# 2021 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 (H5425-045)** | **SCAN Plus (H5425-045)** |
| **Monthly Premium** | **$24.40** | **26.70** | **31.50 $203 deductible** |
| | **$0 (with full Medi-Cal)** | **$0 (with full Medi-Cal)** | **$0 (with full Medi-Cal)** |
| **MOOP** | $3,450 | $3,450 | $7,550 |
| **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** | $800 days 1-3, $0 days 4-90 | $800 days 1-3, $0 days 4-90 | $1484 deductible days 1-60, $371 days 61-90 |
| **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** | DME 20%, dialysis 20%, Diabetes $0-20% | DME 20%, dialysis 20%, diabetes $0-20% | DME 20% per item, dialysis 20%, diabetes $0 |
| **Mental Health** | *Inpatient: $90 copay for days 1-15. $0 per day days 16-90.<br><br>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.<br>Outpatient: 20% for individual therapy w/psychiatrist and without & group therapy w/psychiatrist and without. | *Inpatient: Coming soon.<br>Outpatient: $0 of the cost for group and individual therapy visits. |
| **Ambulance Service** | 20% of cost | 20% of cost | 20% |
| **Emergency Care** | $120; waived if admitted into hospital. Worldwide (always covered), urgent care 20% (always covered) | $120; 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** | $0-20% for diagnostic tests, $0 lab, 20% outpatient x-ray, and 20% therapeutic radiology services. | 20% for diagnostic procedures and tests and x-rays. $0 lab. 20% for radiology servies (not including x-rays) and therapeutic radiology services. | $0 for lab services,<br>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)<br>Tier2: Non Preferred Generic: $20<br>Tier 3: Preferred Brand: $47<br>Tier 4: Non-Preferred Brand: 45%<br>Tier 5: Specialty Tier: 25% coinsurance<br><br>$445 deductible. 20% for Part B drugs | Tier 1: Prefferd generic: $0 (preferred pharmacy)<br>Tier2: Non-preferred generic: $20<br>Tier 3: Preferred brand: $47<br>Tier 4: Non-preferred brand: 42%<br>Tier 5: Specialty: 25%<br><br>$445 deductable, 20% for Part-B drugs | Tier 1: Preferred generic: $0 (preferred pharmacy)<br>Tier 2: Non-preferred generic: $0<br>Tier 3: Preferred brand: 23%<br>Tier 4: Non-preferred brand: 23%<br>Tier 5: Specialty: 25%, Select:$5<br>Deductible $445 to drugs on certain tiers)<br><br>20% for Part B-covered drugs. |
| **Other** | Preventive Dental $0, Comprehensive dental varies, Hearing 20%. Hearing aids $0-$1350. Eye exam $0. Eyeglasses $0. Some transportation. Some fitness. | 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). |

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| | UnitedHealthcare | Imperial | Alignment Health Plan |
|---|---|---|---|
| **Plan Name** | **United Healthcare Medicare Complete Assure (H0543-183)** | **Imperial Traditional Plus (H5496-009)** | **Cal Plus (H3815-009)** |
| **Monthly Premium** | **$26.60** | $31.50 $203 deductible | $20.10 |
| | **$0 (with full Medi-Cal)** | $0 (with full Medi-Cal) | $0 (with full Medi-Cal) |
| **MOOP** | $7,550 | $2,999 | $4,900 |
| **Phone Number** | 1-844-808-4553 Current Members | 1-800-838-8271 current members | 1-866-634-2247 current members |
| | 1-800-555-5757 Prospective Member | 1-800-838-5914 prospective members | 1-888-979-2247 prospective members |
| **Network Provider** | www.uhcmedicaresolutions.com | www.imperialhealthplan.com | www.alignmenthealthplan.com |
| **Network Hospital** | www.uhcmedicaresolutions.com | www.imperialhealthplan.com | www.alignmenthealthplan.com |
| **Physician Visit** | 20% primary 20% specialist. | 20% primary, 20% specialist | $0 primary, $0 specialist |
| **Inpatient Hospital** | $1400 per stay, $0 days 91+ | $1484 deductible days 1-60, $371 days 61-90 | $1484 deductible days 1-60, $371 days 61-90 |
| **Outpatient Surgery** | 20%, coinsurance cost sharing fotr additional plan covered services will apply. | 20% | 20% |
| **DME** | 20%, dialysis 20%,diabetes $0 | 20%, dialy 20%, diabetes 20% | 20%, dialy 20%,diabetes 20% |
| **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%. | outpatient 20% | outpatient 20% |
| **Ambulance Service** | 20% ground, 20% air | 20% | 20% |
| **Emergency Care** | *$90 (always covered),$0 worldwide service; urgent care $65, $0 worldwide service. | emergency 20%, urgent 20% | emergency 20%, urgent 20% |
| **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 | tests 20%, lab $0, x-rays 20%, diagnostic radiation 20% | tests 20%, lab 20%, x-ray 20% |
| **Prescription Drugs Copay (per 30-31 Days)** | Intitial coverage phase: generic 25%<br>Gap coverage phase: generic 25% brand-name 25%<br><br>Part B drugs : 20%<br>$445 deductible<br>20% chemo drugs | Tier 1: Prefered generic: 0% (preferred pharmacy)<br>Tier2: Non-preferred generic: 25%<br>Tier 3: Preferred brand: 25%<br>Tier 4: Non-preferred brand: 25%<br>Tier 5: Specialty: 25%<br><br>$445 deductable, 20% for Part-B drugs | Tier 1: Prefered generic: 0% (preferred pharmacy)<br>Tier2: Non-preferred generic: $14<br>Tier 3: Preferred brand: 23%<br>Tier 4: Non-preferred brand: 23%<br>Tier 5: Specialty: 25% select $5<br>$445 deductable, 20% for Part-B 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. | | |

* data from previous year. Plan did not send 2021 update information to us, yet

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