

2024 San Francisco Medicare Advantage Plans - HMO

	Kaiser Permanente		SCAN	SCAN	United Health
Plan Name	Kaiser Permanente Senior Advantage Basic SF (H0524-060-0)	Kaiser Permanente Senior Advantage Alam., SF, Napa (H0524-032-0)	SCAN Classic (H5425-019-0)	SCAN Affirm Partnered w LGBTQ & Health (H5425-107-0)	UnitedHealthcare Medicare Advantage (CA-001A)
Monthly Premium	\$0.00	70.00	\$29.00	\$29.00	\$27.80 (Health Ded \$240, Drug ded \$545)
Website	https://healthy.kaiserpermanente.org	https://healthy.kaiserpermanente.org	https://www.scanhealthplan.com	https://www.scanhealthplan.com	https://cchphealthplan.com
MOOP	\$6,000 In-network	\$3,900 In-network	\$2,900 In-network	\$3,200 In-network	\$8,850 In-network
Contact	1-800-443-0815 Current Members 1-800-777-1238 Prospective Member	1-800-443-0815 Current Members 1-800-777-1238 Prospective Member	1-800-559-3500 Current Member 1-888-315-7226 Prospective Member	1-800-559-3500 Current Member 1-888-315-7226 Prospective Member	1-866-261-7709 Current Members 1-800-555-5757 Prospective Member
Network Provider	Kaiser providers	Kaiser providers	Brown & Toland, Imperial Health Plan of SF	Call Plan	Hills Physicians (Mostly)
Network Hospital	Kaiser hospitals	Kaiser hospitals	Call Plan	Call Plan	UCSF Medical Center, St Mary's, CPMC Ca
Physician Visit	\$10 primary care. \$15 specialist.	\$0 primary. \$10 specialist	\$0 primary. \$0 specialist	\$0 primary care. \$0 specialist.	0-20% coinsurance primary. 0-20% coinsurance specialist.
Inpatient Visit	\$275 per day for days 1 through 5 \$0 per day for days 6 through 90 \$0 per day for days 91 and beyond	\$225 per day for days 1 through 5 \$0 per day for days 6 through 90 \$0 per day for days 91 and beyond	\$150 per day for days 1 through 7 \$0 per day for days 8 through 90	\$150 per day for days 1 through 7 \$0 per day for days 8 through 90	\$1,450 per stay \$0 per day for days 91 and beyond
Outpatient Surgery	\$0-250	\$0-190	\$0-200	\$0-200	0-20% coinsurance
DME	DME: 0-20% per item, Dialysis in-network: 20% coinsurance, Prosthetics: 20% per item, Diabetic: \$0	DME: 0-20% per item, Dialysis in-network: 20% coinsurance, Prosthetics: 20% per item, Diabetic: \$0	DME, Prosthetics: 0-20% per item, Dialysis In-network: 20%, Diabetes: \$0.	DME, Prosthetics: 0-20% per item, Dialysis In-network: 20%, Diabetes: \$0.	DME: 20% per item, Dialysis in-network: 20% coinsurance, Prosthetics: 20% per item, Diabetic: \$0.
Mental Health	Outpatient group therapy with a psych: \$0-5 Outpatient individual therapy with a psych: \$0-10 Outpatient group therapy: \$5 Outpatient individual therapy: \$10	Outpatient group/individual therapy: \$0	Outpatient group/individual therapy with a psych: \$15 Outpatient group/individual therapy: \$25	Outpatient group/individual therapy with a psych: \$15 Outpatient group/individual therapy: \$10	Outpatient group w Psych 20% Outpatient individual w Psych 0-20% Outpatient group 20% Outpatient individual 0-20%
Ambulance Service	\$300.00	\$120.00	\$175.00	\$175.00	20% coinsurance
Emergency Service	\$120 Emergency care. \$10 Urgent care.	\$110 Emergency care. \$0 Urgent care.	\$90 Emergency care. \$0 Urgent care.	\$90 Emergency care. \$0 Urgent care.	\$100 Emergency care. \$0-40 Urgent care.
Diagnostic Test, X-Ray & Lab Services	\$10 for Diagnostic test & procedures, 0-10 Lab Service. \$20 for X- Ray, Diagnostic radiology services \$20-\$250	\$0 for Diagnostic test & procedures, X- Ray, Lab Service \$0-200 for Diagnostic radiology services	\$0 for Diagnostic test & procedures, X- Ray, Lab Service, \$60 for Diagnostic radiology services	\$0 for Diagnostic test & procedures, X- Ray, Lab Service \$60 for Diagnostic radiology services	\$0 for Diagnostic test & Lab Service. 0 – 20% for Diagnostic radiology services. 20% for X – rays.
Prescription Drugs Copay	Tier 1: Preferred generic: \$5 Tier 2: Non – preferred generic: \$18 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 33% Tier 6: Vaccines :\$0 Chemo and Part B covered drugs: \$0-47 or 0 - 20%, all other drugs pay 25% Part B Insulin \$18 - 35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$7 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 33% Tier 6: Vaccines: \$0 Chemo and Part B covered drugs: \$0-47 copay or 0-20% , all other drugs pay 25% Part B Insulin \$7-35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$42 Tier 4: Non – preferred brand: \$95 Tier 5: Specialty: 33% coinsurance selected care drugs \$11 Chemo and Part B covered drugs: 0 - 20% Part B Insulin 0-20% up to \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$35 Tier 4: Non – preferred brand: \$95 Tier 5: Specialty: 25% selected care drugs \$11 Chemo and Part B covered drugs: 0 - 20% Part B Insulin 0-20% up to \$35	Tier 1: Generic: 25% coinsurance Tier 2: Brand – name: 25% coinsurance coinsurance Chemo drugs and 0-20%, Part B covered drugs 0–20% Part B Insulin 0-20%
Other	Preventive dental covered under office visits, Comprehensive dental varies, optional dental pkg \$21 Eye exam: \$10, some fitness, some telehealth, some acupuncture	Preventive dental: office visit Comprehensive dental some Eye exam: \$0, some fitness, some telehealth, no chiropractic, some acupuncture. Optional dental package: \$21	Hearing exam: \$0, Hearing aids: \$450-750, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth, some chiropractic, some acupuncture, Optional dental package \$ 6, \$ 16	Hearing exam: \$0, Hearing aids: \$450-750, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth, some OTC, Optional dental package \$ 6, \$ 16	Hearing exam: \$0 Hearing aids \$0 both are in network Eye exam: \$ 0 copay, Eyeglasses: \$0, some fitness, some telehealth. some OTC

