Alignment Health Plan®

2026 SUMMARY OF BENEFITS

Alignment Health BreathEasy (HMO C-SNP)
Alignment Health Clarity (HMO C-SNP)

Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Ventura, and Yolo 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

Y0141_26231EN_M

PREMIUMS AND BENEFITS

	ALIGNMENT HEALTH BREATHEASY (HMO C-SNP) 041 Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Ventura, and Yolo counties	**ALIGNMENT HEALTH CLARITY (HMO C-SNP) 042** Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, Ventura, and Yolo counties
MONTHLY PLAN PREMIUM		
• Part C & Part D	$12.00 or $0.00 if you receive “Extra Help” *	$12.00 or $0.00 if you receive “Extra Help” *
PART B PREMIUM REBATE	$5.00	$5.00
DEDUCTIBLE	$0.00	$0.00
MAXIMUM OUT-OF-POCKET RESPONSIBILITY (does not include prescription drugs)	$9,250.00	$9,250.00
INPATIENT HOSPITAL [1, 2]	$1,676.00 deductible for each benefit period Days 1-60: $0.00 per day of each benefit period Days 61-90: $419.00 per day of each benefit period Days 91 and beyond: $838.00 per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime) Beyond lifetime reserve days: all costs These costs are for 2025 and may change for 2026	$1,676.00 deductible for each benefit period Days 1-60: $0.00 per day of each benefit period Days 61-90: $419.00 per day of each benefit period Days 91 and beyond: $838.00 per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime) Beyond lifetime reserve days: all costs These costs are for 2025 and may change for 2026
OUTPATIENT HOSPITAL [1, 2]		
• Hospital Services	20% coinsurance*	20% coinsurance*
• Observation Services	20% coinsurance*	20% coinsurance*
AMBULATORY SURGICAL CENTER [1, 2]	20% coinsurance*	20% coinsurance*
DOCTOR VISITS		
• Primary	$0.00	$0.00

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• Specialists [1, 2]	$0.00	$0.00
PREVENTIVE CARE (e.g., flu vaccine, diabetic screenings)	$0.00	$0.00
EMERGENCY CARE	20% coinsurance* (waived if admitted within 48 hours)	20% coinsurance* (waived if admitted within 48 hours)
URGENTLY NEEDED SERVICES	$0.00	$0.00
OUTPATIENT DIAGNOSTIC [1, 2]		
• Procedures, tests, lab services	20% coinsurance*	20% coinsurance*
• X-Ray	$0.00	$0.00
• Diagnostic	$0.00	$0.00
• Therapeutic radiology services (such as radiation treatment for cancer)	20% coinsurance*	20% coinsurance*
HEARING SERVICES		
• Routine hearing exam	$0.00 Medicare-covered benefits and 1 exam/fitting/ evaluation every year	$0.00 Medicare-covered benefits and 1 exam/fitting/ evaluation every year
• Hearing aids	$0.00 per hearing aid, 2 hearing aids every year	$0.00 per hearing aid, 2 hearing aids every year
DENTAL SERVICES [1]		
Diagnostic and preventive: • Exam & Cleaning • Fluoride treatment • X-Ray	 $0.00 for 1 every six months $0.00 for 1 every year $0.00 for 1 every year	 $0.00 for 1 every six months $0.00 for 1 every year $0.00 for 1 every year
Comprehensive: • Restorative	20% coinsurance* for Medicare-covered services $0.00	20% coinsurance* for Medicare-covered services $0.00

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• Endodontics • Periodontics • Removable Prosthodontics • Fixed Prosthodontics • Oral and Maxillofacial Surgery	$0.00 $0.00 $0.00 $0.00 $0.00 $500.00 coverage limit every three months	$0.00 $0.00 $0.00 $0.00 $0.00 $500.00 coverage limit every three months
VISION SERVICES		
• 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
• Eyewear	$500.00 coverage limit for glasses/contacts every two years	$500.00 coverage limit for glasses/contacts every two years
MENTAL HEALTH SERVICES [1, 2]		
• Inpatient hospital	$1,676.00 deductible for each benefit period Days 1-60: $0.00 per day of each benefit period Days 61-90: $419.00 per day of each benefit period Days 91 and beyond: $838.00 per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime) Beyond lifetime reserve days: all costs These costs are for 2025 and may change for 2026	$1,676.00 deductible for each benefit period Days 1-60: $0.00 per day of each benefit period Days 61-90: $419.00 per day of each benefit period Days 91 and beyond: $838.00 per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime) Beyond lifetime reserve days: all costs These costs are for 2025 and may change for 2026
• Mental health specialty (individual and group)	20% coinsurance*	20% coinsurance*
• Psychiatric services (individual and	20% coinsurance*	20% coinsurance*

