DRAFT

2020 San Francisco Medicare Advantage - HMO

	Aetna Medicare	Allianment Health plan	Anthem Blue Cross		Chinese Community Health Plan
Plan Name	**Aetna Medicare Plus Plan (H4982-007-0)**	**Sutter Advantage (H3815-024-0)**	**Anthem MediBlue Plus (H0544-057)**	**Anthem MediBlue Select (H0544-069)**	**CCHP Senior Program (H0571-001)**
Monthly Premium	**$0.00**	**$44**	**$50.00**	**$0**	**$42**
Website	www.aetnamedicare.com	www.sutterhealth.org	www.anthem.com	www.anthem.com	www.cchphealthplan.com
MOOP	$3,000	$3,900	$4,900	$6,700	$6,700
Contacts	1-800-282-5366 Current Members 1-855-275-6627 Non Members	1-866-634-2247 Current Members 1-888-979-2247 Non Members	1-888-230-7338 Current Members 1-844-316-0357 Non Members	1-888-230-7338 Current Members 1-844-316-0357 Non Members	1-888-775-7888 Current Members 1-888-681-3888 X3282 Prospective Member
Network Provider		Sutter Health providers	Brown and Toland; AAMG; (only Imperial Drs refer to UCSF)	Brown and Toland; AAMG; Imperial	CCHP; Jade
Network Hospital		CPMC	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
Physician Visit	$0 primary, $20 specialty	$5 primary care. $20 specialist.	$0 primary care. $10 specialist.	$5 primary care. $20 specialist.	$10 primary care. $20 specialist.
Inpatient Hospital	$350 days 1-5, $0 for days 6-90,	$225 copay days 1-5. $0 copay days 6-90, $0 copay 91+	$295 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 (CCHP). $300/day for Days 1-7 (other hospitals). $0/day for Days 8-90 (all hosp)
Outpatient Surgery	$20-$295	$195/ visit	Ambulatory surgery center: $0-222 copay depending on the service. Outpatient Hospital: $250 copay per visit	Ambulatory surgical center: $0-200 copay depending on the service. Outpatient Hospital: $350 copay per visit depending on the service.	Outpatient Hospital $100 copay/ per visit (CCHP), $300 copay/visit (all other hospitals) Outpatient Surgery $300 (CCHP)
DME	20% per item DME, $0-20% diabetic supplies	0% coinsurance for items $350 or less. 20% coinsurance for items greater than $350. 20% cost per item, $0 diabetic supplies	20% per item, diabetic supplies $0	$0 or 20% cost per item, $0 diabetic supplies	20% per item, diabetic supplies $0
Mental Health	Impatient: $350/day, days 1-5, $0/day, days 6-90 Outpatient: $25	Inpatient $120 days 1-10, $0 days 11-90, $0 days 91-130 Outpatient with psychiatrist: $40 copay, outpatient other $0	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: $35 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
Ambulance Service	$275	$250	$250 copay	$300 copay or 20% depending on the service	$225
Emergency Care	$90 per visit (always covered), urgent care $20	$90 per visit. Urgent care $0-$10	$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 (covered everywhere).	$90; waived if admitted into hospital within 24 hours. Worldwide. (always covered), $45 Urgent care (always covered)
Diagnostic Test, X- Ray & Lab Service	$0 for lab services, for diagnostic procedures and tests. Diagnostic radiology services $0-$60. $0 for outpatient x-rays	$0 diagnostic, labs $150 MRI, $15 Outpatient x-rays, 20% therapeutic radiology	$0-60 diagnostic procedures and tests. $0 lab services. $0-50 for outpatient x-rays $60 for diagnostic radiology services	$5 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)
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $0 (standard pharmacy) Tier 2: Non-preffer generic: $0 Tier 3: Preferred Brand: $47 Tier 4:Non-preferred brand: $100 Tier 5: Specialty:33%	Tier 1: Preferred generic: $0 (preferred pharmacy Walgreens) Tier 2: Non-preferred generic: $5 Tier 3: Preferred brand: $40 Tier 4:Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance Tier 6: $0 (includes diabetic drugs) 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 CVS) Tier 2: Non-preferred generic: $10 Tier 3: Preferred brand: $42 Tier 4:Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance IngenioRx is mail order 20% for Part B-covered drugs.	Tier 1: Preferred generic: $3 (preferred pharmacy drugs, accept all pharmacies) Tier 2: Non-preferred generic: $7 Tier 3: Preferred brand: $40 Tier 4: Non-preferred brand: $60 Tier 5: Specialty: 30% coinsurance 20% for Part B-covered drugs.
Other	$0 hearing exam, $0 Hearing aids, Preventive dental $0, Comprehensive dental $0, Vision $0 copay, Fitness, OTC, chiropractic.	$0 hearing exam,$0 copay exam/fitting/evaluation, $0 Dental visit (Liberty dental) every 6 months, vision exam $0 once per year, Fitness, OTC, annual physical exam, "Black card" member services: concierge care	Hearing Services: $0 , Hearing Aid $0 ($3000 limit), vision: $0 (I exam/year), dental $0 copay (1 exam/year) Optional supplemental packages ($12,$31,$51) for dental and vision. Silver Sneakers. Facetime w/Dr.Annual physical	Hearing exam (1/year): $0 , Hearing Aid $0 ($3000 limit). Vision: $0 (I exam/year) Dental $0, (1 exam/year) Optional packages ($12,$31,$51) for dental and vision. Silver Sneakers, Personal emergency response unit. Facetime w/Dr.	Vision:$20 exam, VSP; Hearing aids $600-$2075, annual physical, Chiropractic care: $20. Hearing Services: $35 copay. Acupuncture: $20 copay (no limits). $20/month optional comprehensive dental package. Fitness, Transportation.

