Alignment Health Plan®

2026 SUMMARY OF BENEFITS

Alignment Health My Choice Select (HMO)
Alignment Health My Choice (HMO)

Los Angeles, Orange, Riverside, San Bernardino, San Luis Obispo, and Ventura counties

This is a summary of drug and health services benefits covered by Alignment Health Plan for January 1, 2026 - December 31, 2026.

www.AlignmentHealthPlan.com

Y0141_26239EN_M

PREMIUMS AND BENEFITS

	ALIGNMENT HEALTH MY CHOICE SELECT (HMO) 049 Los Angeles, Orange, Riverside, and San Bernardino counties	**ALIGNMENT HEALTH MY CHOICE (HMO) 028** San Luis Obispo and Ventura counties
MONTHLY PLAN PREMIUM		
• Part C & Part D	$0.00	$0.00
DEDUCTIBLE	$0.00	$0.00
MAXIMUM OUT-OF-POCKET RESPONSIBILITY (does not include prescription drugs)	$798.00	$698.00
INPATIENT HOSPITAL [1, 2]	$0.00 (unlimited days per admission)	$0.00 (unlimited days per admission)
OUTPATIENT HOSPITAL [1, 2]		
• Hospital Services	$0.00	$0.00
• Observation Services	$0.00	$0.00
AMBULATORY SURGICAL CENTER [1, 2]	$0.00	$0.00
DOCTOR VISITS		
• Primary	$0.00	$0.00
• Specialists [1, 2]	$0.00	$0.00
PREVENTIVE CARE (e.g., flu vaccine, diabetic screenings)	$0.00	$0.00
EMERGENCY CARE	$70.00 (waived if admitted within 48 hours)	$100.00 (waived if admitted within 48 hours)
URGENTLY NEEDED SERVICES	$0.00	$0.00
OUTPATIENT DIAGNOSTIC [1, 2]		
• Procedures, tests, lab services	$0.00	$0.00
• X-Ray	$0.00	$0.00
• Diagnostic	$0.00	$0.00
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance	20% coinsurance

	ALIGNMENT HEALTH MY CHOICE SELECT (HMO) 049 Los Angeles, Orange, Riverside, and San Bernardino counties	ALIGNMENT HEALTH MY CHOICE (HMO) 028 San Luis Obispo and Ventura counties
HEARING SERVICES		
• Routine hearing exam	$0.00 Medicare-covered benefits and 1 exam/fitting/ evaluation every year	$0.00 Medicare-covered benefits and 1 exam/fitting/ evaluation every year
• Hearing aids	$195.00 - $1,750.00 copay per hearing aid, 2 hearing aids every year	$195.00 - $1,750.00 copay per hearing aid, 2 hearing aids every year
DENTAL SERVICES [1] www.libertydental.com		
Diagnostic and preventive:		
• Exam	$0.00 for 1 every six months	$0.00 for 1 every six months
• Cleaning	$0.00 for 1 every six months	$0.00 for 1 every six months
• Fluoride treatment	$0.00 for 1 every six months	$0.00 for 1 every six months
• X-Ray	$0.00 for 1 every three years	$0.00 for 1 every three years
Comprehensive:		
• Restorative	$0.00	$20.00 - $400.00
• Endodontics	$0.00	$25.00 - $350.00
• Periodontics	$0.00	$15.00 - $550.00
• Removable Prosthodontics	$0.00	$20.00 - $570.00
• Fixed Prosthodontics	$0.00	$40.00 - $400.00
• Oral and Maxillofacial Surgery	$0.00	$25.00 - $250.00
	$2,000.00 coverage limit every year for preventive and comprehensive combined	
VISION SERVICES		
• Routine exam	$0.00 Medicare-covered eye exams/1 routine eye exam every year	$0.00 Medicare-covered eye exams/1 routine eye exam every year
• Eyewear	$200.00 coverage limit for glasses/contacts every year	$100.00 coverage limit for glasses/contacts every year
MENTAL HEALTH SERVICES [1, 2]		
• Inpatient hospital	$120.00 per day, days 1-10 $0.00 per day, days 11-90 $0.00 for 40 additional day limit $0.00 for 60 "lifetime reserve days"	$120.00 per day, days 1-10 $0.00 per day, days 11-90 $0.00 for 40 additional day limit $0.00 for 60 "lifetime reserve days"
• Mental health specialty (individual and group)	$0.00	$0.00

