Your Medicare Choices

1 Use Original Medicare

Part A & B (Original Medicare)

Part A: Hospital Insurance

Part B: Medical Insurance

- You may go to any doctor, provider, hospital, facility or supplier in the Medicare program.
- Medicare pays its portion of your covered service/benefit.
- You pay the deductible, copay, and coinsurance (find these out-of-pocket costs in the on page 3).

Add Supplement Insurance and a Drug Plan to your Original Medicare

Medigap

Medicare Supplement Insurance

- You must have enrolled both Part A and Part B to join.
- Plans cover Original Medicare deductibles, and co-pays/coinsurance.
- Policies offered by private insurance companies.
- Premiums vary by age, zip code, plan and company. Medical underwriting may apply.
- Employers and unions may offer similar retiree coverage.

Part D

Prescription Drug Coverage

- Stand-alone drug plans offered by private insurance companies.
- Covers out-patient prescription drugs.
- Ensure your medications are on the plan's formulary- go to medicare.gov but also verify with the plan.
- Not needed if you have creditable drug coverage, e.g. from VA or employer

OR

2 Join a Medicare Advantage Plan

Part C

Part D Drug Coverage is usually included

A, B and D managed by an HMO or PPO

- You must enroll in both Medicare Part A and Part B to enroll in a Part C Plans.
- Ensure your doctor/medical group accepts, or is in, the Medicare Advantage (MA) Plan network.
- MA-HMOs require you to have a Primary Care Physician/Provider (PCP) from one of its contracted medical groups or IPAs. There is no coverage if you do not get a PCP referral or if you see someone that is not part of your assigned medical group.
- MA-PPOs do not require a PCP or that you stay in-network for your care. Seeing providers in the PPO network, however, will have lower copays than seeing non-network providers.
- May include routine vision, dental, hearing, or other non-medical benefits not found in Part A or B.

You may have other options if you have extra coverage from an employer, union, military, VA, or Medi-Cal (due to limited income). Call HICAP to discuss.

Additional Resources

(800) 434-0222	HICAP statewide access, *www.aging.ca.gov/HICAP/*
(800) 633-4227	Medicare Information, Billing, Status, Appeals, etc., *www.medicare.gov*
(855) 693-7285	Bay Area Legal Aid, Health Consumer Center, *www.baylegal.org*
(800) 999-1118	Coordination of Benefits and Recovery Center, access information about insurance that would pay before Medicare, *www.cms.gov/Medicare/Medicare.html*
(800) 474-1116	California Advocates for Nursing Home Reform (CANHR), *www.canhr.org*
(800) 927-4357	California Department of Insurance, *www.insurance.ca.gov*
(888) 225-7377	California Public Employees' Retirement System (CalPERS), *www.calpers.ca.gov*
(800) 228-5453	California State Teachers Retirement System (CalSTRS), *www.calstrs.com*
(800) 300-1506	Covered California, California Health Insurance Exchange, *www.coveredca.com*
(800) 447-8477	California Department of Health and Human Services, Office of Inspector General, information regarding Medicare fraud, waste, and abuse, *www.oig.hhs.gov*
(800) 827-1000	Department of Veterans Affairs, *www.va.gov*
(888) 767-6738	Federal Employee Health Benefits Program (FEHBP), *www.opm.gov/insure/health*
(916) 930-3927	Indian Health Services, *www.ihs.gov*
(877) 588-1123	Livanta, Quality Improvement Organization, Quality of care issues, hospital appeal rights, denial of admissions or early discharge from hospital, *www.livanta.com*
(703) 838-7760 (800) 456-8410	National Association of Retired Federal Employees (NARFE), *www.narfe.org*
(888) 466-2219	Office of the Patient Advocate, find health care quality report cards, *www.opa.ca.gov*
(877) 772-5772	Railroad Retirement Board (RRB), *www.rrb.gov*
(650) 969-8656 (408) 847-7252	Senior Adults Legal Assistance, *www.sala.org*
(855) 613-7080	Senior Medicare Patrol, report Medicare fraud, waste, or abuse, *www.cahealthadvocates.org/fraud-abuse/*
(800) 772-1213	Social Security Office for Medicare Part A and B enrollment and Part D low income subsidy, *www.ssa.gov*
(877) 962-3633	Social Services Agency County of Santa Clara for Medi-Cal and low income assistance, *www.sccgov.org/sites/ssa/debs/hc/*
(866) 773-0404	TRICARE for Life, for military retirees and their families, *www.tricare4u.com*
(888) 874-9378	TriWest Healthcare Alliance West Region, for Veteran services, *www.triwest.com*

Original Medicare: Part A & B

Premiums, Benefits, & Out-of-Pocket Costs for 2024

Medicare due to Age (65+)[1]

	Your or Your Spouse's Social Security Credits	Monthly Premium
Premium-Free Part A	40	$0
Premium Part A	30-39	$278
	0-29	$505
Part B (standard rate)	N/A	$174.70[2]

Part A

Benefit	Your Deductible and Coinsurance (per benefit period)[3]		
Hospital Inpatient	$1,632 deductible	days	1-60
	$408 / day	days	61-90
	$816 / day	days	91-150 [4]
Hospital Inpatient Psychiatric	Same as Hospital Inpatient but a 190 day lifetime limit		
Skilled Nursing Facility *after a three day hospital inpatient stay with skilled care required daily*	$0	days	1-20
	$204 / day	days	21-100
	You pay all Part A SNF costs	days	101+ (no coverage)
Home Health Care *part-time skilled care; possible home health aide; up to 35 hours / week*	Nothing except 20% of covered durable medical equipment		
Hospice *care of terminal illness*	Nothing except 5% of inpatient respite care and up to $5 per prescription		

Part B

Benefit	Your Deductible and Coinsurance[5]
	Annual Deductible -$240
Some Preventive Services	0/20%
Physician Services	20%[6]
Hospital Outpatient Services	20%[6] (capped at $1,632 for each service)
Medical Equipment & Supplies	20%[6]
Ambulance Services	20%
Mental Health Outpatient	20%
Mental Health Partial Hospitalization	20%-40%
Home Health Care	Nothing except 20% of covered durable medical equipment
Clinical Lab Services	Nothing

1. Medicare Part A due to a disability or End Stage Renal Disease (ESRD) is always premium-free. he credits needed to qualify (from you or a family member) depend on the age the disability started or when dialysis / kidney transplant occurred.
   Earning *$1,730* is equal to one Social Security credit in *2024*. Up to four credits can be earned each year.
2. Some individuals pay less because Part B premium increases can be no greater than the increase in their Social Security benefits. Individuals and couples with an income greater than $103,000/$206,000 pay more. See below for details.
3. You must pay the inpatient hospital deductible for each benefit period. A benefit period begins upon formal admission as an inpatient, and ends when you have not received hospital care (or skilled care in a SNF) for 60 days in a row.
4. he 60 reserve days may be used only once during a lifetime.
5. Coinsurance is a percentage of the Medicare-approved amount (what Medicare says a service/item costs).
6. Plus up to an additional 15% of Medicare's approved amount for providers/suppliers that do not accept Medicare assignment (the approved amount as payment in full).

2024

Beneficiaries who file an individual tax return with 2022 income:	Beneficiaries who file a joint tax return with 2022 income:	Part B Income-related monthly adjustment amount (IRMAA)	Total monthly Part B premium amount	Part D IRMAA
$103,000 or less	$206,000 or less	$0.00	$174.70	$0.00
$103,001 - $129,000	$206,001 - $258,000	$69.90	$244.60	$12.90
$129,001 - $161,000	$258,001 - $322,000	$174.70	$349.40	$33.30
$161,001 - $193,000	$322,001 - $386,000	$279.50	$454.20	$53.80
$193,001 - $500,000	$386.001 - $750,000	$384.30	$559.00	$74.20
Above $500,000	Above $750,000	$419.30	$594.00	$81.00
Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouses:				
$103,000 or less		$0.00	$174.70	$0
$103,001 - $397,000		$384.30	$559.00	$74.20
Above $397,000		$419.30	$594.00	$81.00

Preventive Services:

Abdominal aortic aneurysm screening	HIV screening
Alcohol misuse screenings & counseling	Lung cancer screening
Bone mass measurements (bone density)	Mammograms (screening)
Cardiovascular disease screenings	Nutrition therapy services
Cardiovascular disease (behavioral therapy)	Obesity screenings & counseling
Cervical & vaginal cancer screening	One-time "Welcome to Medicare" preventive visit
Colorectal cancer screenings	Prostate cancer screenings
Depression screenings	Sexually transmitted infections screening & counseling
Diabetes prevention program	Shots:
Diabetes screenings	Flu shots
Diabetes self-management training	Hepatitis B shots
Glaucoma tests	Pneumococcal shots
Hepatitis B Virus (HBV) infection screening	Tobacco use cessation counseling
Hepatitis C screening test	Yearly "Wellness" visit

ACL Administration for Community Living
SHIP State Health Insurance Assistance Program Navigating Medicare
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2024 Medicare Supplement (Medigap) Comparison Chart

The chart shows what each Medicare supplement plan covers. A round dot means 100% coverage. A blank space means it is not a covered benefit of the plan.

50% or 75% indicates the percent of coverage. For example, Plan L pays 75% of the $1,632 hospital deductible in 2024.

	PLANS								Requires Medicare eligibility before 2020	
BENEFITS (2024 Medicare Costs)	**A**	**B**	**D**	**G[1]**	**K**	**L**	**M**	**N**	**C**	**F[1]**
Medicare Part A Hospital Inpatient Coinsurance days 61-90 ($408/day), days 91-150 ($816/day), plus an extra 365 days	●	●	●	●	●	●	●	●	●	●
Medicare Part B Coinsurance (20%)	●	●	●	●	50%	75%	●	copays apply[2]	●	●
Blood (First 3 Pints)	●	●	●	●	50%	75%	●	●	●	●
Medicare Part A Hospice Coinsurance *5%* Inpatient respite and *$5*/prescription	●	●	●	●	50%	75%	●	●	●	●
Medicare Part A Skilled Nursing Facility Coinsurance days 21-100 ($204/day)			●	●	50%	75%	●	●	●	●
Medicare Part A Hospital Inpatient Deductible days 1-60 ($1,632)		●	●	●	50%	75%	50%	●	●	●
Medicare Part B Annual Deductible ($240)									●	●
Medicare Part B Excess Charges (up to 15%)				●						●
Foreign Travel Emergency[3]			●	●			●	●	●	●
Out-of-pocket limit in 2024[4]					$7060[4]	$3530[4]				

(1) Plan F and G High Deductible (HD): After the deductible is met [$2,800 in 2024], the plan pays 100% of covered services for the rest of the calendar year. Payment of the Medicare Part B annual deductible will count toward the HD F and G Plan deductible.

