



Inland Agency HICAP
Health Insurance Counseling and Advocacy Program

2012 HICAP Medicare Advantage Comparison Chart

**Not all Medicare Advantage Plans service all areas throughout
Riverside and San Bernardino Counties.**

Contact the plan to find out if they service your zip-code.

This list is provided for reference only. HICAP makes no claim as to the listed insurers' financial status, reputation or sales practices. We make no claims on the value of products sold by these companies or that this list is complete. HICAP does not endorse any specific health insurer or other related profit making enterprise.



LOCAL HELP FOR PEOPLE WITH MEDICA

This publication had been created or produced by the Inland Agency HICAP with financial assistance, in whole or in part, through a grant from the Centers for Medicare & Medicaid Services, the federal Medicare agency, and the California Department of Aging.

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HICAP 2012 Medicare Advantage Comparison Chart

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Important Information

Medicare beneficiaries may only be enrolled in one Medicare health plan at a time, and are allowed to make only *one* change per enrollment period.

Annual Enrollment: October 15 – December 7

Annual Disenrollment: January 1 – February 14

Extra Help: Reduces out of pocket costs for prescription drugs, and is available to Medicare Beneficiaries with limited income and resources. Apply at the Social Security Administration or local Department of Public and Social Services.

Resources

- Health Insurance Counseling and Advocacy Program: 800-434-0222
- Medicare: 800-633-4227
- Social Security Administration: 800-772-1213
- Office on Aging: 800-510-2020
- Department of Veterans Affairs: 800-827-1000
- Office of Personnel Management – Federal Retiree: 888-767-6738
- TRICARE for Life: 888-874-9378
- CA Public Employee's Retirement System: 888-225-7377

HICAP 2012 Medicare Advantage Comparison Chart

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	ORIGINAL MEDICARE 800-633-4227 www.medicare.gov	AETNA <i>Medicare Select</i> 800-455-1560 www.aetnamedicare.com	Anthem BC <i>Blue Cross Senior Secure Plan I</i> 800-797-6438 www.bluecrossca.com	BLUE SHIELD <i>65 Plus (Riverside County)</i> 800-488-8000 www.mylifepath.com
Monthly Premium	\$115.40 (Medicare Part B Premium)	\$0 (Plus Part B Premium)	\$0 (Plus Part B Premium)	\$0 (Plus Part B Premium)
Yearly Deductible	\$162.00 (Part B Covered Services)	\$0 (MOOP \$3400)	\$0 (MOOP \$3400)	\$0 (MOOP \$6700)
Plan Type	Fee for Service	HMO + Rx	HMO + Rx	HMO + Rx
Important Information		You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.
Office Visit	20% Coinsurance	\$5 – Primary Care \$10 - Specialist	\$0-\$10-Primary Care \$10-\$35 Specialist	\$5 Primary Care \$10 Specialist
Hospitalization	\$1,132 – days 1-60 \$283/day – days 61-90 \$566/day – days 91-150	\$100/day - days 1-5 \$0/day – days 6-90	\$175/day - days 1-7 \$0 - days 8-90	\$250/day - days 1-7 \$0 – days 8-90
Skilled Nursing (Facility Co-Payment Medicare criteria applies)	\$0/day – days 1-20 \$141.50/day–days 21-100 (3 day prior hospital stay required)	\$0/day – days 1-20 \$100/day–days 21-100 (no prior hospital stay required)	\$0/day – days 1-20 \$146/day–days 21-100 (no prior hospital stay required)	\$50/day–days 1-20 \$90/day - days 21-100 (no prior hospital stay required)
Ambulance	20% Coinsurance	\$100	\$200	\$200
Emergency Room	20% Coinsurance (U.S. coverage only)	\$65 (worldwide coverage)	\$60 (worldwide coverage)	\$65 (worldwide coverage)
Podiatry Care	20% –Medicare covered	\$10–Medicare covered	\$35–Medicare covered (12 routine visits per year)	\$10–Medicare covered
Routine Vision Care	Not Covered	\$0–10 routine eye exam (1 routine exam per year) \$0 - eyeglasses (covered up to \$150 for eyewear every 2 years)	\$0 – routine eye exam \$0 – eye glasses (1 routine exam per year) (\$69 limit every year)	\$0 routine eye exam (1 routine exam every 12 months) \$20 – lenses (yearly) \$20 – frames (\$75 for frames every 2yrs)
Urgent Care (Out of Service Area)	20% Coinsurance	\$15	\$35	\$10
Part D Prescription Drugs	Must Join a Stand Alone Medicare Part D Prescription Drug Plan For Coverage	\$0 – deductible Tier 1 - \$5.00 Tier 2 - \$33.00 Tier 3 - \$40.00 Tier 4 - \$90.00 Tier 5 – 33% Co-Pay Coverage gap begins at \$2,930 (Coverage for generic drugs during coverage gap) Mail Order Available	\$0 – deductible Generic – \$7 Preferred Brand – \$43 Non-Pref. Drugs – \$85 Specialty – 33% Coverage gap begins at \$2,930 (Some coverage for generic drugs during coverage gap) Mail Order Available	\$200 – deductible Pref. Generic – \$6 Non-Pref. Generic - \$10 Pref. Brand – \$45 Non-Pref. Brand – \$90 Specialty – 25% Injectibles – 25% Coverage gap begins at \$2,930 (Some coverage for generic drugs during coverage gap) Mail Order Available
Supplemental Benefits	No	Yes	Yes	Yes