	ALIGNMENT HEALTH MY CHOICE SELECT (HMO) 049 Los Angeles, Orange, Riverside, and San Bernardino counties	**ALIGNMENT HEALTH MY CHOICE (HMO) 028** San Luis Obispo and Ventura counties
• Psychiatric services (individual and group)	$20.00	$20.00
SKILLED NURSING FACILITY [1, 2]	$0.00 per day, days 1-20 $30.00 per day, days 21-100 (no prior hospital stay required)	$0.00 per day, days 1-20 $30.00 per day, days 21-100 (no prior hospital stay required)
PHYSICAL AND SPEECH THERAPY [1, 2]	$0.00	$0.00
GROUND AND AIR AMBULANCE SERVICES [1]	$75.00 (waived if admitted)	$100.00 Ground $200.00 Air (waived if admitted)
TRANSPORTATION [1]	$0.00 22 one-way trips to plan approved locations every year (within a 50-mile radius)	$0.00 22 one-way trips to plan approved locations every year (within a 50-mile radius)
MEDICARE PART B DRUGS [1]	0% - 20% coinsurance	0% - 20% coinsurance

OUTPATIENT PRESCRIPTION DRUGS

	ALIGNMENT HEALTH MY CHOICE SELECT (HMO) 049 Los Angeles, Orange, Riverside, and San Bernardino counties	
PART D DEDUCTIBLE	$0.00	
PART D OUT OF POCKET THRESHOLD	$2,100.00	
INITIAL COVERAGE	Retail Standard 30-day supply	Mail-order 100-day supply
Tier 1 (Preferred Generic Drugs):	$0.00	$0.00
Tier 2 (Generic Drugs):	$5.00	$12.50
Tier 3 (Preferred Brand Drugs):	$30.00	$75.00
Tier 4 (Non-Preferred Drugs):	$100.00	$300.00
Tier 5 (Specialty Tier):	33% coinsurance	Not covered
Tier 6 (Select Care Drugs):	$3.00	$0.00

	ALIGNMENT HEALTH MY CHOICE (HMO) 028 San Luis Obispo and Ventura counties	
PART D DEDUCTIBLE	$0.00	
PART D OUT OF POCKET THRESHOLD	$2,100.00	
INITIAL COVERAGE	Retail Standard 30-day supply	Mail-order 100-day supply
Tier 1 (Preferred Generic Drugs):	$0.00	$0.00
Tier 2 (Generic Drugs):	$3.00	$9.00
Tier 3 (Preferred Brand Drugs):	$40.00	$120.00
Tier 4 (Non-Preferred Drugs):	32% coinsurance	32% coinsurance
Tier 5 (Specialty Tier):	33% coinsurance	Not covered
Tier 6 (Select Care Drugs):	$5.00	$0.00

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COST-SHARING	May change depending on the pharmacy you choose and when you enter another of the three phases of the Part D benefit. If you reside in a long-term care facility, you pay the same copayment as at an in-network retail pharmacy for a 31-day supply.
CATASTROPHIC COVERAGE	After your yearly out-of-pocket drug costs reach $2,100.00, you pay $0.00 for plan-covered Part D drugs for the remainder of the year. For excluded drugs covered under our enhanced benefit, you pay the same copayment as you did in the Initial Coverage Stage.
BONUS DRUGS	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.
INSULIN	**Important Message About What You Pay for Insulins (Part B and Part D):** You won't pay more than $35.00 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	**Important Message About What You Pay for Vaccines:** Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible.

