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2019 San Francisco Medicare Advantage - HMO

	UnitedHealthcare	Anthem Blue Cross		Chinese Community Health Plan	Health Net of California
Plan Name	**AARP Medicare Complete Secure Horizons (H0543-175)**	**Anthem MediBlue Plus (H0544-057)**	**Anthem MediBlue Select (H0544-069)**	**CCHP Senior Program (H0571-001)**	**Health Net Ruby Select (H0562-097)**
Monthly Premium	**$54.00**	**$29.00**	**$0**	**$42**	**$0**
MOOP	$4,900	$4,400	$6,700	$6,700	$4,400
Phone Number	1-800-950-9355 Current Members	1-888-230-7338 Current Members	1-888-230-7338 Current Members	1-888-775-7888 Current Members	1-800-275-4737 Current Members
	1-800-555-5757 Non Members	1-844-316-0357 Non Members	1-844-316-0357 Non Members	1-888-681-3888 X3282 Prospective Member	1-800-977-6738 Prospective Member
Network Provider		Brown and Toland; AAMG; (only Imperial Drs refer to UCSF)	Brown and Toland; AAMG; Imperial	CCHP; Jade	Brown and Toland (only B&T referrals to UCSF)
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, Seton, Mills-Peninsula	St. Francis; St. Mary's, CPMC Mission Bay.
Physician Visit	$10 primary, $20 specialty	$0 primary care. $10 specialist.	$5 primary care. $20 specialist.	$10 primary care. $20 specialist.	$5 primary care. $20 specialist.
Inpatient Hospital	$345 days 1-5, $0 for days 6-90.	$250 copay days 1-5. $0 copay days 6-90	$360 copay days 1-4. $0 copay days 5-90	$100/day for Days 1-7. $0/day for Days 8-90.(Chinese Hospital) $220/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.
Outpatient Surgery	$195	Ambulatory surgery center: $0-222 copay depending on the service. Outpatient Hospital: $0-250 copay per visit	Ambulatory surgical center: $0-200 copay depending on the service. Outpatient Hospital: $0-350 copay per visit depending on the service.	$100 copay(at Chinese Hospital) $295 copay (at all other hospitals)	Observation $90-345, $200 each visit to outpatient surgical center. $345 each visit to outpatient hospital facility.
DME	20% per item DME, $0 diabetic supplies	20% per item, diabetic supplies $0	20% cost per item, $0 diabetic supplies	20% per item, diabetic supplies $0	20% per item. Diabetes supplies $0
Mental Health	Inpatient: $345 days 1-4, $0 days 5-90, plus 60 lifetime days. Partial hospitalization: $55/day. Outpatient: individual/$40, group $30.	Inpatient: $250 copay for days 1-5. $0 per day days 6-90. Behavioral Health: 45.00/session, free with smart phone. Outpatient group/individual therapy: $25 copay	Inpatient: $330 copay for days 1-4. $0 per day days 5-90. 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 100 days of impatient 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
Ambulance Service	$250	$250 copay	$300 copay or 20% depending on the service	$225	295 per 1-way trip, 5% air ambulance 2500-10,000
Emergency Care	$90 per visit (always covered), urgent care $20 contacted, $40 non-contracted(always covered).	$90 (always covered),waived if admitted into hospital within 24 hours. Worldwide ($25,000 maximum benefit) $20 urgent care (always covered)	$90 (always covered),waived if admitrted into hospital within 24 hours. Worldwide ($25,000 maximum benefit). Urgent care $40 (always covered).	$90; waived if admitted into hospital within 24 hours. Worldwide. (always covered), $35 Urgent care (always covered)	$90; waived if admitted into hospital, worldwide coverage to 50,000. (always covered) urgent care $20 (always covered)
Diagnostic Test, X- Ray & Lab Service	$0 for lab services, for diagnostic procedures and tests. Diagnostic radiology services $95. $14 for outpatient x-rays $60 for therapeutic radiology services	$0-60 diagnostic procedures and tests. $0 lab services. $0-50 for outpatient x-rays $60 for therapeutic radiology services	$0 for lab services. $ 0-120 for diagnostic procedures and tests. $0-50 for outpatient x-rays $65-120 for therapeutic radiology services	$0 for lab services, for x-rays, for diagnostic procedures and tests, and therapeutic radiology services. $200 for diagnostic 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.
