

## 2026 San Francisco Medicare Advantage Plan HMO- C-SNP

Plan Name	Alignment Health Heart & Diabetes (HMO C-SNP)	Alignment Health Heart & Diabetes CalPlus (HMO C-SNP)	Alignment Health Heart & Diabetes Care (HMO C-SNP)	Alignment Health Heart & Diabetes Choice (HMO C-SNP)	Imperial Senior Value (HMO C-SNP)
<b>Plan ID</b>	H3815-010-0	H3815-039-0	H3815-048-0	H3815-051-0	H5496-005-0
<b>Monthly Premium</b>	\$0.00 (Total monthly premium)	\$12.00 (Total monthly premium)	\$0.00 (Total monthly premium)	\$0.70 (Total monthly premium)	\$0.00 (Total monthly premium)
<b>Website</b>	<a href="https://www.alignmenthealthplan.com/">https://www.alignmenthealthplan.com/</a>	<a href="https://www.alignmenthealthplan.com/">https://www.alignmenthealthplan.com/</a>	<a href="https://www.alignmenthealthplan.com/">https://www.alignmenthealthplan.com/</a>	<a href="https://www.alignmenthealthplan.com/">https://www.alignmenthealthplan.com/</a>	<a href="https://imperialhealthplan.com/">https://imperialhealthplan.com/</a>
<b>MOOP (Maximum Out-of-Pocket)</b>	\$1,499	\$9,250	\$1,990	\$9,250	\$296
<b>Chronic Condition covered</b>	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus
<b>Contact</b>	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 Non-members: 1-888-979-2247	Members: 1-866-634-2247 Non-members: 1-888-979-2247	Members: 1-800-838-8271 Non-members: 1-800-838-5914
<b>Network Provider</b>	Brown & Toland Health Services Inc, North East Medical Services, Optum Behavioral Health Solutions, Santa Clara County IPA	Brown & Toland Health Services Inc, Sutter Health	Brown & Toland Health Services Inc, Sutter Health	Brown & Toland Health Services Inc	Imperial Health Plan of California, Imperial Health Holdings Medical Group, Access Primary Care Medical Group,
<b>Network Hospital</b>	California Pacific Medical Center, Sutter Bay, UCSF Saint Francis, UCSF Mt. Zion, Chinese Hospital, UCSF, CPMC Mission Bernal, Kentfield Hospital, UCSF St. Mary's, University of Southern California	CPMC, Sutter Bay, UCSF Saint Francis Hospital, UCSF Mt. Zion, Chinese Hospital, UCSF, CPMC Mission Bernal, Kentfield Hospital, UCSF St. Mary's, University of Southern California	California Pacific Medical Center, Sutter Bay, UCSF Saint Francis, UCSF Mt. Zion, Chinese Hospital, UCSF, CPMC Mission Bernal, Kentfield Hospital, UCSF St. Mary's, University of Southern California	California Pacific Medical Center, Sutter Bay Hospital, UCSF Saint Francis, UCSF Mt. Zion, Chinese Hospital, UCSF, CPMC Mission Bernal, Kentfield Hospital, UCSF St. Mary's, University of Southern California	Saint Francis Memorial Hospital, UCSF Medical Center, California Pacific Medical Center, Chinese Hospital, Sutter West Bay Hospitals, Kentfield Hospital
<b>Physician Visit</b>	Primary doctor: \$0 copay; Specialist: \$3 copay- 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.	Primary doctor: \$0 copay (In-network); Specialist: \$0 copay (In-network)- Limits apply
<b>Inpatient Visit</b>	Days 1-3: \$100/day, Days 4-90: \$0/day (Advanced Plan approval & Physicians Referral required).	Days 1-6: \$275/day, Days 7-90: \$0/day; \$0/stay- (Advanced Plan approval & Physicians Referral required).	Days 1-5: \$20/day, Days 21-100: \$100/day. (Advanced Plan approval & Physicians Referral required).	Days 1-6: \$225/day; Days 7-90: \$0/day- Limits apply (Advanced Plan approval & Physicians Referral required).	Days 1-90: \$0/day- Limits apply (Advanced Plan approval & Physicians Referral required).
<b>Outpatient Visit</b>	\$0 copay (In-network)- Limits apply (Advanced Plan approval & Physicians Referral required).	20% (In-network)- Limits apply (Advanced Plan approval & Physicians referral required).	\$200 copay- Limits apply (Advanced Plan approval & Physicians Referral required).	\$200 copay (in-network)- Limits apply (Advanced Plan approval & Physicians Referral required).	\$100 copay (In-network)- Limits apply (Advanced Plan approval & Physicians Referral required).