(2) Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to *$20* for some office visits and up to a *$50* co-payment for emergency room visits that do not result in an inpatient admission.

(3) 80% coverage for emergency care within the first 60 days of travel in a foreign country after a *$250* deductible met. $50,000 life time coverage maximum.

(4) Plan K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

SAMPLE PREMIUMS on the following pages are from the California Dept. of Insurance on September 23, 2023 for the 95126 zip code. Request accurate quotes for your own age and zip code from your agent or insurance company.

Some companies offer discounts for households, electronic bill payment, full annual payments, and sometimes dental/vision benefits. Contact plans for more details.

LEGEND:

* Plan Rating:

CR: Community rated: same monthly "Base" premium regardless of age. Discounts apply until age 75.

IA: Issued age rated: premium is based on the age at which you have purchased the policy.

AA: Attained age rated: premium goes up as you age.

<65: Medicare beneficiaries who qualify due to a disability pay higher premiums until age 65.

(+) : Optional benefits at additional costs and some at no additional costs Dental, Gym, Hearing, Vision, Transportation, etc. Call to confirm.

- Certain professional and religious organizations offer additional Medigap policies to their members.
- Premium varies with age, zip code, and sometimes with smoking habit.

Sample Premiums ($ / month)

		PLANS									Only if Eligible for Medicare before 2020			*Plan Rating
	Age	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]	
Accendo Insurance Co.	<65	458			555					394		605		
(800) 264-4000	65	187			227					152		247		
aetnaseniorproducts.com	70	199			241					170		262		AA
	75	233			283					201		308		
	80	274			332					235		361		
Ace Property & Casualty	<65	271			322	103				253		412		
Insurance Co.	65	108			129	41				101		165		
(800) 601-3372	70	132			157	50				123		200		AA
chubb.com/microsites/	75	159			190	61				149		242		
ace-medicare-supplement	80	188			224	72				176		287		
(+) Blue Cross of CA	<65	283			500					374		607		
(800) 333-3883	65	113			145					150		203		
anthem.com	70	137			177					183		247		AA
	75	167			215					222		300		
	80	202			260					269		363		
(+) California Physicians	<65	494		779	766		384			640	911	913	214	
Service	65	110		171	136		80			133	203	182	45	
(800) 248-2341	70	139		216	183		103			174	253	221	62	AA
blueshieldca.com	75	190		280	237		137			232	328	284	83	
	80	218		334	311		166			271	390	384	95	
Cigna Health and Life	<65	295			318					244		390	99	
Insurance Co.	65	130			140					102		172	44	
(866) 459.4272	70	159			171					124		210	53	AA
cigna.com	75	193			208					151		255	65	
	80	224			241					180		296	75	
Continental Life Ins.	<65	318	402		420					318		563		
Co. of Brentwood	65	167	211		221					158		296	55	
Tennessee	70	202	255		267					194		358	67	AA
(800) 264-4000	75	246	310		325					239		434	81	
aetnaseniorproducts.com	80	282	356		373					280		499	94	
Elips Life Insurance Co.	<65	402			386	131				306		471		
(855) 774-4491	65	161			154	53				122		188		
lumico.com	70	196			188	64				149		229		AA
	75	241			232	79				184		283		
	80	301			289	98				229		352		
Everence Association Inc.	<65	337			363					283		389		
(800) 348-7468	65	169			181					135		194		
everence.com	70	205			228					168		244		AA
	75	253			272					209		292		
	80	295			317					249		340		
First Health Life & Health	<65	245	321		375					239		426		
Insurance Co.	65	168	191		205					125		239		
(855) 369-4835	70	192	223		241					148		281		AA
aetnaseniorproducts.com	75	214	254		278					172		322		
	80	227	279		311					194		358		

Sample Premiums ($ / month)

		PLANS									Only if Eligible for Medicare before 2020			*Plan Rating
	Age	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]	
Globe Life and Accident Insurance Co. (800) 801-6831 globecaremedsupp.com	<65	244	361		382					284	409	412		AA
	65	122	178		179	35				130	198	200	32	
	70	159	215		216	47				157	235	237	44	
	75	173	253		254	60				186	273	274	56	
	80	174	258		274	72				203	292	295	67	
(+) Health Net Life Ins. Co. (800) 926-4178 healthnet.com	<65	249		387	328	175				347		356	153	AA
	65	123		144	162	65				129		175	76	
	70	148		177	194	81				159		211	91	
	75	184		229	242	103				204		263	113	
	80	207		264	272	119				235		295	127	
Humana Benefit Plan of IL (888) 310-8482 humana.com	<65	269			328	107				280		367		AA
	65	142			151	50				118		174		
	70	148			156	54				122		181		
	75	173			187	65				151		213		
	80	202			226	75				187		255		
Humana Insurance Co. (888) 310-8482 humana.com	<65	296	318		337	89	162	236		244	396	402	99	AA
	65	160	175		183	48	88	128		132	217	222	54	
	70	192	209		218	58	106	153		158	260	265	64	
	75	227	247		258	68	125	181		187	307	313	76	
	80	262	285		298	79	145	210		216	355	362	88	
Individual Assurance Co., Life, Health & Accident (888) 524-3629 iaclife.com	<65	295			372					327		450		AA
	65	169			182					155		230		
	70	191			206					175		257		
	75	219			243					207		299		
	80	244			282					242		344		
Loyal American Life Insurance Co. (866) 459-4272 cignasupplemental benefits.com	<65	306			341					250		427		AA
	65	177			174					126		228		
	70	208			207					148		266		
	75	239			244					176		310		
	80	269			285					207		359		
Manhattan Life Assurance Co. of America (800) 877-7703 manhattanlife.com	<65	315			317					276		382		AA
	65	135			135					115		167		
	70	153			154					130		189		
	75	187			188					159		232		
	80	229			230					197		286		
National Health Ins. Co. (888) 376-3300 natgenhealth.com	<65	402			448					354		526	154	AA
	65	161			179					142		210	62	
	70	174			194					153		227	67	
	75	209			234					185		274	80	
	80	246			275					217		323	95	
Oxford Life Insurance Co. (800) 308-2318 oxfordlife.com	<65	319			254					310		507		AA
	65	199			152					148		276		
	70	236			164					174		327		
	75	280			199					206		386		
	80	307			227					239		441		

Sample Premiums ($ / month)

	Age	PLANS A	B	D	G	G(1)	K	L	M	N	Only if Eligible for Medicare before 2020 C	F	F(1)	*Plan Rating
Physicians Life Ins. Co.	<65	202			265					219		304		
(800) 325-6300	65	144			156					130		180		
physiciansmutual.com	70	155			169					140		194		AA
	75	180			197					163		226		
	80	196			228					189		262		
State Farm Mutual	<65	233		344	345					264	427	431		
Automobile Insurance	65	98		126	126					96	179	181		
Contact local agent	70	123		160	160					122	226	228		AA
statefarm.com	75	143		190	191					146	262	264		
	80	161		217	217					169	294	297		
Tier One Insurance Co.	<65	427			478					342		526		
(833) 504-0336	65	157			158					121		189		
aflacmedicaresupplement	70	182			184					137		212		AA
.com	75	224			226					170		257		
	80	270			273					201		304		
Transamerica Life Ins. Co.	<65	226			326			181		210	353	355		
(800) 797-2643	65	109			157			87		101	170	171		
transamerica.com	70	138			200			111		128	216	217		IA
	75	170			246			136		158	265	267		
	80	201			290			161		186	314	315		
United American	<65	252	360	463	447					352	528	569		
Insurance Co.	65	128	173	200	186	39	108	153		149	227	233	39	
(800) 755-21377	70	162	221	262	244	53	143	202		197	292	299	53	AA
unitedamerican.com	75	181	252	307	286	68	157	222		231	340	347	68	
	80	185	264	344	320	81	163	231		262	378	385	81	
(+) UnitedHealthcare	<65	203	283		268		107				342	343		
Insurance Co.	65	104	145		137		55	97		116	175	176		
(844) 606-0145	70	128	179		169		67	119		144	216	217		CR
uhc.com	75	203	283		268		107	188		227	342	343		
	80	203	283		268		107	188		227	342	343		
United World Life	<65	305			334					263		424		
Insurance Co.	65	122			134	49				105		170		
(800) 667-2937	70	151			167	55				131		210		AA
mutualofomaha.com	75	183			202	65				159		254		
	80	218			241	76				189		303		
USAA Life Insurance Co.	<65	195			382					221		321		
(800) 531-8000	65	109			130					124		180		
usaa.com	70	127			141					145		210		AA
	75	152			169					173		251		
	80	176			210					200		291		
Washington National	<65	331			354	89				287		390		
Insurance Co.	65	133			142	36				115		156		
(800) 852-6285	70	171			183	43				149		189		AA
bankerslife.com	75	208			223	52				188		229		
	80	240			257	63				229		274		

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2024 Medicare Part D Stand-Alone Prescription Drug Plans

Requires Medicare Part A and/or Part B to qualify for Part D

For use by HICAP Counselors in assisting Medicare beneficiaries. See Plan Formulary, Evidence of Coverage or Medicare Plan Finder for details

