

2026 SUMMARY OF BENEFITS

Alignment Health Freedom (PPO)

San Diego, San Joaquin, and Stanislaus counties

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

PREMIUMS AND BENEFITS

ALIGNMENT HEALTH FREEDOM (PPO) 003 San Diego, San Joaquin, and Stanislaus counties	
MONTHLY PLAN PREMIUM	
• Part C & Part D	\$12.00/\$0.00 if you receive “Extra Help” *
DEDUCTIBLE	\$0.00
MAXIMUM OUT-OF-POCKET RESPONSIBILITY (does not include prescription drugs)	
<u>In-Network</u>	\$8,500.00
<u>Out-of-Network</u>	\$11,950.00 combined
INPATIENT HOSPITAL ^{1, 2}	
<u>In-Network</u>	\$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
<u>Out-of-Network</u>	20% coinsurance*
OUTPATIENT HOSPITAL ¹	
<u>In and Out-of-Network</u>	
• Hospital Services	20% coinsurance*
• Observation Services	20% coinsurance*
AMBULATORY SURGICAL CENTER ^{1, 2}	
<u>In and Out-of-Network</u>	20% coinsurance*
DOCTOR VISITS	
<u>In and Out-of-Network</u>	
• Primary	20% coinsurance*
• Specialists ^{1, 2}	20% coinsurance*
PREVENTIVE CARE (e.g., flu vaccine, diabetic screenings)	
<u>In and Out-of-Network</u>	20% coinsurance*
EMERGENCY CARE	
<u>In and Out-of-Network</u>	20% coinsurance* (waived if admitted within 3 days)

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URGENTLY NEEDED SERVICES

In and Out-of-Network \$0.00

OUTPATIENT DIAGNOSTIC ^{1, 2}

In and Out-of-Network

- Procedures, tests, lab services 20% coinsurance*
- X-Ray 20% coinsurance*
- Diagnostic 20% coinsurance*
- Therapeutic radiology services (such as radiation treatment for cancer) 20% coinsurance*

HEARING SERVICES

In-Network

- Routine hearing exam \$0.00 Medicare-covered benefits and 1 exam/fitting/evaluation every year
- Hearing aids \$0.00 per hearing aid, 2 hearing aids every year

Out-of-Network

- Routine hearing exam 20% coinsurance*
- Hearing aids 20% coinsurance*

DENTAL SERVICES ¹

In-Network

Diagnostic and preventive:

- Exam & Cleaning \$0.00 for 1 every six months
- Fluoride treatment \$0.00 for 1 every year
- X-Ray \$0.00 for 1 every year

Comprehensive:

- Restorative \$0.00
- Endodontics \$0.00
- Periodontics \$0.00
- Removable Prosthodontics \$0.00
- Fixed Prosthodontics \$0.00
- Oral and Maxillofacial Surgery \$0.00

\$300.00 coverage limit every three months in-network or out-of-network

Out-of-Network

Diagnostic and preventive:

20% coinsurance* for Medicare-covered services

Comprehensive:

20% coinsurance* for Medicare-covered services

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VISION SERVICES

In-Network

- Routine exam \$0.00 Medicare-covered eye exams/1 routine eye exam every year
- Eyewear \$500.00 coverage limit for glasses/contacts every two years

Out-of-Network

- Routine exam 20% coinsurance*
- Eyewear 20% coinsurance*

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

- Mental health specialty (individual and group) 20% coinsurance*

- Psychiatric services (individual and group) 20% coinsurance*

Out-of-Network

- Inpatient hospital 20% coinsurance*
- Mental health specialty (individual and group) 20% coinsurance*
- Psychiatric services (individual and group) 20% coinsurance*

SKILLED NURSING FACILITY ^{1, 2}

In-Network

\$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

Out-of-Network

20% coinsurance*

PHYSICAL AND SPEECH THERAPY

In and Out-of-Network

20% coinsurance*

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GROUND AND AIR AMBULANCE SERVICES ¹

In and Out-of-Network 20% coinsurance*

TRANSPORTATION ^{1, 2}

In-Network \$0.00
50 one-way trips to plan approved locations every year (within a 50-mile radius)

Out-of-Network Not covered

MEDICARE PART B DRUGS

In-Network 0% - 20% coinsurance

Out-of-Network 20% coinsurance

OUTPATIENT PRESCRIPTION DRUGS

ALIGNMENT HEALTH FREEDOM (PPO) 003 San Diego, San Joaquin, and Stanislaus counties		
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

ALIGNMENT HEALTH FREEDOM (PPO) 003 San Diego, San Joaquin, and Stanislaus counties	
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

ALIGNMENT HEALTH FREEDOM (PPO) 003 San Diego, San Joaquin, and Stanislaus counties	
ACCESS ON-DEMAND CONCIERGE CARD Provides access to OTC benefits and Healthy Rewards	Included
FITNESS (membership(s) at participating fitness centers)	\$0.00
PERSONAL EMERGENCY RESPONSE SYSTEM (PERS) ¹	\$0.00
CHIROPRACTIC SERVICES ^{1, 2} <u>In-Network</u>	20% coinsurance* Medicare-covered \$0.00 for 12 routine visits every year (combined with acupuncture)
<u>Out-of-Network</u>	20% coinsurance* Medicare-covered
ACUPUNCTURE ^{1, 2} <u>In-Network</u>	\$0.00 Medicare-covered \$0.00 for 12 routine visits every year (combined with chiropractic)
<u>Out-of-Network</u>	\$0.00 Medicare-covered
PODIATRY SERVICES ^{1, 2} <u>In and Out-of-Network</u>	20% coinsurance* Medicare-covered
TELEHEALTH <u>In and Out-of-Network</u>	\$0.00 for primary care provider, mental health specialty, and psychiatric services
WORLDWIDE EMERGENCY/ URGENT CARE	\$0.00 \$25,000.00 coverage limit every year
DURABLE MEDICAL EQUIPMENT (DME) ¹ <u>In and Out-of-Network</u>	20% coinsurance*
IN-HOME SUPPORT SERVICES ¹ <u>In-Network</u>	\$0.00 12 hours every three months, 48 hours every year OR

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	Support for Caregivers (member must choose in advance)
<u>Out-of-Network</u>	Not covered
SUPPORT FOR CAREGIVERS OF ENROLLEE ¹ <u>In-Network</u>	\$0.00 Up to \$300.00 reimbursement every year OR In-home support services (member must choose in advance)
<u>Out-of-Network</u>	Not covered
RE-ADMISSION AND CHRONIC MEALS	\$0.00 copay for 28 meals over 14 days, twice per year

EXTRA BENEFITS FOR THOSE WITH QUALIFYING CONDITION (SSBCI)

Special supplemental benefits for the chronically ill (SSBCI)-qualifying chronic conditions include chronic kidney disease (CKD), limited to 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.

ESSENTIALS ALLOWANCE For qualifying members to assist with groceries, utilities, and home safety.	\$200.00 spending allowance every month (no rollover)
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
PEST CONTROL Annual pest eradication for covered pests to ensure the health, welfare, and safety of members.	\$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](https://www.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.



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.