NOTE: Services notated with a "1" may require prior authorization. Services notated 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

	ALIGNMENT HEALTH MY CHOICE SELECT (HMO) 049 Los Angeles, Orange, Riverside, and San Bernardino counties	**ALIGNMENT HEALTH MY CHOICE (HMO) 028** San Luis Obispo and Ventura counties
ACCESS ON-DEMAND CONCIERGE CARD Provides access to OTC benefits and Healthy Rewards	Included	Included
ENHANCED DENTAL OPTION [1, 2]		
Monthly Premium	Not covered	$36.00
Coverage		
• Diagnostic	Not covered	0% coinsurance
• Restorative		50% coinsurance
• Endodontics		50% coinsurance
• Periodontics		0%-50% coinsurance
• Removable Prosthodontics		50% coinsurance
• Fixed Prosthodontics		50% coinsurance
• Oral and Maxillofacial Surgery		50% coinsurance
		$1,500.00 coverage limit per year
FITNESS (membership(s) at participating fitness centers)	$0.00	$0.00
PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) [1]	$0.00	$0.00
CHIROPRACTIC SERVICES [1, 2]	$0.00 Medicare-covered	$0.00 Medicare-covered
ACUPUNCTURE	$0.00 Medicare-covered	$0.00 Medicare-covered
PODIATRY SERVICES [1, 2]	$0.00 Medicare-covered	$0.00 Medicare-covered
OVER-THE-COUNTER (OTC)	$20.00 spending allowance every month (no rollover)	$20.00 spending allowance every month (no rollover)
TELEHEALTH	$0.00 for primary care provider, mental health specialty, and psychiatric services	$0.00 for primary care provider, mental health specialty, and psychiatric services
WORLDWIDE EMERGENCY/ URGENT CARE	$0.00 $25,000.00 coverage limit every year	$0.00 $50,000.00 coverage limit every year

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DURABLE MEDICAL EQUIPMENT (DME) [1]	0% coinsurance for items $350.00 or less 20% coinsurance for items $350.01 or more 20% coinsurance applies to continuous glucose monitors	0% coinsurance for items $450.00 or less 20% coinsurance for items $450.01 or more 20% coinsurance applies to continuous glucose monitors
IN-HOME SUPPORT SERVICES [1]	$0.00 12 hours every three months, 48 hours every year **OR** Support for Caregivers (member must choose in advance)	Not covered
SUPPORT FOR CAREGIVERS OF ENROLLEE [1]	$0.00 Up to $300.00 reimbursement every year **OR** In-home support services (member must choose in advance)	Not covered
RE-ADMISSION AND CHRONIC MEALS	$0.00 copay for 28 meals over 14 days, twice per year	$0.00 copay for 28 meals over 14 days, twice per year

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 lung disorders, dementia, diabetes, and stroke. Other chronic conditions may apply. Medical records will be used to establish the member qualification. 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.

AIR PURIFIER/HUMIDIFIER For members with a qualified chronic condition.	$0.00 1 air purifier or humidifier every year	Not covered
PET SERVICES For members who have hospital procedures or emergencies and need pet care while they are away.	$0.00 7 boarding days or 14 walks every year	$0.00 7 boarding days or 14 walks every year

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PEST CONTROL Annual pest eradication for covered pests to ensure the health, welfare, and safety of members.	$0.00 1 service every year	$0.00 1 service every year

Alignment

Effective Date: _____

Section 1 **All fields on this page are required (unless marked optional)**

SELECT THE PLAN YOU WANT TO JOIN:

ARIZONA			
☐ H3443-001	Alignment Health the ONE + Walgreens (HMO)	$0 per month	Maricopa
☐ H3443-002	Alignment Health the ONE + Walgreens (HMO)	$0 per month	Pima, Santa Cruz
☐ H3443-005	Alignment Health smartHMO	$0 per month	Maricopa, Pima, Santa Cruz
☐ H3443-005	Complete Package (Optional Buy Up)	$64.90 per month	Maricopa, Pima, Santa Cruz
CALIFORNIA (HMO)			
☐ H3815-001	Alignment Health My Choice (HMO)	$0 per month	Los Angeles, Orange, Riverside, San Bernardino
☐ H3815-008	Alignment Health Platinum + Instacart (HMO)	$0 per month	Los Angeles, Orange
☐ H3815-011	Alignment Health AllCare Preferred (HMO)	$0 per month	Stanislaus
☐ H3813-013	Alignment Health smartHMO	$0 per month	Los Angeles, Orange, Riverside, San Bernardino, San Diego
☐ H3815-016	Alignment Health Platinum + Instacart (HMO-POS)	$0 per month	Marin, San Diego, San Francisco
☐ H3815-019	Alignment Health Sutter Advantage +More (HMO)	$19 per month	Placer, Sacramento, Yolo
☐ H3815-020	Alignment Health Sutter Advantage +More (HMO)	$49 per month	Santa Clara
☐ H3815-021	Alignment Health Sutter Advantage +More (HMO)	$59 per month	Santa Cruz
☐ H3815-023	Alignment Health Sutter Advantage +More (HMO)	$48 per month	San Francisco, San Mateo, Sonoma
☒ H3815-028	Alignment Health My Choice (HMO)	$0 per month	San Luis Obispo, Ventura
☐ H3815-031	Alignment Health Harmony (HMO)	$0 per month	Alameda, San Francisco, Santa Clara, San Mateo
☐ H3815-034	Alignment Health the ONE (HMO)	$0 per month	Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara
☐ H3815-035	Alignment Health the ONE + Walgreens (HMO)	$0 per month	Fresno, Madera, Merced
☐ H3815-038	Alignment Health smartHMO	$0 per month	Placer, Sacramento, Yolo
☐ H3815-040	Alignment Health smartHMO	$0 per month	Merced, Santa Clara, Stanislaus, Ventura
☐ H3815-046	Alignment Heath CommUnity (HMO)	$0 per month	Fresno, Madera
☐ H3815-047	Alignment Health smartSavings (HMO)	$0 per month	Los Angeles, Orange, Riverside, San Bernardino, San Diego
☐ H3815-049	Alignment Health My Choice Select (HMO)	$0 per month	Los Angeles, Orange, Riverside, San Bernardino
☐ H3815-050	Alignment Health My Choice CalCare (HMO)	$0 per month	Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Clara, Stanislaus, Ventura, Yolo
☐ H3815-052	Alignment Health Honor+ Plan (HMO)	$0 per month	Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Stanislaus, Ventura, Yolo
☐ H3815-053	Alignment Health ValorCare (HMO)	$0 per month	Los Angeles, Orange, Riverside, San Bernardino, San Diego
☐ H3815-055	Alignment Health L.A. Premium Giveback (HMO)	$0 per month	Los Angeles
☐ H3815-056	Alignment Health S.D. Premium Giveback (HMO)	$0 per month	San Diego
☐ H3815-001, -008, -011, 019, -020, -021, 023, -028, -031, 034, -035	Enhanced Dental Option (Optional Buy Up)	$36 per month	Alameda, Fresno, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, Ventura, Yolo

Section 1 **All fields on this page are required (unless marked optional)**

SELECT THE PLAN YOU WANT TO JOIN:

☐ H3815-013, -038, -040, -047, -055, -056	Complete Package (Optional Buy Up)	$64.90 per month	Los Angeles, Orange, Riverside, San Bernardino, San Diego, Merced, Santa Clara, Stanislaus, Ventura, Placer, Sacramento, Yolo
CALIFORNIA (PPO)			
☐ H8832-001	Alignment Health Advantage PPO	$45 per month	Fresno, Los Angeles, Madera, Orange, San Diego, Ventura
☐ H8832-002	Alignment Health Advantage PPO	$75 per month	Santa Clara
☐ H8832-003	Alignment Health Freedom (PPO)	$12 per month	San Diego, San Joaquin, Stanislaus
☐ H4961-001	Alignment Health My Choice (PPO)	$77 per month	Placer, Sacramento, San Joaquin, Santa Cruz, Stanislaus, Yolo
☐ H4961-003	Alignment Health My Choice (PPO)	$106 per month	San Mateo, Sonoma
☐ H4961-006	Alignment Health Balance (PPO)	$41 per month	San Joaquin, Stanislaus
☐ H8832-002/ H4961-001, -003, -006	Enhanced Dental Option (Optional Buy Up)	$36 per month	Placer, Sacramento, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, Yolo
☐ H8832-001	Options+ (Optional Buy Up)	$48 per month	Fresno, Los Angeles, Madera, Orange, San Diego, Ventura
NEVADA			
☐ H5296-007	Alignment Health Platinum + Instacart (HMO)	$0 per month	Clark
☐ H9686-007	Alignment Health Platinum + Instacart (HMO)	$0 per month	Washoe
☐ H5296-008	Alignment Health smartHMO	$0 per month	Clark
☐ H9686-008	Alignment Health smartHMO	$0 per month	Washoe
☐ H9686-009	Alignment Health + Intermountain Health (HMO)	$0 per month	Clark
☐ H5296-008	Complete Package (Optional Buy Up)	$64.90 per month	Clark
☐ H9686-008	Complete Package (Optional Buy Up)	$64.90 per month	Washoe
NORTH CAROLINA (HMO)			
☐ H5296-003	Alignment Health Platinum (HMO)	$0 per month	**All plans in North Carolina are available in** Avery, Buncombe, Chatham, Davidson, Davie, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes
☐ H5296-006	Alignment Health smartHMO	$0 per month	
☐ H5296-010	Alignment Health Platinum Select (HMO)	$0 per month	
☐ H5296-006	Complete Package (Optional Buy Up)	$64.90 per month	
NORTH CAROLINA (PPO)			
☐ H7074-001	Alignment Health AVA (PPO)	$10 per month	
TEXAS			
☐ H5472-001	Alignment Health the ONE + Walgreens (HMO-POS)	$0 per month	El Paso, Hudspeth
☐ H5472-003	Alignment Health smartHMO (HMO-POS)	$0 per plan	El Paso, Hudspeth
☐ H5472-010	Alignment Health smartSavings (HMO-POS)	$0 per month	El Paso, Hudspeth
☐ H5472-010	Complete Package (Optional Buy Up)	$64.90 per month	El Paso, Hudspeth

First Name:	Last Name:	Middle Initial (optional):
Birth Date: (MM/DD/YYYY) (/ /)	Sex: ☐ Male ☐ Female	Home Phone Number: ( ) –
Email Address:		Cell Phone Number (Optional): ( ) –
Permanent Residence Street Address (Don't Enter a P.O. Box):		
City:	County (Optional):	State: ZIP Code:
Mailing Address, If Different From Your Permanent Address (P.O. Box Allowed):		
City:	County (Optional):	State: ZIP Code:
Emergency Contact (Optional):	Relationship:	Phone Number: ( ) –

YOUR MEDICARE INFORMATION:

Medicare Number: – –

Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Alignment Health Plan? ☐ Yes ☐ No

Name of Other Coverage: Member Number for this Coverage: Group Number for this Coverage:

Please choose the name of a primary care provider (PCP). **For HMO plans, if the PCP you choose is not available, an available PCP will be automatically assigned to you.**

Primary Care Provider: Primary Care Provider ID: Medical Group:

I am a(n) ☐ Existing Patient ☐ New Patient

Are you eligible or enrolled in a State Medicaid or Medi-Cal program? ☐ Yes ☐ No

If you are enrolled in a State Medicaid Program

Medicaid number:

IMPORTANT: READ AND SIGN BELOW:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Alignment Health Plan.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Alignment Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, and MA MSA plans).
- I understand that when my Alignment Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Alignment Health Plan. Benefits and services provided by Alignment Health Plan and contained in my Alignment Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Alignment Health Plan will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  1. This person is authorized under State law to complete this enrollment, and
  2. Documentation of this authority is available upon request by Medicare.