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	BLUE SHIELD 65 Plus (San Bernardino County) 800-488-8000 www.mylifepath.com	CARE 1st Advantage Optimum Plan 800-847-1222 www.care1st.com	CAREMORE CareMore Value Plus 866-622-2820 www.caremorehealthplan.com	CAREMORE Start Smart 866-622-2820 www.caremorehealthplan.com
Monthly Premium	\$0 (Plus Part B Premium)	\$0 (Plus Part B Premium)	\$0 (Plus Part B Premium)	\$0 (Plus Part B Premium)
Yearly Deductible	\$0 (MOOP \$3400)	\$0 (MOOP \$3400)	\$0 (MOOP \$3400)	\$0 (MOOP \$3400)
Plan Type	HMO + Rx	HMO + Rx	HMO + Rx	HMO + Rx
Important Information	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.
Office Visit	\$0 Primary Care \$10 Specialist	\$0 – Primary Care \$5 – Specialist	\$0-Primary Care \$0 Specialist	\$10 Primary Care \$35 Specialist
Hospitalization	\$175/day - days 1-10 \$0 – days 11-90	\$50/day – days 1-3 \$0 - days 4 - 90	\$0	\$125/day - days 1 - 5 \$0 - days 6 - 90
Skilled Nursing (Facility Co-Payment Medicare criteria applies)	\$50/day – days 1-20 \$90/day–days 21-100 (no prior hospital stay required)	\$0/day – days 1-20 \$50/day – days 21-100 (no prior hospital stay required)	\$0/day – days 1-20 \$50/day – days 21-100 (no prior hospital stay required)	\$0/day – days 1-20 \$125/day – days 21-100 (no prior hospital stay required)
Ambulance	\$200	\$100	\$100	\$100
Emergency Room	\$65 (worldwide coverage)	\$50 (worldwide coverage)	\$65 (worldwide coverage)	\$65 (worldwide coverage)
Podiatry Care	\$10 –Medicare covered	\$5 – Medicare covered \$5 – each routine visit	\$10 –Medicare covered \$0 – each routine visit (up to 4 routine visits per yr)	\$0-\$35 Medicare covered
Routine Vision Care	\$0 routine eye exam (1 routine exam every 12 months) \$20 – lenses (1 per year) \$20 – frames (\$75 for frames every 2 years)	\$5 routine eye exam (1 routine exam per year) \$0 eyeglasses (covered up to \$150 for eyeglasses every 2 years)	\$0 routine eye exam (1 routine exam per year) \$25 eyeglasses (covered up to \$100 for eyeglasses every 1-2 years)	\$20 routine eye exam (1 routine exam per year) \$25 eyeglasses (limit allowance \$80 for eyeglasses every 2 years)
Urgent Care (Out of Service Area)	\$10	\$25	\$10	\$20
Part D Prescription Drugs	\$0 – deductible Pref. Generic – \$6 Non-Pref. Generic - \$10 Pref. Brand – \$45 Non-Pref. Brand – \$90 Specialty – 33% Injectibles – 33% Coverage gap begins at \$2,930 (Some coverage for generic drugs during coverage gap) Mail Order Available	\$0 – deductible Pref. Generic - \$0 Generic - \$5 Brand - \$30 Other Non-Pref. - \$50 Specialty–30% Co-Pay Coverage gap begins at \$2,930 (Coverage for many generic drugs during coverage gap) Mail Order Available	\$0 – deductible Preferred Generic - \$0 Generic - \$5 Preferred Brand - \$29 Brand - \$85 Specialty –33% Co-Pay Coverage gap begins at \$3,000 (Coverage for all generic drugs during coverage gap) Mail Order Available	\$0 – deductible Tier 1 - \$5 Tier 2 - \$10 Tier 3 - \$45 Tier 4 - \$95 Tier 5 –Specialty 33% Co-Pay Tier 6 - \$35 Coverage gap begins at \$3,000 No Gap Coverage Mail Order Available
Supplemental Benefits	No	Yes	Yes	Yes

