b> <a href="http://www.aetnamedicare.com">www.aetnamedicare.com</a>							
<b>Plan Name/Type</b>	<b>Aetna Medicare Select HMO-POS (H0523-070)</b>				<b>Aetna Medicare Plus HMO-POS (H4982-007)</b>			
<b>Star Rating</b>	★ ★ ★				★★1/2			
<b>Annual OOP Max</b>	<b>\$2,500</b>				<b>\$3,400</b>			
<b>Monthly Premium</b>	<b>\$0</b>				<b>\$0</b>			
<b>Doctor Visits</b>	\$0 copay for Primary Care Physician; \$0 for Specialist				\$0 copay for Primary Care Physician; \$0 for Specialist			
<b>Inpatient Hospital</b>	\$245 copay/day for days 1-5; \$0 per day for days 6 and beyond				\$150 copay/day for days 1-5; \$0 per day for days 6 and beyond			
<b>Outpatient Hospital</b>	\$0 copay for ambulatory surgical center visit; \$125 copay for outpatient hospital facility visit				\$0 copay for ambulatory surgical center visit; \$125 copay for outpatient hospital facility visit			
<b>Skilled Nursing Facility</b>	\$0 copay/day for days 1-20; \$75 per day for days 21-100				\$0 copay/day for days 1-20; \$75 per day for days 21-100			
<b>Ambulance</b>	\$295 copay per ground or air ambulance trip				\$325 copay per ground trip; 20% per trip by air			
<b>Emergency &amp; Urgent Care</b>	\$140 copay per emergency room visit; waived if admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no annual limit; \$140 copay per ER/urgent care visit; ER copay waived if admitted to hospital; urgent care copays not waived				\$140 copay per emergency room visit; waived if admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no annual limit; \$140 copay per ER/urgent care visit; ER copay waived if admitted to hospital; urgent care copays not waived			
<b>Lab Tests, Procedures, and Radiation Therapy</b>	\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$0 copay for diagnostic radiology; \$60 copay for therapeutic radiology				\$0 copay for lab services, diagnostic tests, procedures, x-rays and diagnostic radiology; \$60 copay for therapeutic radiology			
<b>Renal Dialysis</b>	20% co-insurance per treatment				20% co-insurance per treatment			
<b>Outpatient Mental Health Visits</b>	\$40 copay per individual or group therapy session				\$0 copay per individual or group therapy session			
<b>Eyewear</b>	\$275 annual allowance for eyewear				<b>Not Covered</b>			
<b>Eye Exams</b>	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam				\$0 copay for diagnostic exam; \$0 copay for one annual routine exam			
<b>Hearing Aids</b>	\$1,250 annual hearing aid allowance per ear; purchased through NationsHearing network				\$2,000 annual hearing aid allowance per ear; purchased through NationsHearing network			
<b>Hearing Exams</b>	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam through NationsHearing network				\$0 copay for diagnostic exam; \$0 copay for one annual routine exam through NationsHearing network			
<b>Dental</b>	\$1,000 annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider				\$1,100 annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider			
<b>Chiropractic</b>	\$0 copay for Medicare covered visits; \$0 copay for unlimited routine visits; through American Specialty Health provider				\$0 copay for Medicare covered visits; \$0 copay for unlimited routine visits; through American Specialty Health provider			
<b>Podiatry</b>	\$0 copay per Medicare-covered visit				\$0 copay per Medicare-covered visit			
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 day retail	100 day mail
	Preferred Generic	\$0	\$0	\$6	Preferred Generic	\$0	\$0	\$0
	Generic	\$5	\$15	\$36	Generic	\$0	\$0	\$0
	Preferred Brand	25%	25%	25%	Preferred Brand	24%	24%	24%
	Non-Preferred Brand	35%	35%	35%	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 \$2,000, you pay \$0.				\$590 deductible applies to Tiers 3, 4, and 5; after total yearly drug costs reach \$2,000, you pay \$0.			
<b>Supplemental Benefits and Optional Plans</b>	<b>Acupuncture:</b> \$0 copay for unlimited acupuncture treatments with American Specialty Health provider <b>Over the Counter:</b> \$75 quarterly allowance for plan-approved items <b>Transportation:</b> \$0 copay for 12 one-way trips per year (up to 60 miles each trip) to plan approved locations, via Access2Care <b>Wellness:</b> \$0 copay for basic Silver Sneakers membership or one home fitness kit per year; \$150 per quarter Direct Member reimbursement allowance for various fitness activities and supplies				<b>Acupuncture:</b> \$0 copay for unlimited acupuncture treatments with American Specialty Health <b>Transportation:</b> \$0 copay for 12 one-way trips per year (up to 60 miles each trip) to plan approved locations, via Access2Care <b>Wellness:</b> \$0 copay for basic Silver Sneakers membership or one home fitness kit per year			
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown and Toland; One Medical; <b>Hospitals:</b> Alameda, Highland (Oak), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleasant/Liv), and Washington Hospital (Fremont)				<b>Medical Groups:</b> Brown and Toland; One Medical; <b>Hospitals:</b> Alameda, Highland (Oak), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleasant/Liv), and Washington Hospital (Fremont)			



**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Aetna Medicare</b> <b>833-859-6031 (Sales &amp; Marketing)</b> <b>833-570-6670 (Member Services)</b> <a href="http://www.aetnamedicare.com">www.aetnamedicare.com</a>	<b>Align Senior Care</b> <b>844-305-3879 (Sales &amp; Marketing)</b> <b>844-305-3879 (Member Services)</b> <a href="http://www.alignseniorcare.com">www.alignseniorcare.com</a>
<b>Plan Name/Type</b>	<b>Aetna Medicare Value Plus HMO-POS (H0523-076)</b>	<b>Align Advantage Care HMO (H3274-005)</b>
<b>Star Rating</b>	★ ★ ★	Not enough data available
<b>Annual OOP Max</b>	<b>\$2,500</b>	<b>\$1,900</b>
<b>Monthly Premium</b>	<b>\$5.90</b>	<b>\$0</b>
<b>Doctor Visits</b>	\$0 copay for Primary Care Physician; \$0 for Specialist	\$0 copay for Primary Care Physician; \$0 for Specialist
<b>Inpatient Hospital</b>	\$250 copay/day for days 1-5; \$0 per day for days 6 and beyond	\$0 per stay; \$0 per day for unlimited additional days
<b>Outpatient Hospital</b>	\$0 copay per ambulatory surgical center visit; \$125 per outpatient hospital facility visit	20% coinsurance per ambulatory surgical center visit; \$225 copay per outpatient hospital facility visit
<b>Skilled Nursing Facility</b>	\$0 copay/day for days 1-20; \$75 per day for days 21-100	\$0 copay/day for days 1-100
<b>Ambulance</b>	\$295 copay per ground trip; 20% per trip by air	\$125 copay per trip by ground; 20% coinsurance per trip by air
<b>Emergency &amp; Urgent Care</b>	\$140 copay per emergency room visit; waived if admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no annual limit; <b>\$140 copay</b> per emergency/urgent care visit; ER copay waived if admitted to hospital; urgent care copays not waived	\$90 copay per emergency room visit; \$40 per urgent care visit; waived if admitted to hospital within 3 days; Coverage limited to the U.S. and territories
<b>Lab Tests, Procedures, and Radiation Therapy</b>	\$0 copay for lab services, diagnostic tests, procedures, and x-rays; \$0 copay for diagnostic radiology; \$60 copay for therapeutic radiology	\$0 copay for lab services and x-rays; 20% coinsurance for diagnostic tests, procedures, and diagnostic radiology; 20% coinsurance for therapeutic radiology
<b>Renal Dialysis</b>	20% co-insurance per treatment	20% co-insurance per treatment
<b>Outpatient Mental Health Visits</b>	\$40 copay for individual or group therapy session	\$0 copay for individual or group therapy session
<b>Eyewear</b>	\$325 annual allowance for eyewear	\$225 annual allowance for eyewear
<b>Eye Exams</b>	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam	20% coinsurance for diagnostic exam; \$0 copay for one annual routine exam
<b>Hearing Aids</b>	\$1,250 annual hearing aid allowance per ear; purchased through NationsHearing network	<b>Not Covered</b>
<b>Hearing Exams</b>	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam through NationsHearing network	20% coinsurance for diagnostic exam
<b>Dental</b>	\$2,000 annual reimbursement allowance for covered preventive and comprehensive services; any licensed dental provider	\$0 copay for certain preventive services; \$3,000 annual allowance for comprehensive services; Must use Liberty Dental network
<b>Chiropractic</b>	\$0 copay for Medicare-covered visits; \$0 copay/visit for unlimited routine visits; must use American Specialty Health provider	20% coinsurance for Medicare-covered visits; \$30 copay/visit for 30 routine visits per year; (contact plan for additional details)
<b>Podiatry</b>	\$0 copay per Medicare-covered visit	20% coinsurance per Medicare-covered visit; \$0 copay per routine visit, up to 6 per year
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>
	30 days	30 days
	100 days retail	90 days retail
	100 days mail	90 days mail
	Preferred Generic	Preferred Generic
	Generic	Generic
<b>Supplemental Benefits and Optional Plans</b>	Preferred Brand	Preferred Brand
	Non-Preferred Brand	Non-Preferred Brand
	Specialty co-insurance	Specialty co-insurance
	\$250 deductible applies to Tiers 3, 4, and 5; <b>after total yearly drug costs reach \$2,000, you pay \$0.</b>	\$0 deductible; <b>after total yearly drug costs reach \$2,000, you pay \$0.</b>
	<b>Acupuncture:</b> \$0 copay for unlimited acupuncture treatments with American Specialty Health provider <b>OTC:</b> \$75 quarterly allowance for plan approved items purchased online or in-store at CVS locations; no rollover <b>Transportation:</b> \$0 copay for 12 one-way trips per year to plan approved locations via Access2Care <b>Wellness:</b> \$0 copay for basic Silver Sneakers membership or one home fitness kit per year; <b>\$150</b> per quarter Direct Member reimbursement allowance for various fitness activities and supplies	<b>In-Home Support Services:</b> \$0 copay; limited to 80 hours annually for help with personal needs, light housekeeping, meal prep, etc. <b>Over the Counter:</b> \$405 quarterly allowance for plan-approved items <b>Part B Premium Rebate:</b> \$10/month <b>Transportation:</b> \$0 copay for 24 one-way trips per year to plan approved locations
	<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland, One Medical <b>Hospitals:</b> Alameda, Highland (Oak), St. Rose (Hayward), San Leandro, Stanford Valley Care (Pleasanton), and Washington Hospital (Fremont)
		<b>Medical Groups:</b> Brown & Toland?, One Medical ? <b>Hospitals:</b> Alta Bates/Summit Med Ctr, (Berk/Oak), Eden (Castro Valley)

