2020 Summary of Benefits

This is a summary of drug and health services covered by **Alignment Health Plan My Choice (HMO) 001** and **Alignment Health Plan Platinum (HMO) 015** for January 1, 2020 - December 31, 2020.

Alignment Health Plan (HMO) plans are Medicare Advantage HMO plans with a Medicare contract. Enrollment in the plans depend on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join **Alignment Health Plan My Choice (HMO) 001** or **Alignment Health Plan Platinum (HMO) 015** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in the service area. The service area for **Alignment Health Plan My Choice (HMO) 001** is Los Angeles, Orange, San Bernardino and Riverside Counties. The services area for **Alignment Health Plan Platinum (HMO) 015** is San Bernardino and Riverside Counties.

If you use the providers that are not in our network, we may not pay for these services. For coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio. For more information, please call us at 1-866-634-2247 (TTY users should call 711), October 1 – March 31: Seven days a week, from 8:00 a.m. to 8:00 p.m. except for Thanksgiving and Christmas Day. April 1 – September 30: Monday through Friday, (except holidays) from 8:00 a.m. to 8:00 p.m. Or visit us at alignmenthealthplan.com.

Premiums and Benefits	**Alignment Health Plan My Choice (HMO) 001** Los Angeles, Orange, San Bernardino and Riverside Counties	**Alignment Health Plan Platinum (HMO) 015** San Bernardino & Riverside Counties
Monthly Plan Premium • Part C & Part D	$0 You must continue to pay your Medicare Part B Premium	$0 You must continue to pay your Medicare Part B Premium
Deductible	No deductible	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	You pay no more than $3,200 annually Includes copays and other costs for medical services for the year	You pay no more than $2,400 annually Includes copays and other costs for medical services for the year
Inpatient Hospital[1,2]	$50 copay per day, days 1-3 $0 copay per day, days 4-90 (unlimited days per admission)	$0 copay
Outpatient • Hospital Services • Observation Services	 $100 copay $0 copay	 $0 copay $0 copay
Ambulatory Surgical Center	$0 copay	$0 copay
Doctor Visits • Primary • Specialists[1,2]	 $0 copay $0 copay (prior authorization is required for specialty visits)	 $0 copay $0 copay (prior authorization is required for specialty visits)
Preventive Care (e.g., flu vaccine, diabetic screenings)	$0 copay Other preventive services are available There are some covered services that have a cost	$0 copay Other preventive services are available There are some covered services that have a cost
Emergency Care/ Post-Stabilization Care	$75 copay (waived if admitted within 48 hours)	$70 copay (waived if admitted within 48 hours)
Urgently Needed Services	$0-10 copay (waived if admitted within 24hrs)	$0-10 copay (waived if admitted within 24hrs)
Outpatient Diagnostic[1,2] • Procedures, tests, lab services • X-Ray/Diagnostic • Therapeutic radiology services (such as radiation treatment for cancer)	 $0 copay $0 copay 20% coinsurance	 $0 copay $0 copay 20% coinsurance

Premiums and Benefits	**Alignment Health Plan My Choice (HMO) 001** Los Angeles, Orange, San Bernardino and Riverside Counties	**Alignment Health Plan Platinum (HMO) 015** San Bernardino & Riverside Counties
Hearing Services[1,2]		
• Routine hearing exam	$0 copay for exam/fitting/ evaluation (1 per year)	$0 copay for exam/fitting/ evaluation (1 per year)
• Hearing aid	Not covered	$0 copay for 2 hearing aids (every two years) $1,000 limit (every two years) Maximum benefit applies to both ears combined
Dental Services[1,2]		
• Oral exam & cleaning	$0 copay (1 every six months)	$0 copay (1 every six months)
• Fluoride treatment	$0-20 copay (1 every six months)	$0-20 copay (1 every six months)
• X-ray	$0-30 copay (1 every three years)	$0-30 copay (1 every three years)
Vision Services		
• Routine exam	$0 copay (1 per year)	$0 copay (1 per year)
• Eyewear coverage limit	$0 copay for glasses/contacts (every two years) $75 plan coverage limit (every two years)	$0 copay for glasses/contacts (every two years) $200 plan coverage limit (every two years)
Mental Health Services[1,2]		
• Outpatient group therapy/ individual therapy visit	$0 copay	$0 copay
Skilled Nursing Facility[1,2]	$0 copay per day, days 1-20 $30 copay per day, days 21-100 (no prior hospital stay required)	$0 copay per day, days 1-20 $30 copay per day, days 21-100 (no prior hospital stay required)
Physical Therapy[1]	$0 copay	$0 copay
Ground and Air Ambulance Services[1]	$125 copay (waived if admitted)	$75 copay (waived if admitted)
Transportation	$0 copay 22 one-way trips to approved locations within 50 miles	$0 copay 22 one-way trips to approved locations within 50 miles
Medicare Part B Drugs	20% of the cost for other Part B drugs	20% of the cost for other Part B drugs

Outpatient Prescription Drugs	**Alignment Health Plan My Choice (HMO) 001** Los Angeles, Orange, San Bernardino and Riverside Counties		
Part D Deductible	$0		
Initial Coverage Limit	$4,020		
Part D Out of Pocket Threshold	$6,350		
	Preferred Retail Rx 30-day supply	**Non-Preferred Retail Rx 30-day supply**	**Mail Order 100-day supply**
Initial Coverage • Tier 1: Preferred Generic • Tier 2: Generic • Tier 3: Preferred Brand • Tier 4: Non-Preferred Brand • Tier 5: Specialty Tier • Tier 6: Select Care	 $0 copay $5 copay $30 copay $100 copay 33% coinsurance $3 copay	 $7 copay $12 copay $37 copay $100 copay 33% coinsurance $3 copay	 $0 copay $12.50 copay $75 copay $300 copay Not covered $0 copay
Gap Coverage • Tiers 1 & 6: All Drugs	Cost-Sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit. If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy for a 31-day supply.		

Outpatient Prescription Drugs	**Alignment Health Plan Platinum (HMO) 015** San Bernardino & Riverside Counties		
Part D Deductible	$0		
Initial Coverage Limit	$4,020		
Part D Out of Pocket Threshold	$6,350		
	Preferred Retail Rx 30-day supply	**Non-Preferred Retail Rx 30-day supply**	**Mail Order 100-day supply**
Initial Coverage • Tier 1: Preferred Generic • Tier 2: Generic • Tier 3: Preferred Brand • Tier 4: Non-Preferred Brand • Tier 5: Specialty Tier • Tier 6: Select Care	 $0 copay $5 copay $30 copay $100 copay 33% coinsurance $3 copay	 $7 copay $12 copay $37 copay $100 copay 33% coinsurance $3 copay	 $0 copay $15 copay $90 copay $300 copay Not covered $0 copay
Gap Coverage • Tiers 1 & 6: All Drugs	Cost-Sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit. If you reside in a long-term care facility, you pay the same as at a preferred retail pharmacy for a 31-day supply.		

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

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_20057EN_M

Understanding the Benefits & Rules

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at:

1-888-979-2247 (TTY USERS CALL 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.

Understanding the Benefits	
☐	Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **alignmenthealthplan.com** or call **1-866-634-2247** to view a copy of the EOC.
☐	Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
☐	Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules	
☐	In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
☐	Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
☐	Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).