2019 San Francisco Medicare Advantage - HMO w/MediCal

	Health Net of California		SCAN Health Plan
Plan Name	**Health Net Seniority Plus Sapphire Premier (H3561-002)**	**Health Net Seniority Plus Sapphire Premier II (H3561-005)**	**SCAN Plus (H5425-045)**
Monthly Premium	**$34.80**	**34.80**	**$34.80**
	$0 (with full Medi-Cal)	**$0 (with full Medi-Cal)**	**$0 (with full Medi-Cal)**
MOOP	$6,700	$6,700	$6,700
Phone Number	1-800-431-9007 Current Members	1-800-431-9007 Current Members	1-800-559-3500 Current Members
	1-800-977-6738 Prospective Member	1-800-977-6738 Prospective Member	1-888-315-7226 Prospective Members
Network Provider	Brown and Toland	Brown & Toland; Hills physician	Brown and Toland; Hills Physicians
Network Hospital	CPMC; St. Francis; St. Mary's.	CPMC; St. Francis; St. Mary's,U	CPMC, St. Francis, St. Mary's, Seton
Physician Visit	$0 copay for primary care or specialist.	$0 copay for primary care or specialist.	$0 copay for primary care or specialist.
Inpatient Hospital	Coming soon.	coming soon	Medicare fee-for-serice costs
Outpatient Surgery	Ambulatory surgical center: 20% of cost. Outpatient Hospital: 20% of cost	20% per visit.	20% of the cost at an ambulatory surgical center and outpatient hospital.
DME	20% of the cost per item	20% of the cost per item	20% of the cost per item, diabetes $0
Mental Health	Inpatient: $90 copay for days 1-15. $0 per day days 16-90. Outpatient group/individual therapy: 20%	Inpatient: Up to 190 Days of impatient psychiatric hospital care in a lifetime. $90 copay for days 1-15. $0 per day days 16-90. Outpatient: 20% for individual therapy w/psychiatrist and without & group therapy w/psychiatrist and without.	Inpatient: Coming soon. Outpatient: $0 of the cost for group and individual therapy visits.
Ambulance Service	20% of cost	20% of cost	20%
Emergency Care	$90; waived if admitted into hospital. Worldwide (always covered), urgent care 20% (always covered)	$90; waived if admitted into hospital (always covered), worldwide, urgent care 20% (always covered)	20% worldwide. (always covered), urgent 20% (always covered)
Diagnostic Test, X- Ray & Lab Service	20% of the cost for diagnostic radiology services,diagnostic tests and procedures, outpatient x-ray, and therapeutic radiology services. $0 for lab services.	$0 for lab services. 20% for diagnostic procedures and tests and x-rays. $60 for radiology servies (not including x-rays) and therapeutic radiology services.	$0 for lab services, 20% for diagnostic procedures and tests, x-rays, radiology services, and therapeutic radiology services.
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred Generic: $0 (preferred pharmacies) Tier2: Non Preferred Generic: $20 Tier 3: Preferred Brand: $47 Tier 4: Non-Preferred Brand: $100 Tier 5: Specialkty Tier: 27% coinsurance Tier 6: Select Care Drugs: $0 $285 deductable tiers 2,3,4,5. 20% for Part B drugs	Tier 1: Prefferd generic: $0 (preferred pharmacy) Tier2: Non-preferred generic: $20 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 27% coinsurance Tier 6: Select Care: $0 $280 deductable, 20% for Part-B drugs	Tier 1: Preferred generic: $0 (preferred pharmacy) Tier 2: Non-preferred generic: 25% Tier 3: Preferred brand: 25% Tier 4: Non-preferred brand: 25% Tier 5: Specialty: 25% Deductible $415 to drugs on certain tiers) 20% for Part B-covered drugs.
Other	Dental (HMO) exam $0. Hearing 20%. Eye exam $0. Optional Package $23. Eyewear allowance $550. Transportation $0 with limits. Fitness. OTC medications $55/quarter.	Vision $0, Hearing 20%. Fitness. $0 transportation with limits. Optional Package $23/month for chiropractic services, acupuncture, dental, vision and fitness. Home delivered meals, 2/day, for 14 days after discharge.	Acupuncture/Chiropractic: $5 (30 visits per year combined) Personal Response System $15/month. Hearing $0, vision $0, dental $0, transportation $0 with limits, fitness, $0 podiatry (6 visits/year), OTC $50/quarter, in-home care (w/limitations).

This is only a guide. Call your doctor, the plan directly or contact HICAP at 1-800-432-0222

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	UnitedHealthcare
Plan Name	**United Healthcare Medicare Complete Assure (H0543-186)**
Monthly Premium	**$18.30**
	$0 (with full Medi-Cal)
MOOP	$6,700
Phone Number	1-800-950-9355 Current Members 1-800-555-5757 Prospective Member
Network Provider	
Network Hospital	
Physician Visit	20% primary 20% specialist.
Inpatient Hospital	$0 days 1-60,(after $1340 deductible); $335 days 61-90; $670 days 91-150.
Outpatient Surgery	20%, coinsurance cost sharing fotr additional plan covered services will apply.
DME	20% per item, diabetes $0
Mental Health	Inpatient: $1340 deductible $0 copay for days 1-60. $335 days 61-90, $670 days 91-150. $55/day for partial hospitization. Outpatient: $0-20%.
Ambulance Service	20% ground, 20% air
Emergency Care	$90 (always covered),$0 worldwide service; urgent care $65, $0 worldwide service.
Diagnostic Test, X- Ray & Lab Service	$0 Non-radiological diagnostic tests and procedure, $0 lab services, $60 Medicare-covered radiology therapy service, $95 Medicare-covered radiological diagnostic service, 20% outpatient x-rays
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferreed genetic: 25% (retail pharmacy) Tier 2: Non-preferred genetic: 25% Tier 3: Preferred brand: 25% Tier 4: Non-preferred brand: $25 Tier 5: Specialty: 28% Part B drugs : 20% $415 deductible 25% for Part B-covered drugs.
Other	$0 Nurseline, fitness, $0 hearing exam, $0 eye exam, $0 eyewear every 2 years up to $70, contacts $105.$20 podiatrist, hearing aids $0 each by HealthInnovations, $0 24 1-way trips, OTC $50 /quarter. $0 personal emer response system.

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