SHIP State Health Insurance Assistance Program
Navigating Medicare

HiCAP Health Insurance Counseling and Advocacy Program

2026 San Francisco Medicare Advantage Plan HMO

Plan Name	Advantage Care (HMO)	Aetna Medicare Signature (HMO)	Alignment Health Harmony (HMO)	Alignment Health Honor+ Plan (HMO)	Alignment Health My Choice CalCare (HMO)
Plan ID	H3274-005-0	H4982-007-0	H3815-031-0	H3815-052-0	H3815-050-0
Monthly Premium	$0.00	$0.00	$0.00	$0.00	$0.00
Website	https://alignseniorcare.com/	https://www.aetna.com/	https://www.alignmenthealthplan.com/	https://www.scanhealthplan.com/	https://wellcare.healthnetcalifornia.com/
MOOP	**$1,900 In-network**	**$3,900 In-network**	**$3,400 In-network**	**$9,250 In-network**	**$3,499 In-network**
Contact	Non-members: 1-844-305-3879 Members: 1-844-305-3879	Non-members: 1-833-859-6031 Members: 1-833-570-6670	Non-members: 1-888-979-2247 Members: 1-866-634-2247	Non-members: 1-888-979-2247 Members: 1-866-634-2247	Non-members: 1-888-979-2247 Members: 1-866-634-2247
Network Provider	Behavioral Health Psychiatry, Behavioral Health Neurology	Brown & Toland Phys/Medicare HMO, One Medical, One Medical Group Spec Medicare HMO	Brown & Toland Health Services Inc., North East Medical Services, Optum Behavioral Health Solutions, Santa Clara County IPA	Brown & Toland Health Services Inc	Call plan for further details.
Network Hospital	Sutter Bay Hospitals, St. Mary's Medical Center	Chinese Hospital	California Pacific Medical Center, Sutter Bay Hospitals, UCSF, Chinese Hospital Association, Kentfield Hospital, University of Southern California	Chinese Hospital, UCSF, California Pacific Medical Center, Saint Francis Hospital, St. Mary's Hospital, Kentfield Hospital, University of Southern California, Alta Bates	Call plan for further details.
Physician Visit	Primary doctor & Specialist: $0 copay (In-network).	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.
Inpatient Visit	$0/stay.	Days 1-5: $325/day, Days 6-90: $0/day.	Days 1-5: $100/day, Days 6-90: $0/day.	Days 1-60: $0/day, Days 61-90: $419/day, Days 91-150: $838/day.	Days 1-5: $100/day, Days 6-90: $0/day.
Outpatient Visit	$0−225 copay (In-network)	$0−250 copay (In-network)	$200 copay (In-network)	$0 copay (In-network)	$200 copay (In-network)
DME	20% coinsurance (In-network)	0%-20% coinsurance (In-network)	20% coinsurance (In-network)	20% coinsurance (In-network)	20% coinsurance (In-network)
Mental Health	Group & Individual therapy (Non-Psychiatrist), Opioid treatment: $0 copay (In-network). Group & Indiv (Psych): 20% coinsurance (In-network).	Group & Indiv (Psych & Non-psych), Opioid treatment: $40 copay (In-network).	Group & Indiv (Non-Psych): $0 copay (In-network). Group & Indiv (Psych): $40 copay (In-network). Opioid treatment: 20% coinsurance (In-network).	Group & Indiv (Psych & Non-psych), Opioid treatment: 20% coinsurance (In-network).	Group & Indiv (Non-Psych): $0 copay (In-network). Group & Indiv (Psych): $40 copay (In-network). Opioid treatment: 20% coinsurance (In-network).
Ambulance Service	Ground ambulance: $125 copay (In-network).	Ground ambulance: $325 copay (In-network).	Ground ambulance: $175 copay (In-network).	Ground ambulance: 20% coinsurance (In-network).	Ground ambulance: $175 copay (In-network).
Emergency Service	Emergency care: $90 copay. Urgent care: $40 copay.	Emergency care: $150 copay. Urgent care: $0 copay.	Emergency care: $100 copay. Urgent care: $0 copay.	Emergency care & Urgent care: 20% coinsurance.	Emergency care: $85 copay. Urgent care: $0 copay.
Diagnostic Test, X-Ray & Lab Services	Lab services & Outpatient x-rays: $0 copay (In-network). Diagnostic tests, Diagnostic radiology: 20% coinsurance (In-network).	Lab services, Diagnostic tests, Diagnostic radiology, Outpatient x-rays: $0 copay (In-network).	Lab services, Diagnostic tests, Diagnostic radiology, Outpatient x-rays: $0 copay (In-network).	Lab services, Diagnostic tests, Diagnostic radiology, Outpatient x-rays: $0 copay (In-network).	Lab services, Diagnostic tests, Diagnostic radiology, Outpatient x-rays: $0 copay (In-network).
Prescription Drugs	Drug deductible: $0.00. Preferred Generic: $0 copay; Generic: $10 copay; Brand: $45 copay; Non-Preferred: $95 copay; Specialty: $0 copay, 33% coinsurance.	Drug deductible: $615. Preferred Generic: $0; Generic: $0; Brand: $0 copay, 24% coinsurance; Non-Preferred: $0 copay, 25% coinsurance; Specialty: $0 copay, 25% coinsurance.	Drug deductible: $0. Preferred Generic: $0 copay; Generic: $3 copay; Brand: $40 copay; Non-Preferred: $100 copay; Specialty: 33% coinsurance; Select: $5 copay.	Drug deductible: $615. Preferred Generic: $0; Generic: 25% coinsurance; Brand: 25% coinsurance; Non-Preferred: 30% coinsurance; Specialty: 25% coinsurance; Select: $0	Drug deductible: $0. Preferred Generic: $0; Generic: $3; Brand: $40; Non-Preferred: $100 copay; Specialty: $0 copay, 33% coinsurance; Select: $5
Transportation	Health-related locations: $0 copay (In-network)-Limits apply. Plan-approved locations: Not covered.	Not covered	Plan-approved: $0 copay (In-network)- Limits apply. Health-related: Not covered.	Plan-approved: $0 copay (In-network)- Limits apply. Health-related: Not covered.	Plan-approved: $0 copay (In-network)- Limits apply. Health-related: Not covered.
Dental	Preventative & Comprehensive services: $0 copay (In-network)- Limits apply. Orthodontics, Prosthetics: Not covered.	Preventative: $0 copay (In-network). Comprehensive: 20%-50% coinsurance (In-network)- Limits apply. Fluoride, Implants, Orthodontics, Prosthetics: Not covered.	Preventative: $0 copay (In-network)- Limits apply. Comprehensive: $15-$570 (In-network). Orthodontics, Prosthetics, Implants, Adjunctive: Not covered.	Preventative & Comprehensive: $0 copay (In-network)- Limits apply. Implants, Orthodontics, Prosthetics: Not covered.	Preventative & Comprehensive: $0 copay (In-network)- Limits apply. Implants, Orthodontics, Prosthetics, Adjunctive: Not covered.
Vision	All (Exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only), Upgrades): $0 copay (Limits apply).	All (Exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only), Upgrades): $0 copay (Limits apply).	Exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay (In-network)- Limits apply. Upgrades: Not covered.	Exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay (In-network)- Limits apply. Upgrades: Not covered.	Exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay (In-network)- Limits apply. Upgrades: Not covered.
Hearing	OTC aids: $0 copay (In-network). Prescription aids, Exam, Fitting: Not covered.	Exam, Fitting, Prescription aids: $0 copay (In-network)- Limits apply. OTC aids: Not covered.	Exam, Fitting: $0 copay (In-network). Prescription aids: $195−1750 copay (In-network)- Limits apply. OTC aids: Not covered.	Not covered.	Prescription aids: $195−1750 copay (In-network) - Limits apply. OTC aids, Exam, Fitting: Not covered.