<b>DME</b>	0%-20% coinsurance (In-network)- Limits apply (Advanced Plan approval required).	20% coinsurance (In-network)- Limits apply (AP required).	0%-20% coinsurance (In-network)- Limits apply (AP required).	20% coinsurance (In-network)- Limits apply (AP required).	20% coinsurance (In-network)- Limits apply (AP required).
<b>Mental Health</b>	Group & Individual (Psychiatrist & Non-Psychiatrist): \$0 copay (In-network). Opioid tx: 20% coinsurance (In-network)- Limits apply (AP/PR Required).	Group & Indiv (Psych & Non-Psych), Opioid tx: 20% coinsurance (In-network)- Limits apply.	Group & Indiv (Psych & Non-Psych): \$0 copay (In-network). Opioid Tx: 20% coinsurance (In-network)- AP/PR Required.	Group & Indiv (Psych): \$40 copay (In-network). Group & Indiv (Non-Psych): \$0 copay (In-network). Opioid Tx: 20% coinsurance (In-network)- AP/PR Required.	Group & Indiv (Psych & Non-Psych), Opioid tx: 20% coinsurance (In-network)- Limits apply (AP/PR required).
<b>Ambulance Service</b>	Ground ambulance: \$100 copay (In-network)- Limits apply.	Ground ambulance: 20% coinsurance (In-network)- Limits apply.	Ground ambulance: \$100 copay (In-netow)	Ground ambulance: In-network: \$175 copay (Limits apply)	Ground ambulance: In-network: \$150 copay (Limits apply)
<b>Emergency Service</b>	Emergency care: \$70 copay; Urgent care: \$0 copay	Emergency care: 20% coinsurance; Urgent care: \$0 copay	Emergency care: \$120 copay; Urgent care: \$0 copay	Emergency care: \$85 copay; Urgent care: \$0 copay	Emergency care: \$125 copay; Urgent care: \$0 copay
<b>Diagnostic Test, X-Ray &amp; Lab Services</b>	All Di \$0 copay (AP/PR Required)	Tests/Labs: 20% coinsurance (In-network). Radiology/X-rays: \$0 copay (In-network)- AP/PR Required	All In-network: \$0 copay (AP/PR Required)	All In-network: \$0 copay (AP/PR Required)	All In-network: \$0 copay (AP/PR Required)
<b>Prescription Drugs</b>	Drug deductible: \$0.00. Preferred Generic: \$0 copay. Generic: \$5 copay. Brand: \$30 copay. Non-Preferred: 40% coinsurance. Specialty: 33% coinsurance. Select: \$5 copay.	Drug deductible: \$615.00. Preferred Generic, Select Care: \$0 copay. Generic, Brand, Specialty: 25% coinsurance. Non-Preferred: 31% coinsurance.	Drug deductible: \$0.00. Preferred Generic: \$0 copay. Generic, Select: \$5 copay. Brand: \$30 copay. Specialty: 33% coinsurance. Non-Preferred: 50% coinsurance.	Drug deductible: \$615.00. Preferred Generic, Select: \$0 copay. Generic, Brand, Specialty: 25% coinsurance. Non-Preferred: 30% coinsurance.	Drug deductible: \$0.00. Pref Gen: \$0 copay. Select: \$3 copay. Gen: \$6 copay. Brand: \$45 copay. Non-Pref: \$90 copay. Specialty: 33% coin
<b>Transportation</b>	Plan-approved locations: \$0 copay (In-network). Any health-related locations: Not covered.	Plan-approved locations: \$0 copay (In-network). Any health-related locations: Not covered.	Plan-approved locations: \$0 copay (In-network). Health-related locations: Not covered.	Plan-approved locations: \$0 copay (In-network). Any health-related locations: Not covered.	Plan-approved locations: \$0 copay (In-network). Any health-related locations: Not covered.
<b>Dental</b>	All Preventative: \$0 copay (In-network). Comprehensive vary \$15-\$570 copay. Prosthetics, Implant, Ortho, Adjunctive: Not covered.	All Preventive & Comprehensive: \$0 copay (In-network). Prosthetics, Implant, Ortho, Adjunctive: Not covered.	All Preventative: \$0 copay (In-network). Comprehensive: \$15-\$570 copay (In-network). Prosthetics, Implant, Ortho, Adjunctive: Not covered.	All Preventive & Comprehensive: \$0 copay. Prosthetics, Implant, Orthodontics, Adjunctive: Not covered.	All Preventive & Comprehensive: \$0 copay (In-network). Prosthetics, Implant, Orthodontics, Adjunctive: Not covered.
