

2026

Benefit Platter

ALIGNMENT HEALTH HARMONY (HMO) 031
Alameda, San Francisco, Santa Clara, San Mateo

ALIGNMENT HEALTH THE ONE (HMO) 034
Los Angeles, Orange, Riverside, San Bernardino,
San Diego, Santa Clara



	ALIGNMENT HEALTH HARMONY (HMO) 031	ALIGNMENT HEALTH THE ONE (HMO) 034
Monthly Premium	\$0	\$0
Annual Plan Deductible	\$0	\$0
Maximum Out of Pocket (MOOP)	\$3,400	\$3,400
PCP	\$0 copay	\$0 copay
Specialist	\$0 copay	\$0 copay
INPATIENT CARE		
Inpatient Hospital-Acute	\$100 copay per day, days 1-5 \$0 copay per day, days 6-90 (unlimited days per admission)	\$0 copay per day, days 1-4 \$100 copay per day, days 5-10 \$0 copay per day, days 11-90 (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	\$1,676 deductible for each benefit period Days 1-60: \$0 copay for each benefit period Days 61-90: \$419 copay per day of each benefit period Days 91-130: \$0 copay for 40 additional days Days 131 and beyond: \$838 copay per each Medicare-covered lifetime reserve day after day 90 for each benefit period (up to 60 days over your lifetime) Beyond lifetime reserve days: all costs
Skilled Nursing Facility (SNF)	\$0 copay per day, days 1-20 \$100 copay per day, days 21-100 (no prior hospital stay required)	\$0 copay
OUTPATIENT CARE		
Ambulatory Surgical Center	\$100 copay	\$100 copay
Annual Physical Exam and Preventive Care (Medicare Covered)	\$0 copay	\$0 copay
Emergency Services	\$100 copay (not waived if admitted)	\$0 copay
Ground and Air Ambulance Services	\$175 copay (waived if admitted)	\$75 copay (not waived if admitted)
Outpatient Hospital and Observation Services	\$200 copay Hospital Services \$0 copay Observation Services	\$200 copay Hospital Services \$0 copay Observation Services
Physical and Speech Therapy	\$0 copay	\$0 copay
Podiatry	\$5 copay Medicare covered	\$0 copay Medicare covered
Urgently Needed Services	\$0 copay	\$0 copay
Worldwide Emergency/Urgent Coverage	\$20 copay (not waived if admitted) \$100,000 maximum coverage per year	\$75 copay (waived if admitted) \$25,000 maximum coverage per year
OUTPATIENT MEDICAL SERVICES & SUPPLIES		
Durable Medical Equipment (DME)	20% coinsurance 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)	\$40 copay	\$0 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	\$150 coverage limit for glasses/contacts per year	\$350 coverage limit for glasses/contacts every 2 years
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	not covered

	ALIGNMENT HEALTH HARMONY (HMO) 031	ALIGNMENT HEALTH THE ONE (HMO) 034
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	not covered
Optional Enhanced Dental	Premium: \$36 Diagnostic: 0% coinsurance Restorative: 50% coinsurance Endodontics: 50% coinsurance Periodontics: 0-50% coinsurance Prosthodontics (fixed/removable): 50% coinsurance Oral & Maxillofacial Surgery: 50% coinsurance \$1,500 maximum coverage per year	Premium: \$36 Diagnostic: 0% coinsurance Restorative: 50% coinsurance Endodontics: 50% coinsurance Periodontics: 0-50% coinsurance Prosthodontics (fixed/removable): 50% coinsurance Oral & Maxillofacial Surgery: 50% coinsurance \$1,500 maximum coverage per year
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)	\$30 spending allowance per month (no rollover)	\$60 spending allowance per month (no rollover)
Acupuncture & Chiropractic Services	\$0 copay for Medicare covered \$0 copay for unlimited routine visits (Acupuncture only)	\$0 copay for Medicare covered \$0 copay for 12 routine visits per year combined
Dialysis Services	\$30 copay	20% coinsurance
Fitness membership(s) at participating fitness centers	\$0 copay	\$0 copay
Personal Emergency Response System (PERS)	not covered	\$0 copay
Telehealth	\$0 copay for Primary Care/Mental Health Specialty/ Psychiatric Services	\$0 copay for Primary Care/Mental Health Specialty/ Psychiatric Services
Transportation	28 one-way trips to plan approved locations per year (within a 20-mile radius)	20 one-way trips to plan approved locations per year (within a 50-mile radius)
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.	\$30 spending allowance per month (no rollover)	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	\$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 \$1 copay 30-day supply \$2 copay 60-day supply \$3 copay 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 \$40 copay 30-day supply \$80 copay 60-day supply \$120 copay 100-day supply
Tier 4: Non-Preferred Drugs	Retail & Mail Order Standard \$100 copay 30-day supply \$200 copay 60-day supply \$300 copay 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 \$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 & 6 drugs
Bonus Drug Coverage	Some prescription drugs, for cough and cold, hairloss, 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.

Y0141_26079EN_M