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	CITIZENS CHOICE Health Plan HMO 323-728-7232 www.citizenschoicehealth.com	Easy Choice Health Plan Easy Choice Best Plan 866-999-3945 www.easychoicehealthplan.com	HEALTH NET Healthy Heart I 800-977-6738 www.healthnet.com	HEALTH NET Healthy Heart II 800-977-6738 www.healthnet.com
Monthly Premium	\$0 (Plus Part B Premium)	\$0 (Plus Part B Premium)	\$0 (Plus Part B Premium)	\$20 (Plus Part B Premium)
Yearly Deductible	\$0 (MOOP \$3400)	\$0 (MOOP \$3400)	\$0 (MOOP \$3400)	\$0 (MOOP \$3400)
Plan Type	HMO + Rx	HMO + Rx	HMO + Rx	HMO + Rx
Important Information	You must go to network doctors, specialists, and hospitals	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals	You must go to network doctors, specialists, and hospitals.
Office Visit	\$0 – Primary Care \$0 – Specialist	\$0 Primary Care \$0 Specialist	\$0 – Primary Care \$0 – Specialist	\$0 – \$25 Primary Care \$0 – \$25 Specialist
Hospitalization	\$0/day - days 1-45 \$100/day- days 46-60 \$0/day – days 61-90	\$0 – 90 days	\$0 - days 1-90	\$275/day – days 1-5 \$0 – days 6 – 90
Skilled Nursing (Facility Co-Payment Medicare criteria applies)	\$0/day – days 1-30 \$100/day – days 31-100 (no prior hospital stay required)	\$0 – 190 days	\$0/day – days 1-20 \$75/day – days 21-100 (no prior hospital stay required)	\$0/day – days 1-20 \$75/day – days 21-100 (no prior hospital stay required)
Ambulance	\$75	\$50	\$175	\$175
Emergency Room	\$65 (worldwide coverage)	\$50 (worldwide coverage)	\$50 (worldwide coverage)	\$50 (worldwide coverage)
Podiatry Care	\$0 Medicare covered	\$0 – Medicare covered	\$0 Medicare covered	\$25 – Medicare covered \$25– each routine visit (limit 12 routine visit per year)
Routine Vision Care	\$0 Routine eye exam (1 routine exam per year) \$0 glasses (covered up to \$150 for eye wear every 2 years)	\$0 Routine eye exam (1 routine exam per year) \$10 eye wear (covered up to \$100 for eye wear every 2 years)	\$0-\$30 Routine eye exam (1 routine exam per year, \$250 limit for eye wear every 2 years)	\$25 Routine eye exam \$0 glasses (every 2 yrs) (1 routine exam per year, \$250 limit for eye wear every 2 years)
Urgent Care	\$0 - \$25	\$0	\$10	\$25
Part D Prescription Drugs	\$0 – deductible Generic – \$0 Preferred Brand – \$15 Non-Pref. Brand – \$60 Injectibles & Specialty 33% Co-Pay Coverage gap begins at \$3,500 (Coverage for many generic drugs during coverage gap) Mail Order Available	\$0 – deductible Pref.Generic – \$0 Non Pref. Generics \$10 Brand – \$30 Non Pref. Brand - \$90 Specialty 25% Co Pay Coverage gap begins at \$2,930 (Coverage for many generic drugs during coverage gap) Mail Order Available	\$0 – deductible Pref. Generic – \$5 Pref. Brand – \$45 Non-Pref. Brand \$84 Injectibles / Specialty 33% Co-Pay Coverage gap begins at \$2,930 (many generic drugs during coverage gap) Mail Order Available	\$0 – deductible Pref.Generic – \$5 Pref. Brand – \$42 Non-Pref. Drugs – \$84 Injectibles & Specialty 33% Co-Pay Coverage gap begins at \$2,930 No gap Coverage Mail Order Available
Supplemental Benefits	No	Yes	Yes	Yes

