Alignment Health Plan®

2026 SUMMARY OF BENEFITS

Alignment Health Advantage (PPO)
Alignment Health Balance (PPO)

Fresno, Los Angeles, Madera, Orange, San Diego, San Joaquin, Santa Clara, Stanislaus, and Ventura counties

This is a summary of drug and health services benefits covered by Alignment Health Plan for January 1, 2026 - December 31, 2026.

www.AlignmentHealthPlan.com

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PREMIUMS AND BENEFITS

	ALIGNMENT HEALTH ADVANTAGE (PPO) 001 Fresno, Los Angeles, Madera, Orange, San Diego, and Ventura counties	**ALIGNMENT HEALTH ADVANTAGE (PPO) 002** Santa Clara County	**ALIGNMENT HEALTH BALANCE (PPO) 006** San Joaquin and Stanislaus counties
MONTHLY PLAN PREMIUM			
• Part C & Part D	$45.00	$75.00	$41.00
DEDUCTIBLE	$0.00	$0.00	$0.00
MAXIMUM OUT-OF-POCKET RESPONSIBILITY (does not include prescription drugs)			
In-Network	$4,201.00	$2,850.00	$2,850.00
Out-of-Network	$8,950.00 combined	$5,150.00 combined	$5,150.00 combined
INPATIENT HOSPITAL [1, 2]			
In-Network	$250.00 per day, days 1-3 $0.00 per day, days 4-90 $0.00 per day, days 91-999 (additional days) (unlimited days per admission)	$75.00 per day, days 1-5 $0.00 per day, days 6-90 $0.00 per day, days 91-999 (additional days) (unlimited days per admission)	$75.00 per day, days 1-3 $0.00 per day, days 4-90 $0.00 per day, days 91-999 (additional days) (unlimited days per admission)
Out-of-Network	40% coinsurance	40% coinsurance	20% coinsurance
OUTPATIENT HOSPITAL [1, 2]			
In-Network			
• Hospital Services	$200.00	$200.00	$200.00
• Observation Services	$0.00	$0.00	$0.00
Out-of-Network	40% coinsurance	40% coinsurance	25% coinsurance
AMBULATORY SURGICAL CENTER [1, 2]			
In-Network	$100.00	$100.00	$100.00
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance
DOCTOR VISITS			
In-Network			
• Primary	$0.00	$0.00	$0.00

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• Specialists [1, 2]	$20.00	$0.00	$0.00
Out-of-Network • Primary	40% coinsurance	40% coinsurance	$25.00
• Specialists [1, 2]	40% coinsurance	40% coinsurance	$25.00
PREVENTIVE CARE (e.g., flu vaccine, diabetic screenings) In-Network	$0.00	$0.00	$0.00
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance
EMERGENCY CARE In and Out-of-Network	$90.00 (not waived if admitted)	$75.00 (not waived if admitted)	$75.00 (not waived if admitted)
URGENTLY NEEDED SERVICES In and Out-of-Network	$20.00 (waived if admitted within 24 hours)	$0.00	$0.00
OUTPATIENT DIAGNOSTIC [1, 2] In-Network • Procedures, tests, lab services	$0.00	$0.00	$0.00
• X-Ray	$15.00	$0.00	$0.00
• Diagnostic	$150.00	$0.00	$0.00
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance	20% coinsurance	20% coinsurance
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance
HEARING SERVICES In-Network • Routine hearing exam	$0.00 Medicare-covered benefits and 1 exam/fitting/	$0.00 Medicare-covered benefits and 1 exam/fitting/	$0.00 Medicare-covered benefits and 1 exam/fitting/