<b>Vision</b>	All (Exam, Contacts, Eyeglasses frames & lenses, frames only, lenses only, Upgrades): \$0 copay (In-network).	\$0 copay (In-network). Upgrades: Not covered.	\$0 copay. Upgrades: Not covered.	\$0 copay (In-network). Upgrades: Not covered.	\$0 copay (In-network). Eyeglass frames only, Eyeglass lenses only, Upgrades: Not covered.
<b>Hearing</b>	Exam, Fitting: \$0 copay (In-network). Prescription and OTC aids: Not covered.	\$0 copay (In-network). OTC aids: Not covered.	Exam, Fitting: \$0 copay (In-network). Prescription & OTC aids: Not covered.	\$0 copay (In-network). OTC aids: Not covered.	\$0 copay (In-network). OTC aids: Not covered.
<b>Fitness</b>	\$0 copay (In-network).	\$0 copay (In-network).	\$0 copay (In-network).	\$0 copay (In-network).	\$0 copay (In-network).
<b>Worldwide Emergency</b>	\$0 copay	\$75 copay	\$0 copay	\$0 copay	\$0 copay
<b>Telehealth</b>	\$0 copay (In-network).	\$0 copay (In-network).	\$0 copay (In-network).	\$0 copay (In-network).	\$0 copay (In-network).
<b>Acupuncture</b>	Not covered	In-network: \$0 copay (AP/PR Required, Plan limits).	Not covered	\$0 copay (In-network).	In-network: \$0 copay (Limits apply)
<b>Chiropractor</b>	Not covered	In-network: \$0 copay (AP/PR Required, Plan limits).	Not covered	\$0 copay (In-network).	In-network: \$0 copay (AP/PR Required)
<b>Extra Notes/Services</b>	SNF: \$0 days 1-31, \$50 days 32-100. Includes: PERS, In-home support, Meals for short duration, Food & produce, Pest control, Indoor air quality, General supports for living (all \$0 copay). Optional Dental Package: \$36.00/month. Note: Plan-approved transportation is ambiguously listed as both covered (\$0) and not covered.	SNF: Not covered. Includes: PERS, In-home support, Meals for short duration, food & produce, Pest control, Indoor air quality (all \$0 copay). General supports for living (\$0-\$50 copay). Note: Plan-approved transportation is ambiguously listed as both covered (\$0) and not covered.	SNF: \$20 days 1-20, \$100 days 21-100. Includes: PERS, In-home support, Meals for short duration, Food & produce, Pest control, Indoor air quality (all \$0 copay). General supports for living (\$0-\$50 copay). Optional Dental Package: \$36.00/month. Note: Plan-approved transportation is ambiguously listed as both covered (\$0) and not covered.	SNF: \$0 days 1-20, \$50 days 21-100. Includes: PERS, In-home support, Meals for short duration, Food & produce, Pest control (all \$0 copay). General supports for living (\$0 copay). Indoor air quality: Not covered. Note: Plan-approved transportation is ambiguously listed as both covered (\$0) and not covered.	Part B premium reduction: -25.00. SNF: \$0 days 1-20, \$100 days 21-50, \$200 days 51-100. Includes: In-home support services, meals for short duration, food & produce (all \$0 copay). PERS, pest control, indoor air quality, general supports for living: not covered.