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	Aetna			Anthem	
Plan Name	Aetna Medicare Select Plan (H0523-070-0)	Aetna Medicare Plus Plan (H4982-007-0)	Aetna Medicare Eagle Plan (H4982-013-0)	Anthem Select (H0544-069-0)	Anthem Prime (H4161-004-0)
Monthly Premium	\$0.00	\$0.00	\$0.00(without drug coverage)	\$0.00	\$0.00
Website	https://www.aetnamedicare.com	https://www.aetnamedicare.com	https://www.aetnamedicare.com	https://shop.anthem.com	https://shop.anthem.com
MOOP	\$2,500 In – network	\$3,400 In – network	\$4,200 In – network	\$7,550 In-network	\$2,500 In-network
Contact	1-833-570-6670 Current Members 1-833-859-6031 Prospective Member	1-833-570-6670 Current Members 1-833-859-6031 Prospective Member	1-833-570-6670 Current Members 1-833-859-6031 Prospective Member	1-800-499-2793 Current Members 1-855-593-0898 Prospective Member	1-833-707-3129 Current Members 1-855-593-0898 Prospective Member
Network Provider	Call Plan	Call Plan	Call Plan	NEMS, Brown & Toland, AAMG, Imperial, Access	NEMS, Brown & Toland, AAMG, Imperial, Access
Network Hospital	Call Plan	Call Plan	Call Plan	Chinese Hospital, St. Mary's, St Francis, CPMC	Chinese Hospital, St. Mary's, St Francis, CPMC
Physician Visit	\$0 primary. \$0 specialist	\$0 primary. \$0 specialist	\$0 primary. \$10 specialist	\$5 primary care. \$20 specialist.	\$0 primary care. \$25 specialist.
Inpatient Visit	\$100 per day for days 1 through 5 \$0 per day for days 6 through 90	\$150 per day for days 1 through 5 \$0 per day for days 6 through 90	\$50 per day for days 1 through 3 \$0 per day for days 4 through 90	\$360 per day for days 1 through 4 \$0 per day for days 5 through 90	\$250 per day for days 1 through 4 \$0 per day for days 5 through 90
Outpatient Surgery	\$0 – 125	\$0 – 125	\$0-50	\$0-350	\$0-250
DME	DME: 0-20% per item, Dialysis in-network: 20% per item, Prosthetics: 20% Diabetes: 0 – 20%.	DME: 0-20% per item, Dialysis in-network: 20% per item, Prosthetics: 20% Diabetes: 0 – 20%	DME:0-20% per item, Dialysis in - network: 20% per item, Prosthetics: 20% per item, Diabetes: 0 – 20%.	DME: 0-20% per item, Dialysis in-network: 20% coinsurance, Prosthetics: \$0 copay or 20% per item, Diabetic \$ 0 copay	DME: 0-20% per item, Dialysis in-network: 20% coinsurance, Prosthetics: 20% per item, Diabetic: \$0.
Mental Health	Outpatient group/individual therapy: \$10	Outpatient group/individual therapy: \$10	Outpatient group/individual therapy: \$25	Outpatient group/individual therapy: \$40	Outpatient group/individual therapy: \$40
Ambulance Service	\$295	\$325	\$275	\$300	\$250
Emergency Service	\$125 Emergency care. \$0 Urgent care.	\$125 Emergency care. \$0 Urgent care.	\$110 Emergency care. \$10 Urgent care.	\$90 Emergency care. \$35 Urgent care.	\$90 Emergency care. \$35 Urgent care.
Diagnostic Test, X-Ray & Lab Services	\$0 for Diagnostic test & procedures, X-Ray, Lab Service, Diagnostic radiology services	\$0 for Diagnostic test & procedures, X-Ray, Lab Service, Diagnostic radiology services	\$0 for Diagnostic test & procedures, X-Ray, Lab Service, \$0 – 100 Diagnostic radiology services	\$0-120 for Diagnostic test & procedures, \$0-50 for X- Ray, \$0-5 Lab Service. \$65-165 for Diagnostic radiology services	\$0-50 for Diagnostic test & procedures, \$10 for X- Ray, \$0-10 Lab Service. \$175 for Diagnostic radiology services
Prescription Drugs Copay	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 33% coinsurance Chemotherapy 0-20% Other Part B covered drugs: 0-20% Part B insulin \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 33% coinsurance Chemo and Part B covered drugs: 0-20% Part B Insulin \$35 All others should be 25%	No drug coverage Chemo and Part B covered drugs: 20% coinsurance Insulin \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$10 Tier 3: Preferred brand: \$42 Tier 4: Non – preferred brand: \$95 Tier 5: Specialty: 33% Chemo and Part B covered drugs: 0-20% All other drugs pay 25% Part B Insulin \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$7 Tier 3: Preferred brand: \$42 Tier 4: Non – preferred brand: \$95 Tier 5: Specialty: 33% Chemo and Part B covered drugs: 0-20% coinsurance Part B Insulin \$35
Other	Preventive dental: \$0 Comprehensive dental: \$0 Hearing exam: \$0, Hearing aids: \$ 0 copay, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth, some chiropractic, some acupuncture.	Preventive dental: \$0 Comprehensive dental: \$0 Hearing exam: \$0, Hearing aids: \$0, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth, some chiropractic, some acupuncture.	Preventive dental: \$0 Comprehensive dental: \$0 Hearing exam: \$0, Hearing aids: \$0, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth, some chiropractic, some acupuncture.	Preventive dental some Hearing exam: \$ 0, Hearing aids: \$0, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth, some OTC, some acupuncture. Optional dental package \$13, \$32 and \$48. .	Hearing exam: \$0, Hearing aids: \$0, Eye exam: \$0, Eyeglasses: \$0 Preventative dental \$0, comprehensive \$0 Optional dental Pkg #1 \$13, #2 \$32 #3 \$48