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	HEALTH NET <i>Seniority Plus Ruby I</i> 800-977-6738 www.healthnet.com	HEALTH NET <i>Salud Con Health Net</i> 800-977-6738 www.healthnet.com	HUMANA <i>Gold Plus H0108-005</i> 800-833-2364 www.humana-medicare.com	HUMANA <i>Gold Plus H0108-006</i> 800-833-2364 www.humana-medicare.com
Monthly Premium	\$0 <i>(Plus Part B Premium)</i>	\$0 <i>(Plus Part B Premium)</i>	\$0 <i>(Plus Part B Premium)</i>	\$29 <i>(Plus Part B Premium)</i>
Yearly Deductible	\$0 <i>(MOOP \$3400)</i>	\$0 <i>(MOOP \$3400)</i>	\$0 <i>(MOOP \$3400)</i>	\$0 <i>(MOOP \$3400)</i>
Plan Type	HMO + Rx	HMO + Rx	HMO + Rx	HMO-POS + Rx
Important Information	You must go to network doctors, specialists, and hospitals	You must go to network doctors, specialists, and hospitals	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.
Office Visit	\$8 – Primary Care \$10 – Specialist	\$0 – Primary Care \$0 – Specialist	\$0–Primary Care \$5 – Specialist	\$5–Primary Care \$5 – Specialist
Hospitalization	\$100/day - days 1-4 \$0 - days 5-90	\$0	\$100/day - days 1-5 \$0 – days 6-90	\$100/day - days 1-5 \$0 – days 6-90
Skilled Nursing	\$0/day – days 1-20 \$75/day – days 21-100 <i>(no prior hospital stay required)</i>	\$0/day – days 1-20 \$75/day – days 21-100 <i>(no prior hospital stay required)</i>	\$0/day – days 1-20 \$75/day–days 21-100 <i>(no prior hospital stay required)</i>	\$0/day – days 1-20 \$75/day–days 21-100 <i>(no prior hospital stay required)</i>
Ambulance	\$175	\$175	\$100	\$100
Emergency Room	\$50 <i>(worldwide coverage)</i>	\$50 <i>(worldwide coverage)</i>	\$65 <i>(worldwide coverage)</i>	\$65 <i>(worldwide coverage)</i>
Podiatry Care	\$10 Medicare covered \$10 each routine visit <i>(limit 12 routine visit per year)</i>	\$0 Medicare covered \$0 each routine visit <i>(limit 12 routine visit per year)</i>	\$5 Medicare Covered	\$5 Medicare Covered
Routine Vision Care	\$10 Routine eye exam <i>(1 routine exam per year)</i> \$0 glasses (every 2 yrs) <i>(1 routine exam per year, \$250 limit for eye wear every 2 years)</i>	\$25 Routine eye exam <i>(1 routine exam per year)</i>	\$0-\$5 Routine eye exam <i>(1 routine exam per year)</i> \$0 glasses <i>(1 routine exam per year, \$200 limit for eye wear every year)</i>	\$0-\$5 Routine eyeexam <i>(1 routine exam per year)</i> \$0 glasses <i>(1 routine exam per year, \$200 limit for eye wear every year)</i>
Urgent Care <i>(Out of Service Area)</i>	\$10	\$10	\$0 – \$5	\$35
Part D Prescription Drugs	\$0 – deductible Preferred Generic – \$5 Preferred Brand – \$45 Non-Pref. Drugs – \$84 Injectibles & Specialty 33% Co-Pay Coverage gap begins at \$2,930 <i>(Coverage for many generic drugs during coverage gap)</i> Mail Order Available	\$0 – deductible Preferred Generic – \$5 Preferred Brand – \$45 Non-Pref. Drugs – \$84 Injectibles & Specialty 33% Co-Pay Coverage gap begins at \$2,930 <i>(Some coverage for generic drugs during coverage gap)</i> Mail Order Available	\$0 – deductible Preferred Generic – \$0 Non Pref. Generic - \$10 Preferred Brand – \$45 Non-Pref. Brand – \$95 Specialty – 33% Coinsurance Coverage gap begins at \$2,930 <i>(Some coverage for few generic and few brand drugs during coverage gap)</i> Mail Order Available	\$0 – deductible Preferred Generic – \$0 Non Pref. Generic - \$10 Preferred Brand – \$45 Non-Pref. Brand – \$95 Specialty – 33% Coinsurance Coverage gap begins at \$2,930 <i>(Some coverage for few generic and few brand drugs during coverage gap)</i> Mail Order Available
Supplemental Benefits	No	No	Yes	Yes