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	evaluation every year	evaluation every year	evaluation every year
• Hearing aids	Not covered	Not covered	Not covered
Out-of-Network • Routine hearing exam	40% coinsurance	40% coinsurance	30% coinsurance
• Hearing aids	Not covered	Not covered	Not covered
DENTAL SERVICES [1] In-Network Diagnostic and preventive: • Exam & Cleaning • Fluoride treatment • X-Ray	$0.00 for 1 every six months $0.00 for 1 every six months $0.00 for 1 every three years	$0.00 copay for Medicare-covered services	50% coinsurance 50% coinsurance 50% coinsurance
Comprehensive: • Restorative • Endodontics • Periodontics • Removable Prosthodontics • Fixed Prosthodontics • Oral and Maxillofacial Surgery	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $1,000.00 coverage limit every year for preventive and comprehensive combined in-network and out-of-network	$0.00 copay for Medicare-covered services	$0.00 copay for Medicare-covered services
Out-of-Network Diagnostic and preventive: • Exam & Cleaning • Fluoride treatment • X-Ray	$0.00 for 1 every six months $0.00 for 1 every six months $0.00 for 1 every three years	40% coinsurance for Medicare-covered services	60% coinsurance 60% coinsurance 60% coinsurance
Comprehensive: • Restorative • Endodontics	$0.00 $0.00	40% coinsurance for Medicare-covered	30% coinsurance for Medicare-covered

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• Periodontics • Removable Prosthodontics • Fixed Prosthodontics • Oral and Maxillofacial Surgery	$0.00 $0.00 $0.00 $0.00 $1,000.00 coverage limit every year for preventive and comprehensive combined in-network and out-of-network	services	services
VISION SERVICES			
In-Network • Routine exam	$0.00 Medicare-covered eye exams/1 routine eye exam every year	$0.00 Medicare-covered eye exams/1 routine eye exam every year	$0.00 Medicare-covered eye exams/1 routine eye exam every year
• Eyewear	$150.00 coverage limit for glasses/ contacts every two years	$200.00 coverage limit for glasses/ contacts every year	$200.00 coverage limit for glasses/ contacts every year
Out-of-Network • Routine exam	40% coinsurance	40% coinsurance	30% coinsurance
• Eyewear	40% coinsurance	40% coinsurance	30% coinsurance
MENTAL HEALTH SERVICES [1, 2]			
• Inpatient hospital	$120.00 per day, days 1-10 $0.00 per day, days 11-90 $0.00 for 40 additional day limit $0.00 for 60 “lifetime reserve days”	$120.00 per day, days 1-10 $0.00 per day, days 11-90 $0.00 for 40 additional day limit $0.00 for 60 “lifetime reserve days”	$120.00 per day, days 1-10 $0.00 per day, days 11-90 $0.00 for 40 additional day limit $0.00 for 60 “lifetime reserve days”
• Mental health specialty (individual and group)	$0.00	$0.00	$0.00
• Psychiatric services (individual and group)	$40.00	$40.00	$40.00

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Out-of-Network • Inpatient hospital	40% coinsurance	40% coinsurance	30% coinsurance
• Mental health specialty (individual and group)	40% coinsurance	40% coinsurance	30% coinsurance
• Psychiatric services (individual and group)	40% coinsurance	40% coinsurance	30% coinsurance
SKILLED NURSING FACILITY [1, 2] In-Network	$0.00 per day, days 1-20 $100.00 per day, days 21-51 $0.00 per day, days 52-100 (no prior hospital stay required)	$0.00 per day, days 1-20 $50.00 per day, days 21-100 (no prior hospital stay required)	$0.00 per day, days 1-20 $50.00 per day, days 21-100 (no prior hospital stay required)
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance
PHYSICAL AND SPEECH THERAPY [1, 2] In-Network	$0.00	$0.00	$0.00
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance
GROUND AND AIR AMBULANCE SERVICES [1] In-Network	$250.00 (waived if admitted)	$100.00 (waived if admitted)	$100.00 (waived if admitted)
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance
TRANSPORTATION [1, 2] In-Network	$0.00 12 one-way trips to plan approved locations every year (within a 30-mile radius)	$0.00 26 one-way trips to plan approved locations every year (within a 50-mile radius)	$0.00 26 one-way trips to plan approved locations every year (within a 50-mile radius)
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance

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MEDICARE PART B DRUGS [1]			
In-Network	0% - 20% coinsurance	0% - 20% coinsurance	0% - 20% coinsurance
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance

OUTPATIENT PRESCRIPTION DRUGS

	ALIGNMENT HEALTH ADVANTAGE (PPO) 001 Fresno, Los Angeles, Madera, Orange, San Diego, and Ventura counties	
PART D DEDUCTIBLE	$0.00	
PART D OUT OF POCKET THRESHOLD	$2,100.00	
INITIAL COVERAGE	Retail Standard 30-day supply	Mail-order 100-day supply
Tier 1 (Preferred Generic Drugs):	$0.00	$0.00
Tier 2 (Generic Drugs):	$5.00	$15.00
Tier 3 (Preferred Brand Drugs):	$40.00	$120.00
Tier 4 (Non-Preferred Drugs):	32% coinsurance	32% coinsurance
Tier 5 (Specialty Tier):	33% coinsurance	Not covered
Tier 6 (Select Care Drugs):	$5.00	$0.00

	ALIGNMENT HEALTH ADVANTAGE (PPO) 002 Santa Clara County	
PART D DEDUCTIBLE	$0.00	
PART D OUT OF POCKET THRESHOLD	$2,100.00	
INITIAL COVERAGE	Retail Standard 30-day supply	Mail-order 100-day supply
Tier 1 (Preferred Generic Drugs):	$0.00	$0.00
Tier 2 (Generic Drugs):	$3.00	$9.00
Tier 3 (Preferred Brand Drugs):	$40.00	$120.00
Tier 4 (Non-Preferred Drugs):	32% coinsurance	32% coinsurance
Tier 5 (Specialty Tier):	33% coinsurance	Not covered
Tier 6 (Select Care Drugs):	$3.00	$0.00

	ALIGNMENT HEALTH BALANCE (PPO) 006 San Joaquin and Stanislaus counties	
PART D DEDUCTIBLE	$0.00	
PART D OUT OF POCKET THRESHOLD	$2,100.00	
INITIAL COVERAGE	Retail Standard 30-day supply	Mail-order 100-day supply
Tier 1 (Preferred Generic Drugs):	$0.00	$0.00
Tier 2 (Generic Drugs):	$3.00	$9.00
Tier 3 (Preferred Brand Drugs):	$40.00	$120.00
Tier 4 (Non-Preferred Drugs):	32% coinsurance	32% coinsurance
Tier 5 (Specialty Tier):	33% coinsurance	Not covered
Tier 6 (Select Care Drugs):	$3.00	$0.00

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COST-SHARING	May change depending on the pharmacy you choose and when you enter another of the three phases of the Part D benefit. If you reside in a long-term care facility, you pay the same copayment as at an in-network retail pharmacy for a 31-day supply.
CATASTROPHIC COVERAGE	After your yearly out-of-pocket drug costs reach $2,100.00, you pay $0.00 for plan-covered Part D drugs for the remainder of the year. For excluded drugs covered under our enhanced benefit, you pay the same copayment as you did in the Initial Coverage Stage.
BONUS DRUGS	Generic Viagra, cough and cold medications, prescription vitamins, and hair loss drugs. For a complete list and coverage details, refer to the Bonus Drug List.
INSULIN	**Important Message About What You Pay for Insulins (Part B and Part D):** You won't pay more than $35.00 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.
VACCINES	**Important Message About What You Pay for Vaccines:** Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible.

NOTE: Services notated with a "1" may require prior authorization. Services notated 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. For more information on the pharmacy-specific copays, please call Alignment Health Plan Member Services Department at the phone number in this document or access your Evidence of Coverage at www.alignmenthealthplan.com.