## 2026 San Francisco Medicare Advantage Plan HMO C-SNP

Plan Name	Central Health Embrace Care Plan (HMO C-SNP)	Central Health Embrace Choice Plan (HMO C-SNP)	SCAN Balance (HMO C-SNP)	SCAN Strive (HMO C-SNP)	Wellcare Specialty Simple Focus (HMO C-SNP)
Plan ID	H5649-025-4	H5649-026-4	H5425-106-0	H5425-098-0	H0562-138-0
Monthly Premium	\$0.00 (Total monthly premium)	\$0.00 (Total monthly premium)	\$0.00 (Total monthly premium)	\$0.00 (Total monthly premium)	\$0.00 (Total monthly premium)
Website (Non-members)	<a href="https://www.centralhealthplan.com/">https://www.centralhealthplan.com/</a>	<a href="https://www.centralhealthplan.com/">https://www.centralhealthplan.com/</a>	<a href="https://www.scanhealthplan.com/">https://www.scanhealthplan.com/</a>	<a href="https://www.scanhealthplan.com/">https://www.scanhealthplan.com/</a>	<a href="https://wellcare.healthnetcalifornia.com/">https://wellcare.healthnetcalifornia.com/</a>
MOOP (Maximum Out-of-Pocket)	<b>\$1,800</b>	<b>\$9,250</b>	<b>\$1,499</b>	<b>\$9,250</b>	<b>\$9,250</b>
Chronic Condition covered	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus
Contact	Members: 1-866-314-2427 Non-members: 1-866-384-2477	Members: 1-866-314-2427 Non-members: 1-866-384-2477	Members: 1-800-559-3500 Non-members: 1-888-315-7226	Members: 1-800-559-3500 Non-members: 1-888-315-7226	Members: 1-800-275-4737 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	Access Primary Care Medical Group, All American Medical Group, Hill Physicians, Imperial Health Plan, John Muir Physician Network, Physician Partners Ipa INC	Brown & Toland Physicians, Hill Physicians Medical Group- San Francisco, Imperial Health Plan of California San Francisco- All American Medical Group	Brown & Toland Physicians, Imperial Health Plan of California San Francisco, Access Primary Care Medical Group	Brown & Toland Physicians, Golden Bay/NEMS- SF, FYB-AAMG, Golden Bay/NEMS- Stockton, Golden Bay/NEMS 1450 Noriega, Pamf Bh, UCSF Medical Group Bh
Network Hospital	CPMC, UCSF, St. Mary's Hospital, Sutter Bay Hospitals, St. Francis Hospital	CPMC, UCSF, St. Mary's Hospital, Sutter Bay Hospitals, St. Francis Hospital	California Pacific Medical Center, CPMC Pacific Campus, CPMC Davies Campus, Chinese Hospital, UCSF	CPMC, CPMC Pacific Campus, CPMC Davies Campus, Chinese Hospital, UCSF	CPMC - Davies Campus, Saint Francis Memorial Hospital, UCSF Medical Center, CPMC - Mission Bernal Campus
Physician Visit	Primary: \$0 copay (In-network). Specialist: \$0 copay (In-network).	Primary: \$0 copay (In-network). Specialist: 0%-30% coinsurance (In-network).	Primary: \$0 copay (In-network). Specialist: \$0 copay (In-network).	Primary: \$0 copay (In-network). Specialist: \$0 copay (In-network).	Primary: \$0 copay (In-network). Specialist: \$25 copay (In-network).
Inpatient Visit	Days 1-5: \$0/day, 6-9: \$200/day, 10-90: \$35/day (AP/PR Required).	\$0 per day days 1-60; \$419 days 61-90; \$838 days 91-150. (AP/PR Required).	\$150 per day days 1-5; \$0 per day days 6-90. (AP/PR Required).	\$0 per day days 1-60; \$419 days 61-90; \$838 days 91-150. (AP/PR Required).	\$800 per day days 1-2; \$0 per day days 3-90. (AP/PR Required).
Outpatient Visit	In-network: \$00-\$150 copay. (AP/PR Required).	In-network: 0%-20% coinsurance. (AP/PR Required).	In-network: \$125 copay. (AP/PR Required).	In-network: 20% coinsurance. (In-network)- AP/PR Required.	In-network: \$300 copay. (AP/PR Required).
DME	In-network: 0%-20% coinsurance. (AP Required).	In-network: 20% coinsurance. (AP Required).	In-network: 0%-20% coinsurance. (AP Required).	In-network: 0%-20% coinsurance. (AP Required).	In-network: 20% coinsurance. (AP Required).
Mental Health	Individual (Psychiatrist, Non-Psychiatrist): \$10 copay (In-network). Group (Psychiatrist, Non-Psychiatrist): 20% coinsurance (In-network). Opioid treatment: \$0 copay (In-network).	Individual/Group Therapy (with/without psychiatrist): \$0 copay (In-network). Opioid Tx: \$0 copay (In-network).	All Individual/Group Therapy (with/without psychiatrist): \$10 copay (In-network). Opioid Tx: \$10 copay (In-network).	All Individual/Group Therapy (with/without psychiatrist): \$0 copay (In-network). Opioid Tx: \$0 copay (In-network).	All Individual/Group Therapy (with/without psychiatrist): \$25 copay (In-network). Opioid Tx: \$25 copay (In-network).
