

2026 San Francisco Medicare Advantage- HMO D-SNP (Medi-Medi Plan (MMP))

Plan Name	SFHP Care Plus (HMO D-SNP) Medi-Medi Plan (MMP)	Anthem Full Dual Advantage Aligned (HMO D-SNP) Medi-Medi Plan (MMP)	Kaiser Permanente Dual Complete North P19 (HMO D-SNP) Medi-Medi Plan (MMP)
Plan ID	H8051-001-0	H4471-010-2	H8794-019-0
Monthly Premium	\$0.00	\$0.00	\$0.00
Website	https://www.sfhp.org/	https://shop.anthem.com/	https://healthy.kaiserpermanente.org/
MOOP	\$9,250 In-network	\$9,250 In-network	\$9,250 In-network
Contact	Members: 1-833-530-7327 Non-members: 1-888-765-7327	Members: 1-833-897-1342 Non-members: 1-833-668-2238	Member: 1-800-443-0815 Non-members: 1-800-777-1238
Network Provider	NEMS Medical Group	Call plan for further details.	Kaiser
Network Hospital	ZSFGH, CPMC	St. Luke, CPMC, St. Mary's Hospital, Kentfield Hospital, Sutter Solano Medical Center, Chinese Hospital, St. Francis Hospital	Kaiser
Physician Visit	Primary doctor & Specialist: \$0 copay & \$0 deductible (In-network).	Primary doctor & Specialist: \$0 copay (In/Out-of-network).	Primary doctor & Specialist: \$0 copay (In/Out-of-network).
Inpatient Visit	Days 1-60: \$0/day, Days 61-90: \$419/day, Days 91-150: \$838/day- Limits apply & Advanced Plan Approval is Required.	Days 1-150: \$0/day.	Days 1-90: \$0/day.
Outpatient Visit	20% coinsurance (In-network)- Limits apply & Advanced Plan Approval is Required.	\$0 copay (In/Out-of-network).	\$0 copay (In/Out-of-network).
DME	20% coinsurance (In-network).	\$0 copay (In/Out-of-network).	\$0 copay (In/Out-of-network).
Mental Health	Group & Individual therapy (Psychiatrist & Non-Psychiatrist), Opioid treatment: 20% coinsurance (In-network).	Group & Indiv (Psych & Non-Psych), Opioid treatment: \$0 copay (In/Out-of-network).	Group & Indiv (Psych & Non-Psych), Opioid treatment: \$0 copay (In/Out-of-network).
Ambulance Service	Ground ambulance: 20% coinsurance (In-network)- Advanced Plan Approval is required.	\$0 copay (In/Out-of-network).	Ground ambulance: \$0 copay (In/Out-of-network)
Emergency Service	Emergency care: 20% coinsurance. Urgent care: 20% coinsurance.	Emergency care: \$0 copay. Urgent care: \$0 copay.	Emergency care: \$0 copay. Urgent care: \$0 copay.
Diagnostic Test, X-Ray & Lab Services	Lab services: 0% coinsurance (In-network). Diagnostic tests, Diagnostic radiology, Outpatient x-rays: 20% coinsurance (In-network)- Advanced Plan Approval is required for all services.	All (Diagnostic tests, Lab services, Diagnostic radiology, Outpatient x-rays): \$0 copay (In/Out-of-network).	All (Diagnostic Tests, Lab services, Diagnostic radiology, Outpatient x-rays): \$0 copay (In/Out-of-network).
Prescription Drugs	Drug deductible is \$615. Preferred Generic, Select: \$0 copay. Generic, Brand, Non-Preferred, Specialty: 25% coinsurance- Advanced Plan Approval is required.	Drug Deductible: \$0. Preferred Generic, Generic: \$0 copay. Brand, Non-Preferred, Specialty: 25% coinsurance. Part B insulin: \$35 copay (In-network). Chemo, Other: 0%-20% coinsurance (In-network).	Drug Deductible: \$615. Preferred Generic, Generic, Vaccines: \$0 copay. Brand, Non-Preferred, Specialty: 25% coinsurance. Part B insulin: \$0 copay (In-network). Chemo, Other: \$0 copay, 0%-20% coinsurance (In-network).