Fitness	Not covered.	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.
Worldwide Emergency	Not covered.	$150 copay- Limits apply.	$20 copay- Limits apply.	$75 copay- Limits apply.	$0 copay- Limits apply.
Telehealth	$0 copay (In-network)- Limits apply.	$0−40 copay, 20% coinsurance (In-network)- Advanced Plan Approval/Physician Referral Required.	$0 copay (In-network)- Limits apply.	$0 copay (In-network).	$0 copay (In-network)- Limits apply.
Part B reduction	Not offered.	Not offered.	Not offered.	Not offered.	Not offered.
Acupuncture	$30 copay (In-network).	Not covered.	Not covered.	$0 copay (In-network).	$0 copay (In-network)
Chiropractor	$30 copay (In-network).	Not covered.	$0 copay (In-network)	$0 copay (In-network).	$0 copay (In-network)
Extra Notes	Health deductible $0.00, Drug deductible $0.00. Advanced Plan Approval Required for most services.	Health deductible $0.00. Drug deductible $615.00. Requires Physician Referral for many services. Wigs for chemotherapy covered at $0 copay (In-network).	Health deductible $0.00, Drug deductible $0.00. Includes over the counter drug benefits, food & produce, and pest control (all $0 copay, Limits apply; may require chronic condition qualification).	High MOOP ($9,250). Health deductible $0.00. Drug deductible $615.00. Includes PERS, Support for Caregivers, In-home support services, and Meals for short duration (all $0 copay).	Health deductible $0.00, Drug deductible $0.00. Includes PERS, Support for Caregivers, In-home support services, and Meals for short duration (all $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.** **Updated date: 10/21/2025 HICAP 1800-434-0222**

2026 San Francisco Medicare Advantage Plan HMO

Plan name	Alignment Health Sutter Advantage +More (HMO)	CCHP Senior Program (HMO)	CCHP Senior Value Program (HMO)	Central Health Classic Care Plan IV (HMO)	Imperial Dynamic Plan (HMO)
Plan ID	H3815-023-0	H0571-001-0	H0571-007-0	H5649-018-0	H5496-012-0
Monthly Premium	$48.00 (Total monthly premium; $0 Health/$48 Drug premium)	$21.00 (Total monthly premium; $21 Health/$0 Drug premium)	$0 (Total monthly premium; $0 Health/$0 Drug premium)	$0 (Total monthly premium; $0 Health/$0 drug premium)	$0.00 (Total monthly premium; $0.00 Health/$0.00 drug premium)
Website	https://www.alignmenthealthplan.com/	https://cchphealthplan.com/	https://cchphealthplan.com/	https://www.centralhealthplan.com/	https://imperialhealthplan.com/
MOOP	**$4,900 In-network**	**$3,000 In-network**	**$3,500 In-network**	**$2,499 In-network**	**$296 In-network**
Contact	Non-members: 1-888-979-2247 Members: 1-866-634-2247	Non-members: 1-888-681-3888 Members: 1-888-775-7888	Non-members: 1-888-681-388 Members: 1-888-775-7888	Non-members: 1-866-384-2477 Members: 1-866-314-2427	Non-members: 1-800-838-5914 Members: 1-800-838-8271
Network Provider	Alignment Health Plan Network, Brown & Toland Health Services Inc, Brown & Toland Physicians, Dignity Health Medical Network- Ventura, North East Medical Services, Optum Care Network- Greater Bay Area, Sutter Independent Physicians, Sutter Medical Group, Sutter Pacific Medical Foundation	Hill Physicians	Hill Physicians	Access Primary Care Medical Group, All American Medical Group, Hill Physicians, Imperial Health Plan, John Muir Physician Network, Physician Partners Ipa INC	Imperial Health Plan of California, Imperial Health Holdings Medical Group, Access Primary Care Medical Group
Network Hospital	California Pacific Medical Center, Sutter Bay Hospitals, California Pacific Medical Center- Mission Bernal Campus, Kentfield Hospital	California Pacific Medical Center- Pacific Heights, California Pacific Medical Center- Van Ness, Chinese Hospital	California Pacific Medical Center- Pacific Heights, California Pacific Medical Center- Van Ness, Chinese Hospital	California Pacific Medical Center, UCSF, St. Mary's Hospital, Sutter Bay Hospitals, St. Francis Hospital	Saint Francis Memorial Hospital, UCSF, California Pacific Medical Center, Chinese Hospital, Sutter West Bay Hospitals, Kentfield Hospital
Physician Visit	Primary doctor: $5 copay (In-network). Specialist: $25 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.	Primary doctor: $0−5 copay (In-network). Specialist: $0 copay (In-network)- Limits apply.	Primary doctor: $0 copay (In-network). Specialist: $10 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.
Inpatient Visit	Days 1-5: $275/day, Days 6-90: $0/day.	Tier 1: $0/stay. Tier 2: Days 1-7: $305/day, Days 8-90: $0/per day.	Tier 1: $0 per stay. Tier 2: Days 1-7: $305/day; Days 8-90: $0/day.	Tier 1: Days 1-6: $200/day; Days 7-90: $0/day.	Days 1-90: $0/per day.
Outpatient Visit	$250 copay (In-network).	$100−310 copay (In-network).	$230−$310 copay (In-network).	$0−$250 copay (In-network).	$100 copay (In-network).
DME	0%-20% coinsurance (In-network)- Limits apply.	20% coinsurance (In-network)- Limits apply.	20% coinsurance (In-network)- Limits apply.	0%-20% coinsurance (In-network)- Limits apply.	20% coinsurance (In-network)- Limits apply.
Mental Health	Group & Individual therapy (Psychiatrist): $40 copay (In-network). Non-Psychiatrist: $0 copay (In-network). Opioid: 20% coinsurance (In-network).	Group & Indiv (Psych & Non-Psych): $15 copay (In-network). Opioid: $0 copay (In-network).	Group & Indiv (Psych & Non-Psych): $20 copay (In-network). Opioid: $0 copay (In-network).	Group & Indiv (Psych & Non-Psych): $25 copay (In-network). Opioid: $0 copay (In-network).	Group & Indiv (Psych & Non-Psych), Opioid: $0 copay (In-network).
Ambulance Service	Ground ambulance: $250 copay- Limits apply.	Ground ambulance: $265 copay (In-network)- Limits apply.	Ground ambulance: $265 copay (In-network)- Limits apply.	Ground ambulance: $0−$250 copay (In-network)- Limits apply.	Ground ambulance: $150 copay (In-network)- Limits apply.
Emergency Service	Emergency care: $120 copay. Urgent care: $0 copay.	Emergency care: $90 copay. Urgent care: $45 copay.	Emergency care: $90 copay. Urgent care: $45 copay.	Emergency care: $150 copay. Urgent care: $0 copay.	Emergency care: $125 copay. Urgent care: $0 copay.
Diagnostic Test, X-Ray & Lab Services	Lab services, Diagnostic tests: $0 copay (In-network). diagnostic radiology: $150 copay (In-network). Outpatient x-rays: $15 copay (In-network).	Lab services, Diagnostic tests, Outpatient x-rays: $0 copay (In-network). Diagnostic radiology: $200 copay (In-network).	Lab services, Diagnostic tests, Outpatient x-rays: $0 copay (In-network). Diagnostic radiology: $200 copay (In-network).	Lab services, Diagnostic tests, Outpatient x-rays: $0 copay (In-network). Diagnostic radiology: $0−200 copay (In-network)	All (Lab services, Diagnostic tests, Diagnostic radiology, Outpatient x-rays): $0 copay.