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $3 (standard pharmacy) Tier 2: Non-preffer generic: $12 Tier 3: Preferred Brand: $47 Tier 4:Non-preferred brand: $100 Tier 5: Specialty: 28% Deductable $0 for tiers 1 and 2, $250 for tiers 3,4,5. 20% for Part B-covered drugs.	Tier 1: Perferred genetic: $0 (preferred pharmacy) Tier 2: Non-preferred generic: $8 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Speciality: 33% coinsurance 20% for Part B-covered drugs.	Tier 1: Preferred generic: $0 (preferred pharmacy) 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: $3 (preferred pharmacy) Tier 2: Non-preferred generic: $7 Tier 3: Preferred brand: $40 Tier 4: Non-preferred brand: $60 Tier 5: Specialty: 30% coinsurance $100 deductible for drugs on certain tiers. 20% for Part B-covered drugs.	Tier 1: Preferred generic: $5 (preferred pharmacy) 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.
Other	Hearing Services: $10. Hearing aids $330 -$380 each. Vision: $20 (I routine exam per year) Optional supplemental packages ($39) for dental and vision with $100 deductible. Health Club Membership. Platinum dental rider option.	Hearing Services: $10 , Hearing Aid $0 ($3000 limit), vision: $0 (I routine exam per year), dental $0 copay Optional supplemental packages ($12,$32,$47) for dental and vision. Silver Sneakers. Facetime w/Dr.	Hearing Services: $20 , Hearing Aid $0 ($3000 limit). Vision: $0 (I routine exam/year) Optional packages ($12,$32,$47) for dental and vision. Silver Sneakers. Preventive dental $0. Personal emergency response unit. Facetime w/Dr.	Vision:$20 exam; one glasses every 2 years (150 max) Chiropractic care: $20. Hearing Services: $35 copay. Acupuncture: $18 copay. $18/month optional comprehensive dental package. Senior Fitness, Transp $0 (8, 1-way trips).	$0 for hearing services, $12 for vision services. Hearing aids $0-1580 (2 aids per year). $10 for chiropractic. $11-21/month optional supplemental package for the following: chiropractic services, acupuncture, dental, vision, fitness membership

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	Health Net of California	Imperial Health Plan	Kaiser Permanente	SCAN Health Plan	
Plan Name	**Health Net Healthy Heart (H0562-009)**	**Traditional -SF (H5496-007)**	**Kaiser Permanente Senior Advantage(H0524-032)**	**SCAN Classic (H5425-019)**	
Monthly Premium	**$124.00**	**$0.00**	**$94.00**	**$35**	
MOOP	$6,700	$4,000	$6,700	$5,000	
Phone Number	1-800-275-4737 Current Members 1-800-977-6738 Prospective Member	1-800-838-8271 Current Members 1-800-838-5914 Prospective Members	1-800-443-0815 Current Members 1-800-777-1238 Prospective Member	1-800-559-3500 Current Members 1-888-315-7236 Prospective Member	
Network Provider	Brown & Toland, Hills Physicians(refer to UCSF)	imperialhealthplan.com	Kaiser Network	Brown and Toland; Hills Physicians	
Network Hospital	CPMC, St. Francis, St. Mary's, UCSF,	St. Mary, UCSF, Chinese Hosp, St.Francis	Kaiser Permanente	CPMC, St. Francis, St. Mary's, Seton	
Physician Visit	$10 primary care. $15 specialist.	$0 primary care or specialist.	$30 primary care or $35 specialist.	$5 Primary Care, $15 specialist.	
