2022 San Francisco Medicare Advantage Plans - HMO & PPO

	Kaiser Permanente		United Health	Chinese Community Health Plan	
Plan Name	**Kaiser Permanente Senior Advantage Basic SF (H0524-060)**	**Kaiser Permanente Senior Advantage, Alam, SF, Napa (H0524-032)**	**United Health Care Canopy (H0543-191-0)**	**CCHP Senior Program H0571-001**	**CCHP Senior Program H0571-007-0**
Monthly Premium	**$19 (for drug premium)**	**$79 ($47.30 health plan and $31.70 Drug plan)**	**$39 (for drug premium)**	**$42 (for drug plan)**	**$0.00**
Website	https://medicare.kaiser.permanente.org	https://medicarekaiserpermanente.org	www.uhcmedicaresolutions.com	https://cchphealthplan.com	**https://cchphealthplan.com**
MOOP	$6,700	$4,900	$3,500	$6,700	$7,550
Contact	1-800-443-0815 Current Members 1-800-777-1238 Prospective Member	1-800-443-0815 Current Members 1-800-777-1238 Prospective Member	866-810-1498 Current Members 800-555-5757 Prospective members	1-888-775-7888 Current Members 1-888-681-3888 Prospective Member	1-888-775-7888 Current Members 1-888-681-3888 Prospective Member
Network Provider	Kaiser	Kaiser Network	Canopy, Hills Physician	CCHP, Brown & Toland (some)	CCHP, Brown & Toland (some)
Network Hospital	Kaiser	Kaiser Permanente	*St. Francis, St. Mary's, UCSF.	*Chinese Hospital, Dignity Health, CPMC	*Chinese Hospital, Dignity Health, CPMC
Physician Visit	$15 primary care. $25 specialist.	$5 primary, $15 specialist.	$0 primary, $10 specialist.	$5 primary care. $20 specialist.	$10 primary care. $35 specialist.
Inpatient Hospital	$ 290/day copay days 1-5, $ 0 copay days 6-90, $ 0 copay days 91+	$225/day for Days 1-5. $0/day for Days 6-90. $0 days 91 and above.	$250/day for days 1-5, $0/day for days 6-90 $0 for day 91+.	$ 100/day for days 1-7, $ 0/day for days 8-90 (Chinese Hospital) $ 305/day for days 1-7, $ 0/day for days 8-90 (All other hospital)	$ 150/day for days 1-7, $ 0/day for days 8-90 (Chinese Hospital), $ 315/day for days 1-7, $ 0/day for days 8-90 (All other hospital)
Outpatient Surgery	$ 0- 270 per visit	$0-$200 each visit to outpatient hospital facility.	$ 0 - $195/visit	$ 130 - $300/visit	$ 230 - $310/visit
DME	$0-20% per item, dialysis $0-20%, diabetic supplies $0	DME $0-20% per item, dialysis In network 0%-20%, Diabetic supplies $0	DME 20%, dialysis In-network 20%, diabetic supplies $0.	DME 20% per item. Dialysis In-Network 20%. Diabetic supplies $0.	DME 20% per item. Dialysis In-Network 20%. Diabetic supplies $0.
Mental Health	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: $0-$15. $0 for partial hospitalization program services.	Inpatient: Up to 190 lifetime days of inpatient psychiatric hospital care. $230/day for Days 1-7. $0/day for Days 8-90. Outpatient: group with psych $0-$2, individual with psych $0-$5, group $2, indiv $5. $0 for partial hospital.	Inpatient: $250/day for Days 1-5. $0/day for Days 6-90. 60 lifetime reserve days, 190 day maximum, partial $55/day Outpatient: group with psych $15, individual with psych $25, group $15, individual $25.	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: $20 copay	Inpatient: $150/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	$200	$200	$275	$265	$265
Emergency Care	$90 emergency care; urgent care $15	emergency $90, urgent care $5.	Emergency $90. Urgent $40.	$90 emergency, $45 urgent care.	$90 emergency, $45 urgent care.
