2016 San Francisco Medicare Advantage - HMO

	Care1st Health Plan	Kaiser Foundation Health Plan	Health Net of California		
Plan Name	**Care1st AdvantageOptimum Plan (H5928-042)**	**Kaiser Permanente Senior Advantage(H0524-032)**	**Health Net Ruby Select (H0562-097)**	**Health Net Healthy Heart (H0562-009)**	**Health Net Seniority Plus Sapphire Premier (H3561-002)**
Monthly Premium	**$32**	**$79**	**$0**	**$127**	**$31 ($0 as SNP)**
MOOP	$6,700	$4,400	$6,700	$6,700	$6,700
Phone Number	1-800-544-0088 Current Members 1-800-847-1222 Prospective Members	1-800-443-0815 Current Members 1-800-777-1238 Prospective Member	1-800-275-4737 Current Members 1-800-977-6738 Prospective Member	1-800-275-4737 Current Members 1-800-977-6738 Prospective Member	1-800-431-9007 Current Members 1-800-977-6738 Prospective Member
Network Provider	Brown and Toland	Kaiser Network	Brown and Toland	Brown and Toland; Hills Physicians	Brown and Toland
Network Hospital	CPMC	Kaiser Permanente	CPMC, St. Francis, St. Mary's, UCSF	CPMC, St. Francis, St. Mary's, UCSF,	CPMC, St. Francis, St. Mary's, UCSF,
Physician Visit	$0 primary care. $10 specialist.	$25 primary care. $25 specialist.	$10 primary care. $25 specialist.	$10 primary care. $15 specialist.	20% of the cost for primary care or specialist.
Inpatient Hospital	$125/day for Days 1-5; $0/day for Days 6-90. $0/day for Days 91 and beyond.	$275/day for Days 1-7. $0/day for Days 8-90. $0 each additional non-Medicare-covered hospital day.	$345/day for Days 1-5; $0 for Days 6-90. $0/day each additional non-Medicare-covered hospital day.	$325/day for Days 1-5; $0 for Days 6-90. $0/day each additional non-Medicare-covered hospital day.	Same as Original Medicare
Outpatient Surgery	$50 copay each visit to outpatient surgical center. $50 each visit to outpatient hospital facility.	$250 each visit to outpatient surgical center. $75-250 each visit to outpatient hospital facility.	$200 each visit to outpatient surgical center. $345 each visit to outpatient hospital facility.	$100 each visit to outpatient surgical center. $250 each visit to outpatient hospital facility.	Ambulatory surgical center: 20% of cost Outpatient Hospital: 20% of cost
DME	20% of the cost per item	20% of the cost per item	20% of the cost per item	20% of the cost per item	20% of the cost per item
Mental Health	Inpatient: $125/day for Days 1-8. $0/day for Days 9-90. Outpatient: $10 individual therapy w/ psychiatrist and without & group therapy w/ psychiatrist and without.	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $210/day for Days 1-7. $0/day for Days 8-90. Outpatient: $25 for individual therapy w/ psychiatrist and without. $12 for group therapy w/ psychiatrist and without. $0 for partial hospitalization program services.	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $900/hospital stay. Plan covers 60 lifetime reserve Days. $0 per lifetime reserve day. Outpatient: $25 for individual therapy w/ psychiatrist and without & group therapy w/ psychiatrist and without. $0 for partial hospitalization program services.	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $900/hospital stay. Plan covers 60 lifetime reserve Days. $0 per lifetime reserve day. Outpatient: $25 for individual therapy w/ psychiatrist and without & group therapy w/ psychiatrist and without.	Inpatient: Same as Original Medicare's Inpatient Hospital policy; Covers 190 days in a lifetime. Outpatient group/individual therapy: 20% of cost
Ambulance Service	$155; waived if admitted into hospital.	$200	$395	$225	20% of cost
Emergency Care	$75 copay; waived if admitted into hospital within 24 hours	$75; waived if admitted into hospital. Worldwide coverage.	$75; waived if admitted into hospital.	$75; waived if admitted into hospital.	20% (up to $75) copay
Diagnostic Test, X- Ray & Lab Service	$0 for Medicare-covered x-rays, clinical/ diagnostic lab tests and diagnostic radiology services. 20% for therapeutic radiology services.	$35 for lab services and diagnostic procedures and tests. $60 for x-rays. $60-215 for radiology services (not including x-rays). $0 therapeutic radiology services.	$0 for lab services, diagnostic procedures and tests, and x-rays. $60 for radiology services (not including x-rays) and therapeutic radiology services.	$0 for lab services, diagnostic procedures and tests, and x-rays. $60 for radiology services (not including x-rays) and therapeutic radiology services.	20% of the cost for diagnostic radiology services,diagnostic tests and procedures, outpatient x-ray, and therapeutic radiology services. $0 for lab services.
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $5 Tier 3: Preferred brand: $40 Tier 4: Non-preferred brand: $80 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred generic: $5 (standard retail) Tier 2: Non-preferred generic: $15 Tier 3: Preferred brand: $45 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 25% coinsurance Tier 6: Vaccines: $0 $0-45 for Part B-covered drugs.	Tier 1: Preferred generic: $8 (standard retail) Tier 2: Non-preferred generic: $15 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $0 20% for Part B-covered drugs.	Tier 1: Preferred generic: $5 (standard retail) Tier 2: Non-preferred generic: $15 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $0 20% for Part B-covered drugs.	Tier 1: Preferred Generic: $0 Tier2: Non Preferred Generic: $20 Tier 3: Preferred Brand: $47 Tier 4: Non-Preferred Brand: $100 Tier 5: Speciality Tier: 26% coinsurance Tier 6: Select Care Drugs: $0
Other	Vision: $0 for 1 routine eye exam every year. $0 for 1 pair of eyeglasses ($150 limit) every 2 years. Dental: $0-$10 copay for limited preventative services. Hearing Services: $0-$10 copay ($350 limit every year). Transportation: $0	$25 for hearing Services, $0-$25 for vision, $25/visit for acupuncture and other alternative therapies. $20 copay for chiropractic care	$0 for hearing services, $0-$25 for vision services, $0 for limited dental, $10 for chiropractic. $18/month optional supplemental package for the following more comprehensive benefits: chiropractic services, acupuncture, dental, vision, fitness membership	$10 for chiropractic care, $0 for dental services, $15 for hearing servies, $0-$15 for vision. $27/month optional supplemental package for the following benefits: chiropractic services, acupuncture, dental, vision.	Dental, Vision, and Hearing: $0-20% of cost depending on service. Chiropractic Care: 20% of cost.