Organization Name Telephone No. Website	Plan Name	Plan Contract/ID	Monthly Premium	Annual Deductible	Copayments & coinsurance after deductible and prior to reaching $5,030 initial coverage limit						Additional Coverage in Gap	Extra Help (LIS)	Star Rating
					Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6			
Anthem Blue Cross 855-793-1938 shop.anthem.com/medicare	**MediBlue Rx Standard***	S5596-087	$100.60	$545	$1	$2	19%	38%	25%	N/A	No		3.0
	MediBlue Rx Plus*	S5596-088	$132.70	$0	$1	$4	$47	50%	33%	N/A	No		3.0
Blue Shield of California 888-292-7591 blueshieldca.com/medicare	**Rx Plus***	S2468-003	$168.90	$545	$1	$14	$45	47%	25%	N/A	No		3.5
	Rx Enhanced*	S2468-004	$188.40	$0	$2	$7	$43	47%	33%	N/A	No		3.5
Cigna 800-735-1459 cignamedicare.com	**Saver Rx***	S5617-382	$15.80	$545	$0	$6	18%	49%	25%	N/A	No		2.5
	Secure Rx	S5617-158	$34.50	$545	$0	$3	16%	40%	25%	N/A	No	**Yes**	2.5
	Extra Rx*	S5617-277	$105.90	$145	$3	$12	20%	46%	31%	N/A	Tier 1,2		2.5
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Humana 800-706-0872 humana.com/medicare	**Walmart Value Rx Plan**	S5884-211	$59.00	$545	$0	$1	15%	47%	25%	N/A	Yes		3.0
	Basic Rx Plan	S5884-114	$75.20	$545	$0	$1	23%	43%	25%	N/A	No		3.0
	Premier Rx Plan*	S5884-178	$129.20	$0	$1	$4	$45	49%	33%	$0	Yes		3.0
Mutual of Omaha Rx 800-961-9006 mutualofomaharx.com	**Rx Essential***	S7126-134	$25.70	$545	$0	$15	20%	48%	25%	N/A	No		1.5
	Rx Premier*	S7126-101	$100.30	$349	$1	$10	$47	45%	28%	N/A	No		1.5
	Rx Plus*	S7126-031	$112.30	$545	$1	$5	17%	39%	25%	N/A	No		1.5
SilverScript 833-526-2445 aetnamedicare.com	**Smart Saver***	S5601-207	$18.60	$280	$0	$5	24%	50%	29%	N/A	No		3.0
	Choice*	S5601-064	$55.20	$545	$2	$7	16%	36%	25%	N/A	No		3.0
	Plus*	S5601-065	$116.00	$200	$0	$0	47	50%	30%	N/A	Tier 1,2		3.0
UnitedHealthcare (AARP) 888-867-5564 aarpmedicarerx.com	**Medicare Rx Walgreens**	S5921-413	$80.40	$410	$2	$8	$40	50%	27%	N/A	Yes		3.0
	Medicare Rx Saver	S5921-376	$89.90	$545	$2	$8	$47	37%	25%	N/A	No		3.0
	Medicare Rx Preferred	S5820-031	$121.60	$0	$7	$12	$47	40%	33%	N/A	No		3.5
WellCare 866-859-9084 wellcare.com/PDP	**Value Script***	S4802-163	$0.40	$545	$0	$5	25%	50%	25%	$11	No		3.5
	Classic*	S4802-094	$35.90	$545	$0	$5	22%	44%	25%	$0	No	**Yes**	3.5
	Medicare Rx Value Plus*	S4802-235	$82.60	$0	$0	$4	$47	50%	33%	$11	No		3.5

2024 Medicare Part D Stand-Alone Prescription Drug Plans

Requires Medicare Part A and/or Part B to qualify for Part D

NOTES:

1 Benchmark plan: $0 premium with full Low-Income Subsidy (Extra Help for Part D) or full Medi-Cal. In 2024 in CA the Benchmark subsidy amount is $40.98. Individuals with full Medi-Cal or full Extra Help in non-benchmark plans would pay the premium minus the benchmark subsidy. Lower copays would still apply. Contact HICAP for more information.

2 Pharmacy cost: The lowest possible copayments are shown, e.g., when a prescription is filled at a Plan's Preferred Cost Sharing Pharmacy if it has one.

3 Coverage Gap: As you fill prescriptions, and the full retail price of your drugs reaches $5031, you leave the Initial Coverage Period and enter the Coverage Gap or "Donut Hole". You then pay 25% of the brand drug price and 25% of the generic drug price. Plans may extend additional benefits in the Donut Hole. You remain in the Donut Hole until your TrOOP (True out-of-Pocket cost) reaches $8000. To calculate your TrOOP, add (1) any deductibles you've paid, (2) drug co-pay/coinsurance prior to and while in the Donut Hole, and (3) 70% of the full retail price of brand drug manufacturer cost sharing while in the Donut Hole. TrOOP does not include the Part D Premium. In 2024, when your TrOOP reaches $8000, you pay no further copays or coinsurance for generic or brand drugs for the remainder of the year. The Catastrophic phase has been eliminated in 2024.

*** Insulin:** Part D plans must not apply a deductible to any Part D covered insulin product, and must charge no more than $35 for a one month's supply of each covered insulin product in the Initial Coverage Phase and the Coverage Gap phase. Verify that the insulin product is in the Plan's formulary before enrolling.

Part D Late Enrollment Penalty: Part D enrollees who signed up late pay an additional $0.35 for each month they could have enrolled in Part D but did not (unless other creditable drug coverage existed). The $0.35
penalty is 1% of the National Base Beneficiary Premium ($34.70 in 2024).