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	INTERVALLEY <i>Total Fit</i> 800-500-7018 www.ivhp.com	INTERVALLEY <i>Desert Preferred Choice</i> 800-756-4407 www.ivhp.com	INTERVALLEY <i>Service to Seniors</i> 800-500-7018 www.ivhp.com	KAISER PERMANENTE <i>Sr. Advantage Inland Empire</i> 800-777-1238 www.kaiserpermanente.org
Monthly Premium	\$0 <i>(Plus Part B Premium)</i>	\$0 <i>(Plus Part B Premium)</i>	\$0 <i>(Plus Part B Premium)</i>	\$0 <i>(Plus Part B Premium)</i>
Yearly Deductible	\$0 <i>(MOOP \$3400)</i>	\$0 <i>(MOOP \$3400)</i>	\$0 <i>(MOOP \$3400)</i>	\$0 <i>(MOOP \$3400)</i>
Plan Type	HMO + Rx	HMO + Rx <i>(Riverside County)</i>	HMO + Rx	HMO + Rx
Important Information	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You must use network doctors, specialists, and hospitals.
Office Visit	\$0 – Primary Care \$10 – Specialist	\$0 – Primary Care \$0 – Specialist	\$0 – Primary Care \$10 – Specialist	\$0 -\$15 – Primary Care \$0-\$15 – Specialist
Hospitalization	\$75/day – days 1-6 \$0/day – days 7-90	\$0/day – days 1-90	\$200	\$200/day – days 1-8 \$0/day – days 9-90
Skilled Nursing <i>(Facility Co-Payment Medicare criteria applies)</i>	\$0/day – days 1-15 \$40/day – days 16-100 <i>(no prior hospital stay required)</i>	\$0/day – days 1-100 <i>(no prior hospital stay required)</i>	\$0/day – days 1-15 \$40/day – days 16-100 <i>(no prior hospital stay required)</i>	\$0/day – days 1-10 \$50/day – days 11-100 <i>(no prior hospital stay required)</i>
Ambulance	\$55	\$100	\$55	\$200
Emergency Room	\$50 <i>(worldwide coverage)</i>	\$50 <i>(worldwide coverage)</i>	\$50 <i>(worldwide coverage)</i>	\$65 <i>(worldwide coverage)</i>
Podiatry Care	\$10 – Medicare covered	\$0 – Medicare covered \$0 – each routine visit <i>(1 visit every 3 months)</i>	\$10 – Medicare covered	\$15 – Medicare covered
Routine Vision Care	\$15 – routine eye exam <i>(1 routine exam per year)</i> \$15 – eyewear <i>(\$125 allowance every 2 years)</i>	\$0 – routine eye exam <i>(1 routine exam per year)</i> \$0 – eyewear <i>(\$100 allowance every 2 years)</i>	\$15 – routine eye exam <i>(1 routine exam per year)</i> \$0 eyewear <i>(\$125 allowance every 2 years)</i>	\$0 glasses <i>(\$315 eye wear allowance every 2 years)</i>
Urgent Care <i>(Out of Service Area)</i>	\$30	\$0 - \$50	\$30	\$15 - \$65
Part D Prescription Drugs	\$0 – deductible Pref. Generic – \$8 Non-Pref. Generic – \$12 Pref. Brand – \$45 Non-Pref. Brand - \$70 Specialty – 33% Co-Pay Coverage gap begins at \$2,930 <i>No Gap Coverage</i> Mail Order Available	\$0 – deductible Preferred Generic – \$0 Non-Pref. Generic – \$3 Preferred Brand – \$25 Non-Pref. Brand - \$40 Specialty – 30% Co-Pay Coverage gap begins at \$2,930 <i>(Coverage for all generic drugs during coverage gap)</i> Mail Order Available	\$0 – deductible Pref. Generic – \$4 Non-Pref. Generic – \$12 Preferred Brand – \$29 Non-Pref. Brand - \$67 Specialty 25% Co-Pay Coverage gap begins at \$3,200 <i>(Some coverage for generic drugs during coverage gap)</i> Mail Order Available	\$0 – deductible Pref. Generic – \$5 Non Pref. Generics - \$10 Pref. Brand – \$45 Non Pref. Brands - \$65 Specialty – 25% Coinsurance Coverage gap begins at \$2,930 <i>(Some coverage for all generic and few brand drugs during coverage gap)</i> Mail Order Available
Supplemental Benefits	No	No	No	Yes