# 2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Alignment Health Plan</b> <b>888-979-2247 (Sales &amp; Marketing)</b> <b>866-634-2247 (Member Services)</b> <a href="http://www.alignmenthealthplan.com">www.alignmenthealthplan.com</a>							
Plan Name/Type	Alignment Health Heroes + HMO (H3815-043)				Alignment Health Harmony HMO (H3815-031)			
Star Rating	★★★★				★★★★			
Annual OOP Max	\$5,900				\$3,400			
Monthly Premium	\$0				\$0			
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist				\$0 for Primary Care Physician; \$0 for Specialist			
Inpatient Hospital	\$1,676 deductible per benefit period; \$0 copay for days 1-60; \$419 copay/day for days 61-90; \$838 copay/day for days 91-150				\$100 copay/day for days 1-5; \$0 copay/day for days 6-90; \$0 copay/day for days 90 and beyond			
Outpatient Hospital	\$0 copay for ambulatory surgical center; \$0 copay for outpatient hospital facility				\$100 copay for ambulatory surgical center visit; \$200 copay for outpatient hospital facility visit			
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$209.50/day for days 21-100				\$0 copay/day for days 1-20; \$100 copay/day for days 21-100			
Ambulance	20% co-insurance per ground or air ambulance trip; Not waived if admitted to hospital				\$175 copay per ground or air ambulance trip; Waived if admitted to hospital			
Emergency & Urgent Care	20% coinsurance for ER and urgent care visits; ER cost waived if admitted to hospital within 3 days; <b>Worldwide coverage: \$75,000</b> annual limit for ER/urgent care with \$10 copays				\$100 copay for ER visit; copay not waived if admitted to hospital; \$0 for urgent care visit; <b>Worldwide coverage: \$100,000</b> annual limit for ER/urgent care with \$20 copays			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology				\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology			
Renal Dialysis	20% co-insurance per treatment				\$30 copay per treatment			
Outpatient Mental Health Visits	20% co-insurance per individual or group therapy session				\$0 copay per individual or group therapy session			
Eyewear	\$500 allowance for eyewear every 2 years				\$150 annual allowance for eyewear			
Eye Exams	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam				\$0 copay for diagnostic exam; \$0 copay for one annual routine exam			
Hearing Aids	Not Covered				\$195-\$1,750 copay per aid; up to 2 aids per year			
Hearing Exams	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam				\$0 copay for diagnostic exam; \$0 copay for one annual routine exam			
Dental	\$0 copay for certain preventive and comprehensive services; \$500 allowance every 3 months; See enhanced dental plan option below				\$0 copay for certain preventive services; \$20-\$570 copays for certain comprehensive services			
Chiropractic	\$0 copay per Medicare-covered visit				\$0 copay per Medicare-covered visit			
Podiatry	\$0 copay for Medicare-covered visit				\$5 copay for Medicare-covered visit			
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$10	\$30	\$30	Generic	\$3	\$9	\$9
	Preferred Brand	25%	25%	25%	Preferred Brand	\$40	\$120	\$120
	Non-Preferred Brand	25%	25%	25%	Non-Preferred Brand	\$100	\$300	\$300
	Specialty co-insurance	25%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A
	\$590 deductible; after total yearly drug costs reach \$2,000, you pay \$0.				\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.			
Supplemental Benefits and Optional Plans	Enhanced Dental Option: \$36/month for 0-50% coinsurance for certain diagnostic and comprehensive services; \$1,500 coverage limit per year Essentials Allowance: \$100 monthly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions; no rollover In-Home Support Services: \$0 copay for 12 hours per quarter OR \$300 annual caregiver reimbursement Meals: \$0 copay for up to 2 meals/day for 14 days (2x/year) for those with qualifying chronic conditions Pet Services: \$0 copay for 7 boarding days or 14 walks/year for those w/qualifying chronic conditions Pest Control: \$0 copay for 1 service per year for those with qualifying chronic conditions Transportation: \$0 copay for 50 one-way trips per year to plan approved locations within 50 miles Wellness: \$0 copay for basic gym membership				Acupuncture: \$0 co-pay/visit for unlimited visits/yr Enhanced Dental Option: \$36/month for 0-50% coinsurance for certain diagnostic and comprehensive services; \$1,500 coverage limit per year Essentials Allowance: \$30 monthly allowance for groceries, gas, utilities, and home safety for those with qualifying chronic conditions Over the Counter: \$30 monthly allowance Pet Services: \$0 copay for 7 boarding days or 14 walks/year for those w/qualifying chronic conditions Pest Control: \$0 copay for 1 service per year for those with qualifying chronic conditions Transportation: \$0 copay for 28 one-way trips each year to plan approved locations within 20 miles Wellness: \$0 copay for basic gym membership			
	Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Brown & Toland, Nivano IPA Hospitals: Alameda; Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)				Medical Groups: Brown & Toland, Nivano IPA Hospitals: Alameda; Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)		

# 2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs

Please contact the Plan for more information or call 1-800-Medicare	<b>Alignment Health Plan</b> <b>888-979-2247 (Sales &amp; Marketing)</b> <b>866-634-2247 (Member Services)</b> <a href="http://www.alignmenthealthplan.com">www.alignmenthealthplan.com</a>				
Plan Name/Type	Alignment Health My Choice CalPlus HMO (H3815-007)			Alignment Health Select HMO (H3815-037)	
Star Rating	★★★★			★★★★	
Annual OOP Max	\$3,499			\$3,400	
Monthly Premium	\$0			\$0	
Doctor Visits	\$0 for Primary Care Physician; \$0 for Specialist			\$10 for Primary Care Physician; \$35 for Specialist	
Inpatient Hospital	\$0 copay for days 1-4; \$100 copay/day for days 5-10; \$0 copay for days 11 and beyond; unlimited			\$295 copay for days 1-7; \$0 copay/day for days 8 and beyond; unlimited	
Outpatient Hospital	\$100 copay for ambulatory surgical center; \$200 copay for outpatient hospital facility			\$35 copay for ambulatory surgical center visit; \$200 for outpatient hospital facility visit	
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$50 copay/day for days 21-100			\$0 copay/day for days 1-20; \$140 per day for days 21-100	
Ambulance	\$175 copay per trip by ground or air; waived if admitted to hospital			\$240 copay per trip by ground or air; waived if admitted to hospital	
Emergency & Urgent Care	\$85 copay for ER visit; waived if admitted to hospital within 48 hours; \$0 for urgent care visit; <b>Worldwide coverage: \$12,000 annual limit for emergency/urgent care with \$0 copays</b>			\$90 copay for ER visit; waived if admitted within 24 hours; \$0 for urgent care visit; <b>Worldwide coverage: \$25,000 annual limit for emergency/urgent care with \$0 copays</b>	
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology			\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% coinsurance for therapeutic radiology	
Renal Dialysis	20% coinsurance per treatment			\$30 copay per treatment	
Outpatient Mental Health Visits	\$0 copay per individual or group therapy session			\$20 copay per individual or group therapy session	
Eyewear	\$100 annual allowance for eyewear			\$300 allowance for eyewear every 2 years	
Eye Exams	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam			\$0 copay for diagnostic exam; \$0 copay for one annual routine exam	
Hearing Aids	\$195-\$1,750 copay per aid; up to 2 aids per year			\$195-\$1,750 copay per aid; up to 2 aids per year	
Hearing Exams	\$0 copay for diagnostic exam; \$0 copay for one annual routine exam			\$10 copay for diagnostic exam; \$0 copay for one annual routine exam	
Dental	\$0 copay for certain preventive services; \$20-\$570 copays for certain comprehensive services			\$10-\$30 copays for certain preventive services; \$20-\$570 copays for certain comprehensive services	
Chiropractic	\$0 copay per Medicare-covered visit; <i>For those with Extra Help, \$0 co-pay for 12 visits per year, combined with acupuncture</i>			\$0 copay per Medicare-covered visit	
Podiatry	\$0 copay for Medicare-covered visit			\$25 copay for Medicare-covered visit	
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>
	Preferred Generic	\$0	\$0	\$0	Preferred Generic
	Generic	\$3	\$9	\$9	Generic
	Preferred Brand	\$40	\$120	\$120	Preferred Brand
	Non-Preferred Brand	\$100	\$300	\$300	Non-Preferred Brand
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance
	\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.			\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.	
Supplemental Benefits and Optional Plans	<b>Acupuncture:</b> <i>For those with Extra Help, \$0 co-pay for 12 visits per year, combined with chiropractic</i> <b>Enhanced Dental Option:</b> \$36/month for 0-50% coinsurance for certain diagnostic and comprehensive services; \$1,500 coverage limit per year <b>In-home Support Services:</b> \$0 copay for 12 hours per quarter OR \$300 annual caregiver reimbursement <b>Meals:</b> \$0 copay for up to 28 meals over 14 days for those with qualifying chronic conditions; <i>For those with Extra Help, up to 56 meals per year</i> <b>Over the Counter:</b> \$20 monthly allowance; <i>For those with Extra Help, additional \$80 per month</i> <b>Pet Services:</b> \$0 copay for 7 boarding days or 14 walks/year for those w/qualifying chronic conditions <b>Pest Control:</b> \$0 copay for 1 service per year for those with qualifying chronic conditions <b>Transportation:</b> \$0 copay for 12 one-way trips per year to plan approved locations within 20 miles <b>Wellness:</b> \$0 copay for basic gym membership at participating fitness centers			<b>Enhanced Dental Option:</b> \$36/month for 0-50% coinsurance for certain diagnostic and comprehensive services; \$1,500 coverage limit per year <b>Meals:</b> \$0 copay for up to 28 meals over 14 days for those with qualifying chronic conditions <b>Over the Counter:</b> \$25 monthly allowance; no rollover <b>Pet Services:</b> \$0 copay for 7 boarding days or 14 walks per year for those with qualifying chronic conditions <b>Pest Control:</b> \$0 copay for 1 service per year for those with qualifying chronic conditions <b>Transportation:</b> \$0 copay for 24 one-way trips per year to plan approved locations within 75 miles <b>Wellness:</b> \$0 copay for basic gym membership at participating fitness centers	
Medical Groups and Hospitals (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland, Nivano IPA <b>Hospitals:</b> Alameda; Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)			<b>Medical Groups:</b> Brown & Toland, Nivano IPA <b>Hospitals:</b> Alameda; Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleas/Liv)	