Diagnostic Test, X-Ray & Lab Service	Tests 4%. Lab $0-$5, X-ray $20, diagnostic radiation $30-$215.	diagnostic tests $0, lab $0, x-ray $5, diagnostic radiation $5-$195.	Tests and lab $0, x-ray $15, Diagnostic radiation $0-$105.	$0 for lab services, for x-rays, for diagnostic procedures and tests. $200 therapeutic radiology services	$0 for lab services, for x-rays, for diagnostic procedures and tests. $200 therapeutic radiology services
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $3 (standard retail) Tier 2: Non-preferred generic: $3 Tier 3: Preferred brand: $12 Tier 4: Non-preferred brand: $12 Tier 5: Specialty: $12 Tier 6: vaccines: $0 catastrophic phase $0-47 for Part B-covered drugs and chemo.	No initial coverage phase. Gap coverage phase: generic 25%, brand-name 25%. Part B drugs and chemo $0-$47.	Tier 1 Preferred Generic : $ 3 Tier 2 Non Preferred Generic: $ 12 Tier 3 Preferred Brand: $ 47 Tier 4 Non-Preferred Brand $ 100 Tier 5: SPecialty Tier: 33% Chemo drugs: 20% co-insurance Other Part B drugs 0 -20% co-insurance	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: 33% 20% for Part B-covered drugs.	Tier 1: Preferred generic: $5 (standard retail) Tier 2: Non-preferred generic: $12 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 31% coinsurance 20% for Part B-covered drugs.
Other	Hearing test: $25. Vision exam: $15. Eyeglasses $0. Telehealth some coverage. Optional supplemental package $16 for dental and vision. Some fitness. Preventive dental covered under office visit. Comprehensive dental varies.	$15 for hearing exam, $0 for eye exam, $0 eyeglasses, telehealth some coverage, preventive dental covered under office visit. $16 Optional Suplemental Benefit (eyewear, hearing aid and some dental)	Hearing exam $0. Hearing Aids $375-$2075. Eye exam $0. Glasses $0. Fitness some coverage. Telehealth some. Optional package $45. Transportation some.	Hearing exam $20, Hearing aids $600-2075, preventive dental $0, eye exam $20, eyeglasses $0, some fitness, some telehealth. OTC $25/ quarter. Optional dental package $10.	Hearing exam $20, Hearing aids $600-2075, eye exam $20, eyeglasses $0, some fitness, some telehealth. OTC $25/ quarter. Optional dental package $10.

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Information	Alignment		Brand New Day		Scan
Plan Name	**My Choice (H3815-007)**	**Sutter Advantage (H3815-023)**	**Brand New Day Classic Care II Plan (H0838-037)**	**Brand New Day Classic Choice Plan (H0838-033)**	**Scan Classic (H5425-019)**
Monthly Premium	**$0.00**	**$48 ($25.80 health plan, $22.20 Drug plan)**	**$0**	**$32.20 (for drug premium)**	**$35 (for health premium)**
Website	www.alignmenthealthplan.com	www.alignmenthealthplan.com	https://bndhmo.com	https://bndhmo.com	www.scanhealthplan.com
MOOP	$3,000	$3,900	$999	$7,550	$5,000
Contact	1-866-634-2247 Current Members 1-888-979-2247 Prospective Member	866-634-2247 Current Members 888-979-2247 Prospective Members	1-866-255-4795 Current Members 1-866-255-4795 Prospective Member	866-255-4795 Current Members 866-255-4795 Prospective Members	1-800-559-3500 Current Members 1-888-315-7226 Prospective Members
Network Provider	Alignment Health Plan Network , Brown and Toland Health Services , Imperial Health Plan of Cal	Sutter Health Medical Group	*Hills Physicians, ACCESS, AAMG	*Hills Physicians, ACCESS, AAMG.	*Brown and Toland, Caremore.
Network Hospital	St. Marys, St Francis	CPMC (Castro, Buchanan & 1101 Vanness) CCHP	St Marys, St Francis, CPMC, Seton	St Marys, St Francis, CPMC, Seton	*St. Francis, CPMC, St. Mary's.
Physician Visit	$0 primary care $0 specialist	$5 primary care. $25 specialist.	$0 primary care. $10 specialist.	$0 primary, $0 specialty	$0 primary care. $10 specialist.
Inpatient Hospital	$0/day days1-4, $100/day days 5-10, $0 days 11-90, $0 days 91 and beyond	$225/day for Days 1-5. $0/day for days 6-90. $0 for days 91+.	$100/day for Days 1-6; $0 for Days 7-90.	Coming soon.	$250/day for Days 1-7. $0/day for Days 8-90.