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Plan Name	Alignment				Chinese Community Health Plan
	Alignment Health Harmony (H3815-031-0)	Alignment Health My Choice CalPlus (H3815-007-0)	Alignment Health CalPlus + Heroes (H3815-036-0)	Alignment Health Sutter Advantage (H3815-023-0)	CCHP Senior Program (H0571-001)
Monthly Premium	\$0.00	0 SOC w LIS	\$ 0.00 (\$ 545 drug deductible)	\$48.00	\$39.50
Website	https://www.alignmenthealthplan.com	https://www.alignmenthealthplan.com	https://www.alignmenthealthplan.com	https://www.alignmenthealthplan.com	https://cchphealthplan.com
MOOP	\$2900 In – network	\$3,000 In – network	\$5,900 In – network	\$3,900 In – network	\$6700 In-network
Contact	1-888-834-2247 Current Members 1-888-979-2247 Prospective Member	1-866-634-2247 Current Members 1-888-979-2247 Prospective Member	1-866-634-2247 Current Members 1-888-979-2247 Prospective Member	1-866-634-2247 Current Members 1-888-979-2247 Prospective Member	1-888-775-7888 Current Members 1-888-681-3888 Prospective Member
Network Provider	Brown & Toland	Alignment Health Plan Network, Brown & Toland	Brown & Toland	Alignment Health Plan Network, Sutter	Jade Medical Group, Access Medical Group, HPMG
Network Hospital	Chines Hospital, St Francis, CPMC, St. Mary's UCSF	CPMC	CPMC	CPMC	Chines Hospital, St. Francis, CPMC, Seton, Dignity Health, Stanford Health, UCSF
Physician Visit	\$0 primary care. \$0 specialist.	\$0 primary care. \$0 specialist.	\$0 primary care. \$0 specialist.	\$5 primary. \$25 specialist	\$0 primary care. \$15 specialist.
Inpatient Visit	\$0 per day for days 1 through 4 \$100 per day for days 5 through 10 \$0 per day for days 11 through 90	\$0 per day for days 1 through 4 \$100 per day for days 5 through 10 \$0 per day for days 11 through 90	In 2024, the amount for each benefit period are: \$1,632 deductible, day 1-60 \$408 per day, days 61-91	\$225 per day for days 1 through 5 \$0 per day for days 6 through 90	Tier 1 \$100 per day for days 1 through 7 \$0 per day for days 8 through 90 (only Chinese Hospital) Tier 2 \$305 per day for days 1 through 7 \$0 per day for days 8 through 90
Outpatient Surgery	\$200	\$200	\$0.00	\$250	\$100-310
DME	DME: 20% per item, Dialysis in-network: \$30, Prosthetics: 20% per item, Diabetes: \$0.	DME: 20% per item, Dialysis in-network: 20% per item, Prosthetics: 20% per item, Diabetes: \$0.	DME: 20% per item, Dialysis in-network: 20% per item, Prosthetics: 20% per item, Diabetes: \$0.	DME: 0-20% per item, Dialysis in-network: 20% per item, Prosthetics: 20% per item, Diabetes: \$0	DME: 20% per item, Dialysis in - network: 20% coinsurance, Prosthetics: 20% per item, Diabetic: \$0.
Mental Health	Outpatient group therapy with a psych: \$40 Outpatient individual therapy with a psych: \$40 Outpatient group therapy: \$0 Outpatient individual therapy: \$0	Outpatient group therapy with a psych: \$40 Outpatient individual therapy with a psych: \$40 Outpatient group therapy: \$0 Outpatient individual therapy: \$0	Outpatient group/individual therapy: 20% coinsurance	Outpatient group therapy with a psych: \$40 Outpatient individual therapy with a psych: \$40 Outpatient group therapy: \$0 Outpatient individual therapy: \$0	Outpatient group/individual therapy: \$15
Ambulance Service	\$175.00	\$175.00	20% coinsurance	\$250.00	\$265.00
Emergency Service	\$85 Emergency care. \$0 Urgent care.	\$85 Emergency care. \$0 Urgent care.	20% coinsurance for Emergency care, Urgent care.	\$90 Emergency care. \$0 Urgent care.	\$90 Emergency care. \$45 Urgent care.
Diagnostic Test, X-Ray & Lab Services	\$0 for Diagnostic test & procedures, X-Ray, Lab Service, Diagnostic radiology services	\$0 for Diagnostic test & procedures, X-Ray, Lab Service, Diagnostic radiology services	\$0 for Diagnostic test & procedures, X-Ray, Lab Service, Diagnostic radiology services	\$0 for Diagnostic test & Lab Service. \$150 for Diagnostic radiology services. \$15 for X – rays.	\$0 for Diagnostic test & procedures, X- Ray, Lab Service. \$200 for Diagnostic radiology services
Prescription Drugs Copay	Gap Coverage Generic 25% Brand Name 25% Chemo and Part B covered drugs: 0-20% coinsurance Part B Insulin 0-20% up to \$35	Gap Coverage Generic 25% Brand Name 25% Chemo and Part B covered drugs: 0-20% coinsurance Part B Insulin 0-20% up to \$35	Gap Coverage Generic 25% Brand Name 25% Chemo and Part B covered drugs: 0-20% coinsurance Part B Insulin 0-20% up to \$35	Gap Coverage Generic 25% Brand Name 25% Chemo and Part B covered drugs: 0-20% coinsurance Part B Insulin 0-20% up to \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$7 Tier 3: Preferred brand: \$40 Tier 4: Non – preferred brand: \$60 Tier 5: Specialty: 33% coinsurance Chemo and Part B covered drugs: 0-20% Part B Insulin \$35
Other	Hearing exam: \$0, Hearing aids: \$0, Eye exam: \$0 Eyeglasses: \$0, some fitness, some telehealth Preventative dental \$0, Comprehensive varies. Optional dental package: \$27	Hearing exam: \$0, Hearing aids: \$0, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth. Optional dental package: \$27.	Hearing exam: \$0, Hearing aids: \$0, Eye exam: \$0, Eyeglasses: \$0, some fitness, telehealth, meals & OTC, optional dental \$27	Hearing exam: \$0, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth. Optional dental package: \$27.	Hearing exam: \$0, Hearing aids: \$600 – 2075, Eye exam: \$20, Eyeglasses: \$0, some fitness, some telehealth. Optional dental package: \$10.