Prescription Drugs Copay	Deductible: $0.00. Preferred Generic: $0.00; Generic: $5.00; Brand: $40.00; Non-Preferred Drug: 32% coinsurance; Specialty: 33% coinsurance.	Deductible: $0.00. Preferred Generic: $0.00; Generic: $0.00; Brand: $45.00; Non-Preferred Drug: $100.00; Specialty: 33% coinsurance.	Deductible: $0.00. Preferred Generic: $0.00; Generic: $0.00; Brand: $47.00; Non-Preferred Drug: $100.00; Specialty: 33% coinsurance.	Deductible: $100.00. Preferred Generic: $0.00; Generic: $2.00; Brand: $35.00; Non-Preferred Drug: $100.00; Specialty: 30% coinsurance.	Deductible: $0.00. Preferred Generic: $0.00; Generic: $6.00; Brand: $45.00; Non-Preferred Drug: $90.00; Specialty: 33% coinsurance.
Transportation	Not covered.	Plan-approved locations: $0 copay (In-network)- Limits apply. Health-related locations: Not covered.	Plan-approved: $0 copay (In-network)- Limits apply. Health-related: Not covered.	Plan-approved: $0 copay (In-network)- Limits apply. Health-related: Not covered.	Plan-approved: $0 copay (In-network)- Limits apply. Health-related: $0 copay (In-network).
Dental	Preventative services: $0 copay (In-network). Comprehensive services: $20-$570 copay (In-network). Implants, Orthodontics: Not Covered. Optional package available: $36/monthly.	Preventative: $0 copay (In-network). Comprehensive: not covered, besides Periodontics: $0-$55 copay (In-network) & Adjunctive: $5 copay (In-network). Optional package available: $16.80/monthly.	Preventative: $0 copay (In-network); Fluoride: not covered. Comprehensive: not covered besides Periodontics: $0-$55 copay (In-network) & Adjunctive: $0-$5 copay. Optional package available ($16.80 monthly).	Preventative: $0 copay (In-network). Comprehensive: $0-$2160 copay (In-network); Prosthetics, Orthodontics: Not covered.	Preventative & Comprehensive: $0 copay (In-network). Prosthetics, Implants, Orthodontics, Adjunctive: Not covered.
Vision	Routine exam, Contact lenses, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay. Upgrades: Not covered.	Routine exam: $20 copay (In-network). Contact lenses & Eyeglasses (frames & lenses): $0 copay (In-network). Frames only, Lenses only, Upgrades: Not covered.	Routine exam: $35 copay (In-network). Contact lenses, Eyeglasses (frames & lenses): $0 copay (In-network). Frames only, lenses only, Upgrades: Not covered.	All (Routine exam, Contact lenses, Eyeglasses (frames & lenses, frames only, lenses only), Upgrades): $0 copay (In-network)	Routine exam, Contact lenses, Eyeglasses (frames & lenses): $0 copay (In-network). Frames only, lenses only, Upgrades: Not covered.
Hearing	Not covered.	Prescription aids: $600−2075 copay (In-network)- Limits apply.	Prescription aids: $600−$2075 copay- Limits apply. Exam, Fitting, OTC aids: Not covered.	Prescription aids: $575−$2099 copay (In-network). OTC aids: $0 copay (In-network). Exam & Fitting: Not covered.	Prescription aids: $0 copay (In-network)- Limits apply.
Fitness	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.	$0 copay (In-network).	$0 copay (In-network)- Limits apply.
Worldwide Emergency	$0 copay- Limits apply.	$90 copay- Limits apply.	$90 copay- Limits apply.	$150 copay	$0 copay- Limits apply.
Telehealth	$0 copay (In-network)- Limits apply.	Not covered.	Not covered.	$0−$25 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.
Part B reduction	Not offered.	Not offered.	Not offered.	Not offered.	−$35.00 reduction.
Acupuncture	Not covered.	$0 copay (In-network).	$5 copay (In-network).	$0 copay (In-network).	$0 copay (In-network).
Chiropractor	Not covered.	Not covered.	$10 copay (In-network).	$0 copay (In-network).	$0 copay (In-network).
Extra Notes	Health and Drug deductibles are 0.00.IncludesOverthecounterdrugbenefits(0 copay). All listed services generally require Advanced Plan Approval.	Low MOOP ($3,000). Includes 0copayforAcupuncture$ and Food & produce benefit ($0 copay). Offers an optional dental package.	Low MOOP ($3,500). Includes $5 copay for Acupuncture and food & produce benefit ($0 copay). Offers an optional dental package.	Low MOOP ($2,499). Drug deductible is $100.00. Includes meals for short duration ($0 copay) and over the counter drug benefits ($0 copay). Skilled Nursing Facility coverage is listed as "not covered."	**Extremely Low MOOP ($296)** Offers a Part B reduction of −35.00. Inpatient hospital stay is $0 for days 1−90. Includes In−home support services ($0 copay) and meals for short duration ($0 copay).

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2026 San Francisco Medicare Advantage Plan HMO

Plan Name	Kaiser Permanente Senior Advantage Alam., SF, Napa (HMO)	Kaiser Permanente Senior Advantage Basic SF (HMO)	SCAN Affirm partnered with Included LGBTQ+ Health (HMO)	SCAN Allied (HMO)	SCAN Classic (HMO)
Plan ID	H0524-032-0	H0524-060-0	H5425-107-0	H5425-118-0	H5425-019-0
Monthly Premium	**99.00**(95.60 Health / $3.40 Drug)	**19.00**(19.00 Health / $0.00 Drug)	$0.00	$0.00	$0.00
Website	https://healthy.kaiserpermanente.org/	https://healthy.kaiserpermanente.org/	https://www.scanhealthplan.com/	https://www.scanhealthplan.com/	https://www.scanhealthplan.com/
MOOP	**$3,900 In-network**	**$6,000 In-network**	**$1,499 In-network**	**$1,999 In-network**	**$1,499 In-network**
Contact	Non-members: 1-800-777-1238 Members: 1-800-443-0815	Non-members: 1-800-777 –1238 Members: 1-800-443-0815	Non-members: 1-888-315-7226 Members: 1-800-559-3500	Non-members: 1-888-315-7226 Members: 1-800-559-3500	Non-members: 1-888-315-7226 Members: 1-800-559-3500
Network Provider	Kaiser	Kaiser	Brown & Tolan Physicians, Hill Physicians Medical Group- San Francisco, All American Medical Group, Access Primary Care Medical Group	All American Medical Group, Access Primary Care Medical Group	Brown & Tolan Physicians, Hill Physicians Medical Group- San Francisco, All American Medical Group, Access Primary Care Medical Group
Network Hospital	Kaiser	Kaiser	California Pacific Medical Center, St. Francis Memorial Hospital, Chinese Hospital, El Camino Hospital, St. Mary's Medical Center, UCSF Medical Center	California Pacific Medical Center, St. Francisc Memorial Hospital, Chinese Hospital, El Camino Hospital, St. Mary's Medical Center, UCSF Medical Center	California Pacific Medical Center, St. Francisc Memorial Hospital, Chinese Hospital, El Camino Hospital, St. Mary's Medical Center, UCSF Medical Center
Physician Visit	Primary doctor: $0 copay (In-network). Specialist: $15 copay (In-network)- Limits apply.	Primary doctor: $10 copay (In-network). Specialist: $25 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.
Inpatient Visit	Days 1-5: $270/day, Days 6-90: $0/day.	Days 1-5: $380/day, Days 6-90: $0/day.	Days 1-5: $150/day, Days 6-90: $0/day.	Days 1-5: $200/day, Days 6-90: $0/day.	Days 1-5: $150/day, Days 6-90: $0/day.