**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Anthem Blue Cross</b> <b>800-619-6164 (Sales &amp; Marketing)</b> <b>833-707-3130 (Member Services)</b> <a href="http://www.anthem.com">www.anthem.com</a>							
<b>Plan Name/Type</b>	<b>Anthem Select</b> <b>HMO-POS (H0544-098)</b>				<b>Anthem Prime</b> <b>HMO-POS (H4161-005)</b>			
<b>Star Rating</b>	<b>★★★</b>				<b>★★★</b>			
<b>Annual OOP Max</b>	<b>\$7,550</b>				<b>\$1,200</b>			
<b>Monthly Premium</b>	<b>\$0</b>				<b>\$0</b>			
<b>Doctor Visits</b>	\$15 copay for Primary Care Physician; \$45 copay for Specialist				\$0 copay for Primary Care Physician; \$10 copay for Specialist			
<b>Inpatient Hospital</b>	\$315 copay/day for days 1-6; \$0 copay for days 7-90 and beyond				\$250 copay for days 1-5; \$0 copay/day for days 6-90 and beyond			
<b>Outpatient Hospital</b>	\$275 copay for ambulatory surgical center visit; \$315 copay for outpatient hospital facility visit				\$150 copay for ambulatory surgical center visit; \$250 for outpatient hospital facility visit			
<b>Skilled Nursing Facility</b>	\$0 copay for days 1-20; \$196 per day for days 21-100				\$0 copay/day for days 1-20; \$188 per day for days 21-100			
<b>Ambulance</b>	\$250 copay per ground ambulance trip; 20% coinsurance per air ambulance trip				\$250 copay per ground ambulance trip; 20% coinsurance per air ambulance trip			
<b>Emergency &amp; Urgent Care</b>	\$90 copay for ER visit; waived if admitted to hospital within 24 hours; \$35 for urgent care visit; <b>Worldwide coverage: \$100,000</b> annual limit for emergency/urgent care with \$90 copays per visit				\$90 copay for ER visit; waived if admitted to hospital within 24 hours; \$35 for urgent care visit; <b>Worldwide coverage: \$100,000</b> annual limit for emergency/urgent care with \$90 copays per visit			
<b>Lab Tests, Procedures, and Radiation Therapy</b>	\$10 copay for lab services and x-rays; \$50-\$75 for diagnostic tests & procedures; \$10-\$150 for diagnostic radiology; 20% coinsurance for therapeutic radiology				\$10 copay for lab services and x-rays; \$25-\$50 for diagnostic tests & procedures; \$10-\$150 for diagnostic radiology; 20% coinsurance for therapeutic radiology			
<b>Renal Dialysis</b>	20% co-insurance per treatment				20% co-insurance per treatment			
<b>Outpatient Mental Health Visits</b>	\$40 copay per individual or group therapy session				\$10 copay per individual or group therapy session			
<b>Eyewear</b>	\$100 annual allowance for eyewear				\$100 annual allowance for eyewear			
<b>Eye Exams</b>	\$45 copay for diagnostic exam; \$0 copay for one annual routine exam				\$10 copay for diagnostic exam; \$0 copay for one annual routine exam			
<b>Hearing Aids</b>	\$3,000 annual allowance with \$0 copay				<b>Not Covered</b>			
<b>Hearing Exams</b>	\$45 copay for diagnostic exam; \$0 copay for one annual routine exam				\$10 copay for diagnostic exam; \$0 copay for one annual routine exam			
<b>Dental</b>	\$45 copay for Medicare covered visit; \$0 copay for 1 oral exam and 1 cleaning per year				\$10 copay for Medicare covered visit; \$0 copay for 1 oral exam and 1 cleaning per year			
<b>Chiropractic</b>	\$15 copay per Medicare-covered visit				\$20 copay per Medicare-covered visit			
<b>Podiatry</b>	\$0-45 copay for Medicare-covered visit; \$0 copay for 24 routine visits each year				\$0-10 copay for Medicare-covered visit; \$0 copay for unlimited routine visits each year			
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	90 days retail	90 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	90 days retail	90 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$0	\$0	\$0	Generic	\$7	\$21	\$0
	Preferred Brand	15%	15%	15%	Preferred Brand	20%	20%	20%
	Non-Preferred Brand	30%	30%	30%	Non-Preferred Brand	25%	25%	25%
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A
	\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.				\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.			
<b>Supplemental Benefits and Optional Plans</b>	<b>Acupuncture: \$0</b> co-pay/visit for 12 visits per year <b>Over the Counter: \$25</b> quarterly allowance <b>Wellness: \$0</b> for basic Silver Sneakers membership <b>Optional supplemental packages:</b> <b>1: Preventive Dental at \$13 per month:</b> up to \$500/year; \$0 co-pays for basic preventive services <b>2: Dental &amp; Vision at \$33 per month:</b> up to \$1,000/year with \$0 copays for certain preventive services and 20-50% coinsurance for certain comprehensive services; <b>\$150</b> annual reimbursement allowance for eyewear <b>3: Enhanced Dental &amp; Vision at \$51 per month:</b> up to \$2,000/year with \$0 copays for certain preventive services and 20-50% coinsurance for certain comprehensive services; <b>\$200</b> annual reimbursement allowance for eyewear				<b>Over the Counter: \$20</b> quarterly allowance <b>Wellness: \$0</b> for basic Silver Sneakers membership <b>Optional supplemental packages:</b> <b>1: Preventive Dental at \$13 per month:</b> up to \$500/year; \$0 co-pays for basic preventive services <b>2: Dental &amp; Vision at \$33 per month:</b> dental services up to \$1,000/year with varying copays; <b>\$150</b> annual reimbursement allowance for eyewear <b>3: Enhanced Dental &amp; Vision at \$51 per month:</b> dental services up to \$2,000/year with varying copays; <b>\$200</b> annual reimbursement allowance for eyewear			
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland; Hill Physicians East Bay, Imperial Health Holdings <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), Washington (Fremont)				<b>Medical Groups:</b> Brown & Toland; Hill Physicians East Bay, Imperial Health Holdings, Nivano Physicians <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), St. Rose, (Hayward), Stanford Valley Care (Pleas/Liv), Washington (Fremont)			