Outpatient Surgery	$200/visit.	$250 each visit to outpatient hospital facility.	$ 0- $150/visit to outpatient surgery	20% coinsurance/visit	$10-$200 each visit
DME	DME 20% per item, dialysis In Network 20%, diabetes $0.	DME 0-20% per item, dialysis In Network, 20%, diabetic supplies $0.	DME $0%-20%/item. Dialysis In Network 20%. Diabetic supplies In Network $0.	DME 20% per item, Dialysis In Network 20%, Diabetic supplies $0.	DME 0-20% per item, dialysis In-network 20%, diabetes $0.
Mental Health	Outpatient: $40 with psych, $0 without.	Inpatient: $120 days 1-10, $0 days 11-90. $0 days 91-130. Outpatient: with psychiatrist $40, without $0.	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: Outpatient group with psychiatrist 20%. All others $10.	Outpatient group and indidivual w/psychiatrist $40, without psychiatrist $0.	Inpatient: Up to 190 Days of inpatient psychiatric hospital care in a lifetime. $900 copay per stay. Outpatient: with psychiatrist $15, without $25.
Ambulance Service	$175	250/visit	$ 0 - $100	20% coinsurance	$175
Emergency Care	Emergency $85, urgent $0.	Emergency $90. Urgent care $0.	$0-$100 emergency, $0 urgent.	Emergency $90, urgent care $0	Emergency $90. Urgent $35.
Diagnostic Test, X-Ray & Lab Service	Tests, lab, x-rays, and diagnostic radiation $0.	$0 for lab services and tests. X-rays $15. Diagnostic radiation $150.	$0 for lab services, diagnostic procedures and tests, and x-rays. $0-$25 for diagnostic radiation.	Lab $0. Tests, xrays and diagnostic radiation 20%.	$0 for lab services, diagnostic procedures and tests, x-rays and radiology services (not including x-rays) and therapeutic radiology services (MRI,CT).
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $0 (standard retail) Tier 2: generic: $3 Tier 3: Preferred brand: $40 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% Tier 6: Select care drugs $ 5 20% for Chemo and Part B-covered drugs.	Tier 1: Preferred Generic: $0 Tier2: Non Preferred Generic: $5 Tier 3: Preferred Brand: $40 Tier 4: Non-Preferred Brand: $100 Tier 5: Speciality Tier: 33% Tier 6: Select Care Drugs: $5 20% for Chemo and Part B-covered drugs	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $12 Tier 3: Preferred brand: $47 Tier 4: Non-preferred brand: $100 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care: $0 Drug deductable $50 20% for Part B-covered drugs and chemo.	Tier 1: Preferred Generic: $0 Tier2: Non Preferred Generic: 25% Tier 3: Preferred Brand: 25% Tier 4: Non-Preferred Brand: 25% Tier 5: Speciality Tier: 25% Tier 6: Select Care Drugs: $0 $480 drug plan deductible 20% for Part B-covered drugs and chemo	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $0 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance 20% for Chemo and Part B-covered drugs.
Other	Hearing exam $0. Hearing Aids $0 with limits. Preventive dental $0. Comprehensive dental varies. Eye Exam $0. Eyeglasses $0. Fitness some coverage. Telehealth some coverage. Optional package $29.	*Hearing Exam $0; Liberty Dental HMO $0; VSP Eye Exam $0, Glasses $0; eyeglasses $15; Peerfit Move gym membership. OTC $15/month using "black card". Some telehealth coverage. Optional package $29.	$0 for hearing exam, $699-$999 hearing aids. $0 for vision exam. $0 Preventive dental. Comprehensive varies. Some telehealth. Some chiropractic, some accupuncture, some fitness.	Hearing exam $0, Hearing aids $149, preventive dental $0, comprehensive dental $0, eye exam $0, fitness some coverage, telehealth some coverage, transportation some, OTC some, chirop some, worldwide emergency some.	Hearing exam $12. Hearing aids $450-$750. Routine Vision Exam $0. Glasses $0. Fitness some coverage. Chiro some coverage. Accupuncture some coverage. Transportation some coverage. Optional package for added benefits $6 and $16.