Transportation	Plan-approved locations: \$0 copay (In-network). Additional transportation: 24 rides.	Plan-approved locations: \$0 copay (In-network). Health-related locations: Not covered.	Not covered (any Health-related or Plan-approved locations).
Dental	Routine dental check-ups including cleanings & x-rays: \$0. Dentures (fixed & removable), Crowns: \$0. Extra services may be covered under Medi-cal Dental.	Preventative & Comprehensive services: \$0 copay (In-network). Maxillofacial, Implant, Orthodontics: Not covered.	Not covered.
Vision	Exam: \$0 copay. Eyeglasses (frames & lenses) OR Contacts: \$300/year.	All (Exam, Contacts, Eyeglasses ((frames & lenses, frames only, lenses only))): \$0 copay (In-network). Upgrades: Not covered.	All (Exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only))): \$0 copay (In-network). Upgrades: Not covered.
Hearing	\$0 Exam, Fitting. Aids: Up to \$2,000/year.	All (Exam, Fitting, Prescription aids, OTC aids): \$0 copay (In-network).	Not covered.
Fitness	Not covered.	\$0 copay (In-network).	\$0 copay (In-network).
Worldwide Emergency	Not covered.	\$0 copay.	\$115 copay.
Telehealth	Not covered.	\$0 copay (In-network).	\$0 copay (In-network).
Acupuncture	\$0 copay, 24 visits/year.	\$0 copay (In-network).	\$0 copay (In-network).
Chiropractor	\$0 copay, 12 visits/year.	Not covered.	Not covered.
Extra Notes	Covered (\$0 copay, Limits apply): Preventive services, over the counter drug benefits (\$150/quarter). Food & Produce: \$20/month for healthy foods & pantry items. Rent & Utilities: \$20/month.	Dual Eligible SNP. Health deductible: \$ 0.00, Part B Premium Reduction: Not offered. Covered Extras (\$0 copay, Limits apply): Preventive Services, PERS, Home safety devices, Food & produce (if qualifying chronic condition applies), General supports for living. Skilled nursing facility: Not covered.	Dual Eligible SNP. Health deductible: \$0.00. Part B Premium Reduction: Not offered. Covered Extras (\$0 copay, limits apply): Preventive services, vaccines, OTC drugs, health education. Skilled nursing facility: \$0 per day for days 1-20, \$214 per day for days 21-100.

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Plan Name	Central Health Dual Access Plan (HMO D-SNP)	CCHP Senior Select Program (HMO D-SNP)	Alignment Health CalPlusDuals (HMO D-SNP)	Wellcare Dual Liberty (HMO D-SNP)
Plan ID	H5649-024-0	H0571-005-0	H3815-030-0	H3561-009-0
Monthly Premium	\$0.00 (Total, Health, and Drug premiums)	\$0.00 (Total, Health, and Drug premiums)	\$0.00 (Total monthly premium)	\$0.00 (Total monthly premium)
Website	https://www.centralhealthplan.com/	https://cchphealthplan.com/	https://www.alignmenthealthplan.com/	https://wellcare.healthnetcalifornia.com/
MOOP	\$9,250 In-network	\$3,400 In-network	\$9,250	\$9,250
Contact	Members: 1-866-314-2427 Non-members: 1-866-384-2477	Members: 1-888-775-7888 Non-members: 1-888-681-3888	Members: 1-866-634-2247 Non-members: 1-888-979-2247	Members: 1-800-431-9007 Non-members: 1-844-480-0680
Network Provider	Access Primary Care Medical Group, All American Medical Group, Hill Physicians, Imperial Health Plan, John Muir Physician Network, Physician Partners Ipa INC	Hill Physicians, Jade, Access Medical Group	Brown & Toland Health Services Inc, Santa Clara IPA	Brown & Toland, Golden Bay/NEMS
Network Hospital	CPMC, UCSF, St. Mary's Hospital, Sutter Bay Hospitals, St. Francis Hospital	CPMC, Chinese Hospital, Northern California Radiation Therapists, UCSF	CPMC, Sutter Bay Hospitals, St. Francis Hospital, UCSF, Kentfield Hospital	CPMC, St. Francis Hospital, UCSF, St. Mary's Hospital
Physician Visit	Primary doctor: 30% coinsurance. Specialist: 30% coinsurance.	Primary doctor & Specialist: \$0 copay (In-network).	Primary doctor & Specialist: \$0 copay (In/Out-of-network).	Primary doctor & Specialist: 20% coinsurance.