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	Brand New Day			Wellcare	
Plan Name	Brand New Day Valor Care Plan (H0838-048-0)	Brand New Day Classic Care II Plan (H0838-051-1)	Brand New Day Classic Care I Plan (H0838-050-2)	Wellcare No Premium Focus (H0562-097-0)	Wellcare Premium Ultra (H0562-009-0)
Monthly Premium	\$0.00 (without drug coverage) Part B premium deduction	\$0 (\$50 Drug Deductible)	\$37.60	\$0 (\$150 Drug Deductible)	\$131 (\$300 Drug Deductible)
Website	https://www.bndhmo.com	https://www.bndhmo.com	https://www.bndhmo.com	https://wellcare.healthnetcalifornia.com	https://wellcare.com
MOOP	\$3,850 In-network	\$2,499 In-network	\$2,100 In-network	\$6,350 In-network	\$8,850 In-network
Contact	1-800-233-4795 Current members 1-888-683-1882 Prospective Member	1-800-233-4795 Current members 1-888-683-1882 Prospective Member	1-800-233-4795 Current members 1-888-683-1882 Prospective Member	1-844-917-0175 Prospective Member	1-800-273-4737 Current members 1-844-917-0175 Prospective Member
Network Provider	AAMG, Hills Physicians Medical Group, ACCESS	AAMG, Hills Physicians Medical Gorups, ACCESS	AAMG, Hills Physicians Medical Group, ACCESS	CBC :Brown & Toland, UCSF only St. Mary, St. Francis, CMPC, AAMG, NEMS	Brown and Toland, AAMG, Hills Physicians
Network Hospital	CPMC,(Davies, Van Ness, Pacific), St. Francis, St. Mary's	CPMC,(Davies, Van Ness, Pacific), St. Francis, St. Mary's	CPMC,(Davies, Van Ness, Pacific), St. Francis, St. Mary's	CPMC-Davies and Mission Bernal, St Mary's, St Francis, AAMG only	HillsPhysicians -UCSF, CPMC, St Mary's, St. Francis
Physician Visit	\$0 primary care. \$10 specialist.	\$0 primary. \$15 specialist	\$0 primary. \$0 specialist	\$0 primary care. \$20 specialist.	\$10 primary. \$15 specialist
Inpatient Visit	In 2024, the amount for each benefit period are: \$1,632 deductible, day 1-60 \$408 per day, days 61-90	\$150 per day for days 1 through 6 \$0 per day for days 7 through 90	\$50/day, days 1 through 6 \$0 /day, say 7-90	\$350 per day for days 1 through 5 \$0 per day for days 6 through 90	\$310per day for days 1 through 6 \$0 per day for days 7 through 90
Outpatient Surgery	0-20% coinsurance	\$0-150 copay	\$0-\$150	\$0-\$200	\$0-350
DME	DME, Prosthetics: 0-20% per item, Dialysis In-network: 20%, Diabetes: \$0.	DME, Prosthetics: 0-20% per item, Dialysis In-network: 20%, Diabetes: \$0.	DME, Prosthetics: 0-20% per item, Dialysis In-network: 20%, Diabetes: \$0.	DME 20%, Prosthetics 20%, Dialysis In-network: 20%, Diabetes: \$0.	DME, Prosthetics, Dialysis In-network: 20%, Diabetes: \$0.
Mental Health	Outpatient group/individual with psych therapy \$0 Outpatient group/individual with no psych therapy: \$30	Outpatient group therapy with a psych: 20% Outpatient individual therapy with a psych: \$10 Outpatient group therapy: 20% Outpatient individual therapy: \$10	Outpatient group/individual therapy with a psych: \$25 Outpatient group/individual therapy: \$25	Outpatient group/individual therapy: \$25 with or without psychiatrist	Outpatient group/individual therapy: \$25
Ambulance Service	\$0-275	\$0-250	\$0-200	\$275.00	\$250.00
Emergency Service	\$0-120 Emergency care. \$0 Urgent care.	\$0-135 Emergency care. \$0 Urgent care.	\$0-100 Emergency care,\$0 Urgent Care	\$120 Emergency care. \$25 Urgent care	\$95 Emergency care. \$15 Urgent care.
Diagnostic Test, X-Ray & Lab Services	\$0 for Diagnostic test & procedures, X-Ray, Lab Service Diagnostic radiology services \$0-50	\$0 for Diagnostic test & procedures, X- Ray, Lab Service; \$0-50 for Diagnostic radiology services	\$0 Diagnostic, test , Lab service Diagnostic, Radiology, X- Ray	\$0-25 for Diagnostic test & procedures \$25 X- Ray, \$0-50 Lab Service, \$0-\$200 for Diagnostic radiology services	\$0 for Diagnostic test & procedures, X- Ray, \$0-50 Lab Service, \$0-350 for Diagnostic radiology services
Prescriptions Drugs Copay	No Part D drug coverage Chemo and Part B covered drugs: 0-20% Part B Insulin \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$12 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 32% coinsurance Tier 6: Select care: \$0 Chemo and Part B covered drugs: 0-20% Part B Insulin \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 33% coinsurance Tier 6: Select care: \$0 Chemotherapy 0-20% Other Part B covered drugs 0-20% Part B insulin \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$42 Tier 4: Non – preferred brand: 41% Tier 5: Specialty: 30% Tier 6: Select care: \$0 Chemo and Part B covered drugs: 0-20% Part B Insulin \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$5 Tier 3: Preferred brand: \$42 Tier 4: Non – preferred brand: 43% Tier 5: Specialty: 28% coinsurance Tier 6: Select care: \$0 Chemo and Part B covered drugs: 0-20% Part B Insulin \$35
Other	Hearing exam: \$0, Hearing aids: \$149, Eye exam: \$0, Eyeglasses: \$0 Preventative dental \$0, Comprehensive varies some fitness, some telehealth, some chiropractic, some acupuncture	Hearing exam: \$0, Hearing aids: \$699-999, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth, some chiropractic, some acupuncture.	Hearing exam: \$0, Hearing aids: \$149, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth, some chiropractic, some acupuncture. Preventive dental \$0 comprhensive varies	Hearing exam: \$0, Hearing aids: \$0, Eye exam: \$0, Eyeglasses: \$0 Preventative dental \$0, Compressive varies some fitness, some telehealth, some chiropractic, some acupuncture.	Hearing exam: \$0, Hearing aids: \$0 Eye exam: \$0, Eyeglasses \$0 some fitness, some telehealth Preventive dental \$0, Comprehensive varies