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	MD CARE INC <i>Advantage I MAPD</i> 562-344-3400 www.mdcareadvantage.com	MOLINA <i>Medicare Options</i> 866-403-8293 www.molinahealthcare.com	SCAN CLASSIC <i>Sr. Care Action Network</i> 800-915-7226 www.scanhealthplan.com	SCAN OPTIONS <i>Sr. Care Action Network</i> 800-915-7226 www.scanhealthplan.com
Monthly Premium	\$0 <i>(Plus Part B Premium)</i>	\$29 <i>(Plus Part B Premium)</i>	\$0 <i>(Plus Part B Premium)</i>	\$0 <i>(Plus Part B Premium)</i>
Yearly Deductible	\$0 <i>(MOOP \$2400)</i>	\$0 <i>(MOOP \$3350)</i>	\$0 <i>(MOOP \$5000)</i>	\$0 <i>(MOOP \$5000)</i>
Plan Type	HMO + Rx	HMO + Rx	HMO + Rx	HMO + Rx
Important Information	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.
Office Visit	\$0 – Primary Care \$10 – Specialist	\$5 – Primary Care \$10 – Specialist	\$10 – Primary Care \$10 – Specialist	\$0 – Primary Care \$0 – Specialist
Hospitalization	\$100/day – days 1-4 \$0/day – days 5-90	\$200/day – days 1-8 \$0/day – days 9-90	\$150/day – days 1-10 \$0/day – days 11-90	\$0
Skilled Nursing <i>(Facility Co-Payment Medicare criteria applies)</i>	\$0/day – days 1-14 \$75/day – days 15-100 <i>(no prior hospital stay required)</i>	\$0/day – days 1-10 \$50/day – days 11-100 <i>(no prior hospital stay required)</i>	\$0/day – days 1-10 \$50/day – days 11-100 <i>(no prior hospital stay required)</i>	\$0/day – days 1-10 \$50/day – days 11-100 <i>(no prior hospital stay required)</i>
Ambulance	\$100	\$50	\$200	\$100
Emergency Room	\$50 <i>(worldwide coverage)</i>	\$65 <i>(worldwide coverage)</i>	\$50 <i>(worldwide coverage)</i>	\$50 <i>(worldwide coverage)</i>
Podiatry Care	\$0 – Medicare covered	\$10 - Medicare covered	\$10 – Medicare covered	\$10 – Medicare covered
Routine Vision Care	\$0 – routine eye exam <i>(1 routine exam per year)</i> \$0 – eyewear <i>(\$160 allowance every 2 years)</i>	\$10 routine eye exam <i>(1 routine exam every year)</i> \$0 – eyeglasses <i>(\$150 allowance every 2 years)</i>	\$0 routine eye exam <i>(1 routine exam per year)</i> \$25 – glasses <i>(\$175 allowance ever 2 years)</i>	\$0 routine eye exam <i>(1 routine exam per year)</i> \$25 – glasses <i>(\$175 allowance every 2 years)</i>
Urgent Care <i>(Out of Service Area)</i>	\$25	\$25	\$35	\$35
Part D Prescription Drugs	\$0 – deductible Tier 1 – \$3 Tier 2 – \$25 Tier 3 – \$59 Tier 4 – 33% Co-insurance Coverage gap begins at 2,930 <i>(Some coverage for generic drugs during coverage gap)</i> Mail Order Available	\$0 – deductible Pref. Generic – \$5 Preferred Brand – \$20 Non-Pref Brand – \$50 Specialty – 33% Coinsurance Coverage gap begins at \$2,930 <i>No Gap coverage</i> Mail Order Available	\$0 – deductible Pref. Generic – \$4 Non Pref. Generic – \$10 Preferred Brand – \$43 Non-Pref. Brand – \$80 Specialty – 33% Coinsurance Coverage gap begins at \$3,000 <i>(Some coverage for many generic drugs during coverage gap)</i> Mail Order Available	\$0 – deductible Pref. Generic – \$5 Non Pref. Generic – \$10 Preferred Brand – \$45 Non-Pref. Brand – \$75 Specialty – 33% Coinsurance Coverage gap begins at \$2,930 <i>(Coverage for many generic drugs during coverage gap)</i> Mail Order Available
Supplemental Benefits	Yes	No	Yes	Yes