Ambulance Service	\$0-\$200 copay (In-network)	Ground ambulance: In-network: 20% coinsurance.	Ground ambulance: In-network: \$175 copay.	Ground ambulance: In-network: 20% coinsurance.	Ground ambulance: In-network: \$200 copay.
Emergency Service	Emergency care: \$150 copay. Urgent care: \$0 copay.	Emergency care: \$115 copay. Urgent care: \$0 copay.	Emergency care: \$90 copay. Urgent care: \$0 copay.	Emergency care: 20% coinsurance. Urgent care: 20% coinsurance.	Emergency care: \$115 copay. Urgent care: \$0 copay.
Diagnostic Test, X-Ray & Lab Services	Tests/Labs/X-rays: \$0 copay. Radiology (MRI): \$0-\$100 copay.	Tests/Radiology: 0%-20% coinsurance (In-network). Labs/X-rays: 0% coinsurance (In-network).	Tests/Labs/X-rays: \$0 copay (In-network). Radiology (MRI): \$50 copay (In-network).	Tests/X-rays: 20% coinsurance. Labs/Radiology (MRI): \$0 copay.	Test: \$0 copay. Lab: \$0-\$50 copay. Radiology: \$0-\$200 copay. X-rays: \$50 copay. All In-network.
Prescription Drugs Copay	Drug deductible: \$615.00. Preferred Generic, Select Care (In-network): \$0 copay. Generic, Brand: 15% coinsurance. Specialty: 25% coinsurance. Non-Preferred: 30% coinsurance.	Drug deductible: \$615.00. Preferred Generic, Select: \$0 copay. Generic, Brand: 15% coinsurance. Specialty: 25% coinsurance. Non-Preferred: 30% coinsurance.	Drug deductible: \$250.00. Preferred Generic, Generic: \$0 copay. Brand: \$42 copay. Specialty: 30% coinsurance. Non-Preferred: 35% coinsurance.	Drug deductible: \$250.00. Preferred Generic, Generic: \$0 copay. Brand: 24% coinsurance. Specialty: 25% coinsurance. Non-Preferred: 30% coinsurance.	Drug deductible: \$615.00. Preferred Generic, Generic, Select: \$0 copay. Brand, Specialty: 25% coinsurance. Non-Preferred: 35% coinsurance.
Transportation	Plan-approved locations: \$0 copay. Any health-related locations: Not covered.	Plan-approved locations: \$0 copay (In-network). Any health-related locations: Not covered.	Plan-approved locations: \$0 copay (In-network). Any health-related locations: Not covered.	Plan-approved locations: \$0 copay (In-network). Any health-related locations: Not covered.	Not covered.
Dental	All Preventative services: \$0 copay (In-network). Most Comprehensive varies: \$0-2160 copay. Prosthetics, Orthodontics: Not covered.	All Preventative & Comprehensive services: \$0 copay (In-network).	All Preventative & Comprehensive services: \$0 copay (In-network). Orthodontics: Not covered.	All Preventative & Comprehensive services: \$0 copay (In-network). Orthodontics: Not covered.	All Preventative & Comprehensive services: \$0 copay (In-network). Prosthetics, Orthodontics: Not covered.
Vision	All (Exam, Contact lenses, Eyeglasses frames and lenses, Eyeglass frames only, Eyeglass lenses only, Upgrades): \$0 copay (In-network).	All (Exam, Contact lenses, Eyeglasses frames & lenses, Eyeglass frames only, Eyeglass lenses only, Upgrades): \$0 copay (In-network).	All (Exam, Contact lenses, Eyeglasses frames & lenses, Eyeglass frames only, Eyeglass lenses only): \$0 copay (In-network). Upgrades: Not covered.	All (Exam, Contact lenses, Eyeglasses frames & lenses, Eyeglass frames only, Eyeglass lenses only): \$0 copay (In-network). Upgrades: Not covered.	All (Exam, Contact lenses, Eyeglasses frames & lenses, Eyeglass frames only, Eyeglass lenses only, Upgrades): \$0 copay (In-network).
Hearing	All (Exam, Fitting, OTC aids): \$0 copay (In-network). Prescription aids: \$575-\$2099 copay (In-network).	Exam, fitting, OTC aids: \$0 copay (In-network). Prescription aids: \$49-\$1549 copay (In-network).	Exam, Fitting: \$0 copay (In-network). Prescription aids: \$550-\$850 copay (In-network). OTC aids: Not covered.	Not covered.	All (Exam, Fitting, Prescription aids): \$0 copay (In-network). OTC aids: Not covered.