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	Imperial				Chinese Community Health Plan
Plan Name	Imperial Dynamic Plan (H5496-012-0)	Imperial Traditional (H5496-007-0)	Imperial Courage Plan (H5496-016-0)	Imperial Strong (H5496-014-0)	CCHP Senior Value Program (H0571-007-0)
Monthly Premium	\$0.00	\$0.00	\$0.00 (without drug coverage)	\$0.00 (Health Deductible \$240, Drug Deductible \$545) Part B premium deduction	\$0.00
Website	https://imperialhealthplan.com	https://imperialhealthplan.com	https://imperialhealthplan.com	https://imperialhealthplan.com	https://cchphealthplan.com
MOOP	\$298 In-network	\$1,349 In-network	\$2,999 In-network	\$8,850 In-network	\$7,550 In-network
Contact	1-800-838-8271 Current Members 1-800-838-5914 Prospective Member	1-800-838-8271 Current Members 1-800-838-5914 Prospective Member	1-800-838-8271 Current Members 1-800-838-5914 Prospective Member	1-800-838-8271 Current Members 1-800-838-5914 Prospective Member	1-888-775-7888 Current Members 1-888-681-3888 Prospective Member
Network Provider	Access/UCSF Imperial Holding referral only	Imperial Holding, Brown a& Toland	Imperial Holding, Brown a& Toland	Imperial Holding, Brown & Toland	Jade Medical Group, Access Medical Group, HPMG
Network Hospital		UCSF (Imperial Holdings), St. Mary's, St. Francis, Sutter (Van Ness)	UCSF (Imperial Holdings), St. Mary's, St. Francis, Sutter (Van Ness)	UCSF (Imperial Holdings), St. Mary's, St. Francis, Sutter (Van Ness)	Chines Hospital, St. Francis, CPMC, Seton, Dignity Health, Stanford Health
Physician Visit	\$0 primary care. \$0 specialist.	\$0 primary. \$0 specialist	\$0 primary. \$5 specialist	20% coinsurance primary. 20% coinsurance specialist	\$0-5 primary. \$20 specialist
Inpatient Visit	\$50 /day, days 1 - 5 \$0/day, days 6 - 90	\$150 per day for days 1 through 5 \$0 per day for days 6 through 90	\$150 per day for days 1 through 5 \$0 per day for days 6 through 90	In 2024, the amount for each benefit period are: \$1,632 deductible, day 1-60 \$408 per day, days 61-90	Tier 1 \$150 per day for days 1 through 7 \$0 per day for days 8 through 90 Tier 2 \$315 per day for days 1 through 7 \$0 per day for days 8 through 90
Outpatient Surgery	\$100.00	\$200.00	\$200.00	20% coinsurance	\$230-310
DME	DME 20%, Prosthetics 20% Dialysis 20%, Diabetes: \$0	DME, Prosthetics, Dialysis In-network: 20%, Diabetes: \$0.	DME, Prosthetics, Dialysis In-network: 20%, Diabetes: \$ 0 copay	DME, Prosthetics, Dialysis In-network: 20%, Diabetes: 20% coinsurance	DME: 20% per item, Dialysis in - network: 20% coinsurance, Prosthetics: 20% per item, Diabetic: \$0.
Mental Health	Outpatient with a psych: \$0 Outpatient without psych : 20%	Outpatient group/individual therapy with a psych: \$0 Outpatient group/individual therapy: 20%	Outpatient group/individual therapy with a psych: \$0 Outpatient group/individual therapy: 20%	Outpatient group/individual therapy: 20% coinsurance	Outpatient group/individual therapy: \$20
Ambulance Service	\$150.00	\$150.00	\$150.00	\$20% coinsurance	\$265.00
Emergency Service	\$125 Emergency care. \$0 Urgent care.	\$125 Emergency care. \$0 Urgent care.	\$125 Emergency care. \$0 Urgent care.	\$20% coinsurance Emergency care. \$20% coinsurance Urgent care.	\$90 Emergency care. \$45 Urgent care.
Diagnostic Test, X-Ray & Lab Services	\$0 for Diagnostic test & procedures, X-Ray, Lab Service, Diagnostic radiology services	Diagnostic, test & Lab Service 0-10% Diagnostic Radiology \$0, X-Ray \$0	Diagnostic test 0-10% Lab Service 0-10%, Diagnostic radiology services \$0, X-Ray \$0	\$20% for Diagnostic test & procedures, X-Ray, Lab Service, Diagnostic radiology services	\$0 for Diagnostic test & procedures, X-Ray, Lab Service. \$200 for Diagnostic radiology services
Prescription Drugs Copay	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$3 Tier 3: Preferred brand: \$30 Tier 4: Non – preferred brand: \$75 Tier 5: Specialty: 33% coinsurance Chemo and Part B covered drugs: 0-20% Part B Insulin \$0	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$5 Tier 3: Preferred brand: \$45 Tier 4: Non – preferred brand: \$90 Tier 5: Specialty: 33% coinsurance Chemo therapy 0-20% Other Part B 0-20% Part B Insulin \$0	No Part D drug coverage Chemo 0-20% Part B covered drugs: 0-20% Part B Insulin \$0	Initial Coverage Phase Generic: 25% coinsurance Chemo and Part B covered drugs: 0-20% Part B Insulin \$0 Gap Coverage Phase Generic 25% Brand Name 25%	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$12 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 31% coinsurance Chemo and Part B covered drugs: 0-20% coinsurance Part B Insulin \$35
Other	Hearing exam:\$0, Hearing aids: \$0 Preventative dental \$0, Comprehensive \$0 Eye exam: \$0, Eyeglasses: \$0 Fitness some	Hearing exam: \$0, Hearing aids: \$0 Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth Preventive dental \$0, comprehensive \$0	Hearing exam: \$0, Hearing aids: \$0 Eye exam: \$0, Eyeglasses: \$0 some OTC, some meals, some fitness some telehealth	Hearing exam: \$0, Hearing aids: \$0, Eye exam: \$0, Eyeglasses: \$0, no fitness, some telehealth, prev and comp dental \$ 0 Some OTC	Hearing exam: \$0, Hearing aids: \$600 – 2075, Eye exam: \$35, Eyeglasses: \$0, some fitness, some telehealth. Optional dental package: \$18.