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	Wellcare (By Health Net)		Anthem	Imperial	
Plan Name	**Wellcare No Premium (H0562-097)**	**Wellcare Premium Ultra (H0562-009)**	**Anthem MediBlue Select (H0544-069)**	**Imperial Strong (H5496-014)**	**Imperial Traditional (H5496-007)**
Monthly Premium	**$0.00**	**$121 (for health premium)**	**$0.00**	**$0.00**	**$0.00**
Website	wellcare.healthnetcalifornia.com	wellcrehealthnetcalifornia.com	https://shop.anthem.com	www.imperialhealthplan.com	www.imperialhealthplan.com
MOOP	$4,400	$6,700	$7,550	$7,550	$2,999
Contact	1-800-275-4737 current member 1-866-277-6583 prospective members	1-800-275-4737 current members 1-866-277-6583 prospective members	1-888-230-7338 Current Members 1-855-593-0898 Non Members	1-800-838-8271 current members 1-800-838-5914 prospective members	1-800-838-8271 Current Members 1-800-838-5914 Prospective Member
Network Provider	Brown and Toland	Brown and Toland	*Brown and Toland, AAMG, Imperial (only Imperial can make UCSF referrals).	Imperial Health Plan of Nothern Ca, One Medical group(some) , UCSP medical group(some) (call plan)	Seton, Brown and Toland.(call plan)
Network Hospital	CPMC	CPMC	*CPMC, St. Francis, UCSF, St. Mary's, Seton.	UCSF, CCHP, Chinese Hospital, Kentfield Hospital, St. Mary's, St. Francis,	UCSF, CCHP, Kentfield Hospital, St. Mary's, St. Francis, St Lukes
Physician Visit	$5 primary care. $20 specialist.	$10-$15 primary care, $15 specialist	$5 primary care. $20 specialist.	20% primary, 20% specialist	$5 primary, $10 specialist.
Inpatient Hospital	$330/day for Days 1-6; $0 for Days 7-90.	$335/day for days 1-4, $0 for days 5-90.	$360/day copay days 1-4. $0 copay days 5-9.	Coming soon.	$150/day for Days 1-5. $0/day for Days 6-90.
Outpatient Surgery	$345	$325	$0-$350	20% coinsurance	$0 each visit to outpatient hospital facility.
DME	DME 20% per item. Dialysis In Network 20%. Diabetic supplies $0.	DME 20% per item. Dialysis In Network 20%. Diabetic supplies $0.	0-20%/item, dialysis In Network 20%, diabetic supplies $0	DME 20% per item, Dialysis In Network 20%, Diabetic supplies 20%..	DME 20% per item, dialysis In-Network 20%, Diabetic supplies $0
Mental Health	Outpatient: group $25, individual $25.	Outpatient:: Group $25, individual $25.	Inpatient: $360 copay for days 1-4. $0 per day days 5-90. Outpatient group/individual therapy: $40 copay	Inpatient: $200 copay days 1-7, $0 cpay for days 8-90. Outpatient: 20%	Inpatient: $200 copay days 1-7, $0 cpay for days 8-90. Outpatient: with psychiatrist $0, without 20%.
Ambulance Service	$255	$165	$300	$0.00	$150
Emergency Care	$90 emergency, $20 urgent.	$90 emergency, $15 urgent.	$90 emergency, $35 urgent care	emergency 20%, urgent 20%	emergency $100, urgent care $20.
Diagnostic Test, X-Ray & Lab Service	$0 for lab services, diagnostic procedures and tests, and x-rays. $0-$345 for diagnostic radiation.	$0 for lab services, diagnostic procedures and tests, and x-rays. $0-$325 for diagnostic radiation.	$0 - $5 for lab services; $0-$120 for tests, $0-$50 for x-rays, $65-$165 therapeutic radiology services	diagnostic tests, lab, x-ray, diagnostic radiation 20%.	diagnostic tests, lab, x-ray, diagnostic radiation $0.
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Pref. generic: $0 (standard retail) Tier 2: Non-preferred generic: $3 Tier 3: Preferred brand: $37 Tier 4: Non-preferred brand: $90 Tier 5: Specialty: 33% coinsurance Tier 6: Select care drugs : $ 0 Chemo and Part B drugs 20%	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $5 Tier 3: Preferred brand: $37 Tier 4: Non-preferred brand: $90 Tier 5: Specialty: 33% coinsurance Tier 6: Select Care $0 Chemo and Part B drugs 20%	Tier 1: Pref generic: $0 (standard retail) Tier 2: Non-preferred generic: $10 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 33% coinsurance 20% for Part B-covered drugs.	Initial phase: 25% generic Gap phase: 25% all. Drug deductible $ 480 20% for Chemo and Part B-covered drugs	Tier 1: Preferred generic: $0 (standard retail) Tier 2: Non-preferred generic: $5 Tier 3: Preferred brand: $45 Tier 4: Non-preferred brand: $90 Tier 5: Specialty: 33% coinsurance 0% copay for Chemo and Part B-covered drugs.