# 2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Blue Shield of CA</b> <b>888-534-4263 (Sales &amp; Marketing)</b> <b>800-776-4466 (Member Services)</b> <a href="http://www.blueshieldca.com/medicare">www.blueshieldca.com/medicare</a>	<b>United Health Care</b> <b>844-723-6473 (Sales and Marketing)</b> <b>866-261-7709 (Member Services)</b> <a href="http://www.aarpmedicareplans.com">www.aarpmedicareplans.com</a>				
<b>Plan Name/Type</b>	<b>Blue Shield Inspire (HMO) (H0504-041)</b>	<b>AARP Medicare Advantage from UHC CA-7P HMO-POS (H0543-188)</b>				
<b>Star Rating</b>	<b>★★★★1/2</b>	<b>★★★</b>				
<b>Annual OOP Max</b>	<b>\$4,300</b>	<b>\$4,900</b>				
<b>Monthly Premium</b>	<b>\$39</b>	<b>\$46</b>				
<b>Doctor Visits</b>	<b>\$0</b> copay for Primary Care Physician; <b>\$15</b> for Specialist	<b>\$0</b> copay for Primary Care Physician; <b>\$25</b> for Specialist				
<b>Inpatient Hospital</b>	<b>\$280</b> copay/day for days 1-5; <b>\$0</b> per day for days 6 and beyond	<b>\$425</b> copay/day for days 1-6; <b>\$0</b> for days 7 and beyond (unlimited)				
<b>Outpatient Hospital</b>	<b>\$100</b> copay per ambulatory surgical center visit; <b>\$250</b> per outpatient hospital facility visit	<b>\$375</b> copay for ambulatory surgical center visit; <b>\$425</b> copay for outpatient hospital visit				
<b>Skilled Nursing Facility</b>	<b>\$0</b> copay/day for days 1-20; <b>\$200</b> per day for days 21-100	<b>\$0</b> copay/day for days 1-20; <b>\$203</b> per day for days 21-100				
<b>Ambulance</b>	<b>\$275</b> copay per trip by ground; <b>20%</b> co-insurance per trip by air	<b>\$290</b> copay per trip by ground or air				
<b>Emergency &amp; Urgent Care</b>	<b>\$125</b> copay per emergency room visit; <b>\$15</b> per urgent care visit; <b>Worldwide coverage:</b> no annual limit with <b>\$120</b> copay per emergency or urgent care visit; waived if admitted to hospital within 24 hours	<b>\$125</b> copay per emergency room visit; waived if admitted to hospital within 24 hours; <b>\$55</b> per urgent care visit; <b>Worldwide coverage:</b> no annual limit with <b>\$0</b> copays for emergency/urgent care visits				
<b>Lab Tests, Procedures, and Radiation Therapy</b>	<b>\$0</b> copay for lab, diagnostic tests and procedures, and x-rays; <b>\$75</b> copay for diagnostic radiology; <b>20%</b> co-insurance for therapeutic radiology	<b>\$0</b> copay for lab, diagnostic tests, and procedures; <b>\$25</b> copay per x-ray; <b>\$200</b> copay for diagnostic radiology; <b>20%</b> coinsurance for therapeutic radiology				
<b>Renal Dialysis</b>	<b>20%</b> co-insurance per treatment	<b>20%</b> co-insurance per treatment				
<b>Outpatient Mental Health Visits</b>	<b>\$30</b> copay for individual or group therapy session	<b>\$25</b> copay for individual therapy session; <b>\$15</b> copay for group therapy session				
<b>Eyewear</b>	<b>\$195</b> annual allowance for eyewear; <b>\$195</b> allowance for frames every 2 years	<b>\$200</b> annual allowance for eyewear; through United Healthcare Vision network				
<b>Eye Exams</b>	<b>\$15</b> copay for diagnostic exams; <b>\$0</b> copay for one annual routine exam	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam				
<b>Hearing Aids</b>	<b>\$449 - \$699</b> copay per aid (depending on type); limited to 2 hearing aids per year	<b>\$99 - \$1,249</b> copay per aid; up to 2 aids each year; through United Healthcare Hearing network				
<b>Hearing Exams</b>	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam				
<b>Dental</b>	<b>\$15</b> copay for Medicare covered visit; <b>\$0</b> copay certain preventive services every six months and 1 full set of x-rays every two years	<b>\$0</b> copays for preventive services; any dental provider; See optional dental plan below				
<b>Chiropractic</b>	<b>\$15</b> copay for Medicare-covered visit; <b>\$0</b> copay/visit for 12 routine visits per year	<b>\$15</b> copay for Medicare-covered visit; Routine care not covered				
<b>Podiatry</b>	<b>\$15</b> copay per Medicare-covered visit; <b>\$15</b> copay/visit for unlimited routine visits per year	<b>\$25</b> copay per Medicare-covered visit; <b>\$25</b> copay/visit for 6 routine visits per year				
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	<i>Cost-sharing shown is for preferred pharmacies</i>				
	Preferred Generic	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>		
	Generic	<b>\$5</b>	<b>\$7.50</b>	<b>\$7.50</b>		
	Preferred Brand	<b>\$40</b>	<b>\$100</b>	<b>\$100</b>		
	Non-Preferred Brand	<b>\$95</b>	<b>\$237.50</b>	<b>\$237.50</b>		
	Specialty co-insurance	<b>33%</b>	<b>N/A</b>	<b>N/A</b>		
	<b>\$0</b> deductible; <b>after total yearly drug costs reach \$2,000</b> , you pay <b>\$0</b> .	<b>\$340</b> deductible for Tiers 3, 4, and 5; <b>after total yearly drug costs reach \$2,000</b> , you pay <b>\$0</b> .				
<b>Supplemental Benefits and Optional Plans</b>	<b>Over the Counter: \$55</b> quarterly allowance <b>Transportation: \$0</b> copay for 12 one-way trips per year to plan approved locations <b>Wellness: \$0</b> for basic Silver Sneakers membership <b>Optional Supplemental Plans:</b> <b>1: Dental HMO at \$16/month:</b> varying copays for certain preventive and comprehensive services; participating dentists only <b>2: Dental PPO at \$47/month: \$50</b> deductible; varying coinsurance for certain preventive and comprehensive services; <b>\$1,500</b> annual allowance for participating dentists; <b>\$1,000</b> for non-participating			<b>Optional Dental Plan at \$54/month: \$0</b> copays for certain preventive and comprehensive benefits; <b>50%</b> coinsurance for dentures and bridges; <b>\$1,500</b> annual allowance <b>Over the Counter: \$25</b> quarterly allowance for items in-store or online <b>Wellness: \$0</b> for Renew Active gym membership		
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland, Hill Physicians East Bay <b>Hospitals:</b> Alameda, Alta Bates/Summit (Berk/Oak), Eden (Castro Valley), Highland (Oak), San Leandro, St. Rose, and Washington (Fremont)			<b>Medical Groups:</b> Canopy Health, Hill Physicians East Bay <b>Hospitals:</b> Alameda, Highland (Oakland), San Leandro, St. Rose (Hayward), Washington (Fremont)		