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2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage			
Plan name	**AARP Medicare Advantage from UHC CA-010P (HMO-POS)**	**AARP Medicare Advantage from UHC CA-031P (HMO-POS)**	**Aetna Medicare Select Plan (HMO)**
Plan ID	UnitedHealthcare | Plan ID: H0543-193-0	UnitedHealthcare | Plan ID: H0543-230-0	Aetna Medicare | Plan ID: H0523-069-0
Star rating	4.5 stars	4.5 stars	2.5 stars
Plan website	http://aarpmedicareplans.com/	http://aarpmedicareplans.com/	http://www.aetnamedicare.com/
Non-members	1-800-555-5757	1-800-555-5757	1-833-859-6031
Members	1-866-261-7709	1-866-261-7709	1-833-570-6670
Contracted Medical Groups (verify with Plan & Provider):	ASB, PMGSJ, SCCIPA	ASB, PMGSJ, SCCIPA	ECHMN / SVMD, IMG CA, NEMS, OM, SCVMCPS
TOTAL PREMIUM:	$0	$79	$0
HEALTH PREMIUM:	$0	$40	$0
DRUG PREMIUM:	$0	$39	$0
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$0	$200	$0
Maximum-out-of-Pocket Limit	$3,500 In-network	$5,900 In-network	$2,900.00
INPATIENT (PART A)			
Inpatient Hospitalization	$175 per day, days 1-5 $0 per day, days 6-90 $0 per day, days 91 and beyond	$390 per day, days 1-6 $0 per day, days 7-90 $0 per day, days 91 and beyond	$175 per day, days 1-4 $0 per day, days 5-90
Skilled Nursing Facility	$0 per day, days 1-20 $203 per day, days 21-100	$0 per day, days 1-20 $203 per day, days 21-100	$0 per day, days 1-20 $100 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0 copay	$0-10 copay	$0 copay
Diagnostic Radiology (like MRI)	$0-150 copay	$0-150 copay	$0 copay
Emergency Care	$135 copay	$120 copay	$125 copay
Urgent Care	$0-40 copay	$0-40 copay	$0 copay
Durable Medical Equipment	20% coinsurance	20% coinsurance	0-20% coinsurance
Chemotherapy Part B drugs	20% coinsurance	20% coinsurance	0-20% coinsurance
Ground Ambulance	$290 copay	$290 copay	$175 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$10 copay	$0 copay
Hearing Aids	$99-$1249 copay	$99-$1249 copay	$0 copay
Preventive Dental	In & Out-of-network $0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	In & Out-of-network $0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Not covered	Some coverage
Transportation Services	Not covered	Not covered	Some coverage
Over the Counter Drug Benefits	Some coverage	Not covered	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 $0 / T2 $0-12 / T3 $0-47 / T4 $0-100- / T5 $0-33%)	$0-30% (T1 $0 / T2 $0-12 / T3 $0-47 / T4 $0-100- / T5 $0-30%)	$0-33% (T1 & T2 $0 / T3 $0-47 / T4 - $0-100 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage			
Plan name	**Aetna Medicare Plus Plan (HMO)**	**Aetna Medicare Value Plus Plan (HMO-POS)**	**Alignment Health AVA + Instacart (HMO-POS)**
Plan ID	Aetna Medicare | Plan ID: H4982-006-0	Aetna Medicare | Plan ID: H0523-077-0	Alignment Health Plan | Plan ID: H3815-026-0
Star rating	3 stars	2.5 stars	4 stars
Plan website	http://www.aetnamedicare.com/	http://www.aetnamedicare.com/	http://www.alignmenthealthplan.com/
Non-members	1-833-859-6031	1-833-859-6031	1-888-979-2247
Members	1-833-570-6670	1-833-570-6670	1-866-634-2247
Contracted Medical Groups (verify with Plan & Provider):	OM, SCCIPA	OM, SCCIPA	AHPN
TOTAL PREMIUM:	$0	$10	$0
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$10	$0
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$0	$0	$0
Maximum-out-of-Pocket Limit	$2,900.00	$2,600.00	$1,999.00
INPATIENT (PART A)			
Inpatient Hospitalization	$300 per day, days 1-7 $0 per day, days 8-90	$175 per day, days 1-4 $0 per day, days 5-90	$0 per day, for days 1-4 $100 per day, days 5-10 $0 per day, 11-90
Skilled Nursing Facility	$0 per day, days 1-20 $100 per day, days 21-100	$0 per day, days 1-20 $100 per day, days 21-100	$0 per day, days 1-20 $50 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	In & Out-of-network $35 copay
Specialist Visit	$0 copay	$0 copay	In & Out-of-network $35 copay
Diagnostic Radiology (like MRI)	$0 copay	$0 copay	$0 copay
Emergency Care	$125 copay	$125 copay per visit	$120 copay per visit
Urgent Care	$0 copay	$0 copay	$0 copay
Durable Medical Equipment	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$175 copay	$175 copay	$115 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	$0 copay	$0 copay	$0 copay
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	In & Out-of-network $0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Not covered
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 & T2 $0 / T3 $0-47 / T4 - $0-100 / T5 $0-33%)	$0-33% (T1 & T2 $0 / T3 $0-47 / T4 - $0-100 / T5 $0-33%)	$0-33% (T1 $0 / T2 $0-3 / T3 $0-40 / T4 - $0-93 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage			
Plan name	**Alignment Health Harmony (HMO)**	**Alignment Health My Choice CalPlus (HMO)**	**Alignment Health the ONE + Rite Aid (HMO)**
Plan ID	Alignment Health Plan | Plan ID: H3815-031-0	Alignment Health Plan | Plan ID: H3815-007-0	Alignment Health Plan | Plan ID: H3815-034-0
Star rating	4 stars	4 stars	4 stars
Plan website	http://www.alignmenthealthplan.com/	http://www.alignmenthealthplan.com/	http://www.alignmenthealthplan.com/
Non-members	1-888-979-2247	1-888-979-2247	1-888-979-2247
Members	1-866-634-2247	1-866-634-2247	1-866-634-2247
Contracted Medical Groups (verify with Plan & Provider):	AHPN, B&TP, CA IPA, NE, SMGMS, NCPG, PMGSJ, SCCIPA, SMG	AHPN, B&TP, CA IPA, NCPG, PMGSJ, SCCIPA, SMG	AHPN, CA IPA, NEMS, NCPG, PMGSJ, SCCIPA, SMG
TOTAL PREMIUM:	$0	$0	$0
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$0	$0
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$0	$0	$0
Maximum-out-of-Pocket Limit	$2,900.00	$3,000.00	$3,400.00
INPATIENT (PART A)			
Inpatient Hospitalization	$0 per day, for days 1-4 $100 per day, days 5-10 $0 per day, 11-90	$0 per day, for days 1-4 $100 per day, days 5-10 $0 per day, 11-90	$0 copay
Skilled Nursing Facility	$0 per day, days 1-20 $100 per day, days 21-100	$0 per day, days 1-20 $50 per day, days 21-100	$0 copay
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0 copay	$0 copay	$0 copay
Diagnostic Radiology (like MRI)	$0 copay	$0 copay	$0 copay
Emergency Care	$85 copay	$85 copay	$0 copay
Urgent Care	$0 copay	$0 copay	$0 copay
Durable Medical Equipment	20% coinsurance	0-20% coinsurance	0-20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$175 copay	$175 copay	$75 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	$0 copay	$0 copay	$0 copay
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	Not covered
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Some coverage
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 $0 / T2 $0-3 / T3 $0-40 / T4 - $0-93 / T5 $0-33%)	$0-33% (T1 $0 / T2 $0-3 / T3 $0-40 / T4 - $0-100 / T5 $0-33%)	$0-33% (T1 $0 / T2 $0-1 / T3 $0-40 / T4 $0-100 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage			
Plan name	**Alignment Health smartHMO (HMO)**	**Alignment Health CalPlus + Veterans (HMO)**	**Alignment Health Sutter Advantage (HMO)**
Plan ID	Alignment Health Plan | Plan ID: H3815-040-0	Alignment Health Plan | Plan ID: H3815-036-0	Alignment Health Plan | Plan ID: H3815-020-0
Star rating	4 stars	4 stars	4 stars
Plan website	http://www.alignmenthealthplan.com/	http://www.alignmenthealthplan.com/	http://www.alignmenthealthplan.com/
Non-members	1-888-979-2247	1-888-979-2247	1-888-979-2247
Members	1-866-634-2247	1-866-634-2247	1-866-634-2247
Contracted Medical Groups (verify with Plan & Provider):	AHPN, CA IPA, NEMS, SCCIPA,	AHPN, CA IPA, NEMS, NCPG, PMGSJ, SCCIPA, SMG	AHPN, PAMF
TOTAL PREMIUM:	$0	$0	$49
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$0	$49
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$545	$545	$0
Maximum-out-of-Pocket Limit	$1,999.00	$5,900.00	$4,900.00
INPATIENT (PART A)			
Inpatient Hospitalization	$200 per day, days 1-5 $0 per day, days 6-90	$1632 deductible for days 1-60 $408 per day, days 61-90	$225 per day, days 1-5 $0 per day, days 6-90
Skilled Nursing Facility	$20 per day, days 1-20 $100 per day ,days 21-100	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $160 per day, days 21-57 $0 per day, days 58-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$5 copay
Specialist Visit	$5 copay	$0 copay	$20 copay
Diagnostic Radiology (like MRI)	$0 copay	$0 copay	$150 copay
Emergency Care	$120 copay	20% coinsurance	$90 copay
Urgent Care	$0 copay	20% coinsurance	$0 copay
Durable Medical Equipment	20% coinsurance	20% coinsurance	0-20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$100 copay	20% coinsurance	$250 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	Not covered	$0 copay	Not covered
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Not covered	Some coverage	Not covered
Over the Counter Drug Benefits	Not covered	Not covered	Some coverage
Worldwide emergency	Not covered	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-25% (T1 & T2 $0 / T3 $0-45 / T4 $0-100 / T5 $0-25%)	$0-25% (T1-T5 $0-25%)	$0-33% (T1 $0 / T2 $0-5 / T3 $0-40 / T4 $0-100 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage			
Plan name	**Anthem Medicare Advantage (HMO)**	**Anthem Prime (HMO)**	**Blue Shield Inspire (HMO)**
Plan ID	Anthem Blue Cross | Plan ID: H0544-108-0	Anthem Blue Cross Partnership Plan | Plan ID: H4161-010-0	Blue Shield of California | Plan ID: H0504-047-0
Star rating	3 stars	Plan too new to be measured	3.5 stars
Plan website	https://shop.anthem.com/medicare/ca	https://shop.anthem.com/medicare	http://blueshieldca.com/medicare
Non-members	1-855-593-0898	1-855-593-0898	1-888-534-4263
Members	1-800-499-2793	1-833-707-3129	1-800-776-4466
Contracted Medical Groups (verify with Plan & Provider):	B&TP, IHI, NEMS, PMGSJ, SCCIPA, SMG	Check with plan	B&TP, HPEB, PMGSJ, SCCIPA
TOTAL PREMIUM:	$0	$0	$22
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$0	$22
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$0	$0	$0
Maximum-out-of-Pocket Limit	$2,899.00	$800.00	$5,900.00
INPATIENT (PART A)			
Inpatient Hospitalization	$95 per day, days 1-5 $0 per day, days 6-90	$0 copay per stay	$140 per day, days 1-5 $0 per day, days 6-90
Skilled Nursing Facility	$0 per day, days 1-20 $100 per day, days 21-100	$0 per day, days 1-20 $50 per day, days 21-100	$0 per day, days 1-20 $120 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0 copay	$0 copay	$0 copay
Diagnostic Radiology (like MRI)	$0 copay	$50 copay	$50 copay
Emergency Care	$90 copay	$90 copay	$120 copay
Urgent Care	$10 copay	$25 copay	$0 copay
Durable Medical Equipment	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$175 copay	$150 copay	$275 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	$0 copay	$0 copay	Not covered
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Not covered
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 $0 / T2 $0-5 / T3 $0-42 / T4 $0-95 / T5 $0-33%)	$0-33% (T1 & T2 $0 / T3 $0-42 / T4 $0-85 / T5 $0-33%)	$0-33% (T1 $0 / T2 $0-10 / T3 $0-40 / T4 $0-95 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage			
Plan name	**Brand New Day Classic Care I Plan (HMO)**	**Brand New Day Classic Care II Plan (HMO)**	**CCA Medicare Excel (HMO)**
Plan ID	Brand New Day | Plan ID: H0838-050-2	Brand New Day | Plan ID: H0838-051-1	CCA Health California | Plan ID: H1426-002-0
Star rating	2.5 stars	2.5 stars	Not enough data available
Plan website	http://www.bndhmo.com/	http://www.bndhmo.com/	http://ccahealthca.org/become-a-member
Non-members	1-888-683-1882	1-888-683-1882	1-833-382-2862
Members	1-866-255-4795	1-866-255-4795	1-866-333-3530
Contracted Medical Groups (verify with Plan & Provider):	PMGSJ, SCCIPA, SMG	PMGSJ, SCCIPA, SMG	Check with plan
TOTAL PREMIUM:	$37.60	$0	$0
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$37.60	$0	$0
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$0	$50	$0
Maximum-out-of-Pocket Limit	$2,100.00	$2,499.00	$1,500.00
INPATIENT (PART A)			
Inpatient Hospitalization	$50 per day, days 1-6 $0 per day, days 7-90	$150 per day, days 1-6 $0 per day, days 7-90	$0 per day, days 1-3 $100 per day, days 4-7 $0 per day, days 8-90
Skilled Nursing Facility	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $100 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0 copay	$15 copay	$0 copay
Diagnostic Radiology (like MRI)	$0 copay	$0-50 copay	$0 copay
Emergency Care	$0-100 copay	$0-135 copay	$90 copay
Urgent Care	$0 copay	$0 copay	$0 copay
Durable Medical Equipment	0-20% coinsurance	0-20% coinsurance	20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$0-200 copay	$0-250 copay	$280 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	$149 copay	$699-$999 copay	$0 copay
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Some coverage
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 & T2 $0 / T3 $0-47 / T4 $0-100 / T5 $0-33%)	$0-32% (T1 $0 / T2 $0-12 / T3 $0-47 / T4 $0-100 / T5 $0-32%)	$0-33% (T1 & T2 $0 / T3 $0-30 / T4 $0-100 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage			
Plan name	**Central Health Premier Plan I (HMO)**	**Central Health Premier Plan II (HMO)**	**Imperial Dynamic Plan (HMO)**
Plan ID	Central Health Medicare Plan | Plan ID: H5649-020-1	Central Health Medicare Plan | Plan ID: H5649-021-2	Imperial Health Plan of California, Inc. | Plan ID: H5496-012-0
Star rating	3.5 stars	3.5 stars	3 stars
Plan website	http://www.centralhealthplan.com/	http://www.centralhealthplan.com/	http://www.imperialhealthplan.com/
Non-members	1-888-714-7550	1-888-714-7550	1-800-838-5914
Members	1-866-314-2427	1-866-314-2427	1-800-838-8271
Contracted Medical Groups (verify with Plan & Provider):	CIPA, MPIPA, MPPCNC, PMGSJ, SMG	CIPA, MPIPA, PMGSJ, SMG	B&TP, CIPA, IHH, MPIPA, Nivano, NCPG, PPIPA, SMG
TOTAL PREMIUM:	$0	$41	$0
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$41	$0
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$0	$0	$0
Maximum-out-of-Pocket Limit	$3,200.00	$1,199.00	$298.00
INPATIENT (PART A)			
Inpatient Hospitalization	$0 per day, days 1-4 $100 per day, days 5-10 $0 per day, days 11-90	$50 per day, days 1-6 $0 per day, days 7-90	$50 per day, days 1-5 $0 per day, days 6-90
Skilled Nursing Facility	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $200 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0 copay	$0 copay	$0 copay
Diagnostic Radiology (like MRI)	$0-50 copay	$0 copay	$0 copay
Emergency Care	$0-100 copay	$0-100 copay	$125 copay
Urgent Care	$0 copay	$0 copay	$0 copay
Durable Medical Equipment	0-20% coinsurance	0-20% coinsurance	20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$0-150 copay	$0-150 copay	$150 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	$0 copay	$0 copay	$0 copay
Preventive Dental	$0-17 copay Oral Exam, $0 copay Cleaning, $0-13 copay Flouride treatment, $0-41 copay X-ray	$0-17 copay Oral Exam, $0 copay Cleaning, $0-13 copay Flouride treatment, $0-41 copay X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Some coverage
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 & T2 $0 / T3 $0-35 / T4 $0-75 / T5 $0-33%)	$0-33% (T1 & T2 $0 / T3 $0-35 / T4 $0-75 / T5 $0-33%)	$0-33% (T1 $0 / T2 $0-3 / T3 $0-30 / T4 $0-75 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage			
Plan name	**Imperial Traditional (HMO)**	**Imperial Strong (HMO)**	**Kaiser Permanente Sr Adv Basic Santa Clara (HMO)**
Plan ID	Imperial Health Plan of California, Inc. | Plan ID: H5496-007-0	Imperial Health Plan of California, Inc. | Plan ID: H5496-014-0	Kaiser Permanente | Plan ID: H0524-062-0
Star rating	3 stars	3 stars	4 stars
Plan website	http://www.imperialhealthplan.com/	http://www.imperialhealthplan.com/	http://kp.org/medicare
Non-members	1-800-838-5914	1-800-838-5914	1-800-777-1238
Members	1-800-838-8271	1-800-838-8271	1-800-443-0815
Contracted Medical Groups (verify with Plan & Provider):	B&TP, CIPA, IHH, MPIPA, Nivano, NCPG, PPIPA, SMG	B&TP, CIPA, IHH, MPIPA, Nivano, NCPG, PPIPA, SMG	Kaiser
TOTAL PREMIUM:	$0	$0	$0
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$0	$0
HEALTH DEDUCTIBLE:	$0	$240	$0
DRUG DEDUCTIBLE:	$0	$545	$0
Maximum-out-of-Pocket Limit	$1,349.00	$8,850.00	$6,000.00
INPATIENT (PART A)			
Inpatient Hospitalization	$150 per day, days 1-5 $0 per day, days 6-90	$1632 deductible for days 1-60 $408 per day, days 61-90	$245 per day, days 1-5 $0 per day, days 6-90 $0 per day, days 90 and beyond
Skilled Nursing Facility	$0 per day, days 1-20 $200 per day, days 21-100	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $100 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	20% coinsurance	$10 copay
Specialist Visit	$0 copay	20% coinsurance	$15 copay
Diagnostic Radiology (like MRI)	$0 copay	20% coinsurance	$10-225 copay
Emergency Care	$125 copay	20% coinsurance	$120 copay
Urgent Care	$0 copay	20% coinsurance	$10 copay
Durable Medical Equipment	20% coinsurance	20% coinsurance	0-20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	$0-47 copay or 0-20%
Ground Ambulance	$150 copay	20% coinsurance	$250 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	Not covered
Hearing Aids	$0 copay	$0 copay	Not covered
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	Covered under office visit: Oral Exam, Cleaning, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$10 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	Not covered
Fitness Benefits	Some coverage	Not covered	Not covered
Transportation Services	Some coverage	Not covered	Not covered
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Not covered	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 $0 / T2 $0-5 / T3 $0-45 / T4 $0-90 / T5 $0-33%)	$0-25% (T1-T5 $0-25%)	$0-33% (T1 $0-3 / T2 $0-15 / T3 $0-47 / T4 $0-100 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage			
Plan name	**Kaiser Permanente Sr Adv Enhanced Santa Clara (HMO)**	**SCAN Options (HMO)**	**SCAN Classic (HMO)**
Plan ID	Kaiser Permanente | Plan ID: H0524-039-0	SCAN Health Plan | Plan ID: H5425-073-0	SCAN Health Plan | Plan ID: H5425-020-0
Star rating	4 stars	3.5 stars	3.5 stars
Plan website	http://kp.org/medicare	http://www.scanhealthplan.com/	http://www.scanhealthplan.com/
Non-members	1-800-777-1238	1-888-315-7226	1-888-315-7226
Members	1-800-443-0815	1-800-559-3500	1-800-559-3500
Contracted Medical Groups (verify with Plan & Provider):	Kaiser	B&TP, IHPCSF, MNC, PMGSJ	B&TP, IHPCSF, MNC, PMGSJ
TOTAL PREMIUM:	$65	$0	$52
HEALTH PREMIUM:	$23.90	$0	$52
DRUG PREMIUM:	$41.10	$0	$0
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$0	$0	$0
Maximum-out-of-Pocket Limit	$3,900.00	$2,500.00	$2,700.00
INPATIENT (PART A)			
Inpatient Hospitalization	$200 per day, days 1-5 $0 per day, days 6-90 $0 per day, days 90 and beyond	$125 per day, days 1-4 $0 per day, days 5-90	$100 per day, days 1-4 $0 per day, days 5-90
Skilled Nursing Facility	$0 per day, days 1-20 $100 per day, days 21-100	$0 per day, days 1-20 $125 per day, days 21-100	$0 per day, days 1-20 $100 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$10 copay	$5 copay	$0 copay
Diagnostic Radiology (like MRI)	$0-205 copay	$0-150 copay	$120 copay
Emergency Care	$120 copay	$100 copay	$95 copay
Urgent Care	$0 copay	$0 copay	$0 copay
Durable Medical Equipment	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Chemotherapy Part B drugs	$0-47 copay or 0-20%	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$250 copay	$200 copay	$195 copay
EXTRA BENEFITS:			
Hearing Exams	Not covered	$0 copay	$0 copay
Hearing Aids	Not covered	$450-$750 copay	$450-$750 copay
Preventive Dental	Covered under office visit: Oral Exam, Cleaning, X-ray	Not covered	Not covered
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	Not covered	$0 copay	$0 copay
Fitness Benefits	Not covered	Some coverage	Some coverage
Transportation Services	Not covered	Some coverage	Some coverage
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 $0 / T2 $0-7 / T3 $0-47 / T4 $0-100 / T5 $0-33%)	$0-33% (T1-T4 $0-25% / T5 $0-33%)	$0-33% (T1-T4 $0-25% / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage

Plan name	UHC Medicare Advantage CA-001A (HMO)	Wellcare No Premium (HMO)
Plan ID	UnitedHealthcare | Plan ID: H0543-183-0	Wellcare by Health Net | Plan ID: H0562-128-0
Star rating	3.5 stars	3 stars
Plan website	http://uhc.com/Medicare	http://www.wellcare.com/healthnetCA
Non-members	1-800-555-5757	1-844-917-0175
Members	1-866-261-7709	1-800-275-4737
Contracted Medical Groups (verify with Plan & Provider):	ASB, PMGSJ, SCCIPA	B&TP, CHP, ECHMN, PAMF (Camino), SMG
TOTAL PREMIUM:	$27.80	$0
HEALTH PREMIUM:	$0	$0
DRUG PREMIUM:	$27.80	$0
HEALTH DEDUCTIBLE:	$240	$200
DRUG DEDUCTIBLE:	$545	$545
Maximum-out-of-Pocket Limit	$8,850.00	$8,850.00
INPATIENT (PART A)		
Inpatient Hospitalization	$1,450 per stay $0 per day, days 91 and beyond	$350 per day, days 1-5 $0 per day, days 6-90
Skilled Nursing Facility	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $203 per day, days 21-70 $0 per day, days 71-100
OUTPATIENT (PART B)		
Primary Doctor Visit	0-20% coinsurance	$0 copay
Specialist Visit	0-20% coinsurance	$25 copay
Diagnostic Radiology (like MRI)	0-20% coinsurance	$0-350 copay
Emergency Care	$100 copay	$100 copay
Urgent Care	$0-40 copay	$25 copay
Durable Medical Equipment	20% coinsurance	20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	20% coinsurance	$275 copay
EXTRA BENEFITS:		
Hearing Exams	$0 copay	$0 copay
Hearing Aids	$0 copay	$0 copay
Preventive Dental	Not covered	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage
Transportation Services	Some coverage	Not covered
Over the Counter Drug Benefits	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)		
Copays	$0-25% (T1-T5 $0-25%)	$0-50% (T1-T3 $0-25% / T4 $0-50% / T5 $0-25%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans without Part D Prescription Drug Coverage			
Plan name	**Aetna Medicare Eagle Plan (HMO)**	**Brand New Day Valor Care Plan (HMO)**	**Imperial Courage Plan (HMO)**
Plan ID	Aetna Medicare | Plan ID: H4982-013-0	Brand New Day | Plan ID: H0838-048-0	Imperial Health Plan of California, Inc. | Plan ID: H5496-016-0
Star rating	3 stars	2.5 stars	3 stars
Plan website	http://www.aetnamedicare.com/	http://www.bndhmo.com/	http://www.imperialhealthplan.com/
Non-members	1-833-859-6031	1-888-683-1882	1-800-838-5914
Members	1-833-570-6670	1-866-255-4795	1-800-838-8271
Contracted Medical Groups (verify with Plan & Provider):	CH, SCCIPA	PMGSJ, SCCIPA, SMG	B&TP, CIPA, IHH, MPIPA, Nivano, NCPG, PPIPA, SMG
TOTAL PREMIUM:	$0	$0	$0
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	**NO PART D**	**NO PART D**	**NO PART D**
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	**NO PART D**	**NO PART D**	**NO PART D**
Maximum-out-of-Pocket Limit	$4,200.00	$3,850.00	$2,999.00
INPATIENT (PART A)			
Inpatient Hospitalization	$50 per day, days 1-3 $0 per day, days 4-90	$1632 deductible for days 1-60 $408 per day, days 61-90	$150 per day, days 1-5 $0 per day, days 6-90
Skilled Nursing Facility	$0 per day, days 1-20 $196 per day, days 21-100	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $200 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$10 copay	$10 copay	$5 copay
Diagnostic Radiology (like MRI)	$0-100 copay	$0-50 copay	$0 copay
Emergency Care	$110 copay per visit	$0-120 copay	$125 copay
Urgent Care	$10 copay	$0 copay	$0 copay
Durable Medical Equipment	0-20% coinsurance	0-20% coinsurance	20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$275 copay	$0-275 copay	$150 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	$0 copay	$149 copay	$0 copay
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Some coverage
Over the Counter Drug Benefits	Some coverage	Not covered	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	**NO PART D**	**NO PART D**	**NO PART D**

See Medicare.gov for more detailed pricing on your medications.