This is only a guide. Call your doctor, the plan directly or contact HICAP at 1-800-432-0222

DRAFT Updated 10/18/19

DRAFT

2020 San Francisco Medicare Advantage - HMO

	Golden State	Health Net		Imperial Health Plan	Kaiser Permanente
Plan Name	**Golden State Senior Health Plan (H2241-014)**	**Health Net Ruby Select (H0562-097)**	**Health Net Healthy Heart (H0562-009)**	**Traditional -SF (H5496-007)**	**Kaiser Permanente Senior Advantage (H0524-032)**
Monthly Premium	**$0.00**	**$0**	**$124.00**	**$0.00**	**$92.00**
Website	www.gsmhp.com	ifp.healthnetcalifornia.com	ifp.healthnetcalifornia.com	www.imperialhealthplan.com	medicare.kaiserpermanente.org
MOOP	$3,000	$4,400	$6,700	$4,000	$4,900
Phone Number	1-877-541-4111 Current Members	1-800-275-4737 Current Members	1-800-275-4737 Current Members	1-800-838-8271 Current Members	1-800-443-0815 Current Members
	1-877-541-4111 Prospective Member	1-800-977-6738 Prospective Member	1-800-977-6738 Prospective Member	1-800-838-5914 Prospective Members	1-800-777-1238 Prospective Member
Network Provider	AAMG, Golden State	Brown and Toland (only B&T referrals to UCSF)	Brown & Toland, Hills Physicians(refer to UCSF)	imperialhealthplan.com for provider list	Kaiser Network
Network Hospital	UCSF	St. Francis; St. Mary's, CPMC Mission Bay.	CPMC, St. Francis, St. Mary's, UCSF,	St. Mary, UCSF, Chinese Hosp, St.Francis	Kaiser Permanente
Physician Visit	$5 primary car, $5 specialist	$5 primary care. $20 specialist.	$10 primary care. $15 specialist.	$0 primary care or specialist.	$10 primary care or $20 specialist.
Inpatient Hospital	$250 days 1-5, $0 Days 0-90	$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 91 days and beyond.	$100 for days 1-5 and $0 for days 6-90. 60 lifetime reserve days	$240/day for Days 1-7. No charge for the remainder of your stay.
Outpatient Surgery	$200 / visit	Observation $90-345, $200 each visit to outpatient surgical center. $345 each visit to outpatient hospital facility.	$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. $200/visit to outpatient hospital facility..
DME	0-20% item , $0 diabetic	20% per item. Diabetes supplies $0	20% cost per item, diabetes supplies $0	20% of the cost per item	20% per item, diabetes supplies $0
Mental Health	$5 - 30 outpatient	Inpatient: Days 1-7, $250 copay/day, Days 8-90, $0 copay/day Outpatient: #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: $15 for individual therapy w/ psychiatrist and without &	Inpatient: $200 copay days 1-7, $0 copay for days 8-90. Outpatient: $0-20% 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: $10 indiv and $5 for group.
Ambulance Service	$200	295 per 1-way trip, 5% air ambulance 2500-10,000	$165	$100 for one-way trip	200 per one-way trip
Emergency Care	$90/visit, $20/urgent	$90; waived if admitted into hospital, worldwide coverage to 50,000. (always covered) urgent care $20 (always covered)	$90; waived if admitted into hospital, worldwide. (always covered) urgent care $15 (always covered).	$90 (always covered) up to $50,000 coverage, $0 Urgent care (always covered)	$90; Worldwide. waived if admitted into hospital. (always covered) Call first if at other hospital. Urgent care $10 (always covered)
Diagnostic Test, X- Ray & Lab Service	$0 tests, procedures, labs, x-rays. $60 diagnostic radiology	$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	$0 for lab services, for diagnostic procedures and tests, x-rays, radiology services, and therapeutic radiology services.	$10 for lab services and diagnostic procedures and tests. $20 for x-rays. $215 for MRI, CT, and PET. $0 therapeutic radiology services.
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $5 (preferred pharmacy) Tier 2: Non-preferred generic: $10 Tier 3: Preferred brand: $45 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance 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.	Tier 1:Preferred generic: $0 (preferred pharmacy) Tier 2:Non-preferred generic: $7 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: $3(preferred pharmacy) Tier 2: Non-preferred generic: $12 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.
Other	Preventative dental covered. Comprehensive dental: copays vary. $0 hearing exam, $0 hearing aids. $0 vision exam. Fitness. Transportation (non-emergency:plan must approve), OTC, telehealth.	$0 hearing exam, $12 for vision services. Hearing aids $0-1580 (2 aids per year). $12 for chiropractic. OTC mail order. $11-$21/month optional supplemental package includes: chiropractic services, acupuncture, dental, vision, fitness.	$0 for limited PPO dental services, $15 for hearing exam, $15 for vision exam. Fitness. $25/month optional supplemental package for the following: chiropractic services, acupuncture, dental, vision and fitness. Annual physical.	Hearing Exam 20%; Hearing Aids 20% max $1250 both ears; Preventive Dental $0; Vision Exam $15; $255 maximum for contacts,lenses and frames; Fitness; OTC; $0 limited transportation to plan approved locations, chiropractic (network).	$10-$20 for hearing exam, $10-20 for vision exam, fitness. Annual physical exam, telehealth. $20 Optional Suplemental Benefit (eyeware, fitness benefit, hearing aid and some dental). $35 accupuncture, $20 physical therapy, travelor's department 24/7.

