










2020

BENEFIT CHART

San Francisco, San Mateo, Santa Clara & Santa Cruz Counties



	SUTTER ADVANTAGE (HMO) 024 San Francisco County	SUTTER ADVANTAGE (HMO) 022 San Mateo County	SUTTER ADVANTAGE (HMO) 020 Santa Clara County	SUTTER ADVANTAGE (HMO) 021 Santa Cruz County
 Plan Premium	\$44	\$46	\$49	\$59
 Max. Out of Pocket	\$3,900		\$4,900	
MEDICARE COVERED BENEFITS				
 Inpatient Hospital	\$225 copay days 1-5 \$0 copay days 6-90 (unlimited days per admission)			
 Skilled Nursing Facility	\$0 copay days 1-20 \$160 copay days 21-51 \$0 copay days 52-100 (no prior hospital stay required)	\$0 copay days 1-20 \$160 copay days 21-62 \$0 copay days 63-100 (no prior hospital stay required)	\$0 copay days 1-20 \$160 copay days 21-57 \$0 copay days 58-100 (no prior hospital stay required)	\$0 copay days 1-20 \$160 copay days 21-62 \$0 copay days 63-100 (no prior hospital stay required)
 Doctor Visits	PCP \$5 copay Specialist \$20 copay	PCP \$5 copay Specialist \$25 copay	PCP \$5 copay Specialist \$20 copay	
 Ground and Air Ambulance Services	\$250 copay (waived if admitted)			
 Emergency/Post-Stabilization Care	\$90 copay (NOT waived if admitted)			
 Urgently Needed Services	\$0-10 copay (waived if admitted within 24hrs)			



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Durable Medical Equipment	0% coinsurance for items \$350 or less 20% coinsurance for items \$350.01 or more
Outpatient Diagnostic (Tests/Lab Services)	\$0 copay
Outpatient Radiology (X-Ray/Diagnostic/ Therapeutic)	\$15 copay (X) \$150 copay (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	\$0 copay
Generic Drugs	\$5 copay
Preferred Brand Drugs	\$40 copay
Non-Preferred Brand Drugs	\$100 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 1 cleaning and 1 exam every six months See Summary of Benefits for Coverage Details








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 Vision Services	\$0 copay for 1 routine eye exam every year
 Eyewear	\$0 copay for glasses/contacts every two years \$150 coverage limit every two years
 Fitness	\$0 copay
 AHC Black Card (24/7 Concierge Care; Telehealth; OTC)	\$0 copay
 Over-The-Counter (OTC)	\$0 copay for \$15 monthly allowance



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_20044EN_M