Fitness	\$0 copay (In-network).	In-network: \$0 copay.	\$0 copay (In-network).	\$0 copay (In-network)	Not covered.
Worldwide Emergency	\$140 copay.	\$110 copay.	\$90 copay.	20% coinsurance.	\$115 copay.
Telehealth	\$0-10 copay, 20% coinsurance (In-network).	In-network: \$0-\$30 copay, 0%-30% coinsurance.	In-network: \$0 copay. (AP/PR Required).	In-network: 0%-20% coinsurance. (AP/PR Required).	\$0-\$25 copay (In-network).
Acupuncture	\$0 copay (In-network).	In-network: \$0 copay. (AP/PR Required).	In-network: \$0 copay. (AP Required).	In-network: \$0 copay. (AP Required).	In-network: \$0 copay. (AP/PR Required).
Chiropractor	\$0 copay (In-network).	In-network: \$0 copay. (AP/PR Required).	In-network: \$0 copay. (AP/PR Required).	In-network: \$0 copay. (AP/PR Required).	In-network: \$15 copay. (AP/PR Required).
Extra Notes/Services	SNF Not covered. Includes: Meals for short duration \$0 copay, Food & produce \$0 copay. PERS/In-home support: Not covered.	SNF Not covered. Includes: PERS \$0 copay, Meals for short duration \$0 copay, Food & produce \$0 copay. In-home support: Not covered.	SNF: \$0 days 1-20, \$125 days 21-100. Includes: PERS \$0 copay, In-home support \$0 copay, Meals for short duration \$0 copay, Food & produce \$0 copay, Support for Caregivers \$0 copay.	SNF Not covered. Includes: PERS \$0 copay, In-home support \$0 copay, Meals for short duration \$0 copay, Food & produce \$0 copay, General supports for living \$0 copay, Support for Caregivers \$0 copay.	SNF: \$0 days 1-20, \$218 days 21-70, \$0 days 71-100. Includes: In-home support \$0 copay, Alternative therapies \$0 copay. PERS/Meals Not covered

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- C & I-SNP

Plan Name	Alignment Health BreathEasy (HMO C-SNP)	Alignment Health Clarity (HMO C-SNP)	UHC Complete Care Support CA-8AP (HMO-POS C-SNP)	Premier Care (HMO I-SNP)	Senior Care (HMO I-SNP)
Plan ID	H3815-041-0	H3815-042-0	H0543-249-0	H3274-002-0	H3274-001-0
Monthly Premium	\$12.00 (Monthly premium); \$0 health/\$615 drug deductible	\$12.00 (Monthly premium); \$0 health/\$615 drug deductible	\$8.90	\$0.00	\$12.00
Website (Non-members)	<a href="https://www.alignmenthealthplan.com/">https://www.alignmenthealthplan.com/</a>	<a href="https://www.alignmenthealthplan.com/">https://www.alignmenthealthplan.com/</a>	<a href="https://www.uhc.com/medicare">https://www.uhc.com/medicare</a>	<a href="https://alignseniorcare.com/">https://alignseniorcare.com/</a>	<a href="https://alignseniorcare.com/">https://alignseniorcare.com/</a>
MOOP (Maximum Out-of-Pocket)	<b>\$9,250</b>	<b>\$9,250</b>	<b>\$9,250</b>	<b>\$1,900</b>	<b>\$9,250</b>
Chronic Conditions	Chronic Lung Disorders	Chronic Mental Health, Substance Use Disorders	Cardiovascular Disorders, Chronic Heart Failure, Diabetes Mellitus	Call plan for further details.	Call plan for further details.
Contact	Members: 1-866-634-2247 Non-members: 1-888-979-2247	Members: 1-866-634-2247 Non-members: 1-888-979-2247	Members: 1-866-261-7709 Non-members: 1-800-555-5757	Members & Non-members: 1-844-305-3879	Members & Non-members: 1-844-305-3879
Network Provider	Brown and Toland, Sutter Pacific Medical Foundation, Alignment Health Plan Network, 'Verify to the plan'	Alignment Health Plan Network, Brown and Toland, Sutter Pacific Medical Foundation 'verify to the plan'	Call plan for further details.	Call plan for further details.	Call plan for further details.