Outpatient Visit	$0−$240 copay (In-network)	$0−$375 copay (In-network)	$125 copay (In-network)	$0−125 copay (In-network)	$125 copay (In-network)
DME	0%-20% coinsurance (In-network)- Limits apply	0%-20% coinsurance (In-network)- Limits apply	0%-20% coinsurance (In-network)- Limits apply	0%-20% coinsurance (In-network)- Limits appl	0%-20% coinsurance (In-network)- Limits apply
Mental Health	Group & Individual therapy (Psychiatrist & Non-Psychiatrist), Opioid Treatment: $0 copay (In-network).	Group (Psych & Non-Psych): $5 copay (In-network); Individual (Psych & Non-psych): $10 copay. Opioid: $0 copay (In-network).	Group & Individual (Psych & Non-psych), Opioid: $10 copay (In-network)- Limits apply.	Group & Individual (Psych & Non-Psych), Opioid: $15 copay (Limits apply).	Group & Individual (Psych & Non-Psych) & Opioid: $10 copay (Limits apply).
Ambulance Service	Ground ambulance: $350 copay (In-network).	Ground ambulance: $350 copay (In-network).	Ground ambulance: $175 copay (In-network)- Limits apply.	Ground ambulance: $175 copay (In-network)- Limits apply.	Ground ambulance: $175 copay (In-network)- Limits apply.
Emergency Service	Emergency care: $150 copay. Urgent care: $0 copay.	Emergency care: $130 copay. Urgent care: $10 copay.	Emergency care: $90 copay. Urgent care: $0 copay.	Emergency care: $90 copay. Urgent care: $0 copay.	Emergency care: $90 copay. Urgent care: $0 copay.
Diagnostic Test, X-Ray & Lab Services	Lab services, Diagnostic tests: $0 copay (In-network). Outpatient x-rays: $10 copay (In-network). Diagnostic radiology: $10−275 copay (In-network).	Lab services, Diagnostic tests: $0 copay (In-network). Diagnostic Radiology: $30−$275 copay (In-network).	Lab services, Diagnostic tests, Outpatient x-rays: $0 copay (In-network). Diagnostic radiology: $50 copay (In-network).	All (Lab services, Diagnostic tests, Diagnostic radiology, Outpatient x-rays	Lab services, Diagnostic tests, Outpatient x-rays: $0 copay (In-network). Radiology (MRI): $50 copay (In-network).
Prescription Drugs	Drug deductible: $0. Preferred Generic: $0; Generic: $7; Brand: $47; Non-Preferred: $100; Specialty: 32% coinsurance.	Drug deductible: $0. Preferred Generic: $3; Generic: $9; Brand: $47; Non-Preferred: $100; Specialty: 28% coinsurance.	Drug deductible: $250. Preferred Generic: $0; Generic: $0; Brand: $42; Non-Preferred: 35% coinsurance; Specialty: 25% coinsurance.	Drug deductible: $250. Preferred Generic: $0; Generic: $0; Brand: $42; Non-Preferred: 35% coinsurance; Specialty: 30% coinsurance.	Drug deductible: $250. Preferred Generic: $0; Generic: $0; Brand: $42; Non-Preferred: 35% coinsurance; Specialty: 30% coinsurance.
Transportation	Not covered (health-related or plan-approved locations).	Not covered (health-related or plan-approved locations).	Plan-approved: $0 copay (In-network)- Limits apply. Health-related: Not covered.	Plan-approved: $0 copay (In-network)- Limits apply. Health-related: Not covered.	Plan-approved: $0 copay (In-network). Health-related: Not covered.
Dental	Preventative services: $0 copay (In-network)- Limits apply. Comprehensive services: Not covered besides Periodontics & Adjunctive: $0 copay (In-network). Optional package available ($20.00 monthly).	Preventative & Comprehensive: $0 copay (In-network)- Limits apply. Restorative, Endodontics, Prosthodontics (removable, fixed, Maxillofacial), Implants, Maxillofacial surgery, Orthodontics: Not covered. Optional package available ($20.00 monthly).	All Preventative & Comprehensive: $0 copay (In-network)- Limits apply. Orthodontics: Not covered.	All Preventative & Comprehensive: $0 copay (In-network)- Limits apply. Orthodontics: Not covered.	Al Preventative & Comprehensive: $0 copay (In-network)- Limits apply. Orthodontics: Not covered.
Vision	Routine exam: $0 copay. Contacts, Eyeglasses, Upgrades: Not covered. Optional package available.	Routine exam: $10 copay (In-network). Contacts, Eyeglasses, Upgrades: Not covered. Optional package available.	Routine exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay. Upgrades: Not covered.	Routine exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay (In-network)- Limits apply. Upgrades: Not covered.	Routine exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay (In-network)- Limits apply. Upgrades: Not covered.
Hearing	Not covered. Optional package available.	Not covered. Optional package available.	Prescription aids: $550−$850 copay (In-network)- Limits apply. Exam, Fitting, OTC aids: Not covered.	Prescription aids: $550−$850 copay (In-network)- Limits apply. Exam, Fitting, OTC aids: Not covered.	Prescription aids: $550−$850 copay (In-network)- Limits apply. Exam, Fitting, OTC aids: Not covered.
Fitness	Not covered. Optional package available.	Not covered.	$0 copay (In-network).	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.
Worldwide Emergency	$150 copay- Limits apply.	$130 copay- Limits apply.	$90 copay- Limits apply.	$90 copay- Limits apply.	$90 copay- Limits apply.
Telehealth	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.
Part B reduction	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
Acupuncture	$0 copay (In-network)- Limits apply.	$10 copay (In-network).	$10 copay (In-network).	$0 copay (In-network)- Limits apply.	$0 copay (In-network)- Limits apply.
Chiropractor	Not covered.	Not covered.	$10 copay (In-network).	Not covered.	$0 copay (In-network)- Limits apply.
Extra Notes	Requires Advanced Plan Approval and Physician Referral. Includes $0 copay for Acupuncture and Over the counter drugs. Health and Drug Deductibles are $0.00.	High MOOP ($6,000). Requires Physician Referral. Includes $10 copay for Acupuncture and $0 copay for Over the counter drugs.	Very Low MOOP ($1,499). Drug deductible $250.00. Includes support for caregivers ($0 copay), PERS ($0 copay), In−home support services ($0 copay), and Meals for short duration ($0 copay).	Low MOOP ($1,999). Drug deductible $250.00. Includes acupuncture ($0 copay), Support for caregivers ($0 copay), Meals for short duration ($0 copay), OTC drug benefits ($0 copay), and food & produce benefits.	Very Low MOOP ($1,499). Drug deductible $250.00. Includes chiropractic services ($0 copay), acupuncture ($0 copay), PERS ($0 copay), and OTC drug benefits ($0 copay).

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2026 San Francisco Medicare Advantage Plan HMO & POS

Plan Name	**SCAN MyChoice (HMO)**	**Wellcare Low Premium (HMO)**	**AARP Medicare Advantage from UHC CA-9 (HMO-POS)**	**Aetna Medicare Signature Extra (HMO-POS)**	**Alignment Health Platinum + Instacart (HMO-POS)**
Plan ID	H5425-121-0	H0562-097-0	H0543-191-0	H0523-070-0	H3815-016-0
Monthly Premium	$0.00	**33.00**(33.00 Health / $0.00 Drug)	**69.00**(0.00 Health / $69.00 Drug)	$0.00	$0.00
Website	https://www.scanhealthplan.com/	https://wellcare.healthnetcalifornia.com/	https://www.aarpmedicareplans.com/	https://www.aetna.com/	https://www.alignmenthealthplan.com/
MOOP	**$1,999 In-network**	**$9,250 In-network**	**$4,900 In-network**	**$3,600 In-network**	**$998 In-network**
Contact	Non-members: 1-888-315-7226 Members: 1-800-559-3500	Non-members: 1-844-480-0680 Members: 1-800-275-4737	Non-members: 1-800-555-5757 Members: 1-866-261-7709	Non-members: 1-833-859-6031 Members: 1-833-570-6670	Non-members: 1-888-979-2247 Members: 1-866-634-2247
Network Provider	Brown & Toland Physicians, Hill Physicians Medical Group- SF, All American Medical Group, Access Primary Care Medical Group	Brown & Toland, Golden Bay/NEMS	United Health Care Direct Network, Hill Physicians San Francisco	Brown & Toland Phys/Medicare HMO, One Medical, One Medical Group Spec Medicare HMO	Brown & Toland Health Services Inc, Sutter Health
Network Hospital	California Pacific Medical Center, St. Francis Memorial Hospital, Chinese Hospital, St. Mary's Medical Center, UCSF	California Pacific Medical Center- Davies, Saint Francis Memorial Hospital, UCSF, CPMC- Mission Bernal, UCSF	California Pacific Medical Center, Saint Francis Memorial Hospital, UCSF, St. Mary's Medical Center	Chinese Hospital	California Pacific Medical Center, Sutter Bay Hospitals, Kentfield Hospital, University of Southern California, UCSF- St. Mary's Hospital, UCSF-Mt. Zion, UCSF, UCSF Saint Francis Hospital, Chinese Hospital, CPMC Mission Bernal Campus
Physician Visit	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.	Primary doctor: $0 copay (In-network). Specialist: $0−25 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.	Primary doctor & Specialist: $0 copay (In-network)- Limits apply.