**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Central Health Medicare Plan</b> <b>866-314-2427 (Sales &amp; Marketing)</b> <b>866-314-2427 (Member Services)</b> <a href="http://www.centralhealthplan.com">www.centralhealthplan.com</a>			
<b>Plan Name/Type</b>	<b>Central Health Premier Plan I (HMO) (H5649-023)</b>		<b>Central Health Classic Care Plan II (HMO) (H5649-028)</b>	
<b>Star Rating</b>	<b>★ ★ 1/2</b>		<b>★ ★ 1/2</b>	
<b>Annual OOP Max</b>	<b>\$2,999</b>		<b>\$2,499</b>	
<b>Monthly Premium</b>	<b>\$0</b>		<b>\$0</b>	
<b>Doctor Visits</b>	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist		<b>\$0</b> for Primary Care Physician; <b>\$10</b> for Specialist	
<b>Inpatient Hospital</b>	<b>\$0</b> copay for days 1-4; <b>\$100</b> copay/day for days 5-10; <b>\$0</b> copay for days 11-90		<b>\$150</b> copay/day for days 1-6; <b>\$0</b> copay for days 7-90	
<b>Outpatient Hospital</b>	<b>\$200</b> copay per ambulatory surgical center visit; <b>\$225</b> copay per outpatient hospital facility visit		<b>\$100</b> per ambulatory surgical center visit; <b>\$250</b> copay per outpatient hospital facility visit	
<b>Skilled Nursing Facility</b>	<b>\$0</b> copay for days 1-20; <b>\$204/day</b> for days 21-100		<b>\$0</b> copay for days 1-20; <b>\$204/day</b> for days 21-100	
<b>Ambulance</b>	<b>\$300</b> copay per one-way trip by ground; <b>20%</b> coinsurance per trip by air		<b>\$250</b> copay per one-way trip by ground; <b>20%</b> coinsurance per trip by air	
<b>Emergency &amp; Urgent Care</b>	<b>\$125</b> copay per emergency room visit; waived if admitted to hospital within 72 hours; <b>\$0</b> for urgent care; <b>Worldwide coverage: \$100,000</b> limit with <b>\$125</b> copays for ER/urgent care		<b>\$140</b> copay per emergency room visit; waived if admitted to hospital within 72 hours; <b>\$0</b> for urgent care; <b>Worldwide coverage: \$50,000</b> limit with <b>\$140</b> copays for ER and urgent care	
<b>Lab Tests, Procedures, and Radiation Therapy</b>	<b>\$0</b> copay for lab services, diagnostic tests & procedures, and x-rays; <b>\$150</b> for diagnostic radiology; <b>20%</b> co-insurance for therapeutic radiology		<b>\$0</b> copay for lab services, diagnostic tests & procedures, x-rays; <b>\$200</b> for diagnostic radiology; <b>20%</b> co-insurance for therapeutic radiology	
<b>Renal Dialysis</b>	<b>20%</b> co-insurance per treatment		<b>20%</b> co-insurance per treatment	
<b>Outpatient Mental Health Visits</b>	<b>\$40</b> copay per individual or group therapy session		<b>\$10</b> copay for individual session; <b>20%</b> coinsurance for group therapy session	
<b>Eyewear</b>	<b>\$300</b> annual allowance for eyewear		<b>\$300</b> annual allowance for eyewear	
<b>Eye Exams</b>	<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> copay for one annual routine exam	
<b>Hearing Aids</b>	<b>\$2,000</b> annual allowance though NationsHearing		<b>\$575 - \$2,099</b> copays for hearing aids, depending on model; up to 2 aids per year	
<b>Hearing Exams</b>	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam		<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for one annual routine exam	
<b>Dental</b>	<b>\$0</b> copay for Medicare covered visit; <b>\$0-\$41</b> copays for certain preventive services; <b>\$0 - \$2,160</b> copays for certain comprehensive services		<b>\$0</b> copay for Medicare covered visit; <b>\$0</b> copay for certain preventive services; <b>\$0 - \$2,160</b> copays for certain comprehensive services	
<b>Chiropractic</b>	<b>\$0</b> copay per Medicare-covered visit		<b>\$0</b> copay per Medicare-covered visit; <b>\$0</b> per routine visit, up to 30 per year, combined with acupuncture	
<b>Podiatry</b>	<b>\$0</b> co-pay per Medicare-covered visit		<b>\$0</b> co-pay per Medicare-covered visit	
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	90 days	100 days mail
	Preferred Generic	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	Generic	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	Preferred Brand	<b>\$35</b>	<b>\$105</b>	<b>\$70</b>
	Non-Preferred Brand	<b>\$75</b>	<b>\$225</b>	<b>\$150</b>
	Specialty co-insurance	<b>31%</b>	<b>N/A</b>	<b>N/A</b>
	<b>\$100</b> deductible for Tiers 2-5; <b>after total yearly drug costs reach \$2,000, you pay \$0.</b>			
<b>Supplemental Benefits and Optional Plans</b>	<b>Acupuncture:</b> <b>\$0</b> co-pay for unlimited visits/year <b>Dental Plan Option:</b> <b>\$45/month</b> for certain preventive and comprehensive services with <b>10%</b> to <b>70%</b> coinsurance; <b>\$1,500</b> annual limit <b>Flex Allowance:</b> <b>\$96</b> quarterly allowance for OTC and herbal catalog items including OTC hearing aids & <b>\$20</b> monthly allowance for fitness fees <b>Groceries:</b> <b>\$50</b> monthly allowance for healthy foods for those with qualifying chronic conditions <b>In-Home Support Services:</b> <b>\$0</b> copay for up to 20 hours per year for qualifying members <b>Meals:</b> <b>\$0</b> copay/meal for 2 meals/day for 14 days for those with qualifying chronic conditions; up to 4 times/year <b>Transportation:</b> <b>\$0</b> co-pay for 12 one-way trips to plan approved locations within 50 miles <b>Wellness:</b> <b>\$0</b> for basic Silver Sneakers membership		<b>Acupuncture:</b> <b>\$0</b> co-pay for up to 30 visits/year, combined with chiropractic <b>Dental Plan Option:</b> <b>\$21/month</b> for certain preventive and comprehensive services with <b>10%</b> to <b>70%</b> coinsurance; <b>\$1,500</b> annual limit for non-network providers <b>Flex Allowance:</b> <b>\$129</b> quarterly allowance for OTC and herbal catalog items including OTC hearing aids & <b>\$60</b> monthly allowance for fitness fees <b>Groceries:</b> <b>\$50</b> monthly allowance for healthy foods for those with qualifying chronic conditions <b>Meals:</b> <b>\$0</b> copay/meal for 15 meals/weeks 6 weeks for those with qualifying chronic conditions; up to 30 additional meals with <b>\$5</b> copay per meal <b>Transportation:</b> <b>\$0</b> co-pay for 24 one-way trips to plan approved locations within 50 miles <b>Wellness:</b> <b>\$0</b> for basic Silver Sneakers membership	
	<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)		<b>Medical Groups:</b> Hill Physicians East Bay <b>Hospitals:</b> Eden (Castro Valley) and Washington (Fremont)	

**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for outline of coverage &amp; provider information or call 1-800-Medicare</i>	<b>Chinese Community Health Plan</b> <b>888-681-3888 (Sales and Marketing)</b> <b>888-775-7888 (Member Services)</b>									
Plan Name/Type	CCHP Senior Program HMO (H0571-010)				CCHP Senior Value Program HMO (H0571-011)					
Star Rating	★★1/2				★★1/2					
Annual OOP Max	\$3,000				\$3,500					
Monthly Premium	\$31				\$0					
Doctor Visits	\$0 copay for Primary Care Physician; \$0 for Specialist				\$0 copay for Primary Care Physician; \$15 for Specialist					
Inpatient Hospital	\$200 copay/day for days 1-7; \$0 for days 8-90				\$250 copay/day for days 1-7; \$0 for days 8-90					
Outpatient Hospital	\$300 copay for ambulatory surgical center visit; \$310 copay for outpatient hospital visit				\$300 copay for ambulatory surgical center visit; \$310 copay for outpatient hospital visit					
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$75 per day for days 21-100				\$0 copay/day for days 1-20; \$100 per day for days 21-100					
Emergency & Urgent Care	\$110 copay per emergency room visit; waived if admitted to hospital within 24 hours; \$20 per urgent care visit; <b>Worldwide coverage: \$25,000</b> limit with \$90 copays for ER/urgent care				\$125 copay per emergency room visit; waived if admitted to hospital within 24 hours; \$25 per urgent care visit; <b>Worldwide coverage: \$5,000</b> limit with \$90 copays for ER/urgent care					
Ambulance	\$180 copay per trip by ground or air				\$200 copay per trip by ground or air					
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic tests and procedures and x-rays; \$100 copay for diagnostic radiology; 20% coinsurance for therapeutic radiology				\$0 copay for lab, diagnostic tests and procedures and x-rays; \$150 copay for diagnostic radiology; 20% coinsurance for therapeutic radiology					
Renal Dialysis	20% co-insurance per treatment				20% co-insurance per treatment					
Outpatient Mental Health Visits	\$15 copay per individual or group therapy session				\$20 copay per individual or group therapy session					
Eyewear	\$0 copay with \$150 allowance every 2 years for eyewear; through VSP network provider				\$0 copay with \$100 allowance every 2 years for eyewear; through VSP network provider					
Eye Exams	\$20 copay for Medicare-covered exam; \$20 copay for one annual routine exam				\$35 copay for Medicare-covered exam; \$35 copay for one annual routine exam					
Hearing Aids	\$3,000 annual allowance though NationsHearing				\$3,000 annual allowance though NationsHearing					
Hearing Exams	\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam				\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam					
Dental	\$0 copays for certain preventive services; See Optional Dental plan below				\$0 copays for certain preventive services; See Optional Dental plan below					
Chiropractic	\$15 copay for Medicare-covered visit; Routine care not covered				\$15 copay for Medicare-covered visit; Routine care not covered					
Podiatry	\$15 copay per Medicare-covered visit; Routine care not covered				\$20 copay per Medicare-covered visit; Routine care not covered					
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>		30 days	90 days retail	90 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>		30 days	90 days retail	90 days mail
	Preferred Generic		\$3	\$9	\$6	Preferred Generic		\$0	\$0	\$0
	Generic		\$7	\$21	\$14	Generic		\$3	\$9	\$0
	Preferred Brand		\$30	\$90	\$60	Preferred Brand		\$35	\$105	\$70
	Non-Preferred Brand		\$50	\$150	\$100	Non-Preferred Brand		\$75	\$225	\$150
	Specialty co-insurance		30%	N/A	N/A	Specialty co-insurance		30%	N/A	N/A
	\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.					\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.				
Supplemental Benefits and Optional Plans	Dental Plan Option: \$18.50/month: varying copays for certain preventive and comprehensive services; through DeltaCare USA Dental HMO network Grocery Flex Card: \$20 monthly allowance for healthy foods; can be combined with OTC allowance Over the Counter: \$52 monthly allowance for plan-approved items from network retail location or Nations OTC catalog; can be combined with grocery flex card allowance Transportation: \$0 copay for 24 one-way trips to plan-approved locations				Acupuncture: \$10 copay for 15 routine visits/year Dental Plan Option: \$18.50/month: varying copays for certain preventive and comprehensive services; through DeltaCare USA Dental HMO network Over the Counter: \$65 monthly allowance for plan-approved items from network retail location or Nations OTC catalog Transportation: \$0 copay for 12 one-way trips to plan-approved locations					
Medical Groups and Hospitals (may not be full list; please check with plan)	Medical Groups: Hill Physicians East Bay, One Medical Hospitals: Alameda, Highland (Oakland), San Leandro				Medical Groups: Hill Physicians East Bay, One Medical Hospitals: Alameda, Highland (Oakland), San Leandro					

