












# 2020

## BENEFIT CHART

Los Angeles,  
Orange, Riverside &  
San Bernardino Counties



	<b>MY CHOICE (HMO) 001</b> Los Angeles, Orange, Riverside & San Bernardino Counties	<b>PLATINUM (HMO) 015</b> Riverside & San Bernardino Counties
 <b>Plan Premium</b>	\$0	
 <b>Max. Out of Pocket</b>	\$3,200	\$2,400
<b>MEDICARE COVERED BENEFITS</b>		
 <b>Inpatient Hospital</b>	\$50 copay days 1-3 \$0 copay days 4-90 (unlimited days per admission)	\$0 copay
 <b>Skilled Nursing Facility</b>	\$0 copay days 1-20 \$30 copay days 21-100 (no prior hospital stay required)	
 <b>Doctor Visits</b>	PCP \$0 copay Specialist \$0 copay	
 <b>Ground and Air Ambulance Services</b>	\$125 copay (waived if admitted)	\$75 copay (waived if admitted)
 <b>Emergency/Post-Stabilization Care</b>	\$75 copay (waived if admitted within 48hrs)	\$70 copay (waived if admitted within 48hrs)
 <b>Urgently Needed Services</b>	\$0-10 copay (waived if admitted within 24hrs)	
 <b>Durable Medical Equipment</b>	0% coinsurance for items \$350 or less 20% coinsurance for items \$350.01 or more	
 <b>Outpatient Diagnostic (Tests/Lab Services)</b>	\$0 copay	



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**Outpatient Radiology**  
 (X-Ray/Diagnostic/  
 Therapeutic)

\$0 copay (X/D)  
 20% coinsurance (T)

**PRESCRIPTION DRUG BENEFITS** (30 day Preferred Retail supply)



**Initial Coverage Limit**

\$4,020



**Part D Deductible**

\$0



**Gap Coverage**

Tier 1: All Drugs  
 Tier 6: All Drugs



**Preferred Generic  
 Drugs**

\$0 copay



**Generic Drugs**

\$5 copay



**Preferred Brand Drugs**

\$30 copay



**Non-Preferred Brand  
 Drugs**

\$100 copay



**Specialty Drugs**

33% coinsurance



**Select Care Drugs**

\$3 copay

**ADDED BENEFITS - MORE THAN ORIGINAL MEDICARE!**



**Hearing Services**

\$0 copay for Medicare covered benefits  
 \$0 copay for exam/fitting/evaluation  
 1 per year



**Hearing Aid**

Not covered

\$0 copay for 2 hearing aids for both  
 ears combined with a \$1,000 limit  
 every two years



**Dental Services**

\$0 copay for 1 exam and 1 cleaning every six months  
 See Summary of Benefits for Coverage Details









**Vision Services**

\$0 copay for 1 routine eye exam every year



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 <b>Eyewear</b>	\$0 copay for glasses/contacts every two years \$75 coverage limit every two years	\$0 copay for glasses/contacts every two years \$200 coverage limit every two years
 <b>Transportation</b>	\$0 copay/22 one-way trips to plan approved locations every year (within a 50-mile radius)	
 <b>Fitness</b>	\$0 copay	
 <b>AHC Black Card</b> (24/7 Concierge Care; Telehealth; OTC)	\$0 copay	
 <b>Over-The-Counter (OTC)</b>	\$0 copay for \$10 monthly allowance (no rollover)	\$0 copay for \$20 monthly allowance (no rollover)
 <b>Readmission Prevention/Post-Discharge Meals</b>	Not covered	\$0 copay for Post-Discharge Meals 28 days, 56 meals



Alignment Health Plan is an HMO, PPO and an HMO SNP plan with a Medicare contract. 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. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-877-399-2247 (TTY 711). ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-399-2247 (TTY 711). Y0141\_20036EN\_M