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2024 San Francisco Medicare Advantage Plans - HMO-POS

	Alignment	Aetna	United Health		
Plan Name	Alignment Health Platinum + Instacart (H3815-016-0) POS	Aetna Medicare Value Plus Plan (H523.076.0)	UnitedHealthcare Canopy (HMO-POS) (H0543-191-0)		
Monthly Premium	\$0.00	\$13.70	\$19.00		
Website	https://www.alignmenthealthplan.com	https://www.aetnamedicare.com	www.uhc.com		
MOOP	\$998 In-network	\$2,900 In-network	\$2900 In-network		
Contact	1-866-634-2297 Current Members 1-888-979-2247 Prospective Member	1-833-570-6670 Current Members 1-833-859-6031 Prospective Member	1-866-261-7709 Current Members 1-800-555-5757 Prospective Member		
Network Provider	Alignment Group, Brown and Toland	See Plan	Hills Physicians		
Network Hospital	CPMC	See Plan	UCSF(Hills), St. Marys, CCHP, St Francis		
Physician Visit	\$0 primary care. \$0 specialist.	\$0 primary. \$0 specialist	\$0 primary care. \$0-10 specialist.		
Inpatient Visit	In-Network: \$0/day, days 1 - 3, \$50/day days 4-7, \$0/day, days 8 - 90 Out of Network: \$0/day, days 1 - 3, \$50/day days 4-7, \$0/day, days 8 - 90	\$250/day, days 1 through 7 \$0 per day for days 8 through 90 Out of Network N/A	In – network: \$250 per day for days 1 through 5 \$0 per day for days 6 through 90 \$0 per day for days 91 and beyond		
Outpatient Surgery	\$85/visit	\$0-150	In – network: \$0 – 220		
DME	DME: 0-20%, Prosthetics: 20%, Dialysis 30%, Diabetic: \$0	DME: 0-20% per item, Dialysis 20% Prosthetics: 20% per item, Diabetic: 0-20%	In – network: DME: 20% per item, Dialysis: 20% coinsurance, Prosthetics: 20% per item, Diabetic: \$0.		
Mental Health	Outpatient group or Ind with psych \$20 Outpatient without \$0	Outpatient : \$25	In – network: Outpatient group therapy with a psych: \$15 Outpatient individual therapy with a psych: \$0-25 Outpatient group therapy: \$15 Outpatient individual therapy: \$0-25		
Ambulance Service	\$75.00	\$225.00	\$290.00		
Emergency Service	\$65 Emergency, \$0 Urgent Care	\$110 Emergency care. \$0 Urgent care.	\$135 Emergency care. \$0-40 Urgent care.		
Diagnostic Test, X-Ray & Lab Services	\$0 for Diagnostic test , \$0 Lab \$0 X-Ray, \$0 Radiology services	\$0 for Diagnostic test , Lab X Ray, Radiology services	In – network: \$0 for Diagnostic test & procedures \$0 for Lab Service, \$15 X-Ray \$0 - 125 for Diagnostic radiology services		
Prescription Drugs Copay	Catastrophic Coverage Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$0 Tier 4: Non – preferred brand: \$0 Tier 5: Specialty: \$0 Select drugs: \$0 Chemo, other Part B 0-20% Part B Insulin 0-20% up to \$35	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 33% Chemo and Part B covered drugs: 0- 20% Part B Insulin \$35	Catastrophic Coverage Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$0 Tier 4: Non – preferred brand: \$0 Tier 5: Specialty: \$0 Chemo drugs: 0- 20% coinsurance Part B covered drugs: 0 – 20% Part B Insulin 0-20% up to \$35		
Other	Hearing exam: \$0, Hearing aids: \$0 Preventive dental \$0, Comprehensive dental \$0 Eye exam: \$0, Eyeglasses: \$0 Chiropractic some Acupuncture some Transportation some OTC some	Preventive dental: \$0, Comprehensive \$0 Hearing exam: \$0, Hearing aids: \$0 Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth some transportation, some OTC	Hearing exam: \$0 copay, Hearing aids: \$99 -1,245, Eye exam: \$0, Eyeglasses: \$0, some fitness, some telehealth		

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2024 San Francisco Medicare Advantage Plans - PPO

	Aetna		Anthem	Humana	
Plan Name	Aetna Medicare Eagle Plus Plan (H5521-369-0)	Aetna Medicare Elite Plan (H5521-293-0)	Anthem Medicare Advantage (H8552-029-0)	HumanaChoice H5525-055 (H5525-055-0)	
Monthly Premium	\$0.00(without drug coverage)	\$0.00(\$250 annual deductible)	\$30 Monthly Premium (\$590 annual deductible,\$370 drug deductible)	\$28 Monthly Premium (\$700 annual deductible, \$250 drug deductible))	
Website	https://www.aetnamedicare.com	https://www.aetnamedicare.com	https://shop.anthem.com	https://www.humana.com	
MOOP	\$9,500 In and Out-of-network \$6,700 In-network	\$8,950 In and Out-of-network \$5,500 In-network	\$13,300 In and Out-of-network \$8,850 In-network	\$10,000 In and Out-of-network \$6,500 In-network	
Contact	1-800-282-5366 Current Members 1-833-859-6031 Prospective Member	1-800-282-5366 Current Members 1-833-859-6031 Prospective Member	1-877-811-3107 Current Members 1-855-768-1053 Prospective Member	1-800-457-4708 Current Members 1-800-833-2364 Prospective Member	
Network Provider	See Plan	See Plan	Blue Cross PPO	See Plan	
Network Hospital	See Plan	See Plan	CPMC, Chinese Hospital, St Francis, St Mary	See Plan	
Physician Visit	Primary: In-network: \$0 copay, Out-of-network: 50% coinsurance Specialist: In-network: \$40 copay Out-of-network: 50% coinsurance	Primary: In-network: \$0 copay, Out-of-network: \$10 copay per visit Specialist: In-network: \$25 copay per visit Out-of-network: \$50 copay per visit	Primary: In-network: \$10 copay per visit Out-of-network: \$30 copay per visit Specialist: In-network: \$35 copay per visit Out-of-network: \$50 copay per visit	Primary: In-network: \$0 copay Out-of-network: \$25 copay per visit Specialist: In-network: \$30 copay per visit Out-of-network: \$60 copay per visit	
Inpatient Visit	In-network: \$430 per day for days 1 - 4 \$0 per day for days 5 - 90 Out-of-network:\$550 per day, days 1-5 \$0 per days, day 6-90	In-network: \$325 per day for days 1 through 4 \$0 per day for days 5 through 90 Out-of-network: 45% per stay	In-network: \$215 per day for days 1 - 7 \$0 per day for days 8 - 90 Out-of-network: 40% per stay	In-network: \$300 per day for days 1 through 5 \$0 per day for days 6 through 90 \$0 per day for days 91 and beyond Out-of-network: 45% per stay	
Outpatient Surgery	In-network: \$0-350 Out-of-network: 50% coinsurance	In-network: \$0-295 Out-of-network: 45% coinsurance	In-network: \$0-175 copay per visit Out-of-network: 40% coinsurance	In-network: \$0-295 copay or 40% coinsurance Out-of-network: 40-45% coinsurance	
DME	In-network: DME 0-20%, Prosthetics, Dialysis: 20% coinsurance per item; Diabetes: 0 – 20%. Out-of-network: DME& Prosthetics 40% coinsurance per item, Dialysis: 50%, Diabetes: 0 – 20%.	In-network: DME 0-20%, Prosthetics, Dialysis: 20% coinsurance per item; Diabetes: 0 – 20%. Out-of-network: DME& Prosthetics 45% coinsurance per item, Dialysis: 50%, Diabetes: 0 – 20%.	In-network: DME: 0-20%, Prosthetics, Dialysis: 20% Diabetes: \$0. Out-of-network: DME, Prosthetics, Diabetes, Dialysis: 40%.	In-network: DME, Prosthetics, Diabetes: 9% coinsurance per item, Dialysis: 20%. Out-of-network: DME, Prosthetics, Diabetes: 15% coinsurance per item; Dialysis: 20%.	
Mental Health	Outpatient individual/group therapy with a psychiatrist and individual/ group therapy visit In-network: \$40 copay Out-of-network: 50% coinsurance	Outpatient individual/group therapy with a psychiatrist and individual/ group therapy visit In-network: \$40 copay Out-of-network: 45% coinsurance	Outpatient individual/group therapy with a psychiatrist and individual/ group therapy visit In-network: \$20 copay Out-of-network: \$50	Outpatient individual/group therapy with a psychiatrist and individual/ group therapy visit In-network: \$30 copay Out-of-network: 40% coinsurance	
Ambulance Service	In-network: \$265 copay Out-of-network: \$265 copay	In-network: \$285 copay Out-of-network: \$285 copay	In-network: \$325 copay Out-of-network: \$325 copay	In-network: \$300 copay Out-of-network: \$300 copay	
Emergency Service	\$100 Emergency care. \$40 Urgent care.	\$120 Emergency care. \$40 Urgent care.	\$90 Emergency care. \$30 Urgent care	\$100 Emergency care. \$30 Urgent care.	

