2025
Benefit Platter

ALIGNMENT HEALTH MY CHOICE (HMO) 028
San Luis Obispo, Ventura

ALIGNMENT HEALTH MY CHOICE SELECT (HMO) 049
Los Angeles, Orange, Riverside, San Bernardino

Alignment Health Plan®

	ALIGNMENT HEALTH MY CHOICE (HMO) 028	ALIGNMENT HEALTH MY CHOICE SELECT (HMO) 049
Monthly Premium	$0	$0
Annual Plan Deductible	$0	$0
Maximum Out of Pocket (MOOP)	$698	$798
PCP	$0 copay	$0 copay
Specialist	$0 copay	$0 copay
INPATIENT CARE		
Inpatient Hospital-Acute	$0 copay (unlimited days per admission)	$0 copay (unlimited days per admission)
Inpatient Hospital Psychiatric	$120 copay per day, days 1-10 $0 copay per day, days 11-90 $0 copay for 40 additional day limit (91-130) $0 copay for 60-days Lifetime reserve	$120 copay per day, days 1-10 $0 copay per day, days 11-90 $0 copay for 40 additional day limit (91-130) $0 copay for 60-days Lifetime reserve
Skilled Nursing Facility (SNF)	$0 copay per day, days 1-20 $30 copay per day, days 21-100 (no prior hospital stay required)	$0 copay per day, days 1-20 $30 copay per day, days 21-100 (no prior hospital stay required)
OUTPATIENT CARE		
Ambulatory Surgical Center	$0 copay	$0 copay
Annual Physical Exam and Preventive Care (Medicare Covered)	$0 copay	$0 copay
Emergency Services	$100 copay (waived if admitted within 48 hours)	$70 copay (waived if admitted within 48 hours)
Ground and Air Ambulance Services	$100 copay Ground $200 copay Air (waived if admitted)	$75 copay (waived if admitted)
Outpatient Hospital and Observation Services	$0 copay	$0 copay
Physical and Speech Therapy	$0 copay	$0 copay
Podiatry	$0 copay Medicare covered	$0 copay Medicare covered Routine visits covered through FLEX Allowance See FLEX Allowance below
Urgently Needed Services	$0 copay	$0 copay
Worldwide Emergency/ Urgent Coverage	$0 copay $50,000 maximum coverage per year	$0 copay $25,000 maximum coverage per year
OUTPATIENT MEDICAL SERVICES & SUPPLIES		
Durable Medical Equipment (DME)	0% coinsurance for items $450 or less 20% coinsurance for items $450.01 or more 20% coinsurance for Continuous Glucose Monitors (CGMs) and supplies	0% coinsurance for items $350 or less 20% coinsurance for items $350.01 or more 20% coinsurance for Continuous Glucose Monitors (CGMs) and supplies
Diabetes Supplies	0% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic Shoes or Inserts	0% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic Shoes or Inserts
Outpatient Diagnostic (Procedures/Tests/Lab Services)	$0 copay	$0 copay
Outpatient Radiology (X-Ray/Diagnostic/Therapeutic)	$0 copay (X/D) 20% coinsurance (T)	$0 copay (X/D) 20% coinsurance (T)
Mental Health Specialty Services (Individual/Group)	$0 copay	$0 copay
Psychiatric Services (Individual/Group)	$20 copay	$20 copay
Prosthetic/Medical Supplies	20% coinsurance	20% coinsurance
VISION, HEARING & DENTAL BENEFITS		
Eye Exams	$0 copay for Medicare covered eye exams and 1 routine eye exam per year	$0 copay for Medicare covered eye exams and 1 routine eye exam per year Additional coverage available through FLEX Allowance
Eyewear	$100 coverage limit for glasses/contacts per year	$200 coverage limit for glasses/contacts per year Additional coverage available through FLEX Allowance
Preventive Dental (Routine)	$0 copay for: 1 Oral Exam every 6 months 1 Cleaning every 6 months 1 X-ray every 3 years 1 Fluoride treatment every 6 months	$0 copay for: 1 Oral Exam every 6 months 1 Cleaning every 6 months 1 X-ray every 3 years 1 Fluoride treatment every 6 months Additional coverage available through FLEX Allowance
Comprehensive Dental	Restorative Services: $20-$400 copay Endodontics: $25-$350 copay Periodontics: $15-$550 copay Prosthodontics (removable): $20-$570 copay Prosthodontics (fixed): $40-$400 copay Oral & Maxillofacial Surgery: $25-$250 copay	Restorative Services: $20-$400 copay Endodontics: $25-$350 copay Periodontics: $15-$550 copay Prosthodontics (removable): $20-$570 copay Prosthodontics (fixed): $40-$400 copay Oral & Maxillofacial Surgery: $25-$250 copay Additional coverage available through FLEX Allowance
Optional Enhanced Dental	Premium: $36 Diagnostic: 0% coinsurance Endodontics: 50% coinsurance Oral & Maxillofacial Surgery: 50% coinsurance Periodontics: 0-50% coinsurance Prosthodontics: 50% coinsurance Restorative: 50% coinsurance $1,500 maximum coverage per year	not covered

