

























2020


BENEFIT CHART

Sacramento, Placer, Yolo,
San Mateo, Sonoma,
San Joaquin & Stanislaus
Counties



		MY CHOICE (PPO) 001	MY CHOICE (PPO) 002	MY CHOICE (PPO) 003	MY CHOICE (PPO) 004
		Sacramento, Placer & Yolo Counties	San Mateo County	Sonoma County	San Joaquin & Stanislaus Counties
 Plan Premium		\$75	\$95	\$97	\$79
 Max. Out of Pocket	In-Network: \$4,200 Out-of-Network \$8,000 combined				
MEDICARE COVERED BENEFITS					
 Inpatient Hospital	In-Network: \$150 copay days 1-5 \$0 copay days 6-90 (unlimited days per admission) Out-of-Network: 40% coinsurance	In-Network: \$225 copay days 1-5 \$0 copay days 6-90 (unlimited days per admission) Out-of-Network: 40% coinsurance	In-Network: \$150 copay days 1-5 \$0 copay days 6-90 (unlimited days per admission) Out-of-Network: 40% coinsurance		
 Skilled Nursing Facility	In-Network: \$0 copay days 1-20 \$160 copay days 21-51 \$0 copay days 52-100 (no prior hospital stay required) Out-of-Network: 40% coinsurance				
 Doctor Visits	PCP In-Network: \$5 copay / Out-of-Network: 25% coinsurance Specialist In-Network: \$35 copay / Out-of-Network: 25% coinsurance				
 Ground and Air Ambulance Services	\$250 copay (waived if admitted)				
 Emergency/Post-Stabilization Care	\$85 copay (NOT waived if admitted)				
 Urgently Needed Services	\$0-10 copay (waived if admitted within 24hrs)				

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	Durable Medical Equipment	In Network: 0% coinsurance for items \$350 or less 0% coinsurance for items \$350.01 or more Out-of-Network: 40% coinsurance			
	Outpatient Diagnostic (Tests/Lab Services)	\$0 copay Out-of-Network: 40% coinsurance			
	Outpatient Radiology (X-Ray/Diagnostic/ Therapeutic)	In-Network: \$15 copay (X) \$150 copay (D) 20% coinsurance (T) Out-of-Network: 40% coinsurance			
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			
	Vision Services	\$0 copay for 1 routine eye exam every year			

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	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_20043EN_M