2018 San Francisco Medicare Advantage - HMO

	Anthem Blue Cross		Chinese Community Health Plan	Health Net of California	
Plan Name	**Anthem MediBlue Plus (H0544-057)**	**Anthem MediBlue Select (H0544-069)**	**CCHP Senior Program (H0571-001)**	**Health Net Ruby Select (H0562-097)**	**Health Net Healthy Heart (H0562-009)**
Monthly Premium	**$29.00**	**$0**	**$42**	**$0**	**$124.00**
MOOP	$4,400	$6,700	$6,700	$5,000	$6,700
Phone Number	1-888-230-7338 Current Members 1-877-867-1982 Non Members	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
Network Provider	Brown and Toland; AAMG; Imperial	Brown and Toland; AAMG; Imperial	CCHP; Jade	Brown and Toland	Brown and Toland; Hills Physicians
Network Hospital	CPMC, St. Francis, St. Mary's, Chin Hos, UCSF	CPMC, St. Francis, St. Mary's, Chin Hos, UCSF	Chinese Hosp, St Marys, St Francis, CPMC	St. Francis; St. Mary's.	CPMC, St. Francis, St. Mary's, UCSF,
Physician Visit	$0 primary care. $10 specialist.	$10 primary care. $25 specialist.	$10 primary care. $20 specialist.	$5 primary care. $20 specialist.	$10 primary care. $15 specialist.
Inpatient Hospital	$222 copay days 1-5. $0 copay days 6-90	$350 copay days 1-5. $0 copay days 6-90	$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.	$335/day for Days 1-4; $0 for Days 5-90. $0/day each additional non-Medicare-covered hospital day.
Outpatient Surgery	Ambulatory surgical center: $0-222 copay depending on the service. Outpatient Hospital: $0-325 copay, depending on the service	Ambulatory surgical center: $0-200 copay depending on the service. Outpatient Hospital: $0-350 copay, depending on the service	$100 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.
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 1-5. $0 per day days 6-90. Outpatient group/individual therapy: $25 copay	Inpatient: $320 copay for days 1-5. $0 per day days 6-90. Outpatient group/individual therapy: $40 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. Outpatient group/individual therapy: $35 copay	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.
Ambulance Service	$250 copay	$300 copay or 20% depending on the service	$225	$375	$210
Emergency Care	$80; waived if admitted into hospital within 24 hours . Worldwide ($25,000 maximum benefit)	$80; waived if admitted into hospital within 24 hours . Worldwide ($25,000 maximum benefit)	$80; waived if admitted into hospital within 24 hours . Worldwide	$80; waived if admitted into hospital.	$80; waived if admitted into hospital.
Diagnostic Test, X- Ray & Lab Service	$0-60 for lab services, for x-rays, for diagnostic procedures and tests, and therapeutic radiology services $0-60 for outpatient x-rays $60 for therapeutic radiology services	$0 -60 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.
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $10 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $8 Tier 3: Preferred brand: $42 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: 30% coinsurance $100 deductible 20% for Part B-covered drugs.	Tier 1: Preferred generic: $5 (standard retail) Tier 2: Non-preferred generic: $12 Tier 3: Preferred brand: $37 Tier 4: Non-preferred brand: $90 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $0 20% for Part B-covered drugs.	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $10 Tier 3: Preferred brand: $37 Tier 4: Non-preferred brand: $90 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $0 20% for Part B-covered drugs.
Other	Hearing Services: $0 , Hearing Aid $3,000.00 maximum benefit per year Vision: $0 (I routine exam per year) Optional supplemental packages ($12,$31,$40) for dental and vision. Health Club Membership	Hearing Services: $0 , Hearing Aid $3,000.00 maximum benefit per year Vision: $0 (I routine exam per year) Optional supplemental packages ($12,$31,$40) for dental and vision. Health Club Membership. 12 one-way transportation. Preventive dental $0. Personal emergency response system. OTC $35 per quarter.	Vision:$20 exam; one glasses every 2 years (150 max) Chiropractic care: $20 Hearing Services: $35 copay. Acupuncture: $25 copay $18/month optional comprehensive dental package. Transportation $0 8/1-way trips a year Fitness Classes: Tai Chi, Qigong, Yoga, Senior Fitness	$0 for hearing services, $0-$12 for vision services, $10 for chiropractic. $10-19/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. $23/month optional supplemental package for the following benefits: chiropractic services, acupuncture, dental, vision and fitness.