Inpatient Hospital	$335/day for Days 1-4; $0 for Days 5-90. $0/day 91 days and beyond.	$100 for days 1-5 and $0 for days 6-90. 60 lifetime reserve days, days 1-60, $670 copay	$285/day for Days 1-7. $0/day for Days 8-90. 40 each additional non-Medicare covreed hospital day.-Medicare covered hospital stay.	$250/day for days 1-7, $0/day for days 8-90.	
Outpatient Surgery	$90-275 observation. $100 each visit to outpatient surgical center. $275 each visit to outpatient hospital facility.	$0 copay.	$0-250 each visit to outpatient surgical center. $250/visit to outpatient hospital facility..	$175 depending on service to ambulatory surgical center. $15-200 for each visit to outpatient hospital facility.	
DME	20% cost per item, diabetes supplies $0	20% of the cost per item	20% per item, diabetes supplies $0	0-20% of the cost per item,diabetic $0	
Mental Health	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	Inpatient: $200 copay days 1-7, $0 copay for days 8-90. Outpatient: 20% individual or group	Inpatient: Up to 190 days of impatient psychiatric hospital care in a lifetime. $230/day for Days 1-7. $0/day for Days 8-90. Outpatient: $30 for individual therapy w/	Inpatient:Up to 190 days of impatient psychiatric hospital care in a lifetime. $900 copay per stay. Outpatient: $25 individual and group therapy,	
Ambulance Service	$165	$85 for one-way trip	$200	$175	
Emergency Care	$90; waived if admitted into hospital, worldwide. (always covered) urgent care $15 (always covered).	$90 (always covered), $0 Urgent care (always covered)	$90; Worldwide. waived if admitted into hospital. (always covered) Call first if at other hospital. Urgent care 20% (always covered)	$90;worldwide, ($0 if admitted to hospital)(always covered), $35 urgent care (always covered) ;	
Diagnostic Test, X- Ray & Lab Service	$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, for diagnostic procedures and tests, x-rays, radiology services, and therapeutic radiology services.	$30 for lab services and diagnostic procedures and tests. $35 for x-rays. $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 (MRI,CT).	
Prescription Drugs Copay (per 30-31 Days)	Tier 1:Preferred generic: $0 (preferred pharmacy) Tier 2:Non-preferred generic: $10 Tier 3: Preferred brand: $37 Tier 4: Non-prefferd brand: $90 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $0 20% for Part B-covered drugs.	Tier 1:Preferred generic: $0 (preferred pharmacy) Tier 2: Non-preferred generic: $5 Tier 3: Preferred brand: $45 Tier 4: Non-preferred brand: $90 Tier 5: Specialty: 33% coinsurance $0 Part B drugs	Tier 1: Preferred generic: $6 (preferred pharmacy) 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 $0-47 for Part B-covered drugs.	Tier 1: Preferred generic: $3 (preferred pharmacy) 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.	
Other	$0 for limited dental services, $15 for hearing exam, $15 for vision. Fitness. $25/month optional supplemental package for the following: chiropractic services, acupuncture, dental, vision and fitness.	Hearing Exam 20%; Hearing Aids up to $1250/year; Preventive Dental 10%; Vision Exam $15; Eyeglases $15; Fitness; OTC up to $50/month includes adult diapers;$0 In-Home Support for 5 hours/year; $0 unlimited one-way transportation to plan approved locations.	$35 for hearing Services, $30-35 for vision, fitness. $20 Optional Suplemental Benefit (eyeware, fitness benefit, hearing aid and some dental)	Transportation $0 with limits. Acupuncture/Chiropractic $5 (unlimited visits). Routine Hearing Exam $10. $0 Health Club memebership. $6 Basic dental plan . $0 eye exam (1 per year) glasses or contacts $0 (every 2 years). $0 Podiatry (routine up to 6 visits/year)	
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