

2026

Benefit Platter

ALIGNMENT HEALTH HONOR+PLAN (HMO) 052
 Alameda, Fresno, Los Angeles, Madera, Marin, Orange, Placer,
 Riverside, Sacramento, San Bernardino, San Diego, San Francisco,
 San Joaquin, San Luis Obispo, Santa Clara, Stanislaus, Ventura, Yolo

ALIGNMENT HEALTH VALORCARE (HMO) 053
 Los Angeles, Orange, Riverside, San Bernardino, San Diego



	ALIGNMENT HEALTH HONOR+PLAN (HMO) 052	ALIGNMENT HEALTH VALORCARE (HMO) 053
Monthly Premium	\$0	\$0
Part B Rebate	N/A	\$125
Annual Plan Deductible	\$0	\$0
Maximum Out of Pocket (MOOP)	\$9,250	\$6,000
PCP	\$0 copay	\$0 copay
Specialist	\$0 copay	\$40 copay
INPATIENT CARE		
Inpatient Hospital-Acute	\$1,676 deductible for each benefit period \$0 copay per day, days 1-60 \$419 copay per day, days 61-90 \$838 copay per day, in lifetime reserve Beyond lifetime reserve days: All costs These costs are for 2025 and may change for 2026	\$400 copay per day, days 1-5 \$0 copay per day, days 6-90 (unlimited days per admission)
Inpatient Hospital Psychiatric	\$1,676 deductible for each benefit period \$0 copay per day, days 1-60 \$419 copay per day, days 61-90 \$838 copay per day, in lifetime reserve Beyond lifetime reserve days: All costs These costs are for 2025 and may change for 2026	\$400 copay per day, days 1-5 \$0 copay per day, days 6-90 \$0 copay for 40 additional day limit (91-130) \$0 copay for 60 days Lifetime Reserve
Skilled Nursing Facility (SNF)	\$0 copay days 1-20 \$209.50 copay per day, days 21-100 Days 101 and beyond: All costs These costs are for 2025 and may change for 2026	\$10 copay per day, days 1-20 \$100 copay per day, days 21-100 (no prior hospital stay required)
OUTPATIENT CARE		
Ambulatory Surgical Center	\$0 copay	\$0 copay
Annual Physical Exam and Preventive Care (Medicare Covered)	\$0 copay	\$0 copay
Emergency Services	20% coinsurance (waived if admitted within 3 days) \$0 copay for Full Duals	\$120 copay (waived if admitted within 24 hours)
Ground and Air Ambulance Services	20% coinsurance (not waived if admitted) \$0 copay for Full Duals	\$300 copay Ground \$1,250 copay Air (not waived if admitted)
Outpatient Hospital and Observation Services	\$0 copay	\$0 copay
Physical and Speech Therapy	20% coinsurance \$0 copay for Full Duals	\$0 copay
Podiatry	\$0 copay Medicare covered	\$0 copay Medicare covered
Urgently Needed Services	20% coinsurance (not waived if admitted) \$0 copay for Full Duals	\$0 copay
Worldwide Emergency/Urgent Coverage	\$75 copay (waived if admitted) \$10,000 maximum coverage per year	\$50 copay (waived if admitted) \$10,000 maximum coverage per year
OUTPATIENT MEDICAL SERVICES & SUPPLIES		
Durable Medical Equipment (DME)	20% coinsurance 20% coinsurance for Continuous Glucose Monitors (CGM) \$0 copay for Full Duals	20% coinsurance 20% coinsurance for Continuous Glucose Monitors (CGM)
Diabetes Supplies	0% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic Shoes or Inserts \$0 copay for Full Duals	10% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic Shoes or Inserts
Outpatient Diagnostic (Procedures/Tests/Lab Services)	\$0 copay	\$0 copay
Outpatient Radiology (X-Ray/Diagnostic/Therapeutic)	\$0 copay (X/D) 20% coinsurance (T)	\$0 copay (X/D) 20% coinsurance (T)
Mental Health Specialty Services (Individual/Group)	20% coinsurance \$0 copay for Full Duals	\$40 copay
Psychiatric Services (Individual/Group)	20% coinsurance \$0 copay for Full Duals	\$40 copay
Prosthetic/Medical Supplies	20% coinsurance \$0 copay for Full Duals	20% coinsurance
VISION, HEARING & DENTAL BENEFITS		
Eye Exams	\$0 copay for Medicare covered exams and 1 routine eye exam per year	\$0 copay for Medicare covered exams and 1 routine eye exam per year
Eyewear	\$500 coverage limit for glasses/contacts every 2 years	\$300 coverage limit for glasses/contacts every year
Diagnostic and Preventive Dental	\$0 copay for: 1 Oral Exam every 6 months 1 Cleaning every 6 months 1 X-ray every 3 years 1 Fluoride treatment every 6 months	\$0 copay for: 1 Oral Exam every 6 months 1 Cleaning every 6 months 1 X-ray every 3 years 1 Fluoride treatment every 6 months
Comprehensive Dental	\$0 copay for: Restorative Services Endodontics Periodontics Prosthodontics Oral & Maxillofacial Surgery \$500 coverage limit per quarter	\$0 copay for: Restorative Services Endodontics Periodontics Prosthodontics Oral & Maxillofacial Surgery \$2,000 coverage limit per year (Preventive and Comprehensive combined)

