Medicare plans

generally for those **over age 65**

IMPORTANT NOTES		Health Net HMO **1.800.522.0088** Group 57358-B **www.healthnet.com**	Health Net Seniority Plus **1.800.275.4737** Group 57358-S **www.healthnet.com**
SDCERA-sponsored medical plans do not have overall annual or lifetime limits. Service area varies by plan. **Please confirm you live within a plan's service area before enrolling**. Refer to each plan's coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary chart and the plan documents, the plan documents will govern.		**Medicare HMO plan** Benefits coordinated with Medicare (primary); may use Medicare outside of network. You must use a primary care physician from the providers list for HMO to cover services.	**Medicare Advantage plan** Medicare benefit must be assigned to the plan. You are required to use the Health Net physician you select from a list of providers.
Monthly premium per person*		**$630.00**	**$286.48**
Annual deductible	Applicable deductible must be met before coverage shown is effective.	None	None
Ambulance	Requires preauthorization.	Covered in full	Covered in full
Anesthesia		Covered in full	Covered in full
Chiropractic visit	If covered, services generally include initial examinations; additional visits for treatment; x-ray and laboratory fees when prescribed. Preauthorization may be required.	Not covered	$5 per visit up to 20 visits through American Specialty Health Network
Durable medical equipment		Covered in full	Covered in full
Emergency care	Includes accidental injury and acute illness; the copayment shown is when visiting an emergency room and is waived if you are admitted.	$35	$20
Fitness club membership		Discounts available	Silver & Fit
Hearing care and hearing aids		Preventive screening covered in full; all other $20 per exam. No coverage for hearing aids.	$20 per exam, 2 standard hearing aids every 36 months covered in full
Home health care	Requires a physician's prescription.	Covered in full up to 30 days; $10 copayment starts on the 31st day after the 1st visit.	Covered in full
Hospice care		Covered in full	Covered per Medicare guidelines
Hospital room and board	Coverage is for a semi-private room.	Covered in full	Covered in full
Laboratory fees		Covered in full	Covered in full
Physician care (doctor visits) unrelated to hospitalization	Copayments shown are for office visits unrelated to hospitalization.	$20 per office visit	$20 per office visit
Physician care (doctor visits) due to hospitalization	Coverage shown is for visits due to hospitalization.	Covered in full	Covered in full
Prescription medications from a mail order sponsored by the carrier	Copayments are for the number of days shown. Copays may vary when the Medicare Part D Catastrophic Coverage stage is reached.	$30 generic, $60 brand name, $100 non-formulary. *90-day supply. Administered by SilverScript.*	$30 generic, $60 brand name, $90 non-formulary. *90-day supply.*
Prescription medications from a pharmacy before reaching Medicare Part D Catastrophic Coverage Stage	Unless noted, non-formulary prescriptions are covered by the same copayments when deemed medically necessary.	$15 generic, $30 brand name, $50 non-formulary. *30-day supply. Administered by SilverScript.*	$15 generic, $30 brand name, $45 non-formulary. *30-day supply.*
Psychiatric care (inpatient)	An asterisk (*) indicates the plan will cover this care in full for diagnoses covered under the Mental Health Parity Act.	*Covered in full	Covered in full
Psychiatric care (outpatient)		$20 per visit	$20 per visit
Rehabilitation therapy	Physical, speech, occupational, pulmonary, and cardiac	Covered in full	No copay for Medicare-covered services
Skilled nursing facility		Covered in full up to 100 days	Covered in full up to 100 days
Surgery (inpatient)		Covered in full	Covered in full
Surgery (outpatient)		Covered in full	Covered in full
Urgent care	An asterisk (*) indicates non-emergency.	$35	$20
Vision care and eyewear		$20 per exam. No coverage for eyewear.	$20 per exam. $100 paid for eyewear every 2 years.
X-rays		Covered in full	Covered in full

Kaiser Permanente Senior Advantage **1.800.464.4000** Group 104302-00 **www.kp.org**	UHC Group Medicare Advantage **Customer service—1.800.457.8506** **Prospective Member—1.877.714.0178** Group CA: 004497; AZ: 060499; NV: 667201 **www.uhcretiree.com**	UHC Senior Supplement **Customer service—1.800.851.3802** **Prospective Member—1.800.698.0822** Group 05408 **www.uhcretiree.com**
Medicare Advantage plan	**Medicare Advantage plan**	**Medicare Supplement plan**
Medicare benefit must be assigned to the plan, or a higher premium and traditional Kaiser HMO benefits apply. You are required to use Kaiser Permanente physicians and facilities.	This plan provides coverage in California, Arizona and Nevada. Medicare benefit must be assigned to the plan. You are required to use the primary care physician you select from a list of providers.	This plan is available nationwide. You may use any physician or facility that accepts Medicare.
$274.10	**$276.61**	**$519.43**
None	None	None
Covered in full	Covered in full	Covered in full. No preauthorization required.
Covered in full	Covered in full	Covered in full
$10 per visit, up to 20 visits	$5 per visit, up to 20 visits	Spinal manipulation covered; $0 per visit. Other services generally not covered.
Covered in full	Covered in full	Covered in full
$20	$20	Covered in full in the U.S.; $250 deductible outside of the U.S., 20% thereafter.
Discounts available www.choosehealthy.com	Silver Sneakers Fitness membership	Silver Sneakers Fitness membership
$10 per exam No coverage for hearing aids.	$0 per exam; hearing aids covered up to $500 every 36 months.	Exams covered; $0 per visit for Medicare covered exams. Hearing aids not covered.
Covered in full. Refer to evidence of coverage from the plan.	Covered in full	Covered in full
Covered in full	Covered per Medicare guidelines	Covered in full
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
$10 per office visit	$20 per office visit	Covered in full
Covered in full	Covered in full	Covered in full
$10 generic, $20 brand name *Up to a100-day supply.*	$20 generic, $60 brand name, $60 non-preferred brand formulary. *90-day supply*.	$20 generic, $70 brand name; $100 non-preferred brand formulary. *90-day supply*.
$10 generic, $20 brand name *Up to a 100-day supply.*	$10 generic, $30 brand name, $30 non-preferred brand formulary. *30-day supply*.	$10 generic, $35 brand name; $50 non-preferred brand formulary. *30-day supply*.
*Covered in full Unlimited visits	Covered per Medicare guidelines up to 190 days per lifetime	Covered in full up to 150 days
$10 per visit, unlimited visits	$20 per visit	Covered in full
$0 inpatient; $10 per visit outpatient	$0 copay	Covered in full
Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 days
Covered in full	Covered in full	Covered in full
$10 per procedure	Covered in full	Covered in full
$10*	$10 copay (in- and out-of-network)	Covered in full
$10 per exam. $150 allowance for eyewear every 2 years.	$20 per exam. $75 per eyewear every 2 years.	$0 per Medicare-covered exam. Medicare-covered eyewear is reimbursed. Non-Medicare is not covered.
Covered in full	Covered in full	Covered in full