Alignment Health Plan

2023

Summary of Benefits

ALIGNMENT HEALTH MY CHOICE (HMO) | ALIGNMENT HEALTH PLATINUM (HMO)

Los Angeles, Orange, Riverside & San Bernardino 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 (HMO) 001 Los Angeles, Orange, Riverside & San Bernardino Counties	ALIGNMENT HEALTH PLATINUM (HMO) 008 Los Angeles & Orange Counties	ALIGNMENT HEALTH PLATINUM (HMO) 015 San Bernadino & Riverside Counties
MONTHLY PLAN PREMIUM			
• Part C & Part D	$0	$0	$0
DEDUCTIBLE	$0	$0	$0
MAXIMUM OUT-OF-POCKET RESPONSIBILITY (does not include prescription drugs)	$780	$698	$998
INPATIENT HOSPITAL[1,2]	$0 (unlimited days per admission)	$0 (unlimited days per admission)	$0 (unlimited days per admission)
OUTPATIENT HOSPITAL[1]			
• Hospital Services	$0	$50	$0
• Observation Services	$0	$0	$0
AMBULATORY SURGICAL CENTER	$0	$0	$0
DOCTOR VISITS			
• Primary	$0	$0	$0
• Specialists[1,2]	$0	$0	$0
PREVENTIVE CARE			
(e.g., flu vaccine, diabetic screenings)	$0	$0	$0
EMERGENCY CARE	$70 (waived if admitted within 48 hours)	$50 (waived if admitted within 48 hours)	$70 (waived if admitted within 48 hours)
URGENTLY NEEDED SERVICES	$0	$0	$0

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OUTPATIENT DIAGNOSTIC[1,2]			
• Procedures, tests, lab services	$0	$0	$0
• X-Ray/Diagnostic	$0	$0	$0
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance	20% coinsurance	20% coinsurance
HEARING SERVICES[1,2]			
• 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
• Hearing aid allowance	$1,000 limit both ears combined every 2 years	$1,000 limit both ears combined every 2 years	$1,000 limit both ears combined every 2 years
DENTAL SERVICES[1,2]			
Preventive:			
• Exam & Cleaning 1 every 6 months	$0	$0	$0
• Fluoride treatment 1 every 6 months	$0	$0	$0
• X-Ray 1 every 3 years	$0	$0	$0
Comprehensive:			
• Restorative	$20-$350	$20-$350	$20-$350
• Endodontics	$15-$295	$15-$295	$15-$295
• Periodontics	$15-$375	$15-$375	$15-$375
• Extractions	$25-$140	$25-$140	$25-$140
• Prosthodontics	$20-$425	$20-$425	$20-$425
VISION SERVICES			
• 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	$200 coverage limit for glasses/contacts per year	$300 coverage limit for glasses/contacts per year	$200 coverage limit for glasses/contacts per year
MENTAL HEALTH SERVICES[1,2]	$0	$0	$0

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SKILLED NURSING FACILITY[1,2]	$0 per day, days 1-20 $30 per day, days 21-100 (no prior hospital stay required)	$0	$0 per day, days 1-20 $30 per day, days 21-100 (no prior hospital stay required)
PHYSICAL AND SPEECH THERAPY	$0	$0	$0
GROUND AND AIR AMBULANCE SERVICES[1]	$75 (waived if admitted)	$50 (waived if admitted)	$75 (waived if admitted)
TRANSPORTATION	$0 22 one-way trips per year to plan approved locations (within a 50-mile radius)	$0 42 one-way trips per year to plan approved locations (within a 50-mile radius)	$0 22 one-way trips per year to plan approved locations (within a 50-mile radius)
MEDICARE PART B DRUGS	20% coinsurance	20% coinsurance	20% coinsurance

OUTPATIENT PRESCRIPTION DRUGS

	ALIGNMENT HEALTH MY CHOICE (HMO) 001 Los Angeles, Orange, Riverside & San Bernardino Counties	
PART D DEDUCTIBLE	$0	
INITIAL COVERAGE LIMIT	$4,660	
PART D OUT OF POCKET THRESHOLD	$7,400	
INITIAL COVERAGE	**Retail Standard 30-day supply**	**Mail Order 100-day supply**
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$5	$12.50
Tier 3: Preferred Brand	$30	$75
Tier 4: Non-Preferred	$100	$300
Tier 5: Specialty Tier	33% coinsurance	not covered
Tier 6: Select Care	$3	$0
GAP COVERAGE	Tier 1: All Drugs Tier 6: All Drugs	

	ALIGNMENT HEALTH PLATINUM (HMO) 008 Los Angeles & Orange Counties	
PART D DEDUCTIBLE	$0	
INITIAL COVERAGE LIMIT	$4,660	
PART D OUT OF POCKET THRESHOLD	$7,400	
INITIAL COVERAGE	**Retail Standard 30-day supply**	**Mail Order 100-day supply**
Tier 1: Preferred Generic Select Insulins Other Drugs	 $0 $0	 $0 $0
Tier 2: Generic	$1	$3
Tier 3: Preferred Brand Select Insulins Other Drugs	 $30 $30	 $90 $75
Tier 4: Non-Preferred Select Insulins Other Drugs	 $35 $75	 $105 $187.50
Tier 5: Specialty Tier	33% coinsurance	not covered
Tier 6: Select Care	$5	$0
GAP COVERAGE	Tier 1: All Drugs Tier 2: All Drugs Tier 6: All Drugs Select Insulins: Platinum (HMO) 008 offers additional gap coverage for Select Insulins under the Insulin Savings Program. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $0 to $35 for a one-month supply.	