ALIGNMENT HEALTH HONOR+PLAN (HMO) 052		ALIGNMENT HEALTH VALORCARE (HMO) 053
Hearing Exams/Fitting and Evaluation for Hearing Aid	\$0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year	\$0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year
Hearing Aids	not covered	\$195-\$1,750 copay per hearing aid, 2 hearing aids per year
ADDITIONAL BENEFITS - MORE THAN ORIGINAL MEDICARE WITH YOUR ACCESS ON-DEMAND CARD BENEFITS!		
24/7 Concierge Service	\$0	\$0
Over-the-Counter (OTC)	\$100 per month (no rollover) combined with Essentials Allowance See Essentials Allowance below	\$20 per month (no rollover)
Acupuncture & Chiropractic Services	\$0 copay for 12 routine visits per year combined	\$0 copay for 12 routine visits per year combined
Dialysis Services	20% coinsurance \$0 copay for Full Duals	20% coinsurance
Fitness membership(s) at participating fitness centers	\$0 copay	\$0 copay
Personal Emergency Response System (PERS)	\$0 copay	not covered
Telehealth	\$0 copay for Primary Care/Mental Health Specialty/ Psychiatric Services	\$0 copay for Primary Care/Mental Health Specialty/ Psychiatric Services
Transportation	50 one-way trips to plan approved locations per year (within a 50 mile radius)	not covered
In-Home Support Services	\$0 copay for 12 hours per quarter, 48 hours per year, OR Caregivers Support (Member must choose in advance)	not covered
Caregivers Support for Enrollees	Up to \$300 reimbursement per year, OR In-Home Support Services (Members must choose in advance)	not covered
SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)†		
Essentials allowance for qualifying members to assist with groceries, general support (excluding tobacco and alcohol) for living, and home safety.	\$100 spending allowance per month (no rollover) combined with OTC	not covered
Pet Services	\$0 copay for 7 boarding days or 14 walks per year	\$0 copay for 7 boarding days or 14 walks per year
Pest Control	\$0 copay for 1 service per year	\$0 copay for 1 service per year
PRESCRIPTION DRUG COVERAGE		
Part D Deductible	\$615 for Tiers 3, 4 & 5	\$0
Part D Out of Pocket Threshold	\$2,100	\$2,100
Tier 1: Preferred Generic Drugs	Retail & Mail Order Standard \$0 copay 30-day supply \$0 copay 60-day supply \$0 copay 100-day supply	Retail & Mail Order Standard \$0 copay 30-day supply \$0 copay 60-day supply \$0 copay 100-day supply
Tier 2: Generic Drugs	Retail & Mail Order Standard 25% coinsurance 30-day/60-day/100-day supply \$0 copay for Full Duals	Retail & Mail Order Standard \$0 copay 30-day supply \$0 copay 60-day supply \$0 copay 100-day supply
Tier 3: Preferred Brand Drugs	Retail & Mail Order Standard 25% coinsurance 30-day/60-day/100-day supply \$0 copay for Full Duals	Retail & Mail Order Standard \$30 copay 30-day supply \$60 copay 60-day supply \$90 copay Retail/\$75 Mail Order 100-day supply
Tier 4: Non-Preferred Drugs	Retail & Mail Order Standard 30% coinsurance 30-day/60-day/100-day supply \$0 copay for Full Duals	Retail & Mail Order Standard \$100 copay 30-day supply \$200 copay 60-day supply \$300 copay 100-day supply
Tier 5: Specialty Tier Drugs	Retail & Mail Order Standard 25% coinsurance 30-day supply \$0 copay for Full Duals	Retail & Mail Order Standard 33% coinsurance 30-day supply
Tier 6: Select Care Drugs	Retail & Mail Order Standard \$0 copay 30-day supply \$0 copay 60-day supply \$0 copay 100-day supply	Retail & Mail Order Standard \$5 copay 30-day supply \$10 copay 60-day supply \$0 copay 100-day supply
Ways To Save on Prescriptions	Pay \$0 for a 100-day supply for Tiers 1 & 6 drugs	Pay \$0 for a 100-day supply for Tiers 1, 2 & 6 drugs
Bonus Drug Coverage	not covered	Some prescription drugs, for cough and cold, hair loss, vitamins, sexual dysfunction, just to name a few. The amount you will pay will be determined by the drug tier. The amount you pay does not count toward your deductible or "total drug costs" that help you qualify for catastrophic coverage). 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. Please refer to the Alignment Drug Formulary for full details.
Insulin	Important Message About What You Pay for Insulin: You won't pay more than \$35 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	Our plan covers most Part D vaccines at no cost to you even if you haven't paid your deductible.	

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. 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. This information is not a complete description of benefits. Call 1-888-979-2247 (TTY: 711), 8 a.m. - 8 p.m. Monday through Friday, for more information.

†Special supplemental benefits for the chronically ill (SSBCI)-qualifying chronic conditions include congestive heart failure (CHF), chronic lung disorders, dementia, diabetes, and stroke. Other chronic conditions may apply. 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.

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