**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Imperial Health Plan of California</b> <b>800-838-8271 (Sales &amp; Marketing)</b> <b>800-838-8271 (Member Services)</b> <a href="http://www.imperialhealthplan.com">www.imperialhealthplan.com</a>						
<b>Plan Name/Type</b>	<b>Imperial Traditional HMO (H5496-007)</b>			<b>Imperial Giveback HMO (H5496-014)</b>			
<b>Star Rating</b>	<b>★★★1/2</b>			<b>★★★1/2</b>			
<b>Annual OOP Max</b>	<b>\$1,449</b>			<b>\$9,350</b>			
<b>Monthly Premium</b>	<b>\$0</b>			<b>\$0 / \$240 Deductible</b>			
<b>Doctor Visits</b>	<b>\$0</b> for Primary Care Physician; <b>\$0</b> for Specialist			<b>20%</b> for Primary Care Physician; <b>20%</b> for Specialist			
<b>Inpatient Hospital</b>	<b>\$0</b> copay for days 1-3; <b>\$150</b> for days 4-5; <b>\$0</b> per day for days 6-90; <b>\$670</b> per day for days 91-150			<b>\$0</b> copay for days 1-60; <b>\$419</b> co-pay/day for days 61-90; <b>\$838</b> per day for days 91-150			
<b>Outpatient Hospital</b>	<b>\$100</b> per ambulatory surgical center visit; <b>\$100</b> copay per outpatient hospital facility visit			<b>20%</b> coinsurance per ambulatory surgical center visit; <b>20%</b> coinsurance per outpatient hospital facility visit			
<b>Skilled Nursing Facility</b>	<b>\$0</b> copay per day for days 1-20; <b>\$100/day</b> for days 21-50; <b>\$200/day</b> for days 51-100			<b>\$0</b> copay per day for days 1-20; <b>\$209.50/day</b> for days 21-100			
<b>Ambulance</b>	<b>\$150</b> copay per one-way trip by ground; <b>20%</b> coinsurance per each trip by air			<b>20%</b> coinsurance per one-way trip by ground; <b>20%</b> coinsurance per each trip by air			
<b>Emergency &amp; Urgent Care</b>	<b>\$125</b> copay per emergency room visit; waived if admitted to hospital within 48 hours; <b>\$0</b> copay for urgent care; <b>Worldwide coverage: \$100,000</b> limit with <b>\$0</b> copay for ER and <b>\$10</b> for urgent care			<b>20%</b> coinsurance, up to <b>\$110</b> per emergency room visit; <b>20%</b> coinsurance up to <b>\$45</b> per urgent care visit; Costs waived if admitted to hospital within 72 hours			
<b>Lab Tests, Procedures, and Radiation Therapy</b>	<b>\$0</b> copay for lab, diagnostic tests and procedures, x-rays, and diagnostic radiology; <b>20%</b> coinsurance for therapeutic radiology			<b>20%</b> coinsurance for lab services, diagnostic tests & procedures, x-rays, diagnostic radiology, and therapeutic radiology			
<b>Renal Dialysis</b>	<b>20%</b> coinsurance per treatment			<b>20%</b> coinsurance per treatment			
<b>Outpatient Mental Health Visits</b>	<b>20%</b> coinsurance per individual or group therapy session			<b>20%</b> coinsurance per individual or group therapy session			
<b>Eyewear</b>	<b>\$500</b> annual allowance for eyewear			<b>\$240</b> annual allowance for eyewear			
<b>Eye Exams</b>	<b>\$0</b> copay per Medicare-covered exam; <b>\$0</b> copay for routine exams			<b>20%</b> coinsurance per Medicare-covered exam; <b>\$0</b> copay for one annual routine exam			
<b>Hearing Aids</b>	<b>\$500</b> annual allowance <b>\$0</b> copay			<b>\$500</b> annual allowance <b>\$0</b> copay			
<b>Hearing Exams</b>	<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for routine exams; <b>\$250/year</b> limit			<b>\$0</b> copay for Medicare-covered exam; <b>\$0</b> copay for exams; <b>\$250/year</b> limit			
<b>Dental</b>	<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for preventive services up to <b>\$500/year</b> ; <b>\$0</b> co-pay for certain comprehensive services up to <b>\$3,000/year</b> ; must use Imperial Traditional contracted provider			<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for preventive services up to <b>\$500/year</b> ; <b>\$0</b> co-pay for certain comprehensive services up to <b>\$2,000/year</b> ; must use Imperial Giveback contracted provider			
<b>Chiropractic</b>	<b>\$0</b> copay per Medicare-covered visit; Routine care not covered			<b>20%</b> co-insurance per Medicare-covered visit; Routine care not covered			
<b>Podiatry</b>	<b>\$0</b> co-pay per Medicare-covered visit; <b>\$0</b> co-pay for 6 routine visits per year			<b>20%</b> coinsurance per Medicare-covered visit			
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days	100 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days mail
	Preferred Generic	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	Preferred Generic	<b>25%</b>	<b>25%</b>
	Generic	<b>\$10</b>	<b>\$30</b>	<b>\$10</b>	Generic	<b>25%</b>	<b>25%</b>
	Preferred Brand	<b>\$45</b>	<b>\$135</b>	<b>\$90</b>	Preferred Brand	<b>25%</b>	<b>25%</b>
	Non-Preferred Brand	<b>\$90</b>	<b>\$270</b>	<b>\$180</b>	Non-Preferred Brand	<b>25%</b>	<b>25%</b>
	Specialty co-insurance	<b>33%</b>	<b>N/A</b>	<b>N/A</b>	Specialty co-insurance	<b>25%</b>	<b>25%</b>
	<b>\$0</b> deductible; after total yearly drug costs reach <b>\$2,000</b> , you pay <b>\$0</b> .			<b>\$590</b> deductible; after total yearly drug costs reach <b>\$2,000</b> , you pay <b>\$0</b> .			
<b>Supplemental Benefits and Optional Plans</b>	<b>In-home Support Services:</b> <b>\$0</b> copay for up to 48 hours per year <b>Meals:</b> <b>\$0</b> copay for up to 7 home-delivered meals following a surgery or hospital stay; up to <b>\$105</b> per benefit period <b>Over the Counter:</b> <b>\$95</b> quarterly allowance for items in OTC mail order catalogue; no rollover <b>Transportation:</b> <b>\$0</b> co-pay for 100 one-way trips per year to plan approved locations <b>Wellness:</b> <b>\$0</b> for one home fitness kit per year through Silver&Fit program			<b>In-home Support Services:</b> <b>\$0</b> copay for up to 48 hours per year <b>Over the Counter:</b> <b>\$75</b> quarterly allowance for items in OTC mail order catalogue; no rollover <b>Part B Premium Reduction:</b> <b>\$100</b> monthly reimbursement			
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), San Leandro, and St. Rose (Hayward)			<b>Medical Groups:</b> Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), San Leandro, and St. Rose (Hayward)			



