2020
BENEFIT CHART

San Joaquin & Stanislaus Counties

ALIGNMENT HEALTH PLAN	MY CHOICE (HMO) 006 San Joaquin & Stanislaus Counties	ALLCARE PREFERRED PLAN (HMO) 011 Stanislaus County	PLATINUM (HMO) 025 San Joaquin County
Plan Premium	$0		$9
Max. Out of Pocket	$4,900	$3,400	$2,850
MEDICARE COVERED BENEFITS			
Inpatient Hospital	$0 copay days 1-3 $100 copay days 4-10 $0 copay days 11-90 (unlimited days)	$0 copay days 1-4 $50 copay days 5-10 $0 copay days 11-90 (unlimited days per admission)	$0 copay days 1-2 $150 copay days 3-8 $0 copay days 9-90 (unlimited days)
Skilled Nursing Facility	$0 copay days 1-20 $50 copay days 21-100 (no prior hospital stay required)		$0 copay days 1-20 $100 copay days 21-100 (no prior hospital stay required)
Doctor Visits	PCP $0 copay Specialist $0 copay		
Ground and Air Ambulance Services	$100 copay (waived if admitted)		$250 copay (waived if admitted)
Emergency/Post-Stabilization Care	$85 copay (NOT waived if admitted)	$75 copay (NOT waived if admitted)	$90 copay (NOT waived if admitted)
Urgently Needed Services	$0-10 copay (waived if admitted within 24hrs)		$0 copay
Durable Medical Equipment	20% coinsurance	0% coinsurance for items $350 or less 20% coinsurance for items $350.01 or more	20% coinsurance

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Outpatient Diagnostic (Tests/Lab Services)	$0 copay		
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 6: All Drugs		
Preferred Generic Drugs	$5 copay		
Generic Drugs	$10 copay		
Preferred Brand Drugs	$40 copay		
Non-Preferred Brand Drugs	$93 copay		
Specialty Drugs	33% coinsurance		
Select Care Drugs	$5 copay		
ADDED BENEFITS - MORE THAN ORIGINAL MEDICARE!			
Hearing Services	$0 copay for Medicare covered benefits $0 copay for exam/fitting/evaluation 1 per year		
Dental Services	$0 copay for 1 exam and 1 cleaning per year See Summary of Benefits for Coverage Details		
Vision Services	$0 copay for 1 routine eye exam every year		

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Eyewear	$0 copay for glasses/ contacts every two years $100 coverage limit every two years	$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
Transportation	$0 copay/12 one-way trips to Care Centers only (within a 20 mile radius)	$0 copay/26 one-way trips to plan approved locations per year (within a 50 mile radius) Unlimited trips to the Care Centers	Not covered
Fitness	$0 copay		
AHC Black Card (24/7 Concierge Care; Telehealth)	$0 copay		
Over-The-Counter (OTC)	Not covered	$15 monthly allowance (no rollover)	$20 monthly allowance (no rollover)
Readmission Prevention/Post-Discharge Meals	$0 copay for Post-Discharge Meals 28 days, 56 meals		Not covered
Social Needs	Not covered	$0 copay 12 hours per quarter 48 hours per year	Not covered
Groceries	Not covered	$0 copay $10 spending limit per month	Not covered

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