Inpatient Visit	Days 1-60: \$0/day, Days 61-90: \$419/day, Days 91-150: \$838/day.	\$0/stay- Limits apply (Advanced Plan approval & Physician referral required).	Days 1-150: \$0/day.	Tier 1: \$1,800/stay- Limits apply (Advanced Plan approval & Physician referral required).
Outpatient Visit	20% coinsurance (In-network).	\$0 copay (In-network)- Limit apply (Advanced Plan approval & Physician referral required).	\$0 copay (In/Out-of-network)	20% coinsurance (In-network)- Limits apply (Advanced Plan approval & Physician referral required).
DME	20% coinsurance (In-network).	\$0 copay (In-network).	\$0 copay (In/Out-of-network)	20% coinsurance (In-network)- Limits apply (Advanced Plan approval & Physician referral required).
Mental Health	Group & Individual therapy (Psychiatrist): \$55 copay (In-network). Group & Individual therapy (Non-Psychiatrist): \$50 copay (In-network). Opioid treatment: 50% coinsurance (In-network).	Group & Indiv (Psych & Non-Psych), Opioid: \$0 copay (In-network).	Group & Indiv (Psych & Non-Psych), Opioid: \$0 copay (In/Out-of-network)- Limits apply (Advanced Plan approval & Physician referral required).	Group & Indiv (Psych & Non-Psych), Opioid: \$0 copay (In/Out-of-network).
Ambulance Service	Ground ambulance: 20% coinsurance (In-network).	Ground ambulance: \$0 copay (In-network).	Ground ambulance: In-network: 20% coinsurance- Limits apply (Advanced Plan approval required).	Ground ambulance: 20% coinsurance (In-network)- Limits apply (Advanced Plan approval required).
Emergency Service	Emergency care: \$115 copay. Urgent: \$0 copay.	Emergency care & Urgent care: \$0 copay.	Emergency care & Urgent care: 20% coinsurance.	Emergency care: \$115 copay. Urgent care: \$40 copay.
Diagnostic Test, X-Ray & Lab Services	Lab services: 0% coinsurance (In-network). Diagnostic tests, Diagnostic radiology, Outpatient x-rays: 20% coinsurance (In-network).	All (Diagnostic tests, Lab services, Diagnostic radiology, Outpatient x-rays): \$0 copay (In-network).	Diagnostic tests, Lab services: 20% coinsurance. Diagnostic radiology, Outpatient x-rays: \$0 copay.	All (Diagnostic tests, Lab services, Diagnostic radiology, Outpatient x-rays): 20% coinsurance (In-network).
Prescription Drugs	Drug Deductible: \$550. Preferred Generic, Select: \$0 copay. Generic: \$2.00 copay. Brand: 20% coinsurance. Non-Preferred: 30% coinsurance. Specialty: 25% coinsurance. Part B Insulin, Chemo, Other: 0%-20% coinsurance (In-network).	Drug Deductible: \$615. Preferred Generic, Chemo, Other: \$0 copay. Generic, Brand, Non-Preferred, Specialty: 25% coinsurance. Part B Insulin: \$35 copay (In-network).	Preferred Generic, Select: \$0 copay. Generic, Brand, Non-Preferred, Specialty: 25% coinsurance. Part B insulin, Chemo, Other: 0%-20% coinsurance (In-network).	Preferred Generic: \$18 copay. Generic: \$19 copay. Brand: 25% coinsurance. Non-Preferred: \$100 copay. Specialty: 25% coinsurance. Select: \$0 copay. Part B insulin: \$35 copay (In-network). Chemo, Other: 0%-20% coinsurance (In-network).