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CA Health Insurance Counseling & Advocacy Program (HICAP) 1.800.434.0222
Sourcewise 3100 De La Cruz Blvd, Suite 310, Santa Clara, CA 95054

This is an abbreviated guide. Medicare has neither reviewed nor endorsed this information. Check with the plan and provider groups for full details. Information is from medicare.gov.

2024 Part C Medicare Advantage PPO Plans with Part D Prescription Drug Coverage			
Plan name	**AARP Medicare Advantage from UHC CA-0032 (PPO)**	**AARP Medicare Advantage from UHC CA-0023 (PPO)**	**Aetna Medicare Core Plan (PPO)**
Plan ID	UnitedHealthcare | Plan ID: H0294-040-0	UnitedHealthcare | Plan ID: H0294-031-0	Aetna Medicare | Plan ID: H5521-425-0
Star rating	3.5 stars	3.5 stars	4 stars
Plan website	http://aarpmedicareplans.com/	http://aarpmedicareplans com/	http://www.aetnamedicare.com/
Non-members	1-800-555-5757	1-800-555-5757	1-833-859-6031
Members	1-866-261-7709	1-866-261-7709	1-833-570-6670
Contracted Medical Groups (verify with Plan & Provider):	Check with plan	Check with plan	CH, IMG CA
TOTAL PREMIUM:	$0	$44	$0
HEALTH PREMIUM:	$0	$1	$0
DRUG PREMIUM:	$0	$43	$0
HEALTH DEDUCTIBLE:	$400	$0	$0
DRUG DEDUCTIBLE:	$0	$0	$0
Maximum-out-of-Pocket Limit	In-network $6,700/In & Out-of-network $10,000	In-network $5,900/In & Out-of-network $8,700	In-network $5,900/In & Out-of-network $8,950
INPATIENT (PART A)			
Inpatient Hospitalization	In-network: $300 per day, days 1-4 $0 per day, days 5-90 $0 per day, days 91 and beyond Out-of-network: $500 per day, days 1-20 $0 per day, days 21 and beyond	In-network: $325 per day, days 1-6 $0 per day, days 7-90 $0 per day, days 91 and beyond Out-of-network: $500 per day, days 1-17 $0 per day, days 18 and beyond	In-network: $425 per day, days 1-4 $0 per day, days 5-90 Out-of-network: 45% per stay
Skilled Nursing Facility	In-network: $0 per day, days 1-20 $203 per day, days 21-100 Out-of-network: $225 per day, days 1-45 $0 per day, days 46-100	In-network: $0 per day, days 1-20 $203 per day, days 21-100 Out-of-network: $225 per day, days 1-39 $0 per day, days 40-100	In-network: $10 per day, days 1-20 $150 per day, days 21-100 Out-of-network: 38% per stay
OUTPATIENT (PART B)			
Primary Doctor Visit	In-network $0/Out-of-network $0	In-network $0/Out-of-network $0	In-network $0/Out-of-network $10
Specialist Visit	In-network $0-45/Out-of-network $65	In-network $0-35/Out-of-network $50	In-network $30/Out-of-network $45
Diagnostic Radiology (like MRI)	In-network $0-115/Out-of-network $350	In-network $0-2250/Out-of-network $350	In-network $0-200/Out-of-network 45%
Emergency Care	$100 copay	$120 copay	$120 copay per visit
Urgent Care	$0-40 copay	$0-40 copay	$40 copay
Durable Medical Equipment	In-network: 20%/ Out-of-network: 50%	In-network: 20%/ Out-of-network: 50%	In-network 0-20%/Out-of-network 45%
Chemotherapy Part B drugs	In-network: 0-20%/ Out-of-network: 0-40%	In-network: 0-20%/ Out-of-network: 0-40%	In-network 0-20%/Out-of-network 45%
Ground Ambulance	In-network $0-115/Out-of-network $350	In-network/Out-of-network $290	In-network/Out-of-network $285
EXTRA BENEFITS:			
Hearing Exams	In-network: $0/Out-of-network: $65	In-network: $0/Out-of-network: $50	In-network $0/Out-of-network 45%
Hearing Aids	In & Out-of-network: $99-1249	In & Out-of-network: $99-1249	In & Out-of-network $0
Preventive Dental	Not covered	In & Out-of-network: $0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	In & Out-of-network $0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	In-network: $0/Out-of-network: $65	In-network: $0/Out-of-network: $50	In-network $0/Out-of-network 45%
Vision: Contact lenses & Eye glasses	In & Out-of-network: $0	In & Out-of-network: $0	In & Out-of-network: $0
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Not covered	Not covered	Not covered
Over the Counter Drug Benefits	Not covered	Not covered	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 $0 / T2 $0-12 / T3 $0-47 / T4 $0-100 / T5 $0-33%)	$0-33% (T1 $0 / T2 $0-10 / T3 $0-47 / T4 $0-100 / T5 $0-33%)	$0-50% (T1 $0 / T2 $0-10 / T3 $0-20% / T4 $0-50% / T5 0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage PPO Plans with Part D Prescription Drug Coverage		
Plan name	**Aetna Medicare Elite Plan (PPO)**	**Alignment Health Balance (PPO)**
Plan ID	Aetna Medicare | Plan ID: H5521-293-0	Alignment Health Plan | Plan ID: H4961-006-0
Star rating	4 stars	3 stars
Plan website	http://www.aetnamedicare com/	http://www.alignmenthealthplan.com/
Non-members	1-833-859-6031	1-888-979-2247
Members	1-833-570-6670	1-866-634-2247
Contracted Medical Groups (verify with Plan & Provider):	CH, IMG CA, SCCIPA	AHPN
TOTAL PREMIUM:	$0	$0
HEALTH PREMIUM:	$0	$0
DRUG PREMIUM:	$0	$0
HEALTH DEDUCTIBLE:	$250	$0
DRUG DEDUCTIBLE:	$0	$0
Maximum-out-of-Pocket Limit	In-network $5500/In & Out-of-network $8950	In-network $2850/In & Out-of-network $5150
INPATIENT (PART A)		
Inpatient Hospitalization	In-network: $325 per day, days 1-4 $0 per day, days 5-90 Out-of-network: 45% per stay	In-network: $0 copay Out-of-network: 30% per stay
Skilled Nursing Facility	In-network: $10 per day, days 1-20 $150 per day, days 21-100 Out-of-network: 34% per stay	In-network: $0 per day, days 1-20 $50 per day, days 21-100 Out-of-network: 30% per stay
OUTPATIENT (PART B)		
Primary Doctor Visit	In-network $0/Out-of-network $10	In-network $0/Out-of-network $25
Specialist Visit	In-network $25/Out-of-network $50	In-network $0/Out-of-network $25
Diagnostic Radiology (like MRI)	In-network $0-200/Out-of-network 45%	In-network $0/Out-of-network 30%
Emergency Care	$120 copay per visit	$75 copay
Urgent Care	$40 copay	$0 copay
Durable Medical Equipment	0-20% coinsurance	In-network 0-20%/Out-of-network 30%
Chemotherapy Part B drugs	In-network 0-20%/Out-of-network 45%	In-network 0-20%/Out-of-network 30%
Ground Ambulance	In-network/Out-of-network $285	In-network: $100 copay Out-of-network: 30%
EXTRA BENEFITS:		
Hearing Exams	In-network $0/Out-of-network 45%	In-network $0/Out-of-network 30%
Hearing Aids	In & Out-of-network $0	Not covered
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	Not covered
Vision: Routine eye exam	In-network $0/Out-of-network 45%	In-network $0/Out-of-network 30%
Vision: Contact lenses & Eye glasses	In & Out-of-network $0	In-network $0/Out-of-network 30%
Fitness Benefits	Some coverage	Some coverage
Transportation Services	Not covered	Some coverage
Over the Counter Drug Benefits	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)		
Copays	$0-33% (T1 & T2 $0 / T3 $0-47 / T4 $0-100 / T5 $0-33%)	$0-33% (T1 $0 / T2 $0-3 / T3 $0-40 / T4 $0-93 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage PPO Plans without Part D Prescription Drug Coverage	
Plan name	**Aetna Medicare Eagle Plus Plan (PPO)**
Plan ID	Aetna Medicare | Plan ID: H5521-369-0
Star rating	4 stars
Plan website	http://www.aetnamedicare com/
Non-members	1-833-859-6031
Members	1-833-570-6670
Contracted Medical Groups (verify with Plan & Provider):	OM, SCCIPA
TOTAL PREMIUM:	$0
HEALTH PREMIUM:	$0
DRUG PREMIUM:	**NO PART D**
HEALTH DEDUCTIBLE:	$0
DRUG DEDUCTIBLE:	**NO PART D**
Maximum-out-of-Pocket Limit	In-network $6700/In & Out-of-network $9500
INPATIENT (PART A)	
Inpatient Hospitalization	In-network: $430 per day, days 1-4 $0 per day, days 5-90 Out-of-network: $550 per day, days 1-5 $0 per day, days 6-90
Skilled Nursing Facility	In-network: $0 per day, days 1-20 $150 per day, days 21-100 Out-of-network: 45% per stay
OUTPATIENT (PART B)	
Primary Doctor Visit	In-network $0/Out-of-network 50%
Specialist Visit	In-network $40/Out-of-network 50%
Diagnostic Radiology (like MRI)	In-network $0-$150/Out-of-network 50%
Emergency Care	$100 copay per visit
Urgent Care	$40 copay
Durable Medical Equipment	In-network 0-20%/Out-of-network 40%
Chemotherapy Part B drugs	In-network 0-20%/Out-of-network 50%
Ground Ambulance	$265 copay
EXTRA BENEFITS:	
Hearing Exams	In-network $0/Out-of-network 50%
Hearing Aids	In-network $0/Out-of-network $0
Preventive Dental	In-network $0/Out-of-network 20%: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	In-network $0/Out-of-network 50%
Vision: Contact lenses & Eye glasses	In-network $0/Out-of-network $0
Fitness Benefits	Some coverage
Transportation Services	Not covered
Over the Counter Drug Benefits	Some coverage
Worldwide emergency	Some coverage
PRESCRIPTION DRUGS (PART D)	
Copays	**NO PART D**

See Medicare.gov for more detailed pricing on your medications.

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2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage for Chronic & Institutional Special Needs Plans (SNP)			
Plan name	**Alignment Health Heart & Diabetes (HMO C-SNP)**	**Alignment Health Heart & Diabetes CalPlus (HMO C-SNP)**	**Align Kidney Care (HMO C-SNP)**
Plan ID	Alignment Health Plan | Plan ID: H3815-010-0	Alignment Health Plan | Plan ID: H3815-039-0	Align Senior Care | Plan ID: H3274-004-0
Star rating	4 stars	4 stars	Not enough data available
Plan website	http://www.alignmenthealthplan.com/	http://www.alignmenthealthplan.com/	http://www.alignseniorcare.com/
Non-members	1-888-979-2247	1-888-979-2247	1-888-979-2247
Members	1-866-634-2247	1-866-634-2247	1-866-634-2247
Contracted Medical Groups (verify with Plan & Provider):	AHPN, CA IPA, NEMS, NCPG, PMGSJ, SCCIPA, SMG	AHPN, CA IPA, NEMS, NCPG, PMGSJ, SCCIPA, SMG	Check with plan
TOTAL PREMIUM:	$0	$8.50	$41
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$8.50	$41
HEALTH DEDUCTIBLE:	$0	$0	$240
DRUG DEDUCTIBLE:	$0	$545	$545
Maximum-out-of-Pocket Limit	$790.00	$8,850.00	$8,850.00
INPATIENT (PART A)			
Inpatient Hospitalization	$0 copay	$1632 deductible for days 1-60 $408 per day, days 61-90	$1632 deductible for days 1-60 $408 per day, days 61-90
Skilled Nursing Facility	$0 per day, days 1-31 $50 per day, days 32-100	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $204 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0 copay	$0 copay	0-20% coinsurance
Diagnostic Radiology (like MRI)	$0 copay	$0 copay	20% coinsurance
Emergency Care	$70 copay	20% coinsurance	$90 copay
Urgent Care	$0 copay	$0 copay	$25 copay
Durable Medical Equipment	0-20% coinsurance	20% coinsurance	20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$100 copay	20% coinsurance	20% coinsurance
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	Not covered	$0 copay	$0 copay
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Some coverage
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Not covered
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 $0 / T2 $0-5 / T3 $0-30 / T4 $0-75 / T5 $0-33%)	$0-25% (T1-T5 $0-25%)	$0-25% (T1-T5 $0-25%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage for Chronic & Institutional Special Needs Plans (SNP)			
Plan name	**Brand New Day Embrace Care Plan (HMO C-SNP)**	**Brand New Day Embrace Choice Plan (HMO C-SNP)**	**Central Health Focus Plan (HMO C-SNP)**
Plan ID	Brand New Day | Plan ID: H0838-039-2	Brand New Day | Plan ID: H0838-040-2	Central Health Medicare Plan | Plan ID: H5649-006-0
Star rating	2.5 stars	2.5 stars	3.5 stars
Plan website	http://www.bndhmo.com/	http://www.bndhmo.com/	http://www.centralhealthplan.com/
Non-members	1-888-683-1882	1-888-683-1882	1-888-714-7550
Members	1-866-255-4795	1-866-255-4795	1-866-314-2427
Contracted Medical Groups (verify with Plan & Provider):	PMGSJ, SCCIPA, SMG	PMGSJ, SCCIPA, SMG	CIPA, MPIPA, MPPCNC, PMGSJ, SMG
TOTAL PREMIUM:	$0	$41	$0
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$41	$0
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$0	$545	$0
Maximum-out-of-Pocket Limit	$3,000.00	$8,850.00	$1,800.00
INPATIENT (PART A)			
Inpatient Hospitalization	$0 per day, days 1-1 $225 per day, days 2-9 $0 per day, days 10-90	$1632 deductible for days 1-60 $408 per day, days 61-90	$0 copay
Skilled Nursing Facility	$0 per day, days 1-20 $204 per day, days 21-100	$0 per day, days 1-20 $204 per day, days 21-100	$0 copay
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0-10 copay	40% coinsurance	$0 copay
Diagnostic Radiology (like MRI)	$0-50 copay	$0 copay	$0-75 copay
Emergency Care	$0-125 copay	$100 copay	$0-125 copay
Urgent Care	$0 copay	$0 copay	$0 copay
Durable Medical Equipment	0-20% coinsurance	20% coinsurance	0-20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$0-150 copay	20% coinsurance	$0-100 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	$699-$999 copay	$149 copay	$0 copay
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0-17 copay Oral Exam, $0 copay Cleaning, $13 copay Flouride treatment, $0 copay X-	$0-17 copay Oral Exam, $0 copay Cleaning, $0-13 copay Flouride treatment, $0-41
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Some coverage
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 $0 / T2 $0-9 / T3 $0-47 / T4 $0-90 / T5 $0-33%)	$0-25% (T1 $0 / T2-T5 $0-25%)	$0-33% (T1 & T2 $0 / T3 $0-35 / T4 $0-75 / T5 $0-33%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage for Chronic & Institutional Special Needs Plans (SNP)			
Plan name	**Imperial Senior Value (HMO C-SNP)**	**Memory Care (HMO C-SNP)**	**Premier Care (HMO I-SNP)**
Plan ID	Imperial Health Plan of California, Inc. | Plan ID: H5496-005-0	Align Senior Care | Plan ID: H3274-003-0	Align Senior Care | Plan ID: H3274-002-0
Star rating	3 stars	Not enough data available	Not enough data available
Plan website	http://www.imperialhealthplan.com/	http://www.alignseniorcare.com/	http://www.alignmenthealthplan.com/
Non-members	1-800-838-5914	1-888-979-2247	1-888-979-2247
Members	1-800-838-8271	1-866-634-2247	1-866-634-2247
Contracted Medical Groups (verify with Plan & Provider):	B&TP, CIPA, IHH, MPIPA, Nivano, NCPG, SMG	Check with plan	Check with plan
TOTAL PREMIUM:	$0	$0	$0
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$0	$0
HEALTH DEDUCTIBLE:	$0	$240	$240
DRUG DEDUCTIBLE:	$0	$400	$400
Maximum-out-of-Pocket Limit	$1,999.00	$3,500.00	$3,500.00
INPATIENT (PART A)			
Inpatient Hospitalization	$150 per day, days 1-5 $0 per day, days 6-90	$150 per day, days 1-10 $0 per day, days 11-90	$150 per day, days 1-10 $0 per day, days 11-90
Skilled Nursing Facility	$0 per day, days 1-20 $200 per day, days 21-100	$0 per day, days 1-20 $100 per day, days 21-100	$0 per day, days 1-20 $100 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0 copay	$0 copay	$0 copay
Diagnostic Radiology (like MRI)	$0 copay	20% coinsurance	20% coinsurance
Emergency Care	$125 copay	$90 copay	$90 copay
Urgent Care	$0 copay	$40 copay	$40 copay
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$150 copay	$125 copay	$125 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	$0 copay	$0 copay	$0 copay
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Some coverage
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Not covered	Not covered
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 $0 / T2 $0-5 / T3 $0-45 / T4 $0-90 / T5 $0-33%)	$0-25% (T1-T5 $0-25%)	$0-25% (T1-T5 $0-25%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage for Chronic & Institutional Special Needs Plans (SNP)			
Plan name	**SCAN Balance (HMO C-SNP)**	**SCAN Heart First (HMO C-SNP)**	**SCAN Strive (HMO C-SNP)**
Plan ID	SCAN Health Plan | Plan ID: H5425-070-0	SCAN Health Plan | Plan ID: H5425-112-0	SCAN Health Plan | Plan ID: H5425-098-0
Star rating	3.5 stars	3.5 stars	3.5 stars
Plan website	http://www.scanhealthplan.com/	http://www.scanhealthplan.com/	http://www.scanhealthplan.com/
Non-members	1-888-315-7226	1-888-315-7226	1-888-315-7226
Members	1-800-559-3500	1-800-559-3500	1-800-559-3500
Contracted Medical Groups (verify with Plan & Provider):	B&TP, IHPCSF, MNC, PMGSJ,	B&TP, IHPCSF, MNC, PMGSJ	PMGSJ
TOTAL PREMIUM:	$0	$0	$23.50
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$0	$0	$23.50
HEALTH DEDUCTIBLE:	$0	$0	$240
DRUG DEDUCTIBLE:	$0	$0	$545
Maximum-out-of-Pocket Limit	$2,700.00	$2,700.00	$8,850.00
INPATIENT (PART A)			
Inpatient Hospitalization	$0 per day, days 1-4 $75 per day, days 5-10 $0 per day, days 11-90	$0 per day, days 1-4 $75 per day, days 5-10 $0 per day, days 11-90	$1632 deductible for days 1-60 $408 per day, days 61-90
Skilled Nursing Facility	$0 per day, days 1-20 $50 per day for days 21 through 100	$0 per day, days 1-20 $50 per day for days 21 through 100	$0 per day, days 1-20 $204 per day, days 21-100
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0 copay	$0 copay	$0 copay
Diagnostic Radiology (like MRI)	$0-100 copay	$0-100 copay	20% coinsurance
Emergency Care	$90 copay	$90 copay	20% coinsurance
Urgent Care	$0 copay	$0 copay	20% coinsurance
Durable Medical Equipment	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance	0-20% coinsurance	0-20% coinsurance
Ground Ambulance	$100 copay	$100 copay	20% coinsurance
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	$0 copay
Hearing Aids	$450-$750 copay	$450-$750 copay	Not covered
Preventive Dental	$10 copay Oral Exam, $5 copay Cleaning, $15 copay X-ray	$10 copay Oral Exam, $5 copay Cleaning, $15 copay X-ray	$0 copay: Oral Exam, Cleaning, X-ray
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Some coverage
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Some coverage
PRESCRIPTION DRUGS (PART D)			
Copays	$0-33% (T1 & T2 $0 / T3 $0-35 / T4 $0-85 / 5 $0-33%)	$0-33% (T1 & T2 $0 / T3 $0-40 / T4 $0-90 / 5 $0-33%)	$0-25% (T1-T5 $0-25%)

See Medicare.gov for more detailed pricing on your medications.