For more information, call San Francisco HICAP at 1-800-434-0222, call Medicare at 1-800-633-4227, visit medicare.gov, or contact the plan directly.

DRAFT Updated 11/10/2015

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	Humana Health Plan of California, Inc.	Chinese Community Health Plan	Anthem Blue Cross	SCAN Health Plan	
Plan Name	**Humana Gold Plus (H5619-024)**	**CCHP Senior Program (H0571-001)**	**Anthem MediBlue Plus (H0564-061)**	**SCAN Plus (H5425-045)**	**SCAN Classic (H5425-019)**
Monthly Premium	**$0**	**$46**	**$0.00**	**$31.1 ($0 as SNP)**	**$50**
MOOP	$6,700	$3,400	$4,500	$6,700	$5,000
Phone Number	1-800-457-4708 Current Members 1-800-833-2364 Prospective Member	1-888-775-7888 Current Members 1-888-681-3888 Prospective Member	1-888-230-7338 Current Members 1-800-797-6438 Non Members	1-800-559-3500 Current Members 1-800-915-7226 Prospective Members	1-800-559-3500 Current Members 1-800-915-7226 Prospective Member
Network Provider	Brown and Toland	CCHP	Brown and Toland	Brown and Toland; Hills Physicians	Brown and Toland; Hills Physicians
Network Hospital	CPMC	CCHP, St Marys, St Francis, CPMC	CPMC, St. Francis, St. Mary's	CPMC, St. Francis, St. Mary's	CPMC, St. Francis, St. Mary's
Physician Visit	$5 primary care. $25 specialist.	$15 primary care. $15 specialist.	$5 primary care. $10 specialist.	20% primary care. 20% specialist.	$5 primary care. $15 specialist.
Inpatient Hospital	$440/day for Days 1-4. $0 for Days 5-90. $0/day for each additional non-Medicare-covered hospital day. No limit to the number of days covered by the plan each hospital stay.	$200/day for Days 1-7. $0/day for Days 8-90. $0 copayment for each additional non-Medicare-covered hospital day. No limit to the number of Days covered by the plan each hospital stay.	$195 copay days 1-6. $0 copay days 7-90	Same as Original Medicare	$125/day for Days 1-3. $300/day for Days 4-7. $0/day for days 8-90. You pay nothing per day for days 91 and beyond.
Outpatient Surgery	$250 for each visit to outpatient surgical center. $345 for each visit to outpatient hospital facility.	$195-295 each visit to outpatient surgical center. $195-295 each visit to outpatient hospital facility.	Ambulatory surgical center: $0-125 copay depending on the service. Outpatient Hospital: $0-200 copay, depending on the service	20% of the cost at an ambulatory surgical center and outpatient hospital.	$15-175 depending on service to ambulatory surgical center. $15-200 (or 20% of cost) foreach visit to outpatient hospital facility.
DME	20% of the cost per item	20% of the cost per item	20% of the cost per item	20% of the cost per item	0-20% of the cost per item
Mental Health	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $390/day for Days 1-4. $0/day for Days 5-90. Plan covers 60 lifetime reserve Days. $0 per lifetime reserve day. Outpatient: $25 individual therapy w/ psychiatrist and without & group therapy w/ psychiatrist and without.	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $250/day for Days 1-7. $0/day for Days 8-90. Plan covers 60 lifetime reserve Days. $0 per lifetime reserve day. Outpatient: $35 individual therapy w/ psychiatrist and without & group therapy w/ psychiatrist and without.	Inpatient: $195 copay for days 1-6. $0 per day days 7-90. Outpatient group/individual therapy: $25 copay	Inpatient: Same as Original Medicare; 190 days in a lifetime Outpatient: 20% of the cost for group and individual therapy visits.	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $900 copay per stay. Outpatient: $25 individual and group therapy.