EXTRA BENEFITS YOU GET WITH ALIGNMENT HEALTH PLAN

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ACCESS ON-DEMAND CONCIERGE CARD Provides access to OTC benefits and Healthy Rewards	Included	Included	Included
ADDITIONAL OPTIONS:	OPTIONS +	ENHANCED DENTAL	ENHANCED DENTAL
Monthly Premium	$48.00	$36.00	$36.00
Dental Coverage			
In-Network			
• Diagnostic	0% coinsurance	0% coinsurance	0% coinsurance
• Restorative	0% coinsurance	50% coinsurance	50% coinsurance
• Endodontics	0% coinsurance	50% coinsurance	50% coinsurance
• Periodontics	0% coinsurance	0%-50% coinsurance	0%-50% coinsurance
• Removable Prosthodontics	0% coinsurance	50% coinsurance	50% coinsurance
• Fixed Prosthodontics	0% coinsurance	50% coinsurance	50% coinsurance
• Oral and Maxillofacial Surgery	0% coinsurance	50% coinsurance	50% coinsurance
Out-of-Network			
• Diagnostic	0% coinsurance	50% coinsurance	50% coinsurance
• Restorative	0% coinsurance	50% coinsurance	50% coinsurance
• Endodontics	0% coinsurance	50% coinsurance	50% coinsurance
• Periodontics	0% coinsurance	50% coinsurance	50% coinsurance
• Removable Prosthodontics	0% coinsurance	50% coinsurance	50% coinsurance
• Fixed Prosthodontics	0% coinsurance	50% coinsurance	50% coinsurance
• Oral and Maxillofacial Surgery	0% coinsurance	50% coinsurance	50% coinsurance
	Additional $1000.00 allowance for a total of $2,000.00 annual in-network & out-of-network every year	$1,500.00 coverage limit in-network and out-of-network every year	$1,500.00 coverage limit in-network and out-of-network every year
Additional Coverage			
• Hearing Aid Coverage	$195.00 - $1,750.00 copay per hearing aid, 2 hearing aids every year	Not covered	Not covered

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• Over-the-counter (OTC)	$15.00 every month	Not covered	Not covered
• Personalized Emergency Response System (PERS)	$0.00	Not covered	Not covered
• Transportation	12 one-way trips every year to plan approved locations (within 30-mile radius)	Not covered	Not covered
• Worldwide Emergency Coverage	Additional $15,000.00 coverage limit every year	Not covered	Not covered
FITNESS (membership(s) at participating fitness centers)	$0.00	$0.00	$0.00
CHIROPRACTIC SERVICES [1, 2]			
In-Network	$0.00 Medicare-covered	$0.00 Medicare-covered	$0.00 Medicare-covered
Out-of-Network	40% coinsurance Medicare-covered	40% coinsurance Medicare-covered	30% coinsurance Medicare-covered
ACUPUNCTURE			
In-Network	$0.00 Medicare-covered	$0.00 Medicare-covered	$0.00 Medicare-covered
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance
PODIATRY SERVICES [1, 2]			
In-Network	$0.00 Medicare-covered	$0.00 Medicare-covered	$0.00 Medicare-covered
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance
OVER-THE-COUNTER (OTC)	$15.00 spending allowance every month (no rollover)	$20.00 spending allowance every month (no rollover)	$20.00 spending allowance every month (no rollover)

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TELEHEALTH			
In and Out-of-Network	$0.00 for primary care provider, mental health specialty, and psychiatric services	$0.00 for primary care provider, mental health specialty, and psychiatric services	$0.00 for primary care provider, mental health specialty, and psychiatric services
WORLDWIDE EMERGENCY/ URGENT CARE	$0.00 $10,000.00 coverage limit every year	$0.00 $25,000.00 coverage limit every year	$0.00 $25,000.00 coverage limit every year
DURABLE MEDICAL EQUIPMENT (DME) [1]			
In-Network	0% coinsurance for items $350.00 or less 20% coinsurance for items $350.01 or more 20% coinsurance applies to continuous glucose monitors	0% coinsurance for items $350.00 or less 20% coinsurance for items $350.01 or more 20% coinsurance applies to continuous glucose monitors	0% coinsurance for items $350.00 or less 20% coinsurance for items $350.01 or more 20% coinsurance applies to continuous glucose monitors
Out-of-Network	40% coinsurance	40% coinsurance	30% coinsurance