Network Hospital	CPMC, UCSF 'verify to the plan'	CPMC, Sutter Bay Hospitals 'verify to the plan'	CPMC, St. Francis, St. Mary's, UCSF, 'Verify to the plan'	CA Pacific Medical Center, Sutter Bay Hospitals, St. Francis, 'verify to the plan'	St Francis, CPMC, St. Marys MC, Sutter Bay Hospitals, "verify to the plan"
Physician Visit	Primary: \$0 copay. Specialist: \$0 copay. (Both In-network, AP/PR Required)	Primary, Specialist : \$0 copay (In-network)- AP/PR Required	Primary: 0%-20% coinsurance. Specialist: 0%-20% coinsurance. (both In-network, AP/PR Required)	Primary: \$0 copay (In-network). Specialist: \$0 copay (In-network).	Primary: \$0 copay. Specialist: 0%-20% coinsurance. (both In-network).
Inpatient Visit	\$0 days 1-60; \$419 days 61-90; \$838 days 91-150. (AP/PR Required).	\$0 days 1-60; \$419 days 61-90; \$838 days 91-150. (AP/PR Required).	\$1,525 per stay. (In-network, AP/PR Required).	\$0 per stay. (AP Required).	\$235 days 1-10; \$0 days 11-90. (AP Required).
Outpatient Visit	In-network: 20% coinsurance. (AP/PR Required).	In-network: 20% coinsurance. (AP/PR Required).	In-network: 0%-20% coinsurance. (In-network, AP/PR Required).	In-network: \$0-\$225 copay. (AP Required).	In-network: 20% coinsurance. (AP Required).
DME	In-network: 20% coinsurance. (AP Required) Diabetes \$0	In-network: 20% coinsurance. (AP Required). Diabetes \$0	In-network: 20% coinsurance. (AP Required).	In-network: 20% coinsurance. (AP Required). Diabetes \$0	In-network: 20% coinsurance. (AP Required).
Mental Health	Outpatient Therapy: 20% coinsurance (Group/Individual, with/without psychiatrist). Opioid Tx: 20% coinsurance. (AP/PR Required).	Outpatient Therapy: 20% coinsurance (Group/Individual, with/without psychiatrist). Opioid Tx: 20% coinsurance. (AP/PR Required).	Group (Psychiatrist, Non-Psychiatrist): 20% coinsurance (In-network). Individual (Psychiatrist/Non-Psychiatrist): 0%-20% coinsurance. Opioid Tx: \$0 copay (In-network). (AP/PR Required).	Individual/Group (No Psych): \$0 copay. With Psych: 20% coinsurance. Opioid Tx: \$0 copay. (All In-network)	Individual/Group (No Psych): \$0 copay. With Psych: 20% coinsurance. Opioid Tx: \$0 copay. (all In-network)
Ambulance Service	Ground ambulance: 20% coinsurance. (AP Required).	Ground ambulance: 20% coinsurance (In-network)- AP Required	Ground ambulance: 20% coinsurance. (AP Required).	Ground ambulance: \$125 copay. (AP Required).	Ground ambulance: 20% coinsurance. (In-network, AP Required).
Emergency Service	Emergency: 20% coinsurance. Urgent: \$0 copay.	Emergency: 20% coinsurance. Urgent: \$0 copay.	Emergency: \$115 copay. Urgent: \$0-\$40 copay.	Emergency: \$90 copay. Urgent: \$40 copay.	Emergency: \$90 copay. Urgent: \$40 copay.
Diagnostic Test, X-Ray & Lab Services	Tests/Labs: 20% coinsurance. Radiology/X-rays: \$0 copay. (All In-network, AP/PR Required).	Tests/Labs: 20% coinsurance. Radiology/X-rays: \$0 copay. (All In-network, AP/PR Required).	Tests/Labs: \$0 copay. Radiology: 0%-20% coinsurance. X-rays: 20% coinsurance. (In-network, AP/PR Required).	Tests/Radiology: 20% coinsurance. Labs/X-rays: \$0 copay. (In-network, AP Required).	Tests/Radiology: 20% coinsurance. Labs/X-rays: \$0 copay. (In-network, AP Required).
Prescription Drugs	Preferred Generic, Select Care: \$0 copay. Generic, Brand, Specialty: 25% coinsurance. Non-Preferred: 30% coinsurance.	Preferred Generic, Select: \$0 copay. Generic, Brand, Specialty: 25% coinsurance. Non-Preferred: 31% coinsurance.	Generic drugs, Brand-name drugs: 25% coinsurance.	Preferred Generic: \$0 copay. Generic: \$10.00 copay. Preferred Brand: \$45.00 copay. Non-Preferred Drug: \$95.00 copay. Specialty Tier: 33% coinsurance.	Generic drugs & Brand-name drugs: 25% coinsurance.
Transportation	Plan-approved locations: \$0 copay (In-network). Any-health related locations: Not covered.	Plan-approved locations: \$0 copay (In-network). Any-health-related locations: Not covered.	Not covered.	Any health-related locations: \$0 copay (In-network). Plan-approved locations: Not covered.	Any health-related locations: \$0 copay (In-network). Plan-approved locations: not covered.
Dental	All Preventative & Comprehensive services: \$0 copay (In-network). Prosthetics, Implant, Orthodontics, Adjunctive: Not covered.	All Preventive & Comprehensive services: \$0 copay (In-network). Prosthetics, Implant, Orthodontics, Adjunctive: Not covered.	Preventive: \$0 copay (In/Out-of-network). Comprehensive services: Not covered.	All Preventive & Comprehensive services: \$0 copay (In-network). Maxillofacial/Orthodontics Not covered.	All Preventive & Comprehensive services: \$0 copay (In-network). Prosthetics/Orthodontics: Not covered.
Vision	Routine exam, Contact lenses, Eyeglasses (frames & lenses, frames only, lenses only): \$0 copay. Upgrades: Not covered.	All (Exam, Contact lenses, Eyeglasses frames & lenses, Eyeglass frames only, Eyeglass lenses only): \$0 copay (In-network), Upgrades: Not covered.	Exam, Contact lenses, Eyeglass frames only, Eyeglass lenses only: \$0 copay (In-network). Eyeglasses frames & lenses, Upgrades: not covered.	All (Exam, Contact lenses, Eyeglasses frames & lenses, Eyeglass frames only, Eyeglass lenses only, Upgrades: \$0 copay (In-network)	All services: \$0 copay (In-network).
Hearing	Exam, Fitting, aids (Rx): \$0 copay. OTC Aids: Not covered.	Exam, Fitting, Prescription aids: \$0 copay (In-network). OTC aids: Not covered.	Exam, Prescription aids, OTC aids: \$0 copay (In-network). Fitting: not covered.	Hearing aids (OTC): \$0 copay (In-network). Aids (Rx)/Exam/Fitting: Not covered.	All (Exam, Fitting, Prescription aids, OTC aids): \$0 copay (In-network).
Fitness	Fitness benefit: \$0 copay. (AP Required).	Fitness benefit: \$0 copay. (AP Required).	\$0 copay (In-network)	Not covered.	Not covered.
Worldwide Emergency	\$75 copay.	\$75 copay.	\$0 copay.	Not covered.	Not covered.
Telehealth	\$0 copay (In-network).	\$0 copay (In-network).	In-network: \$0 copay.	In-network: \$0 copay.	In-network: 0%-20% coinsurance.
Acupuncture	In-network: \$0 copay. (AP/PR Required).	In-network: \$0 copay. (AP/PR Required).	Not covered.	In-network: \$30 copay.	Not covered.
Chiropractor	In-network: \$0 copay. (AP/PR Required).	In-network: \$0 copay. (AP/PR Required).	Not covered.	In-network: \$30 copay. (AP Required).	Not covered.
Extra Notes/Services	Drug deductible: \$615.00. Part B premium reduction: -5.00. SNF: Not covered. Includes: PERS (\$0), In-home support (\$0), Meals for short duration (\$0), Food & produce (\$0), Pest control (\$0), Indoor air quality (\$0), General supports for living (\$0). OTC drug benefits (\$0).	Drug deductible: \$615.00. Part B premium reduction: -5.00. SNF: Not covered. Includes: PERS (\$0), In-home support (\$0), Meals for short duration (\$0), Food & produce (\$0), Pest control (\$0), Indoor air quality (\$0). General supports for living (\$0-\$50). OTC drug benefits (\$0).	Drug deductible: \$615.00. SNF: Not covered. Part B reduction: Not offered \$. Includes: Food & produce (\$0), OTC drug benefits (\$0).	Drug deductible: \$0.00. SNF: \$0 days 1-100. Part B reduction: Not offered. Includes: In-home support (\$0), OTC drug benefits (\$0).	Drug deductible: \$615.00. SNF: \$0 days 1-100. Part B reduction: Not offered. Includes: In-home support (\$0), Food & produce (\$0), OTC drug benefits (\$0).

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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