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	Health Net of California	Kaiser Foundation Health Plan	SCAN Health Plan		Imperial Health Plan
Plan Name	**Health Net Seniority Plus Sapphire Premier (H3561-002)**	**Kaiser Permanente Senior Advantage(H0524-032)**	**SCAN Plus (H5425-045)**	**SCAN Classic (H5425-019)**	**Traditional Plus-SF (H5496-009)**
Monthly Premium	**$35 (no extra help-Medicare);**	**$94.00**	**$35 (no extra help-Medicare);**	**$35**	**$0.00**
	$0 (w/MediCal) review SNP chart		**$0 (w/MediCal) review SNP chart**		
MOOP	$6,700	$6,700	$6,700	$5,000	$4,000
Phone Number	1-800-275-4737 Current Members	1-800-443-0815 Current Members	1-800-559-3500 Current Members	1-800-559-3500 Current Members	1-800-838-8271 Current Members
	1-800-977-6738 Prospective Member	1-800-777-1238 Prospective Member	1-800-915-7226 Prospective Members	1-800-915-7226 Prospective Member	1-800-838-5914 Prospective Members
Network Provider	Brown and Toland	Kaiser Network	Brown and Toland; Hills Physicians	Brown and Toland; Hills Physicians	
Network Hospital	St. Francis; St. Mary's.	Kaiser Permanente	CPMC, St. Francis, St. Mary's	CPMC, St. Francis, St. Mary's	
Physician Visit	$0 copay for primary care or specialist.	$35 primary care or specialist.	$0 copay for primary care or specialist.	$5 primary care. $15 specialist.	$0 doctor, $0 specialist
Inpatient Hospital	Same as Original Medicare	$285/day for Days 1-7. $0/day for Days 8-infinity. $0 each additional non-Medicare-covered hospital day.	Same as Original Medicare	$250/day for Days 1-7. $0/day for Days 8-90.	$100 for days 1-5 and $0 for days 6-90.
Outpatient Surgery	Ambulatory surgical center: 20% of cost Outpatient Hospital: 20% of cost	$0 -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.	20% of the cost at an ambulatory surgical center and outpatient hospital.
DME	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	20% of the cost per item
Mental Health	Inpatient: $90 copay for days 1-5. $0 per day days 6-90. Outpatient group/individual therapy: $ copay	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $230/day for Days 1-7. $0/day for Days 8-90. Outpatient: $35 for individual therapy w/ psychiatrist and without. $17 for group therapy w/ psychiatrist and without. $0 for partial	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.	Inpatient:coming soon Outpatient group/individual therapy:20% copay
Ambulance Service	20% of cost	$200	Medicare Fee For Service	$175	$85 for one-way trip.
Emergency Care	$75; waived if admitted into hospital.	$80; waived if admitted into hospital. Worldwide coverage.	20% (worldwide)	$80; (worldwide, $0 if admitted to hospital)	$80
Diagnostic Test, X- Ray & Lab Service	20% of the cost for diagnostic radiology services,diagnostic tests and procedures, outpatient x-ray, and therapeutic radiology services. $0 for lab services.	$30 for lab services and diagnostic procedures and tests. $40 for x-rays. $215 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. $60 for radiology services (not including x-rays) and therapeutic radiology services (MRI,CT).	$0 for lab services, for diagnostic procedures and tests, x-rays, radiology services, and therapeutic radiology services.
Prescription Drugs Copay (per 30-31 Days)	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	Tier 1: Preferred generic: $6 (standard retail) Tier 2: Non-preferred generic: $18 Tier 3: Preferred brand: $47 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: $0 (standard retail) Tier 2: Non-preferred generic: 25% Tier 3: Preferred brand: 25% Tier 4: Non-preferred brand: 25% Tier 5: Specialty: 25% Deductible $405 (Tiers 2-5) 20% for Part B-covered drugs.	Tier 1: Preferred generic: $3 (standard retail) Tier 2: Non-preferred generic: $5 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred generic: 0% (standard retail) Tier 2: Non-preferred generic:25% Tier 3: Preferred brand: 25% Tier 4: Non-preferred brand: 25% Tier 5: Specialty: 33% coinsurance
Other	Dental, Vision, and Hearing: $0-20% of cost depending on service. Optional Package $23. Eyewear alloowance $550. Transportation 40 one way trips per year. Accupuncture $0 /30 visits.	$35 for hearing Services, $35 for vision, $20 Optional Suplemental Benefit (eyeware, fitness benefit, hearing aid and some dental)	Acupuncture/Chriropractic :$5 (30 visit per year combined). Personal Response System $15/month Hearing Services: $0 (1 per year): Dental: 20% copay for limited services .Vision: $0 - 20% of the cost of service. Transportation: $0 up to 32 one-way trip/year	Routine Vision Exam $0. Dental $6-$16. Acupuncture/Chiropractic $5 (unlimited visits). Routine Hearing Exam $0 copa. Health Club	Hearing Exam 20%; Hearing Aids 20%; Preventive Dental 20%; Vision Exam $15; eyeglases $15; $0 for fitness center membership or up to two home fitness kits.

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