Ambulance Service	$300	$175	$250 copay or 20% depending on the service	20%	$225
Emergency Care	$75; waived if admitted into hospital within 24 hours. Worldwide	$75; waived if admitted into hospital within 24 hours . Worldwide	$75 copay	$75 (worldwide)	$75; waived if admitted into hospital.
Diagnostic Test, X- Ray & Lab Service	$0 for lab services; $5-100 for x-rays; $0-50 for diagnostic procedures and tests;$5-345 for radiology services; 20% for therapeutic radiology services.	$0 for lab services, for x-rays, for diagnostic procedures and tests, and therapeutic radiology services $0-200 for radiology services (not including x-rays)..	$0 for diagnostic radiology services,diagnostic tests and procedures, and lab services. $0-50 for outpatient x-rays $60 for therapeutic radiology services	$0 for lab services, 20% for diagnostic procedures and tests, x-rays, radiology services, and therapeutic radiology services.	$0 for lab services, diagnostic procedures and tests, and x-rays. 20% for radiology services (not including x-rays) and therapeutic radiology services.
Prescription Drugs Copay (per 30-31 Days)	Prescription deductible: $360.00 Tier 1: Preferred generic: $5 (standard retail) Tier 2: Non-preferred generic: $15 Tier 3: Preferred brand: $40 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 25% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred generic: $3 (standard retail) Tier 2: Non-preferred generic: $7 Tier 3: Preferred brand: $40 Tier 4: Non-preferred brand: $60 Tier 5: Specialty: 20% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred generic: $10 (standard retail) Tier 2: Non-preferred generic: $20 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.	Initial Coverage: $360 yearly deductible, you then pay 25% of the cost of the drugs until your yearly drug cost reaches a total of $3,310. You then hit the "donut hole" and have to pay 45% of the cost of the drugs until your yearly drug cost reach $4,850. You are then under catostraphic coverage, and you pay 5% of the cost of the drug.	Tier 1: Preferred generic: $5 (standard retail) Tier 2: Non-preferred generic: $10 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $11 20% for Part B-covered drugs.
Other	Hearing: $25 copay Vision: $0-$25 copay depending on service; $15.30/month optional supplemental package for comprehensive vision Chiropractic Care: $20 copay Dental: $0-$25 copay depending on service	Vision: $0-$35 depending on service Chiropractic care: $15 Dental: $15 for limited services covered Hearing Services: $35 copay Acupuncture: $25 copay $16/month optional comprehensive dental package.	Dental: $0 copay Chiropractic Care:$10 copay Hearing Services: $0-$10 Vision: $0 Optional supplemental packages for dental and vision. Health Club Membership	Chiropractic Care: $5 or 20% of cost Acupumcture: $5 copay (up to 10 visits) Dental: 20% copay for limited services Vision: $0 - 20% of the cost of service Transportation: $0	Vision: $0-$35 copay Limited Dental: $10 copay Acupuncture: 10 visits/year and $5 copay Chiropractic Care: $5-$15 copay Hearing Services: $10 copay Health Club Membership: $0

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DRAFT Updated 11/010/2015