**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Imperial Health Plan of California</b> <b>800-838-8271 (Sales &amp; Marketing)</b> <b>800-838-8271 (Member Services)</b> <a href="http://www.imperialhealthplan.com">www.imperialhealthplan.com</a>				
<b>Plan Name/Type</b>	<b>Imperial Dynamic HMO (H5496-012)</b>			<b>Imperial Courage HMO (H5496-016)</b>	
<b>Star Rating</b>	<b>★★★1/2</b>			<b>★★★1/2</b>	
<b>Annual OOP Max</b>	<b>\$297</b>			<b>\$2,999</b>	
<b>Monthly Premium</b>	<b>\$0</b>			<b>\$0</b>	
<b>Doctor Visits</b>	\$0 copay for Primary Care Physician; \$0 for Specialist			\$0 copay for Primary Care Physician; \$5 for Specialist	
<b>Inpatient Hospital</b>	\$0 copay for days 1-90; \$670 per day for days 91-150			\$150 copay for days 1-5; \$0 co-pay/day for days 61-90; \$670 per day for days 91-150	
<b>Outpatient Hospital</b>	\$100 per ambulatory surgical center visit; \$100 copay per outpatient hospital facility visit			\$200 per ambulatory surgical center visit; \$200 copay per outpatient hospital facility visit	
<b>Skilled Nursing Facility</b>	\$0 copay per day for days 1-20; \$100/day for days 21-50; \$200/day for days 51-100			\$0 copay per day for days 1-20; \$200/day for days 21-100	
<b>Ambulance</b>	\$150 copay per one-way trip by ground; 20% coinsurance per each trip by air			\$150 copay per one-way trip by ground; 20% coinsurance per each trip by air	
<b>Emergency &amp; Urgent Care</b>	\$125 per emergency room visit; copay waived if admitted to hospital within 48 hours; \$0 copay for urgent care; <b>Worldwide coverage: \$100,000</b> limit with \$0 copays for emergency and urgent care			\$125 copay per emergency room visit; waived if admitted to hospital within 48 hours; \$0 copay for urgent care; <b>Worldwide coverage: \$50,000</b> limit with \$0 copay for emergency and \$20 for urgent care	
<b>Lab Tests, Procedures, and Radiation Therapy</b>	\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance for therapeutic radiology			\$0 copay for lab services, diagnostic tests & procedures, x-rays, and diagnostic radiology; 20% co-insurance for therapeutic radiology	
<b>Renal Dialysis</b>	20% co-insurance per treatment			20% co-insurance per treatment	
<b>Outpatient Mental Health Visits</b>	20% coinsurance per individual or group therapy session			20% coinsurance per individual or group therapy session	
<b>Eyewear</b>	\$500 annual allowance for eyewear			\$250 annual allowance for eyewear	
<b>Eye Exams</b>	\$0 copay per Medicare-covered exam; \$0 copay for routine exams			\$0 copay per Medicare-covered exam; \$0 copay for routine exams	
<b>Hearing Aids</b>	\$500 annual allowance \$0 copay			\$500 annual allowance \$0 copay	
<b>Hearing Exams</b>	\$0 copay for Medicare-covered exam; \$0 copay for routine exams up to \$250/year			\$0 copay for Medicare-covered exam; \$0 copay for routine exams up to \$250/year	
<b>Dental</b>	\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services up to \$500/year; \$0 co-pay for certain comprehensive services up to \$4,000/year; must use Imperial Dynamic contracted provider			\$0 co-pay per Medicare-covered visit; \$0 co-pay for preventive services up to \$500/year; \$0 co-pay for certain comprehensive services up to \$1,500/year; must use Imperial Courage contracted provider	
<b>Chiropractic</b>	\$0 copay per Medicare-covered visit; Routine visits not covered			\$0 copay per Medicare-covered visit; Routine visits not covered	
<b>Podiatry</b>	\$0 co-pay per Medicare-covered visit; \$0 co-pay for 6 routine visits per year			\$0 co-pay per Medicare-covered visit; \$0 co-pay for 6 routine visits per year	
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days	100 days mail	<b>THIS PLAN DOES NOT OFFER PRESCRIPTION DRUG COVERAGE.</b>  <b>YOU CANNOT BELONG TO THIS PLAN AND ALSO ENROLL IN A STAND-ALONE MEDICARE PRESCRIPTION DRUG PLAN.</b>
	Preferred Generic	\$0	\$0	\$0	
	Generic	\$6	\$18	\$5	
	Preferred Brand	\$45	\$135	\$90	
	Non-Preferred Brand	\$90	\$270	\$180	
	Specialty co-insurance	33%	N/A	N/A	
<b>Supplemental Benefits and Optional Plans</b>	\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.				<b>Meals: \$0</b> copay for up to 7 home-delivered meals following a surgery or hospital stay; up to <b>\$105</b> per benefit period <b>Over the Counter: \$75</b> quarterly allowance for items in OTC mail order catalogue; no rollover <b>Part B Premium Reduction: \$75</b> monthly reimbursement <b>Transportation: \$0</b> co-pay for 100 one-way trips per year to plan approved locations <b>Wellness: \$0</b> for one home fitness kit per year through Silver&Fit program
	<b>In-home Support Services: \$0</b> copay for up to 48 hours per year <b>Meals: \$0</b> copay for up to 7 home-delivered meals following a surgery or hospital stay, up to <b>\$105</b> per benefit period <b>Over the Counter: \$140</b> quarterly allowance for items in OTC mail order catalogue; no rollover <b>Part B Premium Reduction: \$60</b> monthly reimburs <b>Transportation: \$0</b> co-pay for 100 one-way trips per year to plan approved locations <b>Wellness: \$0</b> for one home fitness kit per year through Silver&Fit program				
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), San Leandro, and St. Rose (Hayward)				<b>Medical Groups:</b> Imperial Health Holdings, MedCare Partners IPA, Nivano Physicians, Physician Partners IPA <b>Hospitals:</b> Alta Bates/Summit (Berk/Oak), Eden Medical Center (Castro Valley), San Leandro, and St. Rose (Hayward)

# 2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>Kaiser Permanente</b> <b>800-777-1238 (Sales &amp; Marketing)</b> <b>800-443-0815 (Member Services)</b> <a href="http://www.medicare.kaiserpermanente.org">www.medicare.kaiserpermanente.org</a>							
Plan Name/Type	<b>Kaiser Permanente Senior Advantage Basic Alameda HMO (H0524-059)</b>				<b>Kaiser Permanente Senior Advantage HMO (H0524-032)</b>			
Star Rating	★★★★1/2				★★★★1/2			
Annual OOP Max	<b>\$6,000</b>				<b>\$3,400</b>			
Monthly Premium	<b>\$0</b>				<b>\$70</b>			
Doctor Visits	\$5 copay for Primary Care Physician; \$10 for Specialist				\$0 copay for Primary Care Physician; \$5 for Specialist			
Inpatient Hospital	\$260 copay/day for days 1-5; \$0 per day for days 6 and beyond				\$225 copay/day for days 1-5; \$0 per day for days 6 and beyond			
Outpatient Hospital	\$225 per ambulatory surgical center visit; \$0-\$225 copay per outpatient hospital facility visit				\$190 per ambulatory surgical center visit; \$0-\$190 copay per outpatient hospital facility visit			
Skilled Nursing Facility	\$0 copay/day for days 1-20; \$100 per day for days 21-100				\$0 copay/day for days 1-20; \$100 per day for days 21-100			
Ambulance	\$250 copay per air or ground ambulance trip				\$250 copay per air or ground ambulance trip			
Emergency & Urgent Care	\$125 for emergency room visit; \$5 for urgent care visit; Worldwide coverage: no limit with \$140 copay for emergency care visit and \$125 for urgent care				\$140 for emergency room visit; \$0 for urgent care visit; Worldwide coverage: no limit with \$140 copay for emergency care visit and \$0 for urgent care			
Lab Tests, Procedures, and Radiation Therapy	\$0 copay for lab, diagnostic tests & procedures, and x-rays; \$200 copay for diagnostic radiology; \$0 for therapeutic radiology				\$0 copay for lab, diagnostic tests, procedures, and x-rays; \$200 copay for diagnostic radiology; \$0 for therapeutic radiology			
Renal Dialysis	20% co-insurance per treatment				20% co-insurance per treatment			
Outpatient Mental Health Visits	\$2 copay per individual session; \$5 per group therapy session				\$0 copay per individual session; \$0 per group therapy session			
Eyewear	<b>Not covered;</b> See Optional Advantage Plus Plan below				<b>Not covered;</b> See Optional Advantage Plus Plan below			
Eye Exams	\$5-\$10 copay per Medicare-covered exam; \$5 per routine exam				\$0-\$5 copay per Medicare-covered exam; \$0 per routine exam			
Hearing Aids	<b>Not covered;</b> See Optional Advantage Plus Plan below				<b>Not covered;</b> See Optional Advantage Plus Plan below			
Hearing Exams	\$10 copay per Medicare-covered exam				\$5 copay per Medicare-covered exam			
Dental	\$10 co-pay per Medicare-covered visit; \$0 copay for certain preventive & diagnostic services; See Optional Advantage Plus Plan below				\$5 co-pay per Medicare-covered visit; \$0 copay for certain preventive & diagnostic services; See Optional Advantage Plus Plan below			
Chiropractic	\$5 copay per Medicare covered visit; Routine visits not covered				\$0 copay per Medicare covered visit; Routine visits not covered			
Podiatry	\$10 copay per Medicare covered visit; Routine visits not covered				\$5 copay per Medicare covered visit; Routine visits not covered			
Prescription Drugs (Part D)	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 day retail	100 days mail	<i>Cost-sharing shown is for preferred pharmacies</i>	30 days	100 days retail	100 days mail
	Preferred Generic	\$4	\$12	\$8	Preferred Generic	\$0	\$0	\$0
	Generic	\$10	\$30	\$20	Generic	\$7	\$21	\$14
	Preferred Brand	\$47	\$141	\$94	Preferred Brand	\$47	\$141	\$94
	Non-Preferred Brand	\$100	\$300	\$200	Non-Preferred Brand	\$100	\$300	\$200
	Specialty co-insurance	33%	33%	33%	Specialty co-insurance	33%	33%	33%
	\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.				\$0 deductible; after total yearly drug costs reach \$2,000, you pay \$0.			
Supplemental Benefits and Optional Plans	<b>Home Medical Care:</b> home treatment plan as an alternative to hospital care and post-acute services, when found medically appropriate by physician <b>Medical Financial Assistance Program:</b> available to eligible members; contact plan for details <b>Over the Counter:</b> \$60 quarterly allowance for items from OTC catalogue; \$25 minimum order; no rollover <b>Optional Advantage Plus Plan:</b> \$21/month: <b>-Dental:</b> Copays vary depending upon the service; Must use Delta Care USA HMO network <b>-Hearing Aids:</b> \$800 allowance per ear every 36 months; \$0 copay for evaluation and fitting <b>-Vision:</b> \$300 allowance for eyewear every two years <b>-Wellness:</b> \$0 for One Pass gym membership and/or one annual at home fitness kit				<b>Medical Financial Assistance Program:</b> available to eligible members; contact plan for details <b>Over the Counter:</b> \$60 quarterly allowance for items from OTC catalogue; \$25 minimum order; no rollover <b>Optional Advantage Plus Plan:</b> \$21/month: <b>-Dental:</b> Copays vary depending upon the service; Must use Delta Care USA HMO network <b>-Hearing Aids:</b> \$800 allowance per ear every 36 months; \$0 copay for evaluation and fitting <b>-Vision:</b> \$300 allowance for eyewear every two years <b>-Wellness:</b> \$0 for One Pass gym membership and/or one annual at home fitness kit			
Medical Groups and Hospitals (may not be full list; please check with plan)	<b>Medical Groups:</b> Kaiser Permanente <b>Hospitals:</b> Kaiser Oakland, San Leandro, Fremont				<b>Medical Groups:</b> Kaiser Permanente <b>Hospitals:</b> Kaiser Oakland, San Leandro, Fremont			