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage for Chronic & Institutional Special Needs Plans (SNP)

Plan name	Senior Care (HMO I-SNP)
Plan ID	Align Senior Care | Plan ID: H3274-001-0
Star rating	Not enough data available
Plan website	http://www.alignseniorcare.com/
Non-members	1-888-979-2247
Members	1-866-634-2247
Contracted Medical Groups (verify with Plan & Provider):	Check with plan
TOTAL PREMIUM:	$41
HEALTH PREMIUM:	$0
DRUG PREMIUM:	$41
HEALTH DEDUCTIBLE:	$240
DRUG DEDUCTIBLE:	$545
Maximum-out-of-Pocket Limit	$8,850.00
INPATIENT (PART A)	
Inpatient Hospitalization	$1632 deductible for days 1-60 $408 per day, days 61-90
Skilled Nursing Facility	$0 per day, days 1-20 $204 per day, days 21-100
OUTPATIENT (PART B)	
Primary Doctor Visit	$0 copay
Specialist Visit	20% coinsurance
Diagnostic Radiology (like MRI)	20% coinsurance
Emergency Care	$90 copay
Urgent Care	$55 copay
Durable Medical Equipment	20% coinsurance
Chemotherapy Part B drugs	0-20% coinsurance
Ground Ambulance	20% coinsurance
EXTRA BENEFITS:	
Hearing Exams	$0 copay
Hearing Aids	$0 copay
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray
Vision: Routine eye exam	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay: Eyeglasses only
Fitness Benefits	Some coverage
Transportation Services	Some coverage
Over the Counter Drug Benefits	Some coverage
Worldwide emergency	Not covered
PRESCRIPTION DRUGS (PART D)	
Copays	$0-25% (T1-T5 $0-25%)

See Medicare.gov for more detailed pricing on your medications.

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2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage for Dual Eligible Beneficiaries (qualify for both Medicare & Medi-Cal)			
Plan name	**Anthem Dual Advantage (HMO D-SNP)**	**Anthem Full Dual Advantage Aligned (HMO D-SNP)**	**DualConnect (HMO D-SNP)**
Plan ID	Anthem Blue Cross Partnership Plan | Plan ID: H4471-009-0	Anthem Blue Cross Partnership Plan | Plan ID: H4471-001-0	Santa Clara Family Health Plan | Plan ID: H4045-001-0
Star rating	Plan too new to be measured	Plan too new to be measured	Plan too new to be measured
Plan website	https://shop.anthem.com/medicare	https://shop.anthem.com/medicare	http://www.scfhp.com/dualconnect
Non-members	1-855-593-0899	1-855-593-0898	1-877-723-4795
Members	1-800-499-27993	1-833-707-3129	1-877-723-4795
Contracted Medical Groups (verify with Plan & Provider):	Check with plan	Check with plan	Check with plan
TOTAL PREMIUM:	$27.60	$0	$0
HEALTH PREMIUM:	$0	$0	$0
DRUG PREMIUM:	$27.60	$0	$0
HEALTH DEDUCTIBLE:	$0	$0	$0
DRUG DEDUCTIBLE:	$545	$545	$545
Maximum-out-of-Pocket Limit	$8,850.00	$8,850.00	$8,850.00
INPATIENT (PART A)			
Inpatient Hospitalization	$1632 deductible for days 1-60 $408 per day, days 61-90	$0 copay	$0 copay
Skilled Nursing Facility	$0 per day, days 1-20 $204 per day, days 21-100	$0 copay	$0 copay
OUTPATIENT (PART B)			
Primary Doctor Visit	$0 copay	$0 copay	$0 copay
Specialist Visit	$0 copay	$0 copay	$0 copay
Diagnostic Radiology (like MRI)	0% or 20% coinsurance	$0 copay	$0 copay
Emergency Care	$0 or $90 copay	$0 copay	$0 copay
Urgent Care	$0 or $55 copay	$0 copay	$0 copay
Durable Medical Equipment	0-20% coinsurance	$0 copay	$0 copay
Chemotherapy Part B drugs	0-20% coinsurance	$0 copay	$0 copay
Ground Ambulance	0% or 20% coinsurance	$0 copay	$0 copay
EXTRA BENEFITS:			
Hearing Exams	$0 copay	$0 copay	Not covered
Hearing Aids	$0 copay	$0 copay	Not covered
Preventive Dental	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	$0 copay: Oral Exam, Cleaning, Flouride treatment, X-ray	Not covered
Vision: Routine eye exam	$0 copay	$0 copay	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay	$0 copay	$0 copay
Fitness Benefits	Some coverage	Some coverage	Some coverage
Transportation Services	Some coverage	Some coverage	Not covered
Over the Counter Drug Benefits	Some coverage	Some coverage	Some coverage
Worldwide emergency	Some coverage	Some coverage	Not covered
PRESCRIPTION DRUGS (PART D)			
Copays	$0-25% (T1-T5 $0-25%)	$0-25% (T1-T5 $0-25%)	$0-25% (T1-T5 $0-25%)

See Medicare.gov for more detailed pricing on your medications. Low Income Subsidy (LIS/Extra Help) Generic: $0 copay; or $1.55 copay; or $4.50 copay / Brand: $0 copay; or $4.60 copay; or $11.20 copay

2024 Part C Medicare Advantage HMO Plans with Part D Prescription Drug Coverage for Dual Eligible Beneficiaries (qualify for both Medicare & Medi-Cal)

Plan name	Senior Advantage Medicare Medi-Cal North P2 (HMO D-SNP)
Plan ID	Kaiser Permanente | Plan ID: H8794-002-0
Star rating	Plan too new to be measured
Plan website	http://kp.org/medicare
Non-members	1-800-777-1238
Members	1-800-443-0815
Contracted Medical Groups (verify with Plan & Provider):	Kaiser
TOTAL PREMIUM:	$0
HEALTH PREMIUM:	$0
DRUG PREMIUM:	$0
HEALTH DEDUCTIBLE:	$0
DRUG DEDUCTIBLE:	$545
Maximum-out-of-Pocket Limit	$3,400.00
INPATIENT (PART A)	
Inpatient Hospitalization	$0 copay
Skilled Nursing Facility	$0 copay
OUTPATIENT (PART B)	
Primary Doctor Visit	$0 copay
Specialist Visit	$0 copay
Diagnostic Radiology (like MRI)	$0 copay
Emergency Care	$0 copay
Urgent Care	$0 copay
Durable Medical Equipment	$0 copay
Chemotherapy Part B drugs	$0 copay
Ground Ambulance	$0 copay
EXTRA BENEFITS:	
Hearing Exams	Not covered
Hearing Aids	Not covered
Preventive Dental	Covered under office visit: Oral Exam, Cleaning, X-ray
Vision: Routine eye exam	$0 copay
Vision: Contact lenses & Eye glasses	$0 copay
Fitness Benefits	Some coverage
Transportation Services	Not covered
Over the Counter Drug Benefits	Some coverage
Worldwide emergency	Some coverage
PRESCRIPTION DRUGS (PART D)	
Copays	$0-25% (T1-T5 $0-25%)

See Medicare.gov for more detailed pricing on your medications. Low Income Subsidy (LIS/Extra Help) Generic: $0 copay; or $1.55 copay; or $4.50 copay / Brand: $0 copay; or $4.60 copay; or $11.20 copay

Santa Clara County Contracted Medical Groups (Acronym Key)

ASB (Affinity South Bay)
AHPN (Alignment Health Plan Network)
B&TP (Brown & Toland Physicians)
CA IPA (California IPA)
CH (Carbon Health)
CHP (Caremore Health Plan)
CIPA (Center IPA)
ECHMN / SVMD (El Camino Health Medical Network / Silicon Valley Medical Development, LLC)
HPEB (Hills Physicians East Bay)
IHH (Imperial Health Holdings)
IHI (Imperial Health Inc)
IHPCSF (Imperial Health Plan of California San Francisco)
IMG CA (Inspire Medical Group of CA)
MPIPA (MedCare Partners IPA)
MedCare Partners- Northern CA Physicians Group
MPPCNC (MedCare Partners- Premier Care of Northern California)
MNC (Multiplan Northern California)
Nivano
NEMS (North East Medical Services)
NCPG (Northern California Physicians Group)
OM (One Medical)
PAMF (Palo Alto Medical Foundation)
Palo Alto Medical Foundation- Camino
Palo Alto Medical Foundation- Assure
Permanente Medical Group (Kaiser)
PPIPA (Physician Partners IPA)
PMGSJ (Physicians Medical Group of San Jose)
SCCIPA (Santa Clara County IPA)
SCVMCPS (Santa Clara Valley Medical Center Physician Services)
Silicon Valley Eye Physicians Medical Group
SMG (Seoul Medical Group)
Stanford Health Care
Sutter

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