Inpatient Visit	Days 1-5: $200/day, Days 6-90: $0/day.	Days 1-5: $405/day, Days 6-90: $0/day.	Days 1-5: $550/day, Days 6-90: $0/day.	Days 1-7: $325/day; Days 8-90: $0/day.	Days 1-3: $0/day, Days 4-7: $50/day, Days 8-90: $0/day.
Outpatient Visit	$175 copay (In-network).	$0−$250 copay (In-network).	$550 copay (In-network).	$0−$250 copay (In-network).	$85 copay (In-network).
DME	0%-20% coinsurance (In-network).	0%-20% coinsurance (In-network).	20% coinsurance (In-network).	0%-20% coinsurance (In-network).	0%-20% coinsurance (In-network).
Mental Health	Group & Individual therapy (Psych & Non-Psych), Opioid treatment: $10 copay (In-network).	Group & Individual (Psych & Non-Psych): $25 copay (In-network). Opioid: $0 copay.	Group (Psych & Non-Psych): $15 copay (In-network). Individual (Psych & Non-Psych): $0−$25 copay (In-network). Opioid: $0 copay (In-network).	Group & Individual (Psych & Non-Psych), Opioid: $40 copay (In-network).	Group & Individual (Psych): $20 copay (In-network). Group & Individual (Non-Psych): $20 copay. Opioid: 20% coinsurance (In-network).
Ambulance Service	Ground ambulance: $175 copay (In-network).	Ground ambulance: $275 copay (In-network).	Ground ambulance: $290 copay (In-network).	Ground ambulance: $295 copay (In-network).	Ground ambulance: $75 copay (In-network).
Emergency Service	Emergency care: $90 copay. Urgent care: $0 copay.	Emergency care: $115 copay. Urgent care: $25 copay.	Emergency care: $130 copay. Urgent care: $0−$50 copay.	Emergency care: $150 copay. Urgent care: $0 copay.	Emergency care: $90 copay. Urgent care: $0 copay.
Diagnostic Test, X-Ray & Lab Services	Lab services, Diagnostic tests, X-rays: $0 copay (In-network). Radiology (MRI): $50 copay (In-network).	Diagnostic tests: $0−25 copay (In-network). Lab services: $0−50 copay (In-network). Radiology (MRI): $0−250 copay (In-network). X-rays: $25 copay (In-network).	Lab services & Diagnostic tests: $0 copay (In-network). Radiology (MRI): $0−260 copay (In-network). X-rays: $30 copay (In-network).	Lab services, Diagnostic tests, Radiology (MRI): $0 copay (In-network).	Lab services, Diagnostic tests, Radiology (MRI), -rays: $0 copay (In-network).
Prescription Drugs	Drug deductible: $250. Preferred Generic: $0; Generic: $0; Brand: $42; Non-Preferred: 35% coinsurance; Specialty: 30% coinsurance.	Drug deductible: $615. Preferred Generic: $0; Generic: $0; Brand: 25% coinsurance; Non-Preferred: 35% coinsurance; Specialty: 25% coinsurance; Select: $0.	Drug deductible: $440. Preferred Generic: $0; Generic: $12; Brand: 16% coinsurance; Non-Preferred: 37% coinsurance; Specialty: 28% coinsurance.	Drug deductible: $300. Preferred Generic: $0; Generic: $10; Brand: 25% coinsurance; Non-Preferred: 26% coinsurance; Specialty: 29% coinsurance.	Drug deductible: $0. Preferred Generic: $0; Generic: $3; Brand: $30; Non-Preferred: $75; Specialty: 33% coinsurance; Select Care: $5.
Transportation	Not covered (health-related or plan-approved locations).	Plan-approved: $0 copay (In-network). Health-related: Not covered.	Not covered (health-related or plan-approved locations).	Not covered (health-related or plan-approved locations).	Plan-approved: $0 copay (In-network). Health-related: Not covered.
Dental	All Preventative & Comprehensive services: $0 copay (In-network); Orthodontics: Not covered.	Preventative: $0 copay (In-network). Comprehensive: $0−$300 copay (In-network); Maxillofacial prosthetics, Implants: Not covered.	Preventative: $0 copay (In-network & Out-of-network). Comprehensive: 50% coinsurance (In-network & Out-of-network). Implants/Orthodontics: Not covered.	Preventative: $0 copay (In-network); Flouride: not covered. Comprehensive: 20%-50% coinsurance (In-network), 50%-70% coinsurance (Out-of-network); Prosthetics, Implants, Orthodontics: Not covered.	Preventative & Comprehensive: $0 copay (In-network); Prosthetics, Implants, Orthodontics, Adjunctive: Not covered.
Vision	Routine exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay (In-network). Upgrades: Not covered.	Routine exam, Contacts, Eyeglass (frames & lenses, frames only, lenses only), Upgrades: $0 copay (In-network).	Routine exam, Contacts, glasses (frames only): $0 copay (In-network). Eyeglasses (lenses only): $0−$153 copay (In-network). Eyeglasses (frames & lenses), 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): $0 copay (In-network). Upgrades: Not covered.
Hearing	Prescription aids: $550−$850 copay (In-network). OTC aids, Exam, Fitting: Not covered.	Prescription aids: $0 copay (In-network). OTC aids, Exam, Fitting: Not covered.	Prescription aids: $199−$1249 copay. OTC aids: $199−$829 copay. Exam, Fitting: Not covered.	Prescription aids: $0 copay (In-network). OTC aids, Exam, Fitting: Not covered.	Prescription aids: $195−1750 copay (In-network). OTC aids, Exam, Fitting: Not covered.
Fitness	$0 copay (In-network).	$0 copay (In-network).	$0 copay (In-network).	$0 copay (In-network).	$0 copay (In-network).
Worldwide Emergency	$90 copay.	$115 copay.	$0 copay.	$150 copay.	$50 copay.
Telehealth	$0 copay (In-network).	$0−25 copay (In-network).	$0 copay (In-network).	0−40 copay, 20% coinsurance (In-network)- Advanced Plan Approval/Physician Referral Required.	$0 copay (In-network).
Part B reduction	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
Acupuncture	$5 copay (In-network).	Not covered.	Not covered.	$0 copay (In-network).	Not covered.
Chiropractor	$5 copay (In-network).	Not covered.	Not covered.	$0 copay (In-network).	Not covered.