Diagnostic Test, X-Ray & Lab Services	In – network: \$0 -10 for Diagnostic test & procedures, \$0 for X- Ray, Lab Service, \$0 – 150 for Diagnostic radiology services Out – of – network: 50% coinsurance	\$0 for Diagnostic test & Lab service \$0-200 for Diagnostic radiology services \$0 for X – rays Out-of-network: 45% Diagnostic test, \$25 Lab svc. 45% Diagnostic radiology services and X-rays	In-network: \$0-75 for Diagnostic test & procedures, \$0-5 Lab Services, \$25 for X- Ray, \$75 for Diagnostic radiology services Out-of-network: 40% coinsurance	In-network: \$0-40 for Diagnostic test & procedures, \$0-40 for Lab Services, \$0-125 for X-Ray, \$0-300 for Diagnostic radiology services Out-of-network: 40% or Diagnostic test & procedures, \$10 or 40% for Lab Services, 40-45% for X- Ray, 40% for Diagnostic radiology services	
Prescription Drugs Copay	No drug coverage 0-20% for In-network Part B-covered drugs and chemo Part B Insulin \$35 50% for Out-of-network Part B-covered drugs and chemo Part B Insulin 50%	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 33% coinsurance 0-20% for In-network Part B-covered drugs and chemo, Part B Insulin \$35 45% for Out-of-network Part B-covered drugs and chemo.	Tier 1: Preferred generic: \$4 Tier 2: Non – preferred generic: \$12 Tier 3: Preferred brand: \$42 Tier 4: Non – preferred brand: \$95 Tier 5: Specialty: 27% coinsurance Tier 6: Select care: \$0 0-20% for In-network Part B-covered drugs and chemo. Part B Insulin \$35 \$35 or 0-40% for Out-of-network Part B-covered drugs and chemo. Part B Insulin \$35 or 0-40%	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$0 Tier 3: Preferred brand: \$47 Tier 4: Non – preferred brand: \$100 Tier 5: Specialty: 29% coinsurance In-network : 0-20% for chemo and Part B-covered drugs Part B Insulin 0-20% up to \$35 Out-of-network: 40% For Chemo and Part B-covered drugs Part B Insulin 40%	
Other	In-network: Preventive dental, Comprehensive dental, Hearing exam, Hearing aids, Eye exam, Eyeglasses: \$0. Out-of-network: Preventive dental: 20%, Comprehensive dental: 20%, Hearing exam: \$,50% Hearing aids: \$0, Eye exam: 50%, Eyeglasses: \$0. some fitness, some telehealth, some OTC	In-network: Preventive dental, Comprehensive dental, Hearing exam, Hearing aids, Eye exam, Eyeglasses: \$0. Out-of-network: Preventive dental, Comprehensive dental \$0, Hearing aids, Eyeglasses: \$0. Hearing exam, Eye exam: 45% some fitness, some telehealth, some OTC	In-network : \$0 for Eye exam, Eyeglasses, Hearing exam & Hearing aids Out-of-network: Hearing exam 20%, \$0 for Eye exam, Eyeglasses & Hearing aids some fitness, some telehealth \$0 for Preventive dental & Comphrensive dental Optional dental packages: \$22, \$35, \$57 Out of Network Preventive dental 20%	Eye exam, Eyeglasses: \$0 In-network: Hearing exam: \$0, Hearing aids: \$499-799, Out-of-network: Hearing exam: 50%, Hearing aids: 50% some fitness, some telehealth, some acupuncture, Optional dental packages: \$37.40	

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2024 San Francisco Medicare Advantage Plans - PPO

