

2026

Benefit Platter

ALIGNMENT HEALTH MY CHOICE (HMO) 028
San Luis Obispo, Ventura

ALIGNMENT HEALTH MY CHOICE SELECT (HMO) 049
Los Angeles, Orange, Riverside, San Bernardino



	ALIGNMENT HEALTH MY CHOICE (HMO) 028	ALIGNMENT HEALTH MY CHOICE SELECT (HMO) 049
Monthly Premium	\$0	\$0
Annual Plan Deductible	\$0	\$0
Maximum Out of Pocket (MOOP)	\$698	\$798
PCP	\$0 copay	\$0 copay
Specialist	\$0 copay	\$0 copay
INPATIENT CARE		
Inpatient Hospital-Acute	\$0 copay (unlimited days per admission)	\$0 copay (unlimited days per admission)
Inpatient Hospital Psychiatric	\$120 copay per day, days 1-10 \$0 copay per day, days 11-90 \$0 copay for 40 additional day limit (91-130) \$0 copay for 60-days Lifetime reserve	\$120 copay per day, days 1-10 \$0 copay per day, days 11-90 \$0 copay for 40 additional day limit (91-130) \$0 copay for 60-days Lifetime reserve
Skilled Nursing Facility (SNF)	\$0 copay per day, days 1-20 \$30 copay per day, days 21-100 (no prior hospital stay required)	\$0 copay per day, days 1-20 \$30 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	\$100 copay (waived if admitted within 48 hours)	\$70 copay (waived if admitted within 48 hours)
Ground and Air Ambulance Services	\$100 copay Ground \$200 copay Air (waived if admitted)	\$75 copay (waived if admitted)
Outpatient Hospital and Observation Services	\$0 copay	\$0 copay
Physical and Speech Therapy	\$0 copay	\$0 copay
Podiatry	\$0 copay Medicare covered	\$0 copay Medicare covered
Urgently Needed Services	\$0 copay	\$0 copay
Worldwide Emergency/ Urgent Coverage	\$0 copay \$50,000 maximum coverage per year	\$0 copay \$25,000 maximum coverage per year
OUTPATIENT MEDICAL SERVICES & SUPPLIES		
Durable Medical Equipment (DME)	0% coinsurance for items \$450 or less 20% coinsurance for items \$450.01 or more 20% coinsurance for Continuous Glucose Monitors (CGM)	0% coinsurance for items \$350 or less 20% coinsurance for items \$350.01 or more 20% coinsurance for Continuous Glucose Monitors (CGM)
Diabetes Supplies	0% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic Shoes or Inserts	0% 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)	\$0 copay	\$0 copay
Psychiatric Services (Individual/Group)	\$20 copay	\$20 copay
Prosthetic/Medical Supplies	20% coinsurance	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	\$100 coverage limit for glasses/contacts per year	\$200 coverage limit for glasses/contacts per 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	Restorative Services: \$20-\$400 copay Endodontics: \$25-\$350 copay Periodontics: \$15-\$550 copay Prosthodontics (removable): \$20-\$570 copay Prosthodontics (fixed): \$40-\$400 copay Oral & Maxillofacial Surgery: \$25-\$250 copay	\$0 copay for: Restorative Services Endodontics Periodontics Prosthodontics Oral & Maxillofacial Surgery \$2,000 coverage limit per year (Preventive and Comprehensive combined)

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Optional Enhanced Dental	Premium: \$36 Diagnostic: 0% coinsurance Restorative: 50% coinsurance Endodontics: 50% coinsurance Periodontics: 0-50% coinsurance Prosthodontics: 50% coinsurance Oral & Maxillofacial Surgery: 50% coinsurance \$1,500 maximum coverage per year	not covered
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	\$195-\$1,750 copay per hearing aid, 2 hearing aids per year	\$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)	\$20 spending allowance per month (no rollover)	\$20 spending allowance per month (no rollover)
Acupuncture & Chiropractic Services	\$0 copay for Medicare covered	\$0 copay for Medicare covered
Dialysis Services	20% coinsurance	\$30 copay
Fitness membership(s) at participating fitness centers	\$0 copay	\$0 copay
Personal Emergency Response System (PERS)	\$0 copay	\$0 copay
Telehealth	\$0 copay for Primary Care/Mental Health Specialty/Psychiatric Services	\$0 copay for Primary Care/Mental Health Specialty/Psychiatric Services
Transportation	22 one-way trips to plan approved locations per year (within a 50-mile radius)	22 one-way trips to plan approved locations per year (within a 50-mile radius)
In-Home Support Services	not covered	\$0 copay for 12 hours per quarter, 48 hours per year, OR Caregivers Support (Member must choose in advance)
Caregivers Support for Enrollees	not covered	Up to \$300 reimbursement per year, OR In-Home Support Services (Members must choose in advance)
SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI)†		
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
Air Purifier/Humidifier	not covered	\$0 copay for 1 air purifier or humidifier per year
PRESCRIPTION DRUG COVERAGE		
Part D Deductible	\$0	\$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 \$3 copay 30-day supply \$6 copay 60-day supply \$9 copay 100-day supply	Retail & Mail Order Standard \$5 copay 30-day supply \$10 copay 60-day supply \$15 copay Retail/\$12.50 Mail Order 100-day supply
Tier 3: Preferred Brand Drugs	Retail & Mail Order Standard \$40 copay 30-day supply \$80 copay 60-day supply \$120 copay 100-day supply	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 32% coinsurance 30-day/60-day/100-day supply	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 33% coinsurance 30-day supply	Retail & Mail Order Standard 33% coinsurance 30-day supply
Tier 6: Select Care Drugs	Retail & Mail Order Standard \$5 copay 30-day supply \$10 copay 60-day supply \$0 copay 100-day supply	Retail & Mail Order Standard \$3 copay 30-day supply \$6 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 & 6 drugs
Bonus Drug Coverage	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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