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	SCAN MY CHOICE Sr. Care Action Network 800-915-7226 www.scanhealthplan.com	United Healthcare AARP Medicare Complete Secure Horizons 1 800-547-5514 www.securehorizons.com	United Healthcare AARP Medicare Complete Secure Horizons 2 800-547-5514 www.securehorizons.com	HEALTH NET Seniority Plus Green 800-977-6738 www.healthnet.com
Monthly Premium	\$40 (Plus Part B Premium)	\$0 (Plus Part B Premium)	\$0 (Plus Part B Premium)	\$0 (Plus Part B Premium)
Yearly Deductible	\$0 (MOOP \$3000)	\$0 (MOOP \$5900)	\$0 (MOOP \$6700)	\$0 (MOOP \$3400)
Plan Type	HMO-POS + Rx	HMO + Rx	HMO + Rx	HMO ONLY
Important Information	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.
Office Visit	\$10 – Primary Care \$20 – Specialist	\$0 – Primary Care \$10 – Specialist	\$0 – Primary Care \$0 - Specialist	\$7 – Primary Care \$10 - Specialist
Hospitalization	\$100/day – days 1-10 \$0/day – days 11-90	\$0/day – days 1-90	\$0/day – days 1-90	\$100/day – days 1-4 \$0/day – days 5-90
Skilled Nursing (Facility Co-Payment Medicare criteria applies)	\$30/day – days 1-20 \$100/day–days 21-100 (no prior hospital stay required)	\$0/day 1-3 \$50/day – day 4-20 \$146day – days 21-100 (no prior hospital stay required)	\$0/day 1-3 \$50/day – day 4-20 \$146day – days 21-100 (no prior hospital stay required)	\$0/day – days 1-20 \$75/day – days 21-100 (no prior hospital stay required)
Ambulance	\$100	\$200	\$200	\$125
Emergency Room	\$50 (worldwide coverage)	\$65 (worldwide coverage)	\$65 (worldwide coverage)	\$50 (worldwide coverage)
Podiatry Care	\$20 –Medicare covered	\$0 Medicare covered	\$0 Medicare covered	\$10 –Medicare covered \$10 – Routine foot care (12 routine visit per year)
Routine Vision Care	\$0 routine eye exam (1 routine exam per year) \$25 – glasses (\$175 allowance every 2years)	\$30 routine eye exam (1 routine exam every 2 years) \$30 – eyeglasses (\$70 allowance every 2 years)	\$30 routine eye exam (1 routine exam every 2 years) \$30 – eyeglasses (\$70 allowance every 2 years)	\$10 routine eye exam (1 routine exam per year)
Urgent Care (Out of Service Area)	\$25	\$50	\$50	\$10
Part D Prescription Drugs	\$0 – deductible Pref.Generic – \$4 Non Pref.Generic – \$8 Preferred Brand – \$37 Non Pref. Brand - \$65 Specialty – 33% Coinsurance Coverage gap begins at \$3,000 (Coverage for many generic drugs during coverage gap) Mail Order Available	\$0 – deductible Pref. Generic – \$3 Non-Pref. Generic-\$6 Preferred Brand – \$45 Non-Pref Drugs – \$95 Specialty – 33% Coinsurance Coverage gap begins at \$2,930 (Some coverage for generic drugs during coverage gap) Mail Order Available	\$0 – deductible Pref. Generic – \$3 Non Pref Generic -\$5 Preferred Brand – \$45 Non-Pref Drugs – \$92 Specialty – 33% Coinsurance Coverage gap begins at \$2,930 (Some coverage for some generic coverage gap) Mail Order Available	Not Covered
Supplemental Benefits	Yes	Yes	Yes	No