Other	Hearing exam $20, Hearing Aids $0 with limits, eye exam $0, eyeglasses $0, preventive dental $0, comprehensive dental varies.	Hearing exam $15, eye exam $0, some fitness, some telehealth, some worldwide emergency, optional package $25.	Hearing test: $20 , Hearing Aid $0 with limits. Vision: $0 (I routine exam per year) Glasses $0 Optional supplemental packages ($12,$32,$48) for dental and vision. OTC $140/year. Silver Sneakers. Some transportation. Personal emergency response system.	Hearing exam 20%, Hearing aids $20%, preventive dental $0, comprehensive dental $0, eye exam $0, telehealth some coverage.	Hearing exam 20%. Hearing Aids 20%. Preventive dental: $0. Comrehensive dental $0. Eye exam $0. Fitness some coverage. Telehealth some coverage. Transportation some coverage. OTC $75/quarter.

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	Aetna	Aetna (without drug coverage)	Brand New Day (w/o drug coverage)	Aetna (PPO)	Anthem (PPO)
Plan Name	**Aetna Medicare Plus Plan (H4982-007)**	**Aetna Medicare Eagle Plan (H4982-013)**	**Brand New Day Valor Care Plan (H0838-048)**	**Aetna Medicare Elite Plan (PPO) (H5521-293-0)**	**Anthem MediBlue Access (PPO) H8552-029-0**
Monthly Premium	**$0.00**	**$ 0 (No drug plan)**	**$ 0 (No drug plan)**	**$ 0 (Health deductible $ 750)**	**Plan $31.10 (Health: $7.10 Drug: $22.90) Health Deductible $ 370**
Website	www.aetnamedicare.com	www.aetnamedicare.com	bndhmo.com	www.aetnamedicare.com	https://shop.anthem.com
MOOP	$3,400	$4,200	$4,500	$11,300 In and Out-of-network, $ 6,700 in network	$10,000 In and Out-of-network, $6,700 In-network
Contact	1-833-570-6670 Current Members 1-833-859-6031 Prospective Members	1-833-570-6670 Current Members 1-833-859-6031 Prospective Member	1-866-255-4795 members 1-866-255-4795 non members	Members: 1-888-268-9800 Non-members:1-833-859-6031	Members: 1-877-811-3107 Non-members: 1-855-768-1053
Network Provider	Brown $ Toland (selective)	Brown $ Toland (selective)	Hills Physician(limited), AAMG, ACCESS	Dignity Health, St. Francis, St. Mary's, Aetna Direct	NEMS, Northwest Medical Group, UCSF Group Services, all others single providers
Network Hospital	CCHP, Kentfield -6th flr. 450 Stanyan St	CCHP, Kentfield -6th flr. 450 Stanyan St	St Marys, St Francis, CPMC, Seton	St. Francis, St Marys, CCHP, Seton	CPMC, CCHP, Kentfield - 6th flr 450 Stanyan St
Physician Visit	$0 copay for primary care or specialist.	$0 primary care. $10 specialist.	$0 copay for primary care, $ 10/visit for specialist	In-network: $0 copay, Out-of-network:45% coinsurance per visit Specialist In network: $ 25/visit, Out-of-network: 45% per visit	In-network: $10 copay per visit, Out-of-network: $30 copay per visit Specialist In-network: $35 copay per visit Out-of-network: $50 copay per visit
Inpatient Hospital	$150/day copay for days 1-5. $0 Days 6-90.	$50/day for Days 1-3. $0/day for Days 4-90.	*Coming soon*	In-network: $325 per day for days 1 through 4, $ 0/day for day 5 through 90, Out of network : 45% per stay	In-network: $175 per day for days 1 through 7 $0 per day for days 8 through 90, Out-of-network: 40% per stay
Outpatient Surgery	$0-$125	$0-$50 each visit	0-20%	In-network: $0-295 copay/visit Out of network : 45% coinsurance/stay	In-network: $0-175 copay per visit Out-of-network: 40% coinsurance
DME	DME 20% per item. Dialysis In-Network 20%. Diabetic supplies $0-20%.	DME 20% per item, dialysis In-Network 20%, diabetes $0-20%.	DME 0-20%, Dialiysis In Network 20%, Diabetes $0	In-network: 20% coinsurance per item, Out-of-network: 45% coinsurance per item	In-network: 0-20% coinsurance per item, Out-of-network: 40% coinsurance per item Diabetes suppliesIn-network: $0 copay