To find out which drugs are Select Insulins, please review the Drug List included in this booklet or download a copy of the Alignment Health Plan Drug Formulary from our website https://www.alignmenthealthplan.com/members/find-a-drug. Select Insulins are covered on Tier 1, Tier 3, and Tier 4 and are different from our Select Care Drugs, which are drugs covered on Tier 6. The cost sharing for Select Insulins is applicable in the Initial Coverage and Coverage Gap stages and does not apply to the Catastrophic Coverage stage.

The cost sharing for Select Insulins does not apply if you qualify for a program that helps pay for your drugs ("Extra Help").

	ALIGNMENT HEALTH PLATINUM HEALTH (HMO) 015 San Bernadino & Riverside Counties	
PART D DEDUCTIBLE	$0	
INITIAL COVERAGE LIMIT	$4,660	
PART D OUT OF POCKET THRESHOLD	$7,400	
INITIAL COVERAGE	**Retail Standard 30-day supply**	**Mail Order 100-day supply**
Tier 1: Preferred Generic	$0	$0
Tier 2: Generic	$5	$15
Tier 3: Preferred Brand	$30	$90
Tier 4: Non-Preferred	$100	$300
Tier 5: Specialty Tier	33% coinsurance	not covered
Tier 6: Select Care	$3	$0
GAP COVERAGE	Tier 1: All Drugs Tier 6: All Drugs	

	ALIGNMENT HEALTH MY CHOICE (HMO) 001; Los Angeles, Orange, Riverside & San Bernardino Counties ALIGNMENT HEALTH PLATINUM (HMO) 008 Los Angeles & Orange Counties
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, whichever is greater.
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 • Restorative • Endodontics • Periodontics • Extractions • Prosthodontics	0% coinsurance 50-70% coinsurance 70% coinsurance 0-70% coinsurance 50-70% coinsurance 70% coinsurance	0% coinsurance 50-70% coinsurance 70% coinsurance 0-70% coinsurance 50-70% coinsurance 70% coinsurance	0% coinsurance 50-70% coinsurance 70% coinsurance 0-70% coinsurance 50-70% coinsurance 70% coinsurance
FITNESS	$0	$0	$0
FLEX ALLOWANCE Additional coverage for Vision, Dental, Hearing, Acupuncture and Chiropractic benefits	Up to $500 maximum spending per year ($250 every 6 months) for services related to Vision, Dental, Hearing, Acupuncture and Chiropractic	Up to $1000 maximum spending per year ($500 every 6 months) for services related to Vision, Dental, Hearing, Acupuncture and Chiropractic	not covered
PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)	$0	not covered	$0
PERSONALIZED HEALTH RISK SCREENING	not covered	$100 1 screening every 2 years	not covered

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CHIROPRACTIC SERVICES	$0 Medicare covered $0 Routine visits with FLEX Allowance	$0 Medicare covered $0 Routine visits with FLEX Allowance	$0 Medicare covered
ACUPUNCTURE	$0 Medicare covered $0 Routine visits with FLEX Allowance	$0 Medicare covered $0 Routine visits with FLEX Allowance	$0 Medicare Covered $0 for 40 visits max, $10 per visit combined with Reflexology
PODIATRY SERVICES	$0 Medicare covered	$0 Medicare covered	$0 Medicare covered
OVER-THE-COUNTER (OTC)	$60 spending allowance every 3 months (no rollover)	$135 spending allowance every 3 months (no rollover)	$75 spending allowance every 3 months (no rollover)
TELEHEALTH	$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	$0 $25,000 coverage limit per year	$0 $25,000 coverage limit per year	$0 $25,000 coverage limit per year
SUPPORT FOR CAREGIVERS	Up to $300 reimbursement per year	Up to $300 reimbursement per year **OR** In-Home Support Services (member must choose in advance)	Up to $300 reimbursement per year **OR** In-Home Support Services (member must choose in advance)
IN-HOME SERVICES	not covered	$0 12 hours per quarter, 48 hours per year. OR Support for Caregivers (member must choose in advance)	$0 12 hours per quarter, 48 hours per year. OR Support for Caregivers (member must choose in advance)

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DURABLE MEDICAL EQUIPMENT (DME)	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

EXTRA BENEFITS FOR THOSE WITH QUALIFYING CONDITION (SSBCI)

Special supplemental benefits for the chronically ill (SSBCI)-qualifying chronic conditions include congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), dementia, diabetes, and stroke. Other chronic conditions may apply. Medical records will be used to establish qualification for the benefit.

GROCERIES			
To assist members with nutritional needs. Members can use their grocery allowance to purchase eligible grocery items at participating retailers.	not covered	$20 spending allowance per month (no rollover)	not covered
PET SERVICES			
For members who have hospital procedures or emergencies and need pet care while they are away.	$0 7 boarding days or 14 walks per year	$0 7 boarding days or 14 walks per year	$0 7 boarding days or 14 walks per year
PEST CONTROL			
Annual pest eradication for covered pests to ensure the health, welfare, and safety of members.	$0 1 service per year	$0 1 service per year	$0 1 service per year
AIR PURIFIER/HUMIDIFIER			
For members with a qualified chronic condition, have breathing conditions or who live in an area impacted by fire and/or smoke.	$0 1 air purifier or humidifier per year	not covered	$0 1 air purifier or humidifier per year

Alignment Health Plan offers access to a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for the services.

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.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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. This information is not a complete description of benefits. Call 1-888-979-2247 (TTY: 711), 8 a.m. to 8 p.m. Monday through Friday, for more information.