HICAP 2012 Medicare Advantage Comparison Chart

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	United Healthcare <i>AARP Medicare Complete Secure Horizons Essential</i> 800-547-5514 www.securehorizons.com	MD CARE INC <i>Advantage Select MA</i> 562-344-3400 www.mdcareadvantage.com	ANTHEM BLUE CROSS <i>Anthem Medicare Preferred Standard PPO</i> 800-797-6438 www.bluecrossca.com
Monthly Premium	\$0 <i>(Plus Part B Premium)</i>	\$0 <i>(Plus Part B Premium)</i>	\$106 <i>(Plus Part B Premium)</i>
Yearly Deductible	\$0 <i>(MOOP \$6700)</i>	\$0 <i>(MOOP \$1000)</i>	\$300 <i>(MOOP \$3400)</i>
Plan Type	HMO ONLY	HMO ONLY	Local PPO + Rx
Important Information	You must go to network doctors, specialists, and hospitals.	You must go to network doctors, specialists, and hospitals.	You can use in or out of network providers.
Office Visit	\$5 – Primary Care \$10 - Specialist	\$0 – Primary Care \$0 – Specialist	In Network: \$0-\$10 Out of Network: \$0-\$35
Hospitalization	\$0/day – days 1-90	\$0	In Network: \$725 days 1-90 Out of Network: 20% coinsurance
Skilled Nursing <i>(Facility Co-Payment Medicare criteria applies)</i>	\$0/day 1-3 \$50/day – day 1-60 \$0/day – days 61-100 <i>(no prior hospital stay required)</i>	\$0 <i>(no prior hospital stay required)</i>	In Network \$0/day – days 1-20 \$140/day – days 21-100 Out of Network: 20% coinsurance <i>(no prior hospital stay required)</i>
Ambulance	\$200	\$100	\$200 max
Emergency Room	\$65 <i>(worldwide coverage)</i>	\$50 <i>(worldwide coverage)</i>	\$65 <i>(worldwide coverage)</i>
Podiatry Care	\$10 Medicare covered	\$0 – Medicare covered	Medicare Covered In Network: \$45 Out of Network: \$55
Routine Vision Care	\$10 routine eye exam <i>(1 routine exam every 2 years)</i> \$0 – eyeglass frames <i>(\$130 allowance every 1 years)</i>	\$0 – routine eye exam <i>(1 routine exam per year)</i> \$0 – eyewear <i>(\$250 allowance every 2 years)</i>	In Network: \$0 – routine eye exam <i>(1 routine exam per year)</i> Out of Network: 20%-30%
Urgent Care <i>(Out of Service Area)</i>	\$50	\$25	\$35
Part D Prescription Drugs	Not Covered	Not Covered	\$316– deductible Preferred Generic – \$2 Preferred Brand – \$43 Non-Pref. Brand – \$90 Injectibles / Specialty – 25% Coinsurance Coverage gap begins at \$2,930 <i>(Some coverage for some generic coverage gap)</i> Mail Order Available
Supplemental Benefits	Yes	No	Yes

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Medicare Advantage Plans cover all Medicare Approved services including:

Preventative Services – such as mammogram, pap smear, prostate screening, diabetes education, bone mass measurement, and colorectal screenings.

Chiropractic Care – Manipulation of the spine to correct a subluxation

Durable Medical Equipment – such as wheelchairs and oxygen

Prosthetic devices

Radiation and Chemotherapy

Home Health Care

Outpatient Mental Health

Diagnostic Tests – such as Labs and X-rays

Contact the plan for specific information about member costs for the above services

Optional / Enhanced supplemental benefits, such as dental care, fitness programs or gym membership, transportation, hearing care and hearing aides, are available with some plans. Contact the plan for costs and more information about these supplemental benefits.

This information was obtained from Medicare and is correct as of 10/1/11.
For the most accurate and up to date information, contact the plan directly.