Extra Notes	Low MOOP ($1,999). Drug deductible $250.00. Includes chiropractic services ($5 copay), Acupuncture ($5 copay), PERS ($0 copay), In-home support services ($0 copay), meals for short duration ($0 copay), and OTC drug benefits ($0 copay).	High MOOP ($9,250). Drug deductible $615.00. Dental coverage includes orthodontics ($0-$2250 copay). Includes alternative therapies ($0 copay) and OTC drug benefits ($0 copay).	Total premium is $69.00 due to a drug premium. Drug deductible $440.00. Requires Advanced Plan Approval and Physician Referral for many services.	Drug deductible $300.00.IncludesChiropracticservices ($0 copay), Acupuncture ($0 copay), OTC drug benefits ($0 copay), and Wigs for chemotherapy ($0 copay).	Extremely Low MOOP ($998). Health and Drug deductibles $0.00. Includes support for caregivers ($0 copay), PERS ($0 copay), In−home support services ($0 copay), Meals for short duration ($0 copay), food & produce ($0 copay), and pest control ($0 copay).

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2026 San Francisco Medicare Advantage Plan HMO-POS/PPO

Plan Name	**Anthem Prime (HMO-POS)**	**Anthem Select (HMO-POS)**	**Aetna Medicare Enhanced (PPO)**	**Aetna Medicare Signature (PPO)**	**HumanaChoice H5525-087 (PPO)**
Plan ID	H4161-004-0	H0544-069-0	H5521-581-0	H5521-425-0	H5525-087-0
Monthly Premium	$0.00	$0.00	$63.00 (Health $50.10 / Drug $12.90)	$0.00	$67.00 (Health $67.00 / Drug $0.00)
Website	https://shop.anthem.com/	https://shop.anthem.com/	https://www.aetna.com/	https://www.aetna.com/	https://www.humana.com/
MOOP	**$2,500 In-network**	**$7,550 In-network**	**$5,900 In-network; $8,900 In and Out-of-network**	**$6,750 In-network; $9,500 In and Out-of-network**	**$6,750 In-network; $10,000 In and Out-of-network**
Contact	Non-members: 1-833-668-2201 Members: 1-833-707-3130	Non-members: 1-833-668-2341 Members: 1-888-230-7338	Non-members: 1-833-859-6031 Members: 1-833-570-6670	Non-members: 1-833-859-6031 Members: 1-833-570-6670	Non-members: 1-888-873-0686 Members: 1-800-457-4708
Network Provider	Call plan for further details.	Call plan for further details.	Aetna Direct - Northern CA, Brown & Toland Medicare CCHP, Cloud Health Medical Group of CA, P.C., DRH Medical Group, HealthRight 360, Lyon-Martin Community Health Services, NEMS, One Medical, Plushcare Of California, Inc., Quang Medical Practice, Inc.,	Aetna Direct - Northern CA, Brown & Toland Medicare PPO, CCHP, Cloud Health Medical Group of CA, P.C., DRH Medical Group, HealthRight 360, Lyon-Martin Community Health Services, NEMS, One Medical, Plushcare Of California, Inc., Quang Medical Practice, Inc., Seen Medical Group, P.A.	Brown & Toland Physicians, My Health Medical Group Inc, Circle Medical Group of California, Pairtu Health Medical Group of CA PC, FLCH-Penn Yan Community Health, TrueLight Medical Corporation, South of Market Health Center, Strategic Wellness Inc, Noe Valley Family Medicine
Network Hospital	Chinese Hospital, St. Francis Hospital, CPMC, Sutter Solano Medical Center, St. Mary's, Kentfield Hospital, St. Luke Center	Chinese Hospital, St. Francisco Hospital, CPMC, Sutter Solano Medical Center, St. Mary's, Kentfield Hospital	Chinese Hospital, St. Francis Memorial, St. Mary's	Chinese Hospital, St. Francis Memorial, St. Mary's	CPMC, Kentfield Hospital
Physician Visit	Primary doctor: $0 copay (In-network). Specialist: $25 copay (In-network).	Primary doctor: $5 copay (In-network). Specialist: $20 copay (In-network).	Primary doctor: $0 copay (In-network), $15 copay (Out-of-network). Specialist: $30 copay (In-network), $55 copay (Out-of-network).	Primary doctor: $0 copay (In-network), 50% coinsurance (Out-of-network). Specialist: $50 copay (In-network), 50% coinsurance (Out-of-network).	Primary doctor: $0 copay (In-network), $25 copay (Out-of-network). Specialist: $45 copay (In-network), $75 copay (Out-of-network).
Inpatient Visit	Days 1-4: $250/day; Days 5-90: $0/day (In-network)	Days 1-4: $360/day; Days 5-90: $0/day (In-network).	Days 1-7: $300/day (In-network), Days 8-90: $0/day (In-network), 45%/stay (Out-of-network).	Days 1-7: $335/day (In-network), Days 8-90: $0/day (In-network), 50%/stay (Out-of-network).	Days 1-5: $225/day, Days 6-90: $0/day (In-network).
Outpatient Visit	$0-$250 copay (In-network).	$0-$350 copay (In-network).	$0−300 copay (In-network), 45% coinsurance (Out-of-network).	$0−$375 copay (In-network).	$0−$325 copay, 40% coinsurance (In-network). $0 copay, 40-45% coinsurance (Out-of-network).
DME	0%-20% coinsurance (In-network).	0%-20% coinsurance (In-network).	0%-20% coinsurance (In-network).	0%-20% coinsurance (In-network).	$0 copay, 15% coinsurance (In-network).
Mental Health	Group & Individual therapy (Psych & Non-Psych), Opioid treatment: $40 copay (In-network).	Group & Individual (Psych & Non-Psych), Opioid: $40 copay (In-network).	Group & Individual (Pysch & Non-Psych): $40 copay (In-network), $45% coinsurance (Out-of-network).	Group & Individual (Psych & Non-Psych), Opiod: $40 copay (In-network), 50% coinsurance (Out-of-network).	Group & Individual (Psych & Non-Psych): $25 copay (In-network), 40% coinsurance (Out-of-network). Opioid: $25−35 copay (In-network), 40% coinsurance (Out-of-network).
Ambulance Service	Ground ambulance: $219 copay (In-network).	Ground ambulance: $325 copay (In-network).	Ground ambulance: $285 copay (In-network & Out-of-network).	Ground ambulance: $285 copay (In-network & Out-of-network).	Ground ambulance: $335 copay (In-network & Out-of-network).
Emergency Service	Emergency care: $150 copay. Urgent care: $35 copay.	Emergency care: $115 copay. Urgent care: $35 copay.	Emergency care: $130 copay. Urgent care: $40 copay.	Emergency care: $130 copay. Urgent care: $40 copay.	Emergency care: $130 copay. Urgent care: $50 copay.
Diagnostic Test, X-Ray & Lab Services	Lab services: $0−$10 copay (In-network). Diagnostic tests: $0−$50 copay (In-network). Radiology (MRI): $10−$175 copay (In-network). Outpatient x-rays: $10 copay (In-network).	Lab services: $0−$5 copay (In-network). Diagnostic tests: $0−$120 copay (In-network). Radiology (MRI): $0−$165 copay (In-network). Outpatient x-rays: $0−$50 copay (In-network).	Lab services: $0−$10 copay (In-network), $55 copay (Out-of-network). Diagnostic tests: $0 copay (In-network), 45% coinsurance (Out-of-network). Radiology (MRI): $0−$250 copay (In-network), 45% coinsurance (Out-of-network). Outpatient x-rays: $0 copay, 45% coinsurance (Out-of-network).	Lab services: $0−$30 copay (In-network), 50% coinsurance (Out-of-network). Diagnostic tests: $0 copay (In-network), 50% coinsurance (Out-of-network). Radiology (MRI): $0−$200 copay, 50% coinsurance (Out-of-network). Outpatient x-rays: $40 copay (In-network), 50% coinsurance (Out-of-network)	Lab services: $0−$50 copay (In-network). $10 copay, 40% coinsurance (Out-of-network). Diagnostic tests: $0−$50 copay (In-network), $25-$75 copay (In-network), 40% coinsurance (Out-of-network). Radiology (MRI): $0−$300 copay (In-network). Outpatient x-rays: $0−$125 copay (In-network).