Signature:	**Today's Date:** / /
If you're the authorized representative, sign above and fill out these fields:	
Name:	Address:
Phone Number: ( ) –	Relationship to Enrollee:

Section 2 **All fields on this page are optional**

ANSWERING THESE QUESTIONS IS YOUR CHOICE. YOU CAN'T BE DENIED COVERAGE BECAUSE YOU DON'T FILL THEM OUT.

Select one if you want us to send you information in a language other than English.
☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Korean ☐ Other

Select one if you want us to send you information in an accessible format. ☐ Standard/Regular Font ☐ Braille ☐ Large Print ☐ Audio ☐ Data CD
Please contact Alignment Health Plan at 1-866-634-2247 (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. If no selection is made, Standard/Regular font will be sent.

Do you work? ☐ Yes ☐ No	Does your spouse work? ☐ Yes ☐ No

The following materials will be sent to you via email unless you prefer to receive a printed copy. Please check below if you prefer to receive a printed version.
☒ Part C Explanation of Benefits (EOB) ☒ Part D Explanation of Benefits (EOB) ☒ Annual Notification of Change (ANOC)

Paying your plan premiums

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month.
You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

Please select a plan premium and/or late enrollment payment option:
☐ Get a bill
☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Alignment Health Plan the Part D-IRMAA.

Sales Representative (if assisted with Enrollment):
Enrolling Sales Representative's Signature: K. Meredith

Print Name: Kian Kip Meredith
Phone Number: (805) 548-8472

NPN#: 2594225
Sales ID#: 0003003
Date: / /

For Office Use Only:

AHC-ENR-HMO/PPO-2026-5

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD

Alignment Health Plan®

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved, and this plan is a new option for me. I moved on (insert date) ____ / ____ / ____.
- ☐ I was recently released from incarceration. I was released on (insert date) ____ / ____ / ____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____ / ____ / ____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ____ / ____ / ____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ____ / ____ / ____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ____ / ____ / ____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) ____ / ____ / ____.
- ☐ I recently left a PACE program on (insert date) ____ / ____ / ____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ____ / ____ / ____.
- ☐ I am leaving employer or union coverage on (insert date) ____ / ____ / ____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (insert date) ____ / ____ / ____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) ____ / ____ / ____.
- ☐ I was affected by a weather-related emergency or major disaster, as declared by the Federal Emergency Management Agency (F.E.M.A). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Alignment Health Plan at 866-634-2247 (TTY 711), 8am-8pm, seven days a week (except Thanksgiving and Christmas) from October 1 to March 31 and 8am-8pm Monday through Friday (except holidays) from April 1 through September 30, to see if you are eligible to enroll. 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.

SCOPE OF SALES APPOINTMENT CONFIRMATION FORM

Alignment Health Plan®

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative. Please initial below beside the type of product(s) you want the agent to discuss.

MEDICARE ADVANTAGE PLANS (PART C) AND COST PLANS

____ **Medicare Health Maintenance Organization (HMO)**
A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

____ **Medicare Preferred Provider Organization (PPO) Plan**
A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals, but you can also use out-of-network providers, usually at a higher cost.

____ **Medicare Point of Service (POS) Plan**
A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

____ **Medicare Special Needs Plan (SNP)**
A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____ **Signature Date:** ☐☐ ☐☐ ☐☐☐☐

If you are the Authorized Representative, please sign above and print below:

Representative's Name:

Your Relationship to the Beneficiary:

TO BE COMPLETED BY AGENT

Agent Name: Alan Kip Meredith	Agent Phone: 805 548 8672
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact (Indicate here if beneficiary was a walk-in):	
Agent's Signature: K. Meredith	
Plan(s) the agent represented during this meeting: Advantage Plans	
Date Appointment Completed:	
Plan Use Only:	

*Scope of Appointment documentation is subject to CMS record retention requirements.
*Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting:

_____

_____

_____