Alignment Health Plan

2023

Summary of Benefits

ALIGNMENT HEALTH MY CHOICE (PPO)| ALIGNMENT HEALTH BALANCE (PPO)

Placer, Sacramento, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Sonoma, Stanislaus & Yolo Counties

This is a summary of drug and health services benefits covered by Alignment Health Plan for January 1, 2023 - December 31, 2023.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the Evidence of Coverage by calling our Member Services Department at the phone number listed in this document or online at www.alignmenthealthplan.com.

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	ALIGNMENT HEALTH MY CHOICE (PPO) 001 Placer, Sacramento, San Joaquin, Santa Cruz, Stanislaus & Yolo Counties	ALIGNMENT HEALTH MY CHOICE (PPO) 003 San Mateo & Sonoma Counties	ALIGNMENT HEALTH BALANCE (PPO) 006 San Joaquin, Santa Clara & Stanislaus Counties
MONTHLY PLAN PREMIUM			
• Part C & Part D	$79	$97	$0
MAXIMUM OUT-OF-POCKET RESPONSIBILITY (does not include prescription drugs)			
In-Network	$4,200	$4,200	$2,850
Out-of-Network	$6,000 combined	$6,000 combined	$5,150 combined
INPATIENT HOSPITAL[1,2]			
In-Network	$150 per day, days 1-5, $0 per day, days 6-90 $0 per day, days 91-999 (unlimited days per admission)	$225 per day, days 1-5, $0 per day, days 6-90 $0 per day, days 91-999 (unlimited days per admission)	$0
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance
OUTPATIENT HOSPITAL[1]			
In-Network			
• Hospital Services	$195	$250	$50
• Observation Services	$0	$0	$0
Out-of-Network	25% coinsurance	25% coinsurance	25% coinsurance
AMBULATORY SURGICAL CENTER			
In-Network	$0	$0	$0
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance

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DOCTOR VISITS			
In-Network			
• Primary	$5	$5	$0
• Specialists[1,2]	$35	$35	$0
Out-of-Network			
• Primary	25% coinsurance	25% coinsurance	$25
• Specialists	25% coinsurance	25% coinsurance	$25
PREVENTIVE CARE			
(e.g., flu vaccine, diabetic screenings)			
In-Network	$0	$0	$0
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance
EMERGENCY CARE	$85 (not waived if admitted)	$85 (not waived if admitted)	$75 (not waived if admitted)
URGENTLY NEEDED SERVICES	$0	$0	$0
OUTPATIENT DIAGNOSTIC[1,2]			
In-Network			
• Procedures, tests, lab services	$0	$0	$0
• X-Ray	$15	$15	$0
• Diagnostic	$150	$150	20% coinsurance
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance	20% coinsurance	20% coinsurance
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance

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HEARING SERVICES[1,2]			
In-Network			
• Routine hearing exam	$0 Medicare covered benefits and 1 exam/ fitting/evaluation per year	$0 Medicare covered benefits and 1 exam/ fitting/evaluation per year	$0 Medicare covered benefits and 1 exam/ fitting/evaluation per year
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance
• Hearing aid allowance	not covered	not covered	not covered
DENTAL SERVICES[1,2]			
Preventive:			
In-Network	$0 Medicare covered only	$0 Medicare covered only	$0 Medicare covered only
Comprehensive:			
In-Network	$0 Medicare covered only	$0 Medicare covered only	$0 Medicare covered only
Out-of-Network	30% coinsurance Medicare covered only	30% coinsurance Medicare covered only	30% coinsurance Medicare covered only
VISION SERVICES			
In-Network			
• Routine exam	$0 Medicare covered eye exams/1 routine eye exam per year	$0 Medicare covered eye exams/1 routine eye exam per year	$0 Medicare covered eye exams/1 routine eye exam per year
• Eyewear	$150 coverage limit for glasses/contacts every 2 years	$150 coverage limit for glasses/contacts per year	$200 coverage limit for glasses/contacts per year
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance
MENTAL HEALTH SERVICES[1,2]			
In-Network	$0	$0	$0
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance
SKILLED NURSING FACILITY[1,2]			
In-Network	$0 per day, days 1-20 $160 per day, days 21-51 $0 per day, days 52-100 (no prior hospital stay required)	$0 per day, days 1-20 $160 per day, days 21-51 $0 per day, days 52-100 (no prior hospital stay required)	$0 per day, days 1-20 $50 per day, days 21-100 (no prior hospital stay required)
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance

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PHYSICAL & SPEECH THERAPY			
In-Network	$0	$0	$0
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance
GROUND AND AIR AMBULANCE SERVICES[1]			
In-Network	$250 (waived if admitted)	$250 (waived if admitted)	$100 (waived if admitted)
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance
TRANSPORTATION			
In-Network	not covered	not covered	$0 26 one-way trips to approved locations per year (within a 50-mile radius)
Out-of-Network	not covered	not covered	30% coinsurance
MEDICARE PART B DRUGS			
In-Network	20% coinsurance	20% coinsurance	20% coinsurance
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance

OUTPATIENT PRESCRIPTION DRUGS

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PART D DEDUCTIBLE	$0		$0	
INITIAL COVERAGE LIMIT	$4,660		$4,660	
PART D OUT OF POCKET THRESHOLD	$7,400		$7,400	
INITIAL COVERAGE	**Retail Standard 30-day supply**	**Mail Order 100-day supply**	**Retail Standard 30-day supply**	**Mail Order 100-day supply**
Tier 1: Preferred Generic	$0	$0	$0	$0
Tier 2: Generic	$5	$15	$3	$9
Tier 3: Preferred Brand	$40	$120	$40	$120
Tier 4: Non-Preferred	$100	$300	$93	$279
Tier 5: Specialty Tier	33% coinsurance	not covered	33% coinsurance	not covered
Tier 6: Select Care	$5	$0	$3	$0
GAP COVERAGE	Tier 6: All Drugs			

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COST-SHARING	May change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit. If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy for a 31-day supply.
CATASTROPHIC COVERAGE	After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: • 5% of the cost, or • $4.15 copay for generic (including drugs that are treated like a generic) and $10.35 copay for all other drugs.
BONUS DRUGS	Generic Viagra, Finasteride, Folic Acid. For complete list and coverage details, refer to Bonus Drug List.

NOTE:

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

For more information on the pharmacy-specific copays, please call Alignment Health Plan Member Services Department at the phone number in this document or access your Evidence of Coverage at www.alignmenthealthplan.com.

EXTRA BENEFITS YOU GET WITH ALIGNMENT HEALTH PLAN

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ACCESS ON-DEMAND BLACK CARD	$0	$0	$0
ENHANCED DENTAL OPTION MONTHLY PREMIUM	$27	$27	$27
ENHANCED DENTAL OPTION COVERAGE	$1,500 coverage limit per year	$1,500 coverage limit per year	$1,500 coverage limit per year
• Diagnostic Services	0% coinsurance	0% coinsurance	0% coinsurance
• Restorative	50-70% coinsurance	50-70% coinsurance	50-70% coinsurance
• Endodontics	70% coinsurance	70% coinsurance	70% coinsurance
• Periodontics	0-70% coinsurance	0-70% coinsurance	0-70% coinsurance
• Extractions	50-70% coinsurance	50-70% coinsurance	50-70% coinsurance
• Prosthodontics	70% coinsurance	70% coinsurance	70% coinsurance
FITNESS	$0	$0	$0
CHIROPRACTIC			
In-Network	$0 Medicare covered	$0 Medicare covered	$0 Medicare covered
Out-of-Network	30% coinsurance Medicare covered	30% coinsurance Medicare covered	30% coinsurance Medicare covered
ACUPUNCTURE			
In-Network	$0 Medicare covered	$0 Medicare covered	$0 Medicare covered
PODIATRY SERVICES			
In-Network	$0	$0	$0
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance

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OVER-THE-COUNTER (OTC)	$60 spending allowance every 3 months (no rollover)	$60 spending allowance every 3 months (no rollover)	$65 spendingallowance every 3 months (no rollover)
TELEHEALTH			
In-Network	$0 Primary Care Provider, Mental Health Specialty, Psychiatric Services	$0 Primary Care Provider, Mental Health Specialty, Psychiatric Services	$0 Primary Care Provider, Mental Health Specialty, Psychiatric Services
WORLDWIDE EMERGENCY/URGENT COVERAGE	$25,000 coverage limit per year	$25,000 coverage limit per year	$25,000 coverage limit per year
DURABLE MEDICAL EQUIPMENT (DME)			
In-Network	0% coinsurance for items $350 or less 20% coinsurance for items $350.01 or more	0% coinsurance for items $350 or less 20% coinsurance for items $350.01 or more	0% coinsurance for items $350 or less 20% coinsurance for items $350.01 or more
Out-of-Network	30% coinsurance	30% coinsurance	30% coinsurance

To join Alignment Health Plan, you must be enrolled in Medicare Part A and Part B and live in one of the counties listed on the cover of this booklet.

To learn more about coverage and costs of Original Medicare, look at the "**Medicare & You**" handbook. You can view it online at medicare.gov or request a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

This document is also available in other languages and formats.

ALIGNMENT HEALTH PLAN MEMBERS	**1-866-634-2247 (TTY 711)**
NON-MEMBERS	**1-888-979-2247 (TTY 711)**
HOURS OF OPERATION	**October 1 – March 31:** seven days a week, from 8:00 a.m. to 8:00 p.m. except for Thanksgiving and Christmas Day. **April 1 – September 30:** Monday through Friday, (except holidays) from 8:00 a.m. to 8:00 p.m.
WEBSITE	**alignmenthealthplan.com**

UNDERSTANDING THE BENEFITS & RULES

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at:

1-888-979-2247 (TTY 711)

8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 to March 31 and 8 a.m. to 8 p.m. Monday through Friday (except holidays) from April 1 through September 30.

UNDERSTANDING THE BENEFITS

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **alignmenthealthplan.com** or call **1-866-634-2247** (**TTY 711**) for a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor. Visit **alignmenthealthplan.com** or call **1-866-634-2247** (**TTY 711**) for a list of Alignment Health Plan network providers.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions. Visit **alignmenthealthplan.com** or call **1-866-634-2247** (**TTY 711**) for the Alignment Health Plan list of covered medications.

UNDERSTANDING IMPORTANT RULES

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ **These plans allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.**

Alignment Health Plan is an HMO, HMO POS, HMO C-SNP, HMO D-SNP and PPO plan with a Medicare contract and a contract with the California, Florida, Nevada and North Carolina Medicaid programs. Enrollment in Alignment Health Plan depends on contract renewal. Alignment Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.