Prescription Drugs	Drug deductible: $0. Preferred Generic: $0 copay, Generic: $0 copay. Brand: $0 copay, 15% coinsurance. Non-Preferred: $0 copay, 30% coinsurance. Specialty: $0 copay, 33% coinsurance.	Drug deductible: $160. Preferred Generic, Generic: $0 copay. Brand: $0 copay, 25% coinsurance. Non-Preferred: $0 copay, 30% coinsurance. Specialty: $0 copay, 31% coinsurance.	Drug deductible: $615.00. Preferred Generic: $0 copay, Generic: $0 copay. Brand: $0 copay, 24% coinsurance. Non-Preferred: $0 copay, 25% coinsurance. Specialty: $0 copay, 25% coinsurance.	Drug deductible: $615. Preferred Generic: $0 copay, Generic: $0 copay. Brand: $0 copay, 24% coinsurance. Non-Preferred : $0 copay, 25% coinsurance. Specialty : $0 copay, 25% coinsurance.	Drug deductible: $615. Preferred Generic: $0 copay. Generic: $5 copay. Brand: $47 copay. Non-Preferred: 42% coinsurance. Specialty:25% coinsurance.
Transportation	Plan-approved locations: $0 copay (In-network). Health-related locations: Not covered.	Plan-approved: $0 copay (In-network). Health-related: Not covered.	Not covered (Any Health-related or Plan-approved).	Not covered (Any Health-related or Plan-approved).	Not covered (Any Health-related or Plan-approved).
Dental	Preventative services: $0 copay (In-network), 20% coinsurance (Out-of-network). X-rays: $0 copay (In-network), Fluoride: $0 co-pay (In-network). Comprehensive services: $0 (In-network). Prosthetics, Implants, Orthodontics: Not covered.	Preventative: $0 copay (In-network), 20% coinsurance (Out-of-network); Fluoride, X-Rays: Not covered. Comprehensive: Not covered.	Preventative: $0 copay (In-network), 50% coinsurance; Fluoride: Not covered. Comprehensive: 20%-50% coinsurance (In-network); 50%-70% coinsurance (Out-of-network). Prosthetics, Implants, Orthodontics: Not covered.	Preventative: $0 copay (In-network), 50% coinsurance (Out-of-network); Fluoride: Not covered. Comprehensive: Not covered.	Preventative: $0 copay (In/Out-of-net); Fluoride: Not covered. Comprehensive: Restorative, Fixed Prostho: $0 copay & 30%-40% coinsurance (In/Out-of-net); Endodontics, Periodontics, Oral surgery, Adjunctive: $0 copay (In/Out-of-net); Removable Prostho, Prosthetics, Implants, Orthodontics: Not covered.
Vision	Routine exam, Contacts, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay (In-network). Upgrades: Not covered.	Routine exam: $0 copay (In-network). Contacts, Eyeglasses (frames & lenses, frames only, lenses only), Upgrades: Not covered.	Routine exam: $0 copay (In-network), 0% coinsurance (Out-of-network). Contacts, Eyeglasses (frames & lenses, frames only, lenses only): $0 copay (In/Out-of-network). Upgrades: $0 copay (Limits apply)	Routine exam: $0 copay (In-network), 0% coinsurance (Out-of-network). Contacts: $0 copay. Eyeglasses (frames & lenses, frames only, lenses only): $0 copay (In/Out-of-network). Upgrades: $0 copay (Limits apply)	Routine exam, Contacts, Eyeglasses (frames & lenses): $0 copay (In/Out-of-Network). Eyeglass frames only, Eyeglass lenses only, Upgrades: Not covered.
Hearing	All (Exam, Fitting, Prescription aids, OTC aids): $0 copay (In-network).	Not covered.	Exam, Fitting: $0 copay (In-network), 45% coinsurance. Prescription aids: $0 copay (In/Out-of-network). OTC aids: Not covered.	Exam, Fitting: $0 copay (In-network), 50% coinsurance. Prescription aids: $0 copay (In/Out-of-network). OTC aids: Not covered. (Limits apply)	Exam, Fitting: $0 copay (In- & Out-of-network). Prescription aids: $499−$799 copay (In/Out-of-network). OTC aids: Not covered.
Fitness	$0 copay (In-network).	Not covered.	$0 copay (In-network & Out-of-network).	$0 copay (In-network & Out-of-network).	Not covered.
Worldwide Emergency	$150 copay	$115 copay.	$130 copay.	$130 copay.	$130 copay.
Telehealth	$0 copay (In-network).	$0 copay (In-network).	$0−$40 copay, 20% coinsurance (In-network).	$0−$50 copay, 20% coinsurance (In-network).	$0−$50 copay (In-network).
Part B reduction	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
Acupuncture	Not covered.	$0 copay (In-network).	Not covered.	Not covered.	$45 copay (In-network & Out-of-network).
Chiropractor	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
Extra Notes	HMO-POS plan. Low MOOP $2,500 and $0 deductibles. Includes home and bathroom safety devices ($0 copay), and food & produce ($0 copay) for qualifying individuals. Optional dental/eyewear packages available.	HMO-POS plan. High MOOP $7,550. Drug deductible $160.00. Includes acupuncture ($0 copay). Optional dental/eyewear packages available.	PPO plan. Drug deductible $615.00. Advanced Plan Approval is required for nearly all services. Includes over the counter drug benefits ($0 copay).	PPO plan. Health deductible $500. Drug deductibl $615.00. Includes wigs for hair loss related to chemotherapy ($0 copay in & out-of-network).	PPO plan. Health deductible $650. Drug deductible $615.00. Mental health copays are lower than the Aetna plans ($25 In−network). Includes meals for short duration ($0 copay).

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2026 San Francisco Medicare Advantage Plan HMO/PPO *No Drug Coverage*

Plan Name	Central Health Valor Care Plan (HMO)- No Drug Coverage	Imperial Courage Plan (HMO)- No Drug Coverage	Aetna Medicare Eagle (PPO)- No Drug Coverage	Humana USAA Honor Giveback (PPO)- No Drug Coverage	
Plan ID	H5649-030-0	H5496-016-0	H5521-369-0	H5525-079-0	
Monthly Premium	$0.00	$0.00	$0.00	$0.00	
Website	https://www.centralhealthplan.com/	https://imperialhealthplan.com/	https://www.aetna.com/	https://www.humana.com/medicare	
MOOP	**$4,400 In-network**	**$2,999 In-network**	**$6,750 In-network; $9,500 In and Out-of-network**	**$6,500 In-network; $10,100 In and Out-of-network**	
Contact	Non-members: 1-866-384-2477 Members: 1-866-314-2427	Non-members: 1-800-838-5914 Members: 1-800-838-8271	Non-members: 1-833-859-6031 Members: 1-833-570-6670	Non-members: 1-888-873-0686 Members: 1-800-457-4708	
Network Provider	Access Primary Care Medical Group, All American Medical Group, Hill Physicians, Imperial Health Plan, John Muir Physician Network, Physician Partners Ipa INC	Imperial Health Holdings Medical Group, Access Primary Care Medical Group,	Aetna Direct - Northern CA, Brown & Toland Medicare PPO, CCHP, Cloud Health Medical Group of CA, P.C., DRH Medical Group, HealthRight 360, Lyon-Martin Community Health Services, NEMS, One Medical, Plushcare Of California, Inc., Quang Medical Practice, Inc., Seen Medical Group, P.A.	Brown & Toland Physicians, My Health Medical Group Inc, Circle Medical Group of California, Pairtu Health Medical Group of CA PC, FLCH-Penn Yan Community Health, TrueLight Medical Corporation, South of Market Health Center, Strategic Wellness Inc, Noe Valley Family Medicine	
Network Hospital	St. Francis Hospital, Sutter Bay Hospitals, CPMC, St. Mary's, UCSF	St. Francis Hospital, UCSF, St. Mary's Hospital, CPMC, Chinese Hospital, Sutter Bay Hospitals, Kentfield Hospital	Chinese Hospital, St. Francis Hospital, St. Mary's	CPMC, Kentfield Hospital	
Physician Visit	Primary doctor & Specialist: $0 copay (In-network).	Primary doctor: $0 copay. Specialist: $5 copay (In-network).	Primary doctor & Specialist: $0 copay (In-network), 50% coinsurance (Out-of-network).	Primary doctor: $0 copay (In/Out-of-network). Specialist: $55 copay (In/Out-of-network).	