**2025 MEDICARE ADVANTAGE COMPARISON CHART FOR ALAMEDA COUNTY: HMOs**

<i>Please contact the Plan for more information or call 1-800-Medicare</i>	<b>SCAN Health Plan</b> <b>877-870-4867 (Sales &amp; Marketing)</b> <b>800-559-3500 (Member Services)</b> <a href="http://www.scanhealthplan.com">www.scanhealthplan.com</a>							
<b>Plan Name/Type</b>	<b>SCAN Classic HMO (H05425-075)</b>				<b>SCAN MyChoice HMO (H05425-110)</b>			
<b>Star Rating</b>	★★★★1/2				★★★★1/2			
<b>Annual OOP Max</b>	<b>\$1,500</b>				<b>\$1,500</b>			
<b>Monthly Premium</b>	<b>\$0</b>				<b>\$0</b>			
<b>Doctor Visits</b>	\$0 copay for Primary Care Physician; \$0 for Specialist				\$0 copay for Primary Care Physician; \$0 for Specialist			
<b>Inpatient Hospital</b>	\$100 copay/day for days 1-5; \$0 per day for days 6 and beyond				\$100 copay/day for days 1-5; \$0 per day for days 6 and beyond			
<b>Outpatient Hospital</b>	\$0 per ambulatory surgical center visit; \$0-\$125 copay per outpatient hospital facility visit				\$0 per ambulatory surgical center visit; \$0-\$125 copay per outpatient hospital facility visit			
<b>Skilled Nursing Facility</b>	\$0 copay/day for days 1-20; \$75 per day for days 21-100				\$0 copay/day for days 1-20; \$75 per day for days 21-100			
<b>Ambulance</b>	<b>\$180</b> copay per one-way trip by ground or air				<b>\$105</b> copay per one-way trip by ground or air			
<b>Emergency &amp; Urgent Care</b>	\$90 copay per ER visit; waived if immediately admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no limit with \$90 copay for emergency care visit and \$0 for urgent care				\$90 copay per ER visit; waived if immediately admitted to hospital; \$0 per urgent care visit; <b>Worldwide coverage:</b> no limit with \$90 copay for emergency care visit and \$0 for urgent care			
<b>Lab Tests, Procedures, and Radiation Therapy</b>	\$0 copay for lab, diagnostic procedures, tests, x-rays and diagnostic radiology; \$60 copay for therapeutic radiology				\$0 copay for lab, diagnostic procedures, tests, x-rays and diagnostic radiology; \$60 copay for therapeutic radiology			
<b>Renal Dialysis</b>	<b>20%</b> co-insurance per treatment				<b>20%</b> co-insurance per treatment			
<b>Outpatient Mental Health Visits</b>	\$10 copay for individual or group therapy session				\$10 copay for individual or group therapy session			
<b>Eyewear</b>	<b>\$200</b> annual allowance for eyewear				<b>\$200</b> annual allowance for eyewear			
<b>Eye Exams</b>	\$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			
<b>Hearing Aids</b>	\$550-\$850 copay per aid; up to 2 aids each year; through TruHearing network provider				\$550-\$850 copay per aid; up to 2 aids each year; through TruHearing network provider			
<b>Hearing Exams</b>	\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam				\$0 copay for Medicare-covered exam; \$0 copay for one annual routine exam			
<b>Dental</b>	\$0 co-pay per Medicare-covered visit; \$0 co-pay for certain preventive and diagnostic services; See Optional Dental Plan below				\$0 co-pay per Medicare-covered visit; \$0 co-pay for certain preventive and diagnostic services; <b>\$2,000</b> annual limit			
<b>Chiropractic</b>	\$0 copay per Medicare covered visit; \$0 copay for 30 routine visits per year				\$0 copay per Medicare covered visit; \$5 copay for 30 routine visits per year, combined with chiropractic			
<b>Podiatry</b>	\$0 copay per Medicare-covered visit				\$0 copay per Medicare-covered visit			
<b>Prescription Drugs (Part D)</b>	<i>Cost-sharing shown is for preferred pharmacies</i>				<i>Cost-sharing shown is for preferred pharmacies</i>			
		30 days	100 days retail	100 days mail		30 days	100 days retail	100 days mail
	Preferred Generic	\$0	\$0	\$0	Preferred Generic	\$0	\$0	\$0
	Generic	\$0	\$0	\$0	Generic	\$0	\$0	\$0
	Preferred Brand	\$42	\$126	\$126	Preferred Brand	\$35	\$126	\$126
	Non-Preferred Brand	50%	50%	50%	Non-Preferred Brand	50%	50%	50%
	Specialty co-insurance	33%	N/A	N/A	Specialty co-insurance	33%	N/A	N/A
	<b>\$0</b> deductible; <b>after total yearly drug costs reach \$2,000</b> , you pay <b>\$0</b> .				<b>\$0</b> deductible; <b>after total yearly drug costs reach \$2,000</b> , you pay <b>\$0</b> .			
<b>Supplemental Benefits and Optional Plans</b>	<b>Acupuncture:</b> \$0 copay per visit for 36 routine visits per year <b>Essential Dental Plan:</b> \$10/month; varying copays for certain diagnostic and comprehensive services <b>In-Home Support Services:</b> 40 hours for personal care following a hospitalization <b>Meals:</b> up to 84 home-delivered meals per year following a hospital stay or due to a chronic condition <b>Over the Counter:</b> \$75 quarterly allowance items in-store at CVS or home delivery; balance carries over to next quarter but not calendar year <b>Transportation:</b> \$0 copay for 24 one-way trips per year to plan-approved locations within 50 miles				<b>Acupuncture:</b> \$0 copay per visit for 30 routine visits per year, combined with chiropractic <b>In-Home Support Services:</b> 40 hours for personal care following a hospitalization <b>Meals:</b> up to 84 home-delivered meals per year following a hospital stay or due to a chronic condition <b>Over the Counter:</b> \$75 quarterly allowance items in-store at CVS or home delivery; balance carries over to next quarter but not calendar year			
<b>Medical Groups and Hospitals</b> (may not be full list; please check with plan)	<b>Medical Groups:</b> Brown & Toland, Imperial Health Holdings, SCAN Direct Contract <b>Hospitals:</b> Alameda, Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleasanton)				<b>Medical Groups:</b> Brown & Toland, Imperial Health Holdings, SCAN Direct Contract <b>Hospitals:</b> Alameda, Alta Bates/Summit (Berk/Oak), Highland (Oak), San Leandro, St. Rose (Hayward), Stanford Valley Care (Pleasanton)			

## 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 (\$257 in 2025). Medicare Advantage plans also cannot charge cost sharing (meaning no deductible, no copayment or coinsurance) for most in-network preventive benefits. These preventive benefits available at no cost include:

- Abdominal Aortic Aneurysm Screening: one per lifetime
- Alcohol Misuse Screening and Counseling: one screening per year and up to 4 counseling sessions per year
- Annual Wellness Visit: one per year
- Bone Mass Measurement: one every 2 years
- Breast Cancer Screening: one per year
- Cardiovascular (Heart Disease) Screening and Therapy: one screening every 5 years and one counseling session (with primary care physician) per year
- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam): one every 2 years or one a year if at high risk
- Colorectal Cancer Screening: frequency varies by type of test
- COVID 19 Vaccine and Boosters
- Depression Screening: one per year
- Diabetes Screening: 2 per year if at risk
- Flu Shot: one per year
- Hepatitis B Shots: as needed depending on health status
- HIV Screening: one per year
- Medical Nutrition Therapy: as needed depending on health status
- Obesity Screening & Counseling: one screening/year and up to 22 counseling sessions/year
- Pneumococcal Shots: one per lifetime
- Prostate Cancer Screening: one per year for age 50 and over
- RSV (Respiratory Syncytial Virus) Vaccine: one per year
- Sexually Transmitted infections (STI) Screening & Counseling: one screening per year and 2 counseling sessions (with primary care physician) per year
- Shingles Vaccine
- Tobacco-use Cessation Counseling (if not diagnosed with related illness): up to 8 sessions per year
- "Welcome to Medicare" Exam: one in the year following enrollment into Part B

The following preventive benefits are subject to cost-sharing under Original Medicare (the Part B deductible and 20% co-insurance). Medicare Advantage plans may charge for these services:

- Barium Enema Screening: one every 4 years for age 50 and over
- Diabetes Self-Management Training Services: as ordered by doctor
- Glaucoma Screening: one per year if at high risk
- Prostate Cancer Screening (digital rectal exam): one per year for age 50 and over
- Tobacco-use Cessation Counseling (if diagnosed with related illness): up to 8 sessions per year

For more information on preventive care coverage, you can refer to the Medicare and You 2024 Handbook. Call 1-800-Medicare to request a copy or visit: [www.medicare.gov/medicare-and-you](https://www.medicare.gov/medicare-and-you).

## Star Ratings

This summary rating gives an overall score of the Medicare Advantage plan's quality and performance on up to 46 unique quality and performance factors that fall into 5 categories:

- Staying healthy: screenings, tests, and vaccines. Includes whether members got various screening tests, vaccines, and other check-ups that help them stay healthy.
- Managing chronic (long-term) conditions. Includes how often members with different conditions got certain tests and treatments that help manage their condition.
- Member experience with the health plan. Includes ratings of member satisfaction with the plan.
- Member complaints and changes in the health plan's performance: Includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- Health plan customer service. Includes how well the plan handles member appeals.

This information is gathered from several different sources. In some cases it is based on member surveys, information from clinicians, or information from plans. In other cases, it is based on results from Medicare's regular monitoring activities. Detailed information is available here:

<https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings>