COUNCIL ON AGING ORANGE COUNTY

2013 Orange County Medicare Advantage (HMO, PPO) Comparison Chart

HICAP (714)560-0424
or 1-800-Medicare
or medicare.gov

Company	Aetna	Anthem Blue Cross	Anthem Blue Cross	Blue Shield
Plan Name	Medicare Select Plan	Senior Secure Plan I	Senior Secure Plan II	65 Plus Plan
Telephone Numbers Website	New enrollment: 1-800-832-2640 Current members: 1-800-282-5366 artamedicare.com	New enrollment: 1-800-797-6438 Current members: 1-888-230-7338 anthem.com/ca	New enrollment: 1-800-797-6438 Current members: 1-888-230-7338 anthem.com/ca	New enrollment: 1-800-488-8000 Current Members: 1-800-776-4466 blueshieldca.com
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium
Size of Network	1501-2000 physicians and providers	18001-19000 physicians and providers	18001-19000 physicians and providers	8501-9000 physicians and providers
Out of Pocket Maximum	$3,400 In-Network	$4,000 In-Network	$4,000 In-Network	$3,000 In-Network
Doctor Visit	$0 each visit	$5 each visit	$0 each visit	$0 each visit
Specialist Visit	$0 each visit	$30 each visit	$5 each visit	$5 each visit
In-patient Hospitalization	$0 copay. Unlimited days each benefit period.	Days 1-7: $150/day, Days 8-90: $0/day. Unlimited days each benefit period.	Days 1-5: $35/day, Days 6-90: $0/day. Unlimited days each benefit period.	Days 1-5: $50/day, Days 6-90: $0/day. $250 out-of-pocket limit. Unlimited days each benefit period.
Skilled Nursing Facility	Days 1-20: $0/day, Days 21-100: $150/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: $0/day, Days 21-100: $150/day. No prior hospital stay required. 100 days each benefit period.	Days 1-20: $0/day, Days 21-100: $150/day. No prior hospital stay required. 100 days each benefit period.	Days 1-10: $0, Days 11-100: $85/day. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	Days 1-6: $100/day, Days 7-90: $0/day. 190-day psychiatric hospital lifetime limit.	Days 1-7: $150/day, Days 8-90: $0/day. 190-day psychiatric hospital lifetime limit.	Days 1-5: $35/day, Days 6-90: $0/day. 190-day psychiatric hospital lifetime limit.	$900 each stay. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	$0 each indiv. or group therapy visit.	$40 each indiv. or group therapy visit.	$40 each indiv. or group therapy visit.	$30 each indiv. or group therapy visit.
Outpatient Hospital Services	$0 each visit	$0-$125 each visit	$0-$30 each visit	$100 each visit
Ambulance	$300 each service	$200 each service	$200 each service	$250 each service
Emergency Room Visit	$65 each visit, waived if admitted immediately.	$65 each visit, waived if admitted within 72-hrs.	$65 each visit, waived if admitted within 72-hrs.	$65 each visit. $10, 000 limit outside of U.S.
Outpatient Rehab Services	$0 each visit	$50 each visit	$5 each visit	$20 each visit
Durable Medical Equipment	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.
Diagnostic Tests	$0 for diagnostic procedures and tests. 20% of the cost for diagnostic radiology services.	$0 to $190 for diagnostic procedures and tests. $45-$190 for diagnostic radiology services. $5-$30 copay may apply for additional services.	$0 to $55 for diagnostic procedures and tests. $20-$55 for diagnostic radiology services. $0-$5 copay may apply for additional services.	$0 for diagnostic procedures and tests. $50 for diagnostic radiology services. $0-$5 copay may apply for additional services
X-Rays	$0-$10 each X-ray	$45 each X-ray	$20 each X-ray	$0 each X-ray
Lab Services	$0 each lab service. 20% of the cost for therapeutic radiology services.	$0 each lab service. 20% for therapeutic radiology services. $5 to $30 copay may apply for additional services.	$0 each lab service. 20% for therapeutic radiology services. $0 to $5 copay may apply for additional services.	$0 each lab service. 20% for therapeutic radiology services. $0-$5 copay may apply for additional services.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	$0 copay for *Medicare-covered* benefits. Preventive benefits not covered.	0% of cost for *Medicare-covered* benefits. Preventive benefits not covered.	0% of cost for *Medicare-covered* benefits. Preventive benefits not covered.	$0-$5 copay for *Medicare-covered* benefits. Preventive benefits not covered.
Hearing Services	$0 copay for diagnostic exams. $0 copay for up to 1 routine exam/yr. Hearing aids not covered.	$30 copay for diagnostic exams. Routine exams and hearing aids not covered.	$5 copay for diagnostic exams. Routine exams and hearing aids not covered.	$0 copay for diagnostic exams. $0-$5 for routine exams. Hearing aids not covered.
Vision Services	$0 copay to diagnose & treat eye conditions. $0 copay for 1 routine exam per year. $0 copay for one pair of eyewear after cataract surgery. $0 copay for glasses/contacts ($100 limit/2 yrs.).	$0 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery.	$0 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery.	$0 copay to diagnose & treat eye conditions. $20 for up to 1 routine exam/yr. $0 copay for eye wear after cataract surgery. $20 for up to 1 pair of lenses/yr. $20 for up to 1 pair of frames/2 yrs. ($75 limit/2 yrs.). $0-$5 copay may apply for additional services.
Prescription Drugs	See separate chart	See separate chart	See separate chart	See separate chart

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Company	Blue Shield	Brand New Day	Brand New Day	Care1st
Plan Name	65 Plus Choice	Brand New Day	Brand New Day HMO Extra Care	Care1st Medicare AdvantageOptimum Plan
Telephone Numbers Website	New enrollment: 1-800-488-8000 Current Members: 1-800-776-4466 blueshieldca.com/findamedicare	New enrollment: 1-866-255-4795 Current Members: 1-866-255-4795 brandnewdayhmo.com	New enrollment: 1-866-255-4795 Current Members: 1-866-255-4795 brandnewdayhmo.com	New enrollment: 1-800-847-1222 Current Members: 1-800-544-0088 care1st.com/ca/medicare
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$29.80 Monthly Premium	$0 Monthly Premium
Size of Network	501-1000 physicians and providers	251-500 physicians and providers	251-500 physicians and providers	1501-2000 physicians and providers
Out of Pocket Maximum	$2,000 In-Network	$3,400 In-Network	$6,700 In-Network	$3,400 In-Network
Doctor Visit	$0 each visit	$5 each visit	20% of the cost each visit	$0 each visit
Specialist Visit	$0 each visit	$10 each visit	20% of the cost each visit	$3 each visit
In-patient Hospitalization	$0 copay. Unlimited days each benefit period.	Days 1-5: $100/day, Days 6-60: $0/day, Days 61-90: $289/day. 60 lifetime reserve days at $578/day.	**Data is unavailable - contact plan**	$0 copay. Unlimited days each benefit period.
Skilled Nursing Facility	Days 1-20: $0/day, Days 21-100: $75/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: $0/day, Days 21-100: $144.50/day. No prior hospital stay required. 100 days each benefit period.	**Data is unavailable - contact plan**	Days 1-20: $0/day, Days 21-100: $50/day. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	$900 copay per Medicare-covered. 190-day psychiatric hospital lifetime limit.	Days 1-8: $100/day, Days 9-60, $0/day, Days 61-90: $289/day. $600 out-of-pocket limit every year. 190-day psychiatric hospital lifetime limit. 60 lifetime reserve days at $578/day.	**Data is unavailable - contact plan**	Days 1-8: $50/day, Days 9-90, $0/day. $400 out-of-pocket limit per benefit period. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	$30 each indiv. or group therapy visit.	$0-$10 each indiv. or group therapy visit.	20% of the cost for each indiv. or group therapy visit.	$10 each indiv. or group therapy visit.
Outpatient Hospital Services	$50 each visit	$50 each visit	20% of the cost for each visit	$20-$50 each visit
Ambulance	$100 each service	20% of the cost for each service.	20% of the cost for each service.	$115 each service, waived if admitted.
Emergency Room Visit	$65 each visit. $10, 000 limit outside of U.S.	$65 each visit, waived if admitted within 1-day. Not covered outside of U.S.	$65 each visit, waived if admitted within 3-days. Worldwide coverage.	$50 each visit, waived if admitted within 1-day. $25,000 limit outside of U.S.
Outpatient Rehab Services	$15 each visit	$10 - 20% of the cost for each visit.	20% of the cost for each visit.	$10 each visit
Durable Medical Equipment	0%-20% of cost *Medicare-covered* items.	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.	0%-20% of cost for *Medicare-covered* items.
Diagnostic Tests	$0 for diagnostic procedures and tests. $50 for diagnostic radiology services.	20% of the cost for diagnostic procedures and tests. 0% - 20% of the cost for diagnostic radiology services.	20% of the cost for diagnostic procedures and tests. 20% of the cost for diagnostic radiology services.	$0 for diagnostic procedures and tests. $0 for diagnostic radiology services.
X-Rays	$0 each X-ray	$0 each X-ray	20% of the cost for each X-ray	$0 each X-ray
Lab Services	$0 copay for lab services. 20% of cost for therapeutic radiology services.	20% of the cost for lab services. 10% of cost for therapeutic radiology services.	20% of the cost for lab services. 20% of the cost for therapeutic radiology services.	$0 for lab services. 10% for therapeutic radiology services.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	$0-$5 copay for *Medicare-covered* benefits. Preventive benefits not covered.	$0 copay for *Medicare-covered* benefits. Preventive benefits not covered.	$0 copay for *Medicare-covered* benefits. $0 for up to 2 oral exams/yr, up to 1 cleaning/6 mo., up to 1 fluoride treatment/yr., up to 1 X-ray/yr. ($1900 limit for dental benefits/yr.)	$0-$570 for *Medicare-covered* benefits. $0 copay for up to 1 oral exam/yr, up to 1 cleaning/6 mo. $5 for up to 1 fluoride treatment/yr. $0 for up to 1 X-ray/2yrs.
Hearing Services	$0 copay for diagnostic exams. $0 copay for up to 1 routine exam. $0 for up to 1 fitting-eval./2 yrs. $0 copay for hearing aids ($500 limit/2 yrs.).	20% of the cost for *Medicare-covered* diagnostic exams. Routine exams. Hearing aids not covered.	20% of the cost for *Medicare-covered* diagnostic exams. Routine exams and hearing aids not covered.	$10 copay for diagnostic exams. $10 copay for up to 1 routine exam/yr. $0 for up to 1 hearing aid fitting-eval./yr. $0 for up to 2 hearing aids/2 yrs. ($500 limit every year).
Vision Services	$0 copay to diagnose & treat eye conditions. $0 for eye wear after cataract surgery. $20 for up to 1 routine exam/yr. $20 for up to1 pair of lenses/yr. $20 for up to 1 frame/2 yrs. ($90 limit)	$0 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery.	20% of the cost to diagnose & treat eye conditions. $0 copay for up to 1 routine exam/yr. $0 copay for eye wear after cataract surgery. $0 copay for up to 1 pair of lenses/yr. $0 copay for up to 1 pair of frames/ 2yrs.	$0 copay to diagnose & treat eye conditions. $0 for eye wear after cataract surgery. $0 copay for up to 1 pair of glasses/2 yrs. $5 copay for up to 1 routine exam/yr. $150 limit for eye wear/2 yrs.
Prescription Drugs	See separate chart	See separate chart	See separate chart	See separate chart

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Company	CareMore Health Plan	CareMore Health Plan	Central Health	Central Health
Plan Name	CareMore Value Plus	StartSmart Plan	Central Health Medicare Plan	Central Health Premier Plan
Telephone Numbers Website	New enrollment: 1-866-622-2820 Current Members: 1-800-822-6991 caremore.com	New enrollment: 1-866-622-2820 Current Members: 1-800-822-8720 caremore.com	New enrollment: 1-866-314-2427 Current Members: 1-866-314-2427 centralhealthplan.com	New enrollment: 1-866-314-2427 Current Members: 1-866-314-2427 centralhealthplan.com
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium
Size of Network	1001-1500 physicians and providers	1001-1500 physicians and providers	7501-8000 physicians and providers	7501-8000 physicians and providers
Out of Pocket Maximum	$3,400 In-Network	$6,700 In-Network	$6,700 In-Network	$6,700 In-Network
Doctor Visit	$0 each visit	$5 each visit	$0 each visit	20% of the cost each visit
Specialist Visit	$0 each visit	$20 each visit	$0 each visit	20% of the cost each visit
In-patient Hospitalization	$0 copay. Unlimited days each benefit period.	Days 1-5: $100/day, Days 6-90: $0/day. Unlimited days each benefit period.	$0 copay. Unlimited days each benefit period.	**Data is unavailable - contact plan**
Skilled Nursing Facility	Days 1-20: $0/day, Days 21-100: $25/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: $0/day, Days 21-100: $50/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-14: $0/day, Days 15-20: $50/day, Days 21-100: $150/day. No prior hospital stay required. 100 days covered each benefit period.	**Data is unavailable - contact plan**
In-patient Mental Health	$0 copay. Contact plan for coverage beyond 190 days.	Days 1-5: $100/day, Days 6-90, $0/day. $0 copay for additional days. Contact plan for coverage beyond 190 days.	$0 copay. 190-day psychiatric hospital lifetime limit.	**Data is unavailable - contact plan**
Outpatient Mental Health	$0 each indiv. or group therapy visit.	$0-$20 each indiv. or group therapy visit.	$5 each indiv. or group therapy visit.	40% of the cost for each indiv. or group therapy visit.
Outpatient Hospital Services	$0 each visit	$75 each visit	$0 each visit	20% of the cost for each visit
Ambulance	$100 each service.	$0-$100 each service.	$50 each service	20% of the cost of each service
Emergency Room Visit	$65 each visit, waived if admitted within 24-hrs. $10,000 limit outside of U.S.	$65 each visit, waived if admitted within 24-hrs. $10,000 limit outside of U.S.	$65 each visit, waived if admitted within 24-hrs. $50,000 limit outside of U.S.	20% of the cost (max $65) each visit, waived if admitted within 24-hrs. $50,000 limit outside of U.S.
Outpatient Rehab Services	$0 each visit	$20 each visit	$0 each visit	20% of the cost for each visit
Durable Medical Equipment	0%-20% of cost for *Medicare-covered* items.	0%-20% of cost for *Medicare-covered* items.	0%-20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.
Diagnostic Tests	$0 for diagnostic procedures and tests. $0 - $75 for diagnostic radiology services.	$0 for diagnostic procedures and tests. $0-$75 for diagnostic radiology services. $5-$20 copay for office visit may apply.	$0 for diagnostic procedures and tests. $0 for diagnostic radiology services.	20% of the cost for diagnostic procedures and tests. 20% of the cost for diagnostic radiology services.
X-Rays	$0 each X-ray	$0 each X-ray	$0 each X-rays	20% of cost for X-rays
Lab Services	$0 copay for lab services. $60 for therapeutic radiology services.	$0 for lab services. $10 for therapeutic radiology services. 20% of the cost for therapeutic radiology services. $5 -$20 copay for office visit may apply.	$0 for lab services. 20% of cost for therapeutic radiology services.	20% of the cost for lab services. 20% of cost for therapeutic radiology services.
Part B Chemotherapy Drugs	0%-20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	$0 for *Medicare-covered* benefits. $5-$20 for oral exams. $35 for up to 2 cleanings/yr. $5 for up to 2 fluoride treatments/yr. $0-$10 copay for up to 1 X-ray/3 yrs.	$5-$20 for *Medicare-covered* benefits. $5-$15 for oral exams. $35 for up to 2 cleanings/yr. $5 for up to 2 fluoride treatments/yr. $0-$10 for up to 1 X-ray every 3 yrs.	$0 for *Medicare-covered* benefits. $0 for up to 1 oral exam/cleaning/yr and up to 1 X-ray every 6 months.	$0 for *Medicare-covered* benefits. $0 for oral exam and up to 2 fluoride treatments/yr, up to 2 cleaning/yr and 1 X-ray every 6 months.
Hearing Services	$0 copay for diagnostic exams. $0 copay for up to 1 routine exam. $0 for up to 1 fitting-eval./yr. $0 copay for hearing aids ($250 limit/yr.).	$0 copy for diagnostic exams. $0 copay for up to 1 routine exam and 1 hearing aid fitting-eval./yr. Hearing aids not covered.	$0 copay for diagnostic exams. $0 copay for up to 1 routine exam and 1 hearing aid fitting-eval./yr. $0 copay for up to 1 hearing aid/yr.($500 limit)	20% of the cost for diagnostic exams. $0 copay for up to 1 routine exam and 1 hearing aid fitting-eval./yr. $0 copay for up to 1 hearing aid/yr.($1,500 limit)
Vision Services	$0 copay to diagnose & treat eye conditions. $0 copay for 1 routine exam/yr. $0 for eye wear after cataract surgery. $0 for up to 1 pair of frames/2 yrs. and 1 pair of lenses/yr. ($100 limit for eye class frames/2yrs.). $0 for up to 1 pair of contacts/yr. ($100 limit/yr.)	$5-$20 copay to diagnose & treat eye conditions. $0 for up to 1 routine exam/yr. $0 for eye wear after cataract surgery. $20 for up to 1 pair of lenses/yr. $0 for up to 1 pair of frames/2 yrs.($100 limit for eye glass frames/2 yrs.). $0 for up to 1 pair of contacts/yr. ($100 limit/yr.)	$0 copay to diagnose & treat eye conditions. $0 copay for exams and for eye wear after cataract surgery. $0 for up to 1 pair of glasses/contacts/lenses/and frames/yr. ($75 limit/yr.).	20% of the cost to diagnose & treat eye conditions. 20% of the cost for eye wear after cataract surgery. $0 for up to 1 routine exam/yr. $0 for up to 1 pair of glasses /contacts /lenses /and frames/yr. ($300 limit/yr.).
Prescription Drugs	See separate chart	See separate chart	See separate chart	See separate chart

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Company	Citizens Choice	Easy Choice	Easy Choice	Golden State
Plan Name	Citizens Choice Healthplan	Best Plan	Plus Plan	Medicare Health Plan, Golden
Telephone Numbers Website	New enrollment: 1-866-646-2247 ext: 5551 Current Members: 1-866-634-2247 ext: 5550 citizenschoicehealth.com	New enrollment: 1-866-999-3945 Current Members: 1-866-999-3945 easychoicehealthplan.com	New enrollment: 1-866-999-3945 Current Members: 1-866-999-3945 easychoicehealthplan.com	New enrollment: 1-877-541-4111 Current Members: 1-877-541-4111 GoldenStateMHP.com
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$29.90 Monthly Premium	$0 Monthly Premium
Size of Network	6001-6500 physicians and providers	6501-7000 physicians and providers	2001-2500 physicians and providers	501-1000 physicians and providers
Out of Pocket Maximum	$3,400 In-Network	$6,700 In-Network	$6,700 In-Network	$3,400 In-Network
Doctor Visit	$0 each visit	$0 each visit	$0 each visit	$0 each visit
Specialist Visit	$0 each visit	$0 each visit	$0 each visit	$0 each visit
In-patient Hospitalization	Days 1-45: $0/day, Days 46-60: $100/day, Days 61-90: $0/day. Unlimited days each benefit period.	$0 copay. Unlimited days each benefit period.	**Data is unavailable - contact plan**	$0 copay. Unlimited days each benefit period.
Skilled Nursing Facility	Days 1-20: $0/day, Days 21-100: $85/day. No prior hospital stay required. 100 days covered each benefit period.	$0 copay. No prior hospital stay is required. 100 days covered each benefit period.	**Data is unavailable - contact plan**	Days 1-20: $0/day, Days 21-100: $50/day. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	$250 copay each *Medicare-covered* stay. Days 1-10: $115/day, Days 11-90: $0/day. **60 lifetime days** - Days 1-60: $0/day.	$0 copay. 190-day psychiatric hospital lifetime limit.	**Data is unavailable - contact plan**	$0 copay. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	$40 each indiv. or group therapy visit.	$0 each indiv. or group therapy visit.	20% of the cost for each indiv. or group therapy visit.	$0 each indiv. or group therapy visit.
Outpatient Hospital Services	$75 each visit	$0 each visit	20% of the cost for each visit	$0 each visit
Ambulance	$75 each service, waived if admitted.	$50 each service	20% of the cost of each service	$60 each service
Emergency Room Visit	$65 each visit, waived if admitted within 24-hrs.. $20,000 limit outside of U.S.	$50 each visit, waived if admitted within 24-hrs. $25,000 limit outside of U.S.	$65 each visit, waived if admitted within 24-hrs. $25,000 limit outside of U.S.	$65 each visit, waived if admitted within 24-hrs. No coverage outside of U.S.
Outpatient Rehab Services	$0 each visit	$0 each visit	$0 each visit	$0 each visit
Durable Medical Equipment	0%-20% of cost for *Medicare-covered* items.	$0 copay for *Medicare-covered* items.	20% of the cost for *Medicare-covered* items.	0%-20% for *Medicare-covered* items.
Diagnostic Tests	$0 for diagnostic procedures and tests. $0 for diagnostic radiology services.	$0 for diagnostic procedures and tests. $0 for diagnostic radiology services.	$0 for diagnostic procedures and tests. 20% of the cost for diagnostic radiology services.	$0 for diagnostic procedures and tests. $0 for diagnostic radiology services.
X-Rays	$0 each X-ray	$0 each X-ray	$0 each X-ray	$0 each X-ray
Lab Services	$0 copay for lab services. $50 copay for therapeutic radiology services.	$0 copay for lab services. 20% of the cost for therapeutic radiology services.	$0 copay for lab services. 20% of the cost for therapeutic radiology services.	$0 copay for lab services. $0 copay for therapeutic radiology services.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	$0-$675 for *Medicare-covered* benefits. $0 copay/1 oral exams/6 mo. $0-$30/1 X-ray/3 yrs. $0-$54/1 cleaning/6mo. $0-$20/1 fluoride treatment/6 mo. ($1,000 limit/yr.)	20% of the cost for *Medicare-covered* benefits.$20 copay/1 oral exams /yr. $20 /1 X-ray/yr. $20/1 cleaning /yr. $0/1 fluoride treatment/yr. ($1,000 limit/yr.)	$0 copay for *Medicare-covered* benefits. $0 copay for up to 1 oral exam/1 cleaning/1 X-ray/1 fluoride treatment/yr.($750 limit/yr).	$0 for *Medicare-covered* benefits. $8 copay for up to 1 oral exam, 1 cleaning/6 mo., 1 fluoride treatment/yr., 1 dental x-ray/3 yrs.
Hearing Services	$0 copay for diagnostic exams. $0 copay for up to 1 routine exam and hearing aid fitting-eval./ yr. $0 copay for up to 2 hearing aids/yr.($1,000 limit).	$20 copay for diagnostic exams. $20 copay for up to 1 routine exam/hearing aid fitting-eval./yr. 20% of the cost for up to 1 hearing aid/yr.($500 limit).	$0 copay for *Medicare-covered* diagnostic exams. Hearing aids not covered.	$0 copay for *Medicare-covered* diagnostic exams. $0 copay for 1 routine test/yr. $0 copay for 1 hearing aid fitting-eval./2 yrs. $0 copay for hearing aids. ($400 limit for hearing aids/2 yrs.)_
Vision Services	$0 copay to diagnose & treat eye conditions. $0 copay for exams and for eye wear after cataract surgery. $0 copay for up to 1 routine exam/yr. $0 copay for up to 1 pair of glasses/contacts/lenses and frames/2 yrs. ($100 limit/2yr.).	$0 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery.	$0 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery.	$0 copay to diagnose & treat eye conditions and up to 1 routine exam/yr. $0 copay for eye wear after cataract surgery. $0 for glasses/contacts. ($150 limit for eye wear/2 yrs.)
Prescription Drugs	See separate chart	See separate chart	See separate chart	See separate chart

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Company	Health Net	Health Net	Health Net	Health Net
Plan Name	**Health Net Healthy Heart I**	**Health Net Healthy Heart 2**	**Seniority Plus Green Plan**	**Seniority Plus Ruby Plan 1**
Telephone Numbers Website	New enrollment: 1-800-977-6738 Current Members: 1-800-275-4737 healthnet.com	New enrollment: 1-800-977-6738 Current Members: 1-800-275-4737 healthnet.com	New enrollment: 1-800-275-4737 Current Members: 1-800-275-4737 healthnet.com	New enrollment: 1-800-977-6738 Current Members: 1-800-275-4737 healthnet.com
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA ONLY (HMO)** Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	$0 Monthly Premium	$39 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium
Size of Network	13001-14000 physicians and providers	1501-2000 physicians and providers	13001-14000 physicians and providers	13001-14000 physicians and providers
Out of Pocket Maximum	$3,400 In-Network	$3,400 In-Network	$3,400 In-Network	$3,400 In-Network
Doctor Visit	$0 each visit	$15 each visit	$7 each visit	$8 each visit
Specialist Visit	$0 each visit	$25 each visit	$10 each visit	$10 each visit
In-patient Hospitalization	$0 copay. Unlimited days each benefit period.	Days 1-5: $275/day, Days 6-90: $0/day. Unlimited days each benefit period.	Days 1-5: $200/day, Days 6-90: $0/day. Unlimited days each benefit period.	Days 1-4: $100/day, Days 5-90: $0/day. Unlimited days each benefit period.
Skilled Nursing Facility	Days 1-20: $0/day, Days 21-100: $75/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: $0/day, Days 21-100: $75/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: $0/day, Days 21-100: $75/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: $0/day, Days 21-100: $75/day. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	$900 copay. 190-day psychiatric hospital lifetime limit.	$900 copay. 190-day psychiatric hospital lifetime limit.	$900 copay. 190-day psychiatric hospital lifetime limit.	$900 copay. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	$25 each indiv. or group therapy visit.	$25 each indiv. or group therapy visit.	$25 each indiv. or group therapy visit.	$25 each indiv. or group therapy visit.
Outpatient Hospital Services	$0 each visit	$275 each visit	$200 each visit	$100 each visit
Ambulance	$225 each service	$225 each service	$125 each service	$200 each service
Emergency Room Visit	$65 each visit, waived if admitted immediately. $50,000 limit outside of U.S.	$65 each visit, waived if admitted immediately. $50,000 limit outside of U.S.	$50 each visit, waived if admitted immediately. $50,000 limit outside of U.S.	$65 each visit, waived if admitted immediately. $50,000 limit outside of U.S.
Outpatient Rehab Services	$0 each visit	$0 each visit	$0 each visit	$0 each visit
Durable Medical Equipment	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.
Diagnostic Tests	$0 for diagnostic procedures and tests. $60 for diagnostic radiology services.	$0 for diagnostic procedures and tests. $60 for diagnostic radiology services.	$0 for diagnostic procedures and tests. $60 for diagnostic radiology services.	$0 for diagnostic procedures and tests. $60 for diagnostic radiology services.
X-Rays	$0 each X-ray	$0 each X-ray	$0 each X-ray	$0 each X-ray
Lab Services	$0 copay for lab services. $60 copay for therapeutic radiology services.	$0 copay for lab services. $60 copay for therapeutic radiology services.	$0 copay for lab services. $60 copay for therapeutic radiology services.	$0 copay for lab services. $60 copay for therapeutic radiology services.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	$0 copay for *Medicare-covered* benefits. Preventive benefits not covered.	$0 copay for *Medicare-covered* benefits. Preventive benefits not covered.	$0 copay for *Medicare-covered* benefits. $0 copay for up to 2 oral exams, 2 cleanings and 1 X-ray/yr. ($500 limit/yr.) $35 annual deductible for preventive benefits.	$0 copay for *Medicare-covered* benefits. Preventive benefits not covered.
Hearing Services	$30 copay for diagnostic exams. $30 copay for up to 1 routine exam/yr. Hearing aids not covered.	$25 copay for diagnostic exams. $25 for up to 1 routine exam/yr. Hearing aids not covered.	$10 copay for diagnostic exams. $10 copay for up to 1 routine exam/yr. Hearing aids not covered.	$10 copay for diagnostic exams. $10 copay for up to 1 routine exam/yr. Hearing aids not covered.
Vision Services	$0-$30 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery. $30 copay for up to 1 routine exam/yr.	$0-$25 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery. $25 copay for up to 1 routine exam/yr.	$0-$10 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery. $10 copay for up to 1 routine exam/yr. $0 copay for up to 1 pair of glasses/contacts/lenses and frames/2 yrs. ($100 limit/2 yrs.).	$0-$10 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery. $10 copay for up to 1 routine exam/yr.
Prescription Drugs	See separate chart	See separate chart	**None**	See separate chart

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Contact the plan to verify information.

COUNCIL ON AGING ORANGE COUNTY

2013 Orange County Medicare Advantage (HMO, PPO) Comparison Chart

HICAP (714)560-0424 or 1-800-Medicare or medicare.gov

Company	Health Net	Humana	Humana	Humana
Plan Name	**Gold Select**	**Humana Gold Plus (013)**	**Humana Gold Plus (030)**	**Humana Gold Plus HMO/POS (014)**
Telephone Numbers Website	New enrollment: 1-800-977-6738 Current Members: 1-800-275-4737 healthnet.com	New enrollment: 1-800-833-2364 Current Members: 1-800-457-4708 humana-medicare.com	New enrollment: 1-800-833-2364 Current Members: 1-800-457-4708 humana-medicare.com	New enrollment: 1-800-833-2364 Current Members: 1-800-457-4708 humana-medicare.com
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA ONLY (HMO)** Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO-POS Option)** Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals. May go out of network for certain services.
Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$39 Monthly Premium
Size of Network	8001-8500 physicians and providers	2001-2500 physicians and providers	2001-2500 physicians and providers	2001-2500 physicians and providers
Out of Pocket Maximum	$3,400 In-Network	$3,400 In-Network	$1,000 In-Network	$5,000 In/Out-Network
Doctor Visit	$0 each visit	$0 each visit	$0 each visit	$0 each visit
Specialist Visit	$0 each visit	$5 each visit	$0 each visit	$10 each visit
In-patient Hospitalization	$0 copay. Unlimited days each benefit period.	Days 1-10: $50/day, Days 11-90: $0/day. Unlimited days each benefit period.	$0 copay. Unlimited days each benefit period.	Days 1-10: $50/day, Days 11-90: $0/day. Unlimited days each benefit period. POS: Days 1-8: $300/day, Days 9-60: $0/day, Days 61-90: $100/day.
Skilled Nursing Facility	Days 1-20: $0/day, Days 21-100: $75/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-20: $0/day, Days 21-100: $75/day. No prior hospital stay required. 100 days covered each benefit period.	$0 copay. No prior hospital stay is required. 100 days covered each benefit period.	Days 1-20: $0/day, Days 21-100: $75/day. No prior hospital stay required. 100 days covered each benefit period. POS: Days 1-20: $50/day, Days 21-100: $120/day.
In-patient Mental Health	$900 copay. 190-day psychiatric hospital lifetime limit.	Days 1-10: $50/day, Days 11-90: $0/day. 190-day psychiatric hospital lifetime limit.	Days 1-5: $250/day, Days 6-90: $0/day. 190-day psychiatric hospital lifetime limit.	Days 1-10: $50/day, Days 11-90: $0/day. 190-day psychiatric hospital lifetime limit. POS: Days 1-8: $300/day, Days 9-90: $0/day.
Outpatient Mental Health	$25 each indiv. or group therapy visit.	$5 each indiv. or group therapy visit.	$0 each indiv. or group therapy visit.	$10 each indiv. or group therapy visit.
Outpatient Hospital Services	$0 each visit	$0-$100 or 20% of cost for each visit.	20% of cost for each visit.	$0-$100 or 20% of cost for each visit
Ambulance	$250 each service	$125 each service	$100 each service	$125 each service
Emergency Room Visit	$65 each visit, waived if admitted immediately. $50,000 limit outside of U.S.	$65 each visit, waived if admitted within 24-hrs. Worldwide coverage.	$65 each visit, waived if admitted within 24-hrs. Worldwide coverage.	$65 each visit, waived if admitted within 24-hrs. Worldwide coverage.
Outpatient Rehab Services	$0 each visit	$25 each visit	$0 each visit	$25 each visit
Durable Medical Equipment	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.	$0 copay for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.
Diagnostic Tests	$0 for diagnostic procedures and tests. $60 for diagnostic radiology services.	$0-$100 for diagnostic procedures and tests. $0-$100 for diagnostic radiology services.	$0-$25 for diagnostic procedures and tests. $0 for diagnostic radiology services.	$0-$100 for diagnostic procedures and tests. $0-$50 for diagnostic radiology services.
X-Rays	$0 each X-ray	$0-$100 each X-ray	$0-$25 each X-ray	$0-$25 each X-ray
Lab Services	$0 copay for lab services. $60 copay for therapeutic radiology services.	$0-$25 copay for lab services. $5 copay or 20% of cost for therapeutic radiology services.	$0-$25 copay for lab services. $0 copay for therapeutic radiology services.	$0-$25 copay for lab services. $10 copay or 20% of cost for therapeutic radiology services.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	$0 copay for *Medicare-covered* benefits. $0 copay for oral exams/fluoride treatments/X-rays and up to 2 cleanings/yr.	$5 copay for *Medicare-covered* benefits. $0 copay for up to 1 oral exams/cleaning/X-ray/yr.	$0 copay for *Medicare-covered* benefits. $0 copay for up to 1 oral exams/cleaning/X-ray/yr.	$10 copay for *Medicare-covered* benefits. $0 copay for up to 1 oral exams/cleaning/X-ray/yr.
Hearing Services	$25 for diagnostic exams. $25 for up to 1 routine exam/yr. Hearing aids not covered.	$5 for diagnostic exams. Routine exams and hearing aids not covered.	$0 for diagnostic exams. Routine exams and hearing aids not covered.	$10 for diagnostic exams. Routine exams and hearing aids not covered.
Vision Services	$0-$25 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery. $25 copay for up to 1 routine exam/yr.	$0-$5 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery. $0 copay for up to 1 routine exam/yr.	$0 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery. $0 copay for up to 1 routine exam/yr.	$0-$10 copay to diagnose & treat eye conditions. $0 copay for eye wear after cataract surgery. $0 copay for up to 1 routine exam/yr.
Prescription Drugs	See separate chart	See separate chart	**None**	See separate chart

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COUNCIL ON AGING ORANGE COUNTY

2013 Orange County Medicare Advantage (HMO, PPO) Comparison Chart

HICAP (714)560-0424
or 1-800-Medicare
or medicare.gov

Company	Kaiser	SCAN	SCAN	UnitedHealthcare
Plan Name	Senior Advantage	Scan Classic	Scan Plus	Medicare Complete SecureHorizons Plan 2
Telephone Numbers Website	New enrollment: 1-800-777-1238 Current Members: 1-800-443-0815 kp.org/medicare	New enrollment: 1-800-915-7226 Current Members: 1-877-559-3500 scanhealthplan.com	New enrollment: 1-800-915-7226 Current Members: 1-877-559-3500 scanhealthplan.com	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 AARPMedicarePlans.com
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.
Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$0 Monthly Premium
Size of Network	3501-4000 physicians and providers	3001-3500 physicians and providers	3001-3500 physicians and providers	3501-4000 physicians and providers
Out of Pocket Maximum	$3,400 In-Network	$3,400 In-Network	$3,000 In-Network	$3,400 In-Network
Doctor Visit	$5 each visit	$0 each visit	20% of the cost each visit	$0 each visit
Specialist Visit	$5 each visit	$0 each visit	20% of the cost each visit	$0 each visit
In-patient Hospitalization	Days 1-10: $170/day, Days 11-90: $0/day. Unlimited days each benefit period.	$0 copay. Unlimited days each benefit period.	**Data is unavailable - contact plan**	Days 1-90: $0/day. Unlimited days each benefit period.
Skilled Nursing Facility	Days 1-10: $0/day, Days 11-100: $50/day. No prior hospital stay required. 100 days covered each benefit period.	$0 copay. No prior hospital stay is required. Unlimited days each benefit period.	**Data is unavailable - contact plan**	Days 1-20: $0/day, Days 21-43: $150/day, Days 44-100: $0/day. No prior hospital stay required. 100 days covered each benefit period.
In-patient Mental Health	Days 1-10: $170/day, Days 11-90: $0/day. Contact plan for coverage beyond 190 days.	$0 copay. 190-day psychiatric hospital lifetime limit.	**Data is unavailable - contact plan**	Days 1-90: $0/day. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	$5 each individual visit. $2 each group therapy visit.	$25 each indiv. or group therapy visit.	35% of the cost for each indiv. or group therapy visit.	$30 each indiv. or group therapy visit.
Outpatient Hospital Services	$0-$125 each visit	$0 each visit	20% of cost for each visit	$0 each visit
Ambulance	$200 each service	$50 each service	20% of the cost for each service	$200 each service
Emergency Room Visit	$65 each visit, waived if admitted within 24-hrs. Worldwide coverage.	$65 each visit, waived if admitted within 24-hrs. Worldwide coverage.	20% of the cost up to $65 each visit. Worldwide coverage.	$65 each visit, waived if admitted within 24-hours. Worldwide coverage.
Outpatient Rehab Services	$5 each visit	$0 each visit	20% of the cost for each visit	$0 each visit
Durable Medical Equipment	20% of cost for *Medicare-covered* items.	0%-20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.
Diagnostic Tests	$0-$20 for diagnostic procedures and tests. $170 for diagnostic radiology services. $5 copay may apply for additional services.	$0 for diagnostic procedures and tests. $40 copay for diagnostic radiology services.	20% of cost for diagnostic procedures and tests. 20% of cost for diagnostic radiology services.	$0 copay for diagnostic procedures and tests. $50 copay for diagnostic radiology services.
X-Rays	$20 each X-ray	$0 for each X-ray	20% of cost for each X-ray	$0 each X-ray
Lab Services	$0-$20 copay for lab services. $0 copay for therapeutic radiology services. $5 copay may apply for additional services.	$0 copay for lab services. $10 copay for therapeutic radiology services.	$0 copay for lab services. 20% of cost for therapeutic radiology services.	$0 for lab services. $50 copay for therapeutic radiology services.
Part B Chemotherapy Drugs	$0-$40 copay for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs
Dental Services	$5 copay for *Medicare-covered* benefits. Preventive benefits not covered.	$0 copay for *Medicare-covered* benefits. Preventive benefits not covered.	20% of the cost for *Medicare-covered* benefits. $0 copay for up to 2 oral exams/2 cleanings/yr. $0 copay for up 1 X-ray/6 mo.	$0 copay for *Medicare-covered* benefits. Preventive benefits not covered.
Hearing Services	$5 copay for diagnostic exams. Routine exams and hearing aids not covered.	$0 copay for diagnostic exams. $0 copay for up to 1 routine exam/yr. and hearing aid fitting-eval./2 yrs. $0 copay for up to 2 hearing aids/2yrs.($500 limit).	20% of the cost for diagnostic exams. $0 copay for up to 1 routine exam/yr. and hearing aid fitting-eval./2 yrs. $0 copay for up to 2 hearing aids/2yrs.($1,400 limit).	$0 copay for diagnostic exams. $0 for up to 1 routine exam/yr. $390 copay for up to 2 inner-ear hearing aids/yr. $340 copay for up to 2 over-the-ear hearing aids/yr.
Vision Services	$5 copay to diagnose & treat eye conditions. $0 for eye wear after cataract surgery. $5 copay for routine exams. $0 copay for glasses/contacts (*$50 limit* /2 yrs.).	$0 copay to diagnose & treat eye conditions. $0 for up to 1 routine exam/yr. $10 for eye wear after cataract surgery. $35 for up to 1 pair of glasses/contacts/lenses and frames/2 yrs. ($105 limit each for lenses/frames/2 yrs.)	0%-20% of the cost to diagnose & treat eye conditions. $0 for up to 1 routine exam/yr. 20% of the cost for eye wear after cataract surgery. $0 for up to 1 pair of glasses/contacts/yr. ($125 limit each for lenses/frames/ yr.)	$0 copay to diagnose & treat eye conditions. $0 for eye wear after cataract surgery. $0 for up to 1 routine exam/yr. $30 copay contacts ($105 limit/2 yrs.). $0 for up to 1 pair of lenses/2 yrs. $30 for up to 1 pair of frames/2 yrs. ($70 limit/2 yrs.)
Prescription Drugs	See separate chart	See separate chart	See separate chart	See separate chart

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COUNCIL ON AGING ORANGE COUNTY

2013 Orange County Medicare Advantage (HMO, PPO) Comparison Chart

HICAP (714)560-0424
or 1-800-Medicare
or medicare.gov

Company	UnitedHealthcare	UnitedHealthcare	Anthem Blue Cross
Plan Name	MedicareComplete Premier Plan	MedicareComplete Essential Plan	Medicare Preferred Standard
Telephone Numbers Website	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 AARPMedicarePlans.com	New enrollment: 1-800-547-5514 Current Members: 1-800-950-9355 AARPMedicarePlans.com	New enrollment: 1-800-797-6438 Current members: 1-877-811-3107 anthem.com/ca
Plan Type	**MA-PD (HMO)** Medicare Advantage Plan with Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA ONLY (HMO)** Medicare Advantage Plan only. Plan does NOT have Prescription Drug Benefit. Must utilize plan physicians, providers and hospitals.	**MA-PD (PPO)** Preferred Provider Plan with Prescription Drug Benefit. May choose any provider. Plan Network providers at lower cost.
Monthly Premium	$0 Monthly Premium	$0 Monthly Premium	$66 Monthly Premium ($300 Deductible)
Size of Network	3501-4000 physicians and providers	14001-15000 physicians and providers	20000 and above physicians and providers
Out of Pocket Maximum	$4,900 In-Network	$4,900 In-Network	$4,500 In-Network
Doctor Visit	$5 each visit	$5 each visit	In-Network: $15 Out: $35
Specialist Visit	$10 each visit	$10 each visit	In-Network: $45 Out: $55
In-patient Hospitalization	Days 1-5: $150/day, Days 6-90: $0. Unlimited days each benefit period.	$50 copay for each *Medicare-covered/* stay. $0 for each additional day. Unlimited days each benefit period.	In-Network: $795 copay/ *Medicare-covered* stay. $0 additional days. Out of Network: 20% of cost/ stay. Unlimited days each benefit period.
Skilled Nursing Facility	Days 1-20: $50/day, Days 21-72: $75/day, Days 73-100: $0/day. No prior hospital stay required. 100 days covered each benefit period.	Days 1-98: $50/day, Days 99-100: $0/day. No prior hospital stay required. 100 days covered each benefit period.	In-Network: Days 1-20: $0, Days 21-100: $135/day. Out of Network: 20% of cost/stay. No prior hospital required. 100 days each benefit period
In-patient Mental Health	Days 1-5: $150/day, Days 6-90: $0/day. 190-day psychiatric hospital lifetime limit.	$50 each stay. 190-day psychiatric hospital lifetime limit.	In-Network: $795/stay. Out of Network: 20% of cost/stay. 190-day psychiatric hospital lifetime limit.
Outpatient Mental Health	$30 each indiv. or group therapy visit.	$30 each indiv. or group therapy visit.	In-Network: $40 each visit. Out of Network: 30% of cost each visit
Outpatient Hospital Services	$125 each visit	$0 each visit	In-Network: $0-$45 or 15% of the cost, each visit. Out of Network: 25% of cost for services.
Ambulance	$200 each service	$200 each service	$200 each service: In/Out
Emergency Room Visit	$65 each visit, waived if admitted within 24-hours. Worldwide coverage.	$65 each visit, waived if admitted within 24-hours. Worldwide coverage.	$65 each visit, waived if admitted within 72-hrs.
Outpatient Rehab Services	$10 each visit	$10 each visit	In-Network: $50 each visit Out of Net.: 30% of cost each visit
Durable Medical Equipment	20% of cost for *Medicare-covered* items.	20% of cost for *Medicare-covered* items.	In-Network: 20% of cost for *Medicare-covered* items Out of Network: 25% of cost for *Medicare-covered* items
Diagnostic Tests	20% of cost for diagnostic procedures and tests. 20% of cost for diagnostic radiology services.	20% of cost for diagnostic procedures and tests. 20% of cost for diagnostic radiology services.	In-Network: $0-$200 for diagnostic procedures and tests. $65-$200 for diagnostic radiology services. $15-$45 may apply for additional services. Out of Network: 30% of cost
X-Rays	$0 each X-ray	$0 each X-ray	In-Network: $65 each X-ray Out of Network: 30% of cost for each X-ray
Lab Services	$12 for lab services. 20% of cost for therapeutic radiology services.	$0 for lab services. 20% of cost for therapeutic radiology services.	In-Network: $0 for lab services. 20% for therapeutic radiology services. $15-$45 may apply for additional services. Out of Network: 30% for lab services and therapeutic radiology.
Part B Chemotherapy Drugs	20% of the cost for Part B chemotherapy drugs	20% of the cost for Part B chemotherapy drugs	19% of the cost for Part B chemotherapy drugs. In or Out.
Dental Services	$10 copay for *Medicare-covered* benefits. Preventive benefits not covered.	$10 copay for *Medicare-covered* benefits. Preventive benefits not covered.	0% of cost for *Medicare-covered* benefits. Preventive benefits not covered. Out: $0 copay for comprehensive benefits.
Hearing Services	$10 copay for diagnostic exams. $5 for up to 1 routine exam/yr. $390 copay for up to 2 inner-ear hearing aids/yr. $340 copay for up to 2 over-the-ear hearing aids/yr.	$10 copay for diagnostic exams. $5 for up to 1 routine exam/yr. $380 copay for up to 2 inner-ear hearing aids/yr. $330 copay for up to 2 over-the-ear hearing aids/yr.	In-Network: $45 for diagnostic exams. Routine exams and hearing aids not covered. Out of Network: 30% of cost for hearing exams.
Vision Services	$0-$10 copay to diagnose & treat eye conditions. $0 for eye wear after cataract surgery. $10 for up to 1 routine exam/yr. $30 copay for contacts ($105 limit/2 yrs.). $0 for up to 1 pair of lenses/2 yrs. $30 for up to 1 frames/2 yrs. ($70 limit/2 yrs.)	$0-$10 copay to diagnose & treat eye conditions. $0 for eye wear after cataract surgery. $10 for up to 1 routine exam/yr. $0 for contacts ($125 limit/2 yrs.). $0 for up to 1 pair of lenses/frames/yr. ($130 limit for frames/yr.).	In-Network: $0 copay to diagnose & treat eye conditions. $0 for 1 pair of eye wear after cataract surgery. Out of Network: $0 for exams. $0 for eye wear.
Prescription Drugs	See separate chart	**None**	See separate chart

Notes:

Out of Pocket Maximum: All local MA plans must establish a mandatory maximum out-of-pocket (MOOP) amount for all Medicare Parts A and B services to mirror the same out-of-pocket costs an average beneficiary would have under Original Medicare's fee for service program. After meeting the MOOP, a beneficiary's MA plan will cover his/her remaining Medicare-covered costs for the rest of the calendar year. The mandatory MOOP is $6,700, but plans can voluntarily set a lower MOOP at $3,400 in exchange for more flexibility in setting their cost-sharing amounts.

Medicare Advantage Plans: These plans are also called Medicare Health Plans and are offered by private companies that contract with Medicare to provide Part A and Part B benefits to people with Medicare. There are several different types of Medicare Advantage Plans incuding HMO's and PPO's. In this chart you will find the type of plan, offered by each company, in the "Plan Type" row.

Dental Coverage: The dental coverage benefit section of this chart details the standard dental coverage from each plan. Standard coverage does not require an additional premium. Please verify all information with the respective plan.

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Orange County HICAP

2013 MA-PD Medicare Advantage (HMO & PPO) Prescription Drug Plans

Beneficiary must have <u>both</u> Medicare Part A and B to enroll in a Medicare Advantage Plan with the drug benefits shown below.

For Assistance, call HICAP 714-560-0424 or 1-800-Medicare or www.medicare.gov

Prescription Drug Plans associated with Health Maintenance Organizations (HMOs)

Organization Name Non-Member Telephone No. Plan Internet Website	**Plan Name**	**Monthly Plan Premium***	**Annual Deductible for Part D**	**Co-Payments after deductible has been met and prior to reaching $2,970 in full drug cost**					**Coverage in Gap**	**Mail Order**	**Overall Quality Rating** (Out of 5)	**Drug Plan Quality Rating** (Out of 5)
				Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5 / 6**				
Aetna Medicare Select Plan 800-832-2640 aetnamedicare.com	Aetna Medicare Select Plan	$0	$0	$7	$33	$45	$95	33%	Some Gen	Yes	3.5	3.5
Anthem Blue Cross 800-797-643 anthem.com/ca/medicare	Blue Cross Senior Secure Plan I	$0	$0	$7	$43	$85	33%	33%	Many Gen	Yes	3.0	3.0
	Blue Cross Senior Secure Plan II	$0	$0	$7	$13	$36	$80	33%	Many Gen	Yes	3.0	3.0
Blue Shield of California 800-488-8000 blueshieldca.com/findmedicareplan	Blue Shield 65 Plus	$0	$0	$5	$40	$80	25%	33%	Many Gen	Yes	4.0	4.0
	Blue Shield 65 Plus Choice	$0	$0	$0	$35	$70	25%	33%	Many Gen	Yes	4.0	4.0
Brand New Day 866-255-4795 brandnewdayhmo.com	Brand New Day	$0	$0	$5	$40	n/a	n/a	n/a	Many Gen	Yes	3.0	3.0
	Brand New Day HMO Extra Care	$29.80	$325	25%	25%	n/a	n/a	n/a	No	Yes	3.0	3.0
Care1st 800-847-1222 care1st.com/ca/medicare	AdvantageOptimum Plan	$0	$0	$0	$5	$30	$50	30%	Many Gen	Yes	3.5	3.5
CareMore Health Plan 866-622-2820 caremore.com	Value Plus	$0	$0	$0	$5	$25	$85	33% / $0	All Formulary	Yes	4.0	4.0
	StartSmart with CareMore	$0	$0	$5	$10	$45	$95	33% / $10	No	Yes	4.0	4.0
Central Health Medicare Plan 866-314-2427 centralhealthplan.com	Central Health Medicare Plan	$0	$0	$0	$5	$25	$50	33%	All Gen	Yes	3.0	3.5
	Central Health Premier Plan	$0	$325	25%	25%	25%	25%	25%	No	Yes	3.0	3.5
Citizens Choice Health Plan 866-646-2247 citizenschoicehealth.com	Citizens Choice Healthplan	$0	$0	$0	$15	$60	25%	33%	Many Gen	Yes	3.0	3.0
Easy Choice Health Plan 866-999-3945 easychoicehealthplan.com	Easy Choice Best Plan	$0	$0	$0	$10	$40	$90	25%	Many Gen	Yes	3.0	3.0
	Easy Choice Plus Plan	$29.90	$325	25%	25%	25%	25%	25%	No	Yes	3.0	3.0
Golden State Medicare Health Plan 1-877-551-4111 goldenstatemhp.com	Golden State Medicare Health Plan, Golden	$0	$0	$0	$40	$80	33%	n/a	Many Gen	Yes	Not enough data availabe	3.5

* The premiums listed on the document are the same as the premiums listed on the Medicare Advantage HMO, PPO Comparison Chart and are not in addition to those amounts.

Generally, Tier 1 = Generics
Tier 2 = Generics and Preferred Brands
Tier 3 = Non-Preferred Brands
Tiers 4 and 5 = Specialties and Injectables

Rev.10/15/2012
Information subject to change.
Contact plans to verify information.

Orange
County
HICAP

2013 MA-PD Medicare Advantage (HMO & PPO) Prescription Drug Plans

Beneficiary must have both Medicare Part A and B to enroll in a Medicare Advantage Plan with the drug benefits shown below.

For Assistance, call HICAP
714-560-0424
or 1-800-Medicare
or www.medicare.gov

Prescription Drug Plans associated with Health Maintenance Organizations (HMOs) continued

Organization Name Non-Member Telephone No. Plan Internet Website	Plan Name	Monthly Plan Premium*	Annual Deductible for Part D	Co-Payments after deductible has been met and prior to reaching $2,970 in full drug cost					Coverage in Gap	Mail Order	Overall Quality Rating (Out of 5)	Drug Plan Quality Rating (Out of 5)
				Tier 1	Tier 2	Tier 3	Tier 4	Tier 5 / 6				
Health Net of California 800-977-6739 healthnet.com	Healthy Heart 1	$0	$0	$3	$10	$45	$95	33%	Many Gen	Yes	3.5	3.5
	Healthy Heart 2	$39	$0	$3	$10	$45	$95	33%	No	Yes	3.5	3.5
	Ruby Plan 1	$0	$0	$3	$10	$45	$95	133%	Many Gen	Yes	3.5	3.5
	Gold Select	$0	$0	$0	$10	$45	$95	33%	Many Gen	Yes	3.5	3.5
Humana Health Plan of CA, Inc. 800-833-2364 humana-medicare.com	Gold Plus (013)	$0	$0	$0	$10	$45	$95	33%	Some Gen & Few Brands	Yes	3.0	3.5
	Gold Plus HMO/POS* (014)	$39	$0	$0	$10	$45	$95	33%	Few Gen & Few Brands	Yes	3.0	3.5
Kaiser Permanente Senior Advantage 800-777-1238 kp.org	Senior Advantage LA, Orange Co.	$0	$0	$3	$7	$40	$60	25%	All Gen & Few Brands	Yes	5.0	5.0
SCAN Health Plan 800-915-7226 scanhealthplan.com	SCAN Classic	$0	$0	$4	$10	$40	$75	33% / $10	Many Gen	Yes	3.5	3.0
	SCAN Plus	$0	$0	$0	$0	25%	25%	25% / $6	No	Yes	3.5	3.0
UnitedHealthcare 800-547-5514 aarpmedicareplans.com	AARP MedciareComplete SecureHorizons Plan 2	$0	$0	$0	$5	$45	$92	33%	Some Gen	Yes	3.5	4.0
	AARP MedicareComplete SecureHorizons Premier	$0	$0	$3	$6	$45	$95	33%	No	Yes	3.5	4.0

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Prescription Drug Plans associated with Preferred Provider Organizations (PPOs)

Organization Name Non-Member Telephone No. Plan Internet Website	Plan Name	Monthly Plan Premium*	Annual Deductible for Part D	Co-Payments after deductible has been met and prior to reaching $2,970 in full drug cost					Coverage in Gap	Mail Order	Overall Quality Rating (Out of 5)	Drug Plan Quality Rating (Out of 5)
				Tier 1	Tier 2	Tier 3	Tier 4	Tier 5/6				
Anthem Blue Cross 800-797-6438 anthem.com/ca/medicare	Anthem Medicare Preferred Standard	$66	$90	$7	$43	$85	33%	33% / $7	No	Yes	Too new to be measured	Not enough data available

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Generally, Tier 1 = Generics
Tier 2 = Generics and Preferred Brands
Tier 3 = Non-Preferred Brands
Tiers 4 and 5 = Specialties and Injectables

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