Transportation	Plan-approved locations: \$0 copay (In-network). Health-related locations: Not covered.	Plan-approved: \$0 copay (In-network). Health-related: Not covered.	Plan-approved: \$0 copay (In-network). Health-related: Not covered.	Not covered (Any health-related or Plan-approved locations).
Dental	Not covered.	Preventative & Comprehensive services: \$0 copay (In-network). Fluoride, Orthodontics: Not covered.	Preventative & Comprehensive services: \$0 copay (In-network). Prosthetics, Implant, Orthodontics, Adjunctive: Not covered.	Removable, Fixed Prosthodontics: \$0 copay (In-network). Everything else not covered.
Vision	Routine exam, Contacts, Eyeglasses (frames & lenses, Frames only, Lenses only), Upgrades: \$0 copay (In-network).	Routine exam, Contacts, Eyeglasses (frames & lenses): \$0 copay (In-network). Frames only, lenses only, Upgrades: Not covered.	Routine exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only), Upgrades: \$0 copay (In-network).	Routine exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only, Upgrades): \$0 copay (In-network).
Hearing	Prescription aids: \$49-\$1549 copay (In-network). Exam, Fitting, OTC aids: \$0 copay (In-network).	Exam, Fitting, Prescription aids: \$0 copay (In-network). OTC aids: Not covered.	Exam, Fitting, Prescription aids: \$0 copay (In-network). OTC aids: Not covered.	Exam, Fitting, Prescription aids: \$0 copay (In-network). OTC aids: Not covered.
Fitness	\$0 copay (In-network).	\$0 copay (In-network).	\$0 copay (In-network).	Not covered.
Worldwide Emergency	\$115 copay.	\$90 copay- Limits apply.	\$0 copay	\$115 copay.
Telehealth	\$0 copay, 0%-50% coinsurance (In-network).	Not covered.	\$0 copay (In-network).	\$40 copay, 20% coinsurance (In-network).
Acupuncture	\$0 copay (In-network).	\$0 copay- Limits apply (Advanced plan approval & Physicians referral required).	\$0 copay (In-network).	Not covered.
Chiropractor	\$0 copay (In-network).	Not covered.	\$0 copay (In-network).	Not covered.
Extra Notes	Dual Eligible SNP. Drug Deductible: \$550.00. Part B Premium Reduction: Not offered. Covered Extras (\$0 copay, limits apply): Preventive Services, PERS, OTC drugs, meals for short duration, food & produce (if chronic condition applies), health education. Skilled nursing facility: Not covered.	Dual Eligible SNP. Health deductible: \$0.00. Part B Premium Reduction: Not offered. Covered Extras (\$0 copay, Limits apply): Preventive Services, OTC drugs, food & produce (if qualifying chronic condition applies), health education. Skilled nursing facility: Not covered.	Drug deductible: \$615.00. Includes: Personal Emergency Response System (PERS) \$0 copay, In-home support services \$0 copay, Meals for short duration \$0 copay, Food & produce \$0 copay, Pest control \$0 copay, Indoor air quality equipment and services \$0 copay, General supports for living \$0 copay. Skilled nursing facility is Not covered.	Drug deductible: \$425.00. Skilled nursing facility: \$0 per day for days 1-20; \$218 per day for days 21-70; \$0 per day for days 71-100 (Limits apply). Includes: Structural home modifications \$0 copay, Meals \$0 copay, Alternative therapies \$0 copay, Food & produce \$0 copay, Pest control \$0 copay, Indoor air quality equipment and services \$0 copay, General supports for living \$0 copay.

This is only a guide and the information is subject to change at any time, please contact plan directly for the most up-to-date details.

Strictly used for HICAP counseling only, not to sell any insurance.

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