Inpatient Visit	Days 1-6: $150/day; Days 7-90: $0/day (In-network).	Days 1-5: $150/day; Days 6-90: $0/day (In-network).	Days 1-4: $430/day, Days 5-90: $0/day (In-network). 50%/stay (Out-of-Network).	Days 1-5: $300/day; Days 6-90: $0/day (In-network).	**HICAP San Francisco** **601 Jackson St. 2nd Floor, SF 94133**
Outpatient Visit	$0−$295 copay (In-network)	$200 copay (In-network)	$0−$350 copay (In-network)	$0−$350 copay (In-network); $0-$495 copay, 40% coinsurance (Out-of-network)	**Tel # 1-800 434-0222 or 415-677-7520** **Email:info@hicapsanfrancisco.org**
DME	0%-20% coinsurance	20% coinsurance. (In-network)	0%-17% coinsurance (In-network). 40% coinsurance (Out-of-network).	$0 copay, 15% coinsurance (In-network); 40% coinsurance (Out-of-network).	**Website: www.hicap.org**
Mental Health	Group & Individual therapy (Psych & Non-Psych), Opioid treatment: $0 copay (In-network).	Group & Individual (Psychiatrist), Opioid: $0 copay (In-network). Group & Individual (Non-Psych): 20% coinsurance (In-network).	Group & Individual (Psych & Non-Psych), Opioid: $40 copay (In-network), 50% coinsurance (Out-of-network).	Group & Individual (Psych & Non-Psych), Opioid: $0 copay (In/Out-of-network).	
Ambulance Service	Ground ambulance: $0−$275 copay (In-network).	Ground ambulance: $150 copay (In-network).	Ground ambulance: $265 copay (In/Out-of-network)	Ground ambulance: $335 copay (In/Out-of-network).	
Emergency Service	Emergency care: $130 copay. Urgent care: $0 copay.	Emergency care: $125 copay. Urgent care: $0 copay.	Emergency care: $130 copay. Urgent care: $40 copay.	Emergency care: $130 copay. Urgent care: $50 copay.	**This project was supported, in part by**
Diagnostic Test, X-Ray & Lab Services	All services: $0 copay (In-network), except Radiology (MRI): $0−$100 copay.	All services (Lab services, X-rays, Diagnostic tests, Radiology (MRI)): $0 copay (In-network).	Lab services, Outpatient x-rays: $0 copay (In-network), 50% coinsurance (Out-of-network). Diagnostic tests: $0−$10 copay (In-network), 50% coinsurance (Out-of-network). Radiology (MRI): $0−$150 copay (In-network), 50% coinsurance (Out-of-network).	Lab services: $0 copay (In/Out-of-network). Outpatient x-rays/Diagnostic tests: $0−$55 copay (In/Out-of-network). Radiology (MRI): 0−300 copay (In-network); 0% copay, 40% coinsurance (Out-of-network).	**grant number 90SAPG0094-01-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees**
Prescription Drugs	Part B insulin, Chemotherapy, & Other Part B drugs: 0%-20% coinsurance (In-network).	Part B insulin: $0 copay. Chemotherapy/Other Part B drugs: 0%-20% coinsurance (In-network).	Part B insulin: $35 copay (In/Out-of-network). Chemotherapy, Other Part B drugs: 0%-20% coinsurance (In-network), 50% coinsurance (Out-of-network).	Part B insulin, Chemotherapy, & Other Part B drugs: 0%-20% coinsurance (In-network).	**undertaking projects under government sponsorship are encouraged to express freely their**
Transportation	Not covered (Any health-related or Plan-approved locations).	Plan-approved: $0 copay (In-network). Health-related: Not covered.	Not covered (Any health-related or Plan-approved).	Not covered (Any health-related or Plan-approved).	**findings and conclusions. Points of view or opinions do not, therefore,**
Dental	Preventative services: $0 copay (In-network). Comprehensive services: $45−$2160 copay. Prosthetics, Orthodontics: Not covered.	Preventative & Comprehensive: $0 copay (In-network). Prosthetics, Implants, Orthodontics, Adjunctive general services: Not covered.	Preventative: $0 copay (In-network), 50% coinsurance (Out-of-network); Fluoride: Not covered. Comprehensive: 20%-50% coinsurance (In-network), 50%-70% coinsurance (Out-of-network). Prosthetics, Implant, Orthodontics: Not covered.	Preventative: $0 copay (In/Out-of-network): Not covered. Endodontics, Periodontics, Oral Surgery, Adjunctive: $0 copay (In/Out-of-network). Restorative, Prosthodontics: $0 copay, 30%-40% coinsurance (In/Out-of-network). Fluoride/Prosthetic/Implants/Orthodontics: Not covered.	**necessarily represent the official Administration for Community Living policy.**
Vision	Routine exam, Contacts, Eyeglasses (frames & lenses, lenses only, frames 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), 0% coinsurance (Out-of-network).	Routine exam, Contacts, Eyeglasses (frames & lenses): $0 copay (In/Out-of-network). Frames only, lenses only, Upgrades: Not covered.	
Hearing	Prescription aids: $575−$2099 copay (In-network). Exam/Fitting/OTC aids: Not covered.	Exam, Fitting, Prescription aids: $0 copay (In-network). OTC aids: Not covered.	Prescription aids: $0 copay (In/Out-of-network). Exam, Fitting, OTC aids: Not covered.	Exam, Fitting: $0 copay (In/Out-of-network). Prescription aids: $699−$999 copay (In/Out-of-network). OTC aids: Not covered.	
Fitness	$0 copay (In-network).	$0 copay (In-network).	$0 copay (In/Out-of-network).	$0 copay (In/Out-of-network).	
Worldwide Emergency	$130 copay.	$0 copay.	$130 copay.	$130 copay.	
Telehealth	$0−$10 copay (In-network).	$0 copay (In-network)- Advanced Plan Approval/Physician Referral Required.	$0−$40 copay, 20% coinsurance (In-network)- Advanced Plan Approval Required.	$0−$55 copay (In-network).	
Part B reduction	−$79.00 reduction.	−$75.00 reduction.	−$65.00 reduction.	−$55.00 reduction.	
Acupuncture	$0 copay (In-network).	$0 copay (In-network).	Not covered.	$55 copay (In/Out-of-network).	
Chiropractor	$0 copay (In-network).	Not covered.	Not covered.	Not covered.	
Extra Notes	HMO plan. **Highest Part B reduction: -79.00**. SNF is not covered. Includes PERS ($0 copay) and meals for short duration ($0−$5 copay). Chiropractic and acupuncture are $0 copay.	HMO plan with very low MOOP ($2,999). High Part B reduction: −75.00. **Worldwide Emergency $0 copay**. Includes Acupuncture ($0 copay) and OTC drug benefits ($0 copay).	PPO plan with high MOOP. MA without drug coverage. Includes Over the counter drug benefits ($0 copay). Advanced Plan Approval is Required for nearly all services.	PPO plan. MA without drug coverage. Mental health is $0 copay (In/Out−of−network).Includes meals for short duration ($0 copay).	

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