EXTRA BENEFITS FOR THOSE WITH QUALIFYING CONDITION (SSBCI)

Special supplemental benefits for the chronically ill (SSBCI)-qualifying chronic conditions include end-stage renal disease (ESRD). Medical records will be used to establish the member qualification. The benefits mentioned are a part of a special supplemental program for the chronically ill. Not all members qualify because other eligibility and coverage criteria also apply. For Alignment Health Balance (PPO) 006, the qualifying condition is chronic kidney disease (CKD), limited to end-stage renal disease (ESRD).

ESSENTIALS ALLOWANCE For qualifying members to assist with groceries, utilities, and home safety.	Not covered	Not covered	$100.00 spending allowance every month (no rollover)

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PET SERVICES For members who have hospital procedures or emergencies and need pet care while they are away.	$0.00 7 boarding days or 14 walks every year	$0.00 7 boarding days or 14 walks every year	$0.00 7 boarding days or 14 walks every year
PEST CONTROL Annual pest eradication for covered pests to ensure the health, welfare, and safety of members.	$0.00 1 service every year	$0.00 1 service every year	$0.00 1 service every year

To join Alignment Health Plan, you must be enrolled in Medicare Part A and Part B and live in one of the counties listed on the cover of this booklet.

To learn more about coverage and costs of Original Medicare, look at the "**Medicare & You**" handbook. You can view it online at medicare.gov or request a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

This document is also available in other languages and formats.

ALIGNMENT HEALTH PLAN MEMBERS	1-866-634-2247 (TTY 711)
NON-MEMBERS	1-888-979-2247 (TTY 711)
HOURS OF OPERATION	October 1 – March 31: Seven days a week from 8:00 a.m. to 8:00 p.m. except Thanksgiving and Christmas Day April 1 – September 30: Monday through Friday (except holidays) from 8:00 a.m. to 8:00 p.m.
WEBSITE	www.alignmenthealthplan.com

Alignment Health Plan is an HMO, HMO POS, HMO C-SNP, HMO D-SNP and PPO plan with a Medicare contract and a contract with the California, Nevada, North Carolina, and Texas Medicaid programs. Enrollment in Alignment Health Plan depends on contract renewal. This information is not a complete description of benefits. Call 1-866-634-2247 (TTY 711), 8 a.m. to 8 p.m. Monday through Friday, for more information. 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.

English: Our Medicare Advantage Organization provides language assistance services and appropriate auxiliary aids and services free of charge. For assistance, please call 1-866-634-2247.

Spanish: Nuestra Organización Medicare Advantage ofrece servicios de asistencia lingüística y ayudas y servicios auxiliares adecuados sin costo alguno. Para obtener ayuda, llame al 1-866-634-2247.

Chinese: 我們的聯邦醫療保險優勢組織 (Medicare Advantage Organization) 免費提供語言協助服務以及相應的輔助設備和服務。如需協助, 請致電 1-866-634-2247。

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 711)

8:00 a.m. to 8:00 p.m., 7 days a week (except holidays) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

UNDERSTANDING THE BENEFITS

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.alignmenthealthplan.com or call **1-866-634-2247** (**TTY 711**) for 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. Visit www.alignmenthealthplan.com or call **1-866-634-2247** (**TTY 711**) for a list of Alignment Health Plan network providers.
- ☐ 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. Visit www.alignmenthealthplan.com or call **1-866-634-2247** (**TTY 711**) for the Alignment Health Plan list of covered medications.

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, 2027.
- ☐ **This 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.**
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.