This is only a guide. Call your doctor, the plan directly or contact HICAP at 1-800-432-0222

DRAFT Updated 10/18/19

DRAFT

2020 San Francisco Medicare Advantage - HMO

	SCAN Health Plan	United Health Care			
Plan Name	**SCAN Classic (H5425-019)**	**AARP Medicare Complete Secure Horizons (H0543-175)**	**United Health Care Canopy (H0544-057)**		
Monthly Premium	**$35**	**$54.00**	**$39.00**		
Website	www.scanhealthplan.com	www.aarpmedicareplans.com	www.canopyhealth.com		
MOOP	$5,000	$4,000	$3,500		
Phone Number	1-800-559-3500 Current Members	1-800-950-9355 Current Members	1-800-950-9355 Current Members		
	1-888-315-7226 Prospective Member	1-800-555-5757 Non Members	800-555-5757 Non Member		
Network Provider	Brown and Toland; Hills Physicians	www.connect.werally.com	www.connect.werally.com		
Network Hospital	CPMC, St. Francis, St. Mary's, Seton	CMPC Pacific, CPMC California, UCSF	St. Francis, UCSF, St. Mary's		
Physician Visit	$5 Primary Care, $15 specialist.	$5 primary, $10 specialty	$0 primary care. $10 specialist.		
Inpatient Hospital	$250/day for days 1-7, $0/day for days 8-90.	$345 days 1-5, $0 for days 6-90, $0 for days 90+	$250 copay days 1-5. $0 copay days 6-90, $0 91+		
Outpatient Surgery	$175 depending on service to ambulatory surgical center. $15-200 for each visit to outpatient hospital facility.	$0-$195	$0-195/visit		
DME	0-20% of the cost per item,diabetic $0	20% per item DME, $0 diabetic supplies	20% per item, diabetic supplies $0		
Mental Health	Inpatient:Up to 190 days of impatient psychiatric hospital care in a lifetime. $900 copay per stay. Outpatient: $15-$25 individual and group.	Inpatient: $345 days 1-4, $0 days 5-90, plus 60 lifetime days. Partial hospitalization: $55/day. Outpatient: individual/$40, group $30.	Inpatient $250 Days 1-5, $0 days 6-90, 60 lifetime reserve days, 190 day maximum, partial, $55/day Outpatient $30-$40		
Ambulance Service	$175	$250	$250 copay		
Emergency Care	$90;worldwide, ($0 if admitted to hospital)(always covered), $35 urgent care (always covered) ;	$90 per visit (always covered), urgent care $40	$90 per visit. $40 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 (MRI,CT).	$0 for lab services, for diagnostic procedures and tests. Diagnostic radiology services $0-$105. $15 for outpatient x-rays $60 for therapeutic radiology services	$0 diagnostic tests,labs. Diagnostic radiological services 0-105, $15 outpatient x-rays		
Prescription Drugs Copay (per 30-31 Days)	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.	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 $250 20% for Part B-covered drugs.	Tier 1: Preferred generic: $3 (prefered pharmacy) Tier 2: Non-preffer generic: $12 Tier 3: Preferred Brand: $47 Tier 4:Non-preferred brand: $100 Tier 5: Specialty:31% $100 drug deductable		
Other	Transportation $0 with limits. Acupuncture/Chiropractic $5 (unlimited visits). Routine Hearing Exam $10. $0 Health Club memebership. $0 eye exam (1 per year) glasses or contacts $0 (every 2 years). $0 Podiatry (routine up to 6 visits/year). Hearing aids $450-750. optional package $6-$16.	Hearing exam: $0. Hearing aids $375 -$2075 each. Vision: $0 (I routine exam per year) Optional supplemental packages ($43) for dental and vision with $100 deductible. Health Club membership. Annual physical. Telehealth.	$0 Hearing exam. Hearing aids, Vision exam $0, Fitness,transportation, OTC , Annual physical exam, telehealth, Optioanl package $43		

This is only a guide. Call your doctor, the plan directly or contact HICAP at 1-800-432-0222

DRAFT Updated 10/18/19