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2017 San Francisco Medicare Advantage - HMO

	Anthem Blue Cross	Chinese Community Health Plan	Health Net of California		
Plan Name	**Anthem MediBlue Plus (H0564-061)**	**CCHP Senior Program (H0571-001)**	**Health Net Ruby Select (H0562-097)**	**Health Net Healthy Heart (H0562-009)**	**Health Net Seniority Plus Sapphire Premier (H3561-002)**
Monthly Premium	**$0.00**	**$50**	**$29**	**$127**	**$36.20**
MOOP	$6,700	$4,500	$6,700	$6,700	$6,700
Phone Number	1-888-230-7338 Current Members 1-877-867-1982 Non Members	1-888-775-7888 Current Members 1-888-681-3888 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	1-800-275-4737 Current Members 1-800-977-6738 Prospective Member
Network Provider	Brown and Toland; AAMG	CCHP; Imperial health; Jade	Brown and Toland	Brown and Toland; Hills Physicians	Brown and Toland
Network Hospital	CPMC, St. Francis, St. Mary's, Chinese Hosp.	CCHP, St Marys, St Francis, CPMC	CPMC; St. Francis; St. Mary's.	CPMC, St. Francis, St. Mary's, UCSF,	CPMC; St. Francis; St. Mary's.
Physician Visit	$5 primary care. $20 specialist.	$10 primary care. $15 specialist.	$10 primary care. $25 specialist.	$10 primary care. $15 specialist.	$0 copay for primary care or specialist.
Inpatient Hospital	$250 copay days 1-7. $0 copay days 8-90	$100/day for Days 1-7. $0/day for Days 8-90 (Chinese Hospital).$280/day for Days 1-7. $0/day for Days 8-90 (all other)	$345/day for Days 1-5; $0 for Days 6-90. $0/day each additional non-Medicare-covered hospital day.	$395/day for Days 1-4; $0 for Days 5-90. $0/day each additional non-Medicare-covered hospital day.	Same as Original Medicare
Outpatient Surgery	Ambulatory surgical center: $0-200 copay depending on the service. Outpatient Hospital: $0-250 copay, depending on the service	$150 copay (at Chinese Hospital). $295 copay (at all other hospitals)	$200 each visit to outpatient surgical center. $345 each visit to outpatient hospital facility.	$100 each visit to outpatient surgical center. $275 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: $227 copay for days 1-7. $0 per day days 8-90. Outpatient group/individual therapy: $25 copay	Inpatient: $225/day for Days 1-7. $0/day for Days 8-90. Plan covers 60 lifetime reserve Days. $0 per lifetime reserve day. .	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	$250 copay or 20% depending on the service	$200	$375	$210	20% of cost
Emergency Care	$75; waived if admitted into hospital within 24 hours . Worldwide ($25,000 maximum benefit)	$75; waived if admitted into hospital within 24 hours . Worldwide	$75; waived if admitted into hospital.	$75; waived if admitted into hospital.	$75; waived if admitted into hospital.
Diagnostic Test, X- Ray & Lab Service	$0 for lab services, for x-rays, for diagnostic procedures and tests, and therapeutic radiology services $0-50 for outpatient x-rays $60 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 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: $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.	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: 25% coinsurance 20% 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	Dental: $0 copay Chiropractic Care:$10 copay Hearing Services: $20 , Hearing Aid $3,000.00 maximum benefit per year Vision: $0 Optional supplemental packages for dental and vision. Health Club Membership	Vision: $0-$20 depending on service Chiropractic care: $20 Dental: $15 for limited services covered Hearing Services: $35 copay Acupuncture: $25 copay $16/month optional comprehensive dental package.	$0 for hearing services, $0-$25 for vision services, $0 for limited dental, $10 for chiropractic. $23/month optional supplemental package for the following more comprehensive benefits: chiropractic services, acupuncture, dental, vision, fitness membership	$10 for chiropractic care, $0 for limited dental services, $15 for hearing servies, $0-$15 for vision. $30/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.

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	Kaiser Foundation Health Plan	SCAN Health Plan			
Plan Name	**Kaiser Permanente Senior Advantage(H0524-032)**	**SCAN Plus (H5425-045)**	**SCAN Classic (H5425-019)**		
Monthly Premium	**$86**	**$36.30**	**$50**		
MOOP	$4,400	$4,500	$5,000		
Phone Number	1-800-443-0815 Current Members 1-800-777-1238 Prospective Member	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	Kaiser Network	Brown and Toland; Hills Physicians	Brown and Toland; Hills Physicians		
Network Hospital	Kaiser Permanente	CPMC, St. Francis, St. Mary's	CPMC, St. Francis, St. Mary's		
Physician Visit	$35 primary care or specialist.	$0 copay for primary care or specialist.	$5 primary care. $15 specialist.		
Inpatient Hospital	$275/day for Days 1-7. $0/day for Days 8-90. $0 each additional non-Medicare-covered hospital day.	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 each visit to outpatient surgical center. $75-250 each visit to outpatient hospital facility.	20% of the cost at an ambulatory surgical center and outpatient hospital.	$175 depending on service to ambulatory surgical center. $200 (or 20% of cost) foreach visit to outpatient hospital facility.		
DME	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. $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: Same as Original Medicare; 190 days in a lifetime Outpatient: $0 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	$200	20%	$225		
Emergency Care	$75; waived if admitted into hospital. Worldwide coverage.	$75 (worldwide)	$75; waived if admitted into hospital.		
Diagnostic Test, X- Ray & Lab Service	$35 for lab services and diagnostic procedures and tests. $55 for x-rays. $205 for radiology services (not including x-rays). $0 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)	Tier 1: Preferred generic: $5 (standard retail) Tier 2: Non-preferred generic: $15 Tier 3: Preferred brand: $45 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance Tier 6: Vaccines: $0 $0-45 for Part B-covered drugs.	Tier 1: Preferred generic: $9 (standard retail) Tier 2: Non-preferred generic: 25% Tier 3: Preferred brand: 25% Tier 4: Non-preferred brand: 25% Tier 5: Specialty: Not available Tier 6: Select Care: $11 20% for Part B-covered drugs.	Tier 1: Preferred generic: $8 (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	$35 for hearing Services, $35 for vision, $20 Optional Suplemental Benefit (eyeware, fitness benefit, hearing aid and some dental)	Acupuncture/Chriropractic :$5 (10 visit per year) Hearing Services: $0 (1 per year): Dental: 20% copay for limited services Vision: $0 - 20% of the cost of service Transportation: $0 up to 28 one-way trip/year	Vision: $10 copay Limited Dental: $8 copay Acupuncture/Chriropractic :$5 (10 visit per year) Hearing Services: $10 copay Health Club Membership: $0		

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