2020 Summary of Benefits

This is a summary of drug and health services covered by **My Choice (PPO) 001** and **My Choice (PPO) 003** for January 1, 2020 - December 31, 2020.

My Choice (PPO) plans are Medicare Advantage PPO 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 **My Choice (PPO) 001** or **My Choice (PPO) 003**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in the plans service area. The service area for **My Choice (PPO) 001** is Sacramento, Placer, and Yolo Counties. The service area for **My Choice (PPO) 003** is Sonoma County.

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	**My Choice (PPO) 001** Sacramento, Placer, Yolo	**My Choice (PPO) 003** Sonoma
Monthly Plan Premium • Part C & Part D	$75	$97
Deductible	$0	$0
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	In-Network: $4,200 Out-of-Network: $8,000 combined	In-Network: $4,200 Out-of-Network: $8,000 combined
Inpatient Hospital[1,2]	In-Network: $150 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
Outpatient • Hospital Services • Observation Services	In-Network: $195 copay Out-of-Network: 25% coinsurance In-Network: $0 copay Out-of-Network: 25% coinsurance	In-Network: $195 copay Out-of-Network: 25% coinsurance $0 copay for Observation services Out-of-Network: 25% coinsurance
Ambulatory Surgical Center	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance
Doctor Visits • Primary • Specialists[1,2]	In-Network: $5 copay Out-of-Network: 25% coinsurance In-Network: $35 copay Out-of-Network: 25% coinsurance	In-Network: $5 copay Out-of-Network: 25% coinsurance In-Network: $35 copay Out-of-Network: 25% coinsurance
Preventive Care	In-Network only $0 copay	In-Network only $0 copay
Emergency Care/ Post-Stabilization Care	$85 copay (NOT waived if admitted)	$85 copay (NOT waived if admitted)
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 / Diagnostics • Therapeutic radiology services (such as radiation treatment for cancer)	$0 copay $15 copay (X) / $150 copay (D) 20% coinsurance (T) Out-of-Network: 40% coinsurance	$0 copay $15 copay (X) / $150 copay (D) 20% coinsurance (T) Out-of-Network: 40% coinsurance
Hearing Services[1,2] • Routine hearing exam • Hearing aid	$0 copay for exam/fitting/ evaluation (1 per year) Not covered	$0 copay for exam/fitting/ evaluation (1 per year) Not covered
Dental Services[1,2] • Oral exam & cleaning • Fluoride treatment • X-ray	In-Network: $0 copay Medicare Covered only Out-of-Network: 40% coinsurance Medicare Covered only	In-Network: $0 copay Medicare Covered only Out-of-Network: 40% coinsurance Medicare Covered only

Premiums and Benefits	**My Choice (PPO) 001** Sacramento, Placer, Yolo	**My Choice (PPO) 003** Sonoma
Vision Services • Routine exam • Eyewear coverage limit	In-Network only $0 copay (1 per year) $0 copay for glasses/contacts (every two years) $150 plan coverage limit (every two years)	In-Network only $0 copay (1 per year) $0 copay for glasses/contacts (every two years) $150 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]	In-Network: $0 copay per day, days 1-20 $160 copay per day, days 21-51 $0 copay per day, days 52-100 (no prior hospital stay required)	In-Network: $0 copay per day, days 1-20 $160 copay per day, days 21-51 $0 copay per day, days 52-100 (no prior hospital stay required)
Physical Therapy[1]	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance
Ground and Air Ambulance Services[1]	In-Network: $250 copay (waived if admitted) Out of Network: 40% coinsurance	In-Network: $250 copay (waived if admitted) Out of Network: 40% coinsurance
Transportation	Not covered	Not covered
Medicare Part B Drugs	20% coinsurance	20% coinsurance

Outpatient Prescription Drugs	Copays apply to both **My Choice (PPO) 001** and **My Choice (PPO) 003** Sacramento, Placer, Yolo & Sonoma Counties		
Part D Deductible	$0		
Initial Coverage Limit	$4,020		
Part D Out of Pocket Threshold	$6,350		
	Preferred Retail 30-day supply	**Non-Preferred Retail 30-day supply**	**Mail Order 100-day supply**
Initial Coverage			
• Tier 1: Preferred Generic	$0 copay	$7 copay	$0 copay
• Tier 2: Generic	$5 copay	$12 copay	$15 copay
• Tier 3: Preferred Brand	$40 copay	$47 copay	$120 copay
• Tier 4: Non-Preferred Brand	$100 copay	$100 copay	$300 copay
• Tier 5: Specialty Tier	33% coinsurance	33% coinsurance	Not covered
• Tier 6: Select Care	$5 copay	$5 copay	$0 copay
Gap Coverage			
• Tier 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.

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.
☐	Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.