	United Health				
Plan Name	AARP Medicare Advantage UHC CA-0032 (H0294.040-0)	AARP Medicare Advantage UHC CA-0023 (H0294.031.0)	Aetna Medicare Core Plan (H5521-425-0)		
Monthly Premium	\$0.00(\$400 annual deductible)	\$44	\$0.00		
Website	https://www.aarpmedicareplans.com	https://www.aarpmedicareplans.com	https://www.aetnamedicare.com		
MOOP	\$10,000 In and Out-of-network \$6,700 In-network	\$8,700 In and Out-of-network \$5,900 In-network	\$8,950 In and Out-of-network \$5,900 In-network		
Contact	1-866-261-7709 Current Members 1-800-555-5757 Prospective Member	1-866-261-7709 Current Members 1-800-555-5757 Prospective Member	1-800-282-5366 Current Members 1-833-859-6031 Prospective Member		
Network Provider	Call Plan	Call Plan	Call Plan providers		
Network Hospital	UCSF, St Mary, St Francis	UCSF, St Mary, St Francis	Call Plan Hospitals		
Physician Visit	Primary: In-network: \$0 copay per visit Out-of-network: \$0 copay per visit Specialist: In-network: \$0-45 copay per visit Out-of-network: \$65 copay per visit	In-network: Primary \$0, Specialist \$0-35 Out-of-network: Primary \$0, Specialist \$50	In-network: Primary \$0 , Specialist \$30 Out-of-network: Primary \$10, Specialist \$45		
Inpatient Visit	In-network: \$300 per day for days 1 - 4 \$0 per day for days 5 and beyond Out-of-network: \$500 per day for days 1 through 20 \$0 per day for days 21 and beyond	In-network: \$325/day , days 1 - 6 \$0 per day for days 7 - 90 \$0 per day for days 91 and beyond Out-of-network: \$500 per day for days 1 -17 \$0 per day for days 18 and beyond	In-network: \$425/day, days 1 - 4 \$0/day, days 5 - 90 Out-of-network: 45%		
Outpatient Surgery	In-network: \$0-300 copay per visit Out-of-network: \$500 copay per visit	In-network: \$0-300 copay per visit Out-of-network: \$500 copay per visit	In-network: \$0-325 Out-of-network: 45% coinsurance		
DME	In-network: DME 20%, Prosthetics 20%, Dialysis 20%, Diabetes \$0 Out-of-network: DME 50%, Prosthetics 50%, Diabetes 50%, Dialysis: 20%.	In-network: 20% for DME, Prosthetics& Dialysis,\$0 for Diabetes Out-of-network: 50% for DME, Prosthetics & Diabetes, 20% for Dialysis	In-network: DME 0-20%, Prosthetics, Dialysis: 20% coinsurance per item; Diabetes: 0 – 20%. Out-of-network: DME& Prosthetics 45% coinsurance per item, Dialysis: 50%, Diabetes: 0 – 20%.		
Mental Health	In-network: Outpatient group w psych visit \$15 Outpatient individual w psych visit \$0-25 Outpatient group \$15, outpatient individual \$0-25 Out-of-network: Outpatient group/individual therapy: \$30-40	In-network: Outpatient group w psych \$15, individual w psych \$0-25 Outpatient group visit: \$15,Outpatient individual visit: \$0-25 Out-of-network: Outpatient group/individual therapy w psych \$30-40 Outpatient group/individual \$30-40	Outpatient individual/group therapy with a psychiatrist and individual/ group therapy visit In-network: \$40 copay Out-of-network: 45% coinsurance		
Ambulance Service	In-network: \$290 copay Out-of-network: \$290 copay	In-network: \$290 copay Out-of-network: \$290 copay	In-network: \$285 copay Out-of-network: \$285 copay		
Emergency Service	\$100 Emergency care. \$0-40 Urgent care.	\$120 Emergency care. \$0-40 Urgent care.	\$120 Emergency care. \$40 Urgent care.		

Diagnostic Test, X-Ray & Lab Services	In-network: Diagnostic test & procedures \$50, Lab svc \$0, X-Ray \$15 Diagnostic radiology services 0-\$115 Out of network :Diagnostic test & procedures \$70, Lab svc \$0, X-Ray \$30 Diagnostic radiology services \$350	Diagnostic test & procedures: In-network: \$50, Out-of-network: \$70 Lab Service: \$0 for both in network and out of network X- Ray: In-network: \$25, Out-of-network: \$30 Diagnostic radiology services: In-network: \$0-250, Out-of-network: \$350	In-network: \$0 for Diagnostic test & procedures, \$0 for X- Ray & Lab Service, \$0-200 for Diagnostic radiology services Out of network: 45% for Diagonostic test, Diagnostic radiology and X Ray, \$25 for Lab		
Prescription Drugs Copay	Catastrophic coverage All Part D drugs \$0 In-network : 0-20% for Chemo and Part B-covered drugs Part B insulin 0-20% up to \$35 Out-of-network : Chemo and Part B-covered drugs and chemo 0-40% Part B insulin 0-40% up to \$35 Gap Coverage All other drugs : 25% generic & brand	Catastrophic coverage \$0 Part D In-network : 0-20% on chemo and Part B-covered drugs, part B insulin 0-20% up to \$35 Out-of-network : 0-40% on chemo and Part B-covered drugs, part B insulin 0-40% Gap Coverage All other drugs: 25% generic & brand	Tier 1: Preferred generic: \$0 Tier 2: Non – preferred generic: \$10 Tier 3: Preferred brand: 20% Tier 4: Non – preferred brand: 50% Tier 5: Specialty: 33% Chemo and Part B covered drugs: 0- 20% Part B Insulin \$35 Out of network Chemo, Part B and Insulin 45%		
Other	In-network : Hearing exam \$0, Hearing aids: \$99-1249 Eye exam: \$0, Glasses \$0 Out of Network: Hearing exam \$65, Hearing aids \$99-1249 Eye exam \$65, Glasses \$0 Some, Fitness, telehealth & optional pkg \$62 Out-of-network: Hearing exam: \$65, Eye exam: \$65 some fitness, some telehealth, Optional dental packages: \$62	In-network : Hearing exam \$0, Hearing aids: \$99-1249 Eye exam: \$0, Glasses \$0, preventive dental \$0 Out of Network: Hearing exam \$50, Hearing aids \$99-1249 Eye exam \$50, Glasses \$0, preventive dental \$0 Opt package \$56 Some Fitness, telehealth	In-network: \$0 for Hearing exam, Hearing aids, Eye exam, Eyeglasses Out-of-network: 45%, Hearing exam, Hearing aid \$0, Eye exam 45%, Eyeglasses: \$0 some fitness, some telehealth, some OTC		

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