Mental Health	Inpatient: $350 copay days 1-5, $0 copay for days 6-90. Outpatient: $10	Outpatient: $25 all.	Outpatient $0 for all	Outpatient individual/group therapy with a psychiatrist and individual/ group therapy visit In-network: $40 copay Out-of-network: 45% coinsurance	Outpatient individaul/group therapy with a psychiatrist and theraphy visit: In-network: $20 copay Out-of-network: $50 copay Opioid treatment program services: In-network: $20 copay Out-of-network:40%
Ambulance Service	$325	$275	$0-$75	In-network: $285 copay Out of network: $ 285	In-network.Out of network : $325 copay
Emergency Care	Emergency $90. Urgent $0.	Emergency $90/visit. Urgent $10/visit	$0-$90 emergency , urgent care $0	$90 copay per visit (always covered), urgent care $ 40 copay/visit	$90 copay per visit, urgent $30 copay per visit
Diagnostic Test, X-Ray & Lab Service	Diagnostic tests, lab, x-rays, and diagnostic radiation $0.	$0 for lab services, diagnostic procedures and tests, and x-rays. $0-$100 for radiology services (not including x-rays) and therapeutic radiology services (MRI,CT).	$0 lab, $0 tests, $0 x-rays, $0 therapeutic radiology services.	In-network: $0 copay, Out-of-network: 45% coinsurance, Diagnostic radiology services (like MRI) In-network: $0-200 copay Out-of-network: 45% coinsurance	Diagnostic tests & procedures In-network: $0-75 copay Out-of-network: 40% coinsurance, Lab servicesIn-network: $0-5 copay Out-of-network: 40% coinsurance, Diagnostic radiology services (like MRI) In-network: $75 copay Out-of-network: 40% coinsurance, Outpatient x-rays In-network: $25 copay Out-of-network: 40% coinsurance
Prescription Drugs Copay (per 30-31 Days)	Tier 1: Preferred generic: $0 (standard retail) Tier 2: generic: $0 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $99 Tier 5: Specialty: 33% 20% for Chemo and Part B-covered drugs.	**No drug coverage** 20% for Chemo and Part B-covered drugs.	**No drug coverage** 20% for Part B-covered drugs and chemo.	Tier 1 Preferred Generic $ 0 Tier 2 Generic $ 0 Tier 3 Preferred Brand $ 47 Tier 4 Non-Preferred Drug $ 100 Tier 5 Specialty Tier 6 33% Chemo and Part B drugs In-network: 20% coinsurance Out-of-network: 45% coinsurance	Tier 1: Preferred generic: $4 Tier 2: Generic: $12 Tier 3: Preferred brand: $42 Tier 4: Non-preferred brand: $95 Tier 5: Specialty: 26% coinsurance Tier 6: Selected Care $ 0 Chemo and Part B-covered drugs: In-network: 20% coinsurance Out-of-network: 40% coinsurance
Other	Hearing exam $0, Hearing Aids $0 with limits, Preventive dental $0. Comprehensive Dental $0. eye exam $0. Eyeglasses, contacts $0. Fitness some coverage. Telehealth some coverage.	Hearing exam $0. Hearing Aids $0 with limits.Preventive dental $0. Comprehensive dental $0.Eye Exam $0. Eyeglasses, contacts, $0.Fitness some coverage. Telehealth some coverage. Chiropractor some coverage, accupuncture some coverage.	Hearing test $0, hearing aids $149, eye exam $0, preventive dental $0, comprehensive dental varies, chiropractor some, accupuncture some, fitness some, transportation some, telehealth some.	Hearing exam, Fitting/evaluation In-network: $0 copay Out-of-network: 45% coinsuranceHearing aids - all types Oral exam,Cleaning, Fluoride treatment, Dental x-rays: In-network: $0 copay Out-of-network: $0 copay	Hearing exam In-network: $35 copay Out-of-network: 40% coinsurance; Fitting/evaluation In-network: $0 copay Out-of-network: 20% coinsurance; Hearing aids - all types In-network: $0 copay Out-of-network: $0 copay ; Oral exam and Cleaning In-network: $0 copay Out-of-network: 20% coinsurance; routine eye exam, contact lenses, eyeglass frames and lenses In-network: $0 copay Out-of-network: $0 copay;

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