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group)		
SKILLED NURSING FACILITY [1, 2]	$0.00 per day, days 1-20 $209.50 per day, days 21-100 Days 101 and beyond: All costs These costs are for 2025 and may change for 2026	$0.00 per day, days 1-20 $209.50 per day, days 21-100 Days 101 and beyond: All costs These costs are for 2025 and may change for 2026
PHYSICAL AND SPEECH THERAPY [1, 2]	20% coinsurance*	20% coinsurance*
GROUND AND AIR AMBULANCE SERVICES [1]	20% coinsurance* (not waived if admitted)	20% coinsurance* (not waived if admitted)
TRANSPORTATION [1]	$0.00 50 one-way trips to plan approved locations every year (within a 50-mile radius)	$0.00 50 one-way trips to plan approved locations every year (within a 50-mile radius)
MEDICARE PART B DRUGS [1]	0% - 20% coinsurance	0% - 20% coinsurance

OUTPATIENT PRESCRIPTION DRUGS

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PART D DEDUCTIBLE	$615.00 for Tier 3, Tier 4, and Tier 5	
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):	25% coinsurance	25% coinsurance
Tier 3 (Preferred Brand Drugs):	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drugs):	30% coinsurance	30% coinsurance
Tier 5 (Specialty Tier):	25% coinsurance	Not covered
Tier 6 (Select Care Drugs):	$0.00	$0.00

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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):	25% coinsurance	25% coinsurance
Tier 3 (Preferred Brand Drugs):	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Drugs):	31% coinsurance	31% coinsurance
Tier 5 (Specialty Tier):	25% coinsurance	Not covered
Tier 6 (Select Care Drugs):	$0.00	$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.
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, 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
FITNESS (membership(s) at participating fitness centers)	$0.00	$0.00
PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) [1]	$0.00	$0.00
CHIROPRACTIC SERVICES [1, 2]	$0.00 Medicare-covered $0.00 for 24 routine visits every year (combined with acupuncture)	$0.00 Medicare-covered $0.00 for 24 routine visits every year (combined with acupuncture)
ACUPUNCTURE [1, 2]	$0.00 Medicare-covered $0.00 for 24 routine visits every year (combined with chiropractic)	$0.00 Medicare-covered $0.00 for 24 routine visits every year (combined with chiropractic)
PODIATRY SERVICES [1, 2]	$0.00 Medicare-covered	$0.00 Medicare-covered
OVER-THE-COUNTER (OTC)	$124.00 spending allowance every month (no rollover) Combined with Essentials Allowance benefit for a total of $124.00 spending allowance every month. See Essentials Allowance below.	$124.00 spending allowance every month (no rollover) Combined with Essentials Allowance benefit for a total of $124.00 spending allowance every month. See Essentials Allowance below.
TELEHEALTH	$0.00 for primary care provider, mental health specialty, and psychiatric services	$0.00 for primary care provider, mental health specialty, and psychiatric services

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WORLDWIDE EMERGENCY/ URGENT CARE	$75.00 $25,000.00 coverage limit every year (waived if admitted)	$75.00 $25,000.00 coverage limit every year (waived if admitted)
DURABLE MEDICAL EQUIPMENT (DME) [1]	20% coinsurance* 20% coinsurance* applies to continuous glucose monitors	20% coinsurance* 20% coinsurance* applies to continuous glucose monitors
IN-HOME SUPPORT SERVICES [1]	$0.00 12 hours every three months, 48 hours every year **OR** Support for Caregivers (member must choose in advance)	$0.00 12 hours every three months, 48 hours every year **OR** Support for Caregivers (member must choose in advance)
SUPPORT FOR CAREGIVERS OF ENROLLEE [1]	$0.00 Up to $300.00 reimbursement every year **OR** In-home support services (member must choose in advance)	$0.00 Up to $300.00 reimbursement every year **OR** In-home support services (member must choose in advance)
RE-ADMISSION AND CHRONIC MEALS	$0.00 copay for 28 meals over 14 days, three times per year	$0.00 copay for 28 meals over 14 days, three times per year

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EXTRA BENEFITS FOR THOSE WITH QUALIFYING CONDITION (SSBCI)

Special supplemental benefits for the chronically ill (SSBCI), qualifying chronic conditions for Alignment Health BreathEasy (HMO C-SNP): Chronic Lung Disorders. Qualifying chronic conditions for Alignment Health Clarity (HMO C-SNP) includes Chronic and Disabling Mental Health Conditions, Substance Use Disorders (SUD), and Chronic Mental Health Disorders.

AIR PURIFIER/HUMIDIFIER For members with a qualified chronic condition.	$0.00 1 air purifier or humidifier every year	$0.00 1 air purifier or humidifier every year
ESSENTIALS ALLOWANCE For qualifying members to assist with groceries, utilities, and home safety.	$124.00 spending allowance every month (no rollover) Combined with over-the-counter (OTC) items for a total of $124.00 spending allowance every month	$124.00 spending allowance every month (no rollover) Combined with over-the-counter (OTC) items for a total of $124.00 spending allowance every month
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
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

Alignment Health Plan offers access to a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for the services.

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.

*For those with full Medi-Cal, the copay for services may be paid in part or in full by Medi-Cal, or a third party.

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.
- ☐ 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).
- ☐ Alignment Health BreathEasy (HMO C-SNP) 041 and Alignment Health Clarity (HMO C-SNP) 042 are chronic condition special needs plans. Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- ☐ **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.