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Hearing Exams/Fitting and Evaluation for Hearing Aid	$0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year	$0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year Additional coverage available through FLEX Allowance
Hearing Aids	$195-$1,750 copay, 2 hearing aids per year	$195-$1,750 copay, 2 hearing aids per year Additional coverage available through FLEX Allowance
ADDITIONAL BENEFITS - MORE THAN ORIGINAL MEDICARE WITH YOUR ACCESS ON-DEMAND CARD BENEFITS!		
24/7 Concierge Service	$0	$0
FLEX Allowance	not covered	Up to $200 maximum spending per year for services related to Vision, Dental, Hearing, Routine, Acupuncture Chiropractic and Podiatry visits
Over-the-Counter (OTC)	$20 spending allowance per month (no rollover)	$20 spending allowance per month (no rollover)
Acupuncture & Chiropractic Services	$0 copay for Medicare covered	$0 copay for Medicare covered Routine visits covered through FLEX Allowance
Dialysis Services	20% coinsurance	$30 copay
Fitness	$0 copay	$0 copay
Meal Benefit	$0 copay for 28 days, 56 meals per year (28 meals over 14 days, twice per year)	$0 copay for 28 days, 56 meals per year (28 meals over 14 days, twice per year)
Personal Emergency Response System (PERS)	$0 copay	$0 copay
Telehealth	$0 copay for Primary Care/Mental Health Specialty/ Psychiatric Services	$0 copay for Primary Care/Mental Health Specialty/ Psychiatric Services
Transportation	22 one-way trips to approved locations per year (within a 50-mile radius)	22 one-way trips to approved locations per year (within a 50-mile radius)
Caregivers Support	not covered	Up to $300 reimbursement per year **OR** In-Home Support Services (Members must choose in advance)
In-Home Support Services	not covered	$0 copay for 12 hours per quarter, 48 hours per year **OR** Caregivers Support (Member must choose in advance)
SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI) Qualifying chronic conditions include congestive heart failure (CHF), chronic lung disorders, dementia, diabetes, and stroke. Other chronic conditions may apply. Medical records will be used to establish the member qualification.†		
Pet Services	$0 copay for 7 boarding days or 14 walks per year	$0 copay for 7 boarding days or 14 walks per year
Pest Control	$0 copay for 1 service per year	$0 copay for 1 service per year
Air Purifier/Humidifier	not covered	$0 copay for either an air purifier or humidifier per year
PRESCRIPTION DRUG COVERAGE		
Part D Deductible	$0	$0
Part D Out of Pocket Threshold	$2,000	$2,000
Tier 1: Preferred Generic Drugs	**Retail & Mail Order Standard** $0 copay 30-day supply $0 copay 60-day supply $0 copay 100-day supply	**Retail & Mail Order Standard** $0 copay 30-day supply $0 copay 60-day supply $0 copay 100-day supply
Tier 2: Generic Drugs	**Retail & Mail Order Standard** $3 copay 30-day supply $6 copay 60-day supply $9 copay 100-day supply	**Retail & Mail Order Standard** $5 copay 30-day supply $10 copay 60-day supply $15 copay Retail/$12.50 Mail Order 100-day supply
Tier 3: Preferred Brand Drugs	**Retail & Mail Order Standard** $40 copay 30-day supply $80 copay 60-day supply $120 copay 100-day supply	**Retail & Mail Order Standard** $30 copay 30-day supply $60 copay 60-day supply $90 copay Retail/$75 Mail Order 100-day supply
Tier 4: Non-Preferred Drugs	**Retail & Mail Order Standard** $100 copay 30-day supply $200 copay 60-day supply $300 copay 100-day supply	**Retail & Mail Order Standard** $100 copay 30-day supply $200 copay 60-day supply $300 copay 100-day supply
Tier 5: Specialty Tier Drugs	**Retail & Mail Order Standard** 33% coinsurance 30-day supply	**Retail & Mail Order Standard** 33% coinsurance 30-day supply
Tier 6: Select Care Drugs	**Retail & Mail Order Standard** $5 copay 30-day supply $10 copay 60-day supply $0 copay 100-day supply	**Retail & Mail Order Standard** $3 copay 30-day supply $6 copay 60-day supply $0 copay 100-day supply
Ways To Save on Prescriptions	Pay $0 for a 100-day supply for Tier 1 and Tier 6 drugs	Pay $0 for a 100-day supply for Tier 1 and Tier 6 drugs
Bonus Drug Coverage	Some prescription drugs, for cough and cold, hair loss, vitamins, sexual dysfunction, just to name a few. The amount you will pay will be determined by the drug tier. The amount you pay does not count toward your deductible or “total drug costs” that help you qualify for catastrophic coverage). Generic Viagra, cough and cold medications, prescription vitamins, and hair loss drugs. For a complete list and coverage details, refer to the Bonus Drug List. Please refer to the Alignment Drug Formulary for full details.	
Insulin	**Important Message About What You Pay for Insulin:** You won’t pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on, even if you haven’t paid your deductible.	
Vaccines	Our plan covers most Part D vaccines at no cost to you even if you haven’t paid your deductible.	

†The benefits mentioned are a part of a special supplemental program for the chronically ill. Not all members qualify because other eligibility and coverage criteria also apply.

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, Nevada, North Carolina and Texas 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. This information is not a complete description of benefits. Call 1-888-979-2247 (TTY: 711), 8 a.m. - 8 p.m. Monday through Friday, for more information. ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-866-634-2247 (TTY 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-399-2247 (TTY 711). 注 意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-634-2247 (TTY 711).