2026
Benefit Platter

ALIGNMENT HEALTH ADVANTAGE PPO (PPO) 001
Fresno, Los Angeles, Madera, Orange, San Diego, Ventura

ALIGNMENT HEALTH ADVANTAGE PPO (PPO) 002
Santa Clara

ALIGNMENT HEALTH BALANCE (PPO) 006
San Joaquin, Stanislaus

Alignment Health Plan®

	ALIGNMENT HEALTH ADVANTAGE PPO (PPO) 001	ALIGNMENT HEALTH ADVANTAGE PPO (PPO) 002	ALIGNMENT HEALTH BALANCE (PPO) 006
Monthly Premium	$45	$75	$41
Plan Deductible	$0	$0	$0
Maximum Out of Pocket (MOOP)	In-Network: $4,201 Out-of-Network: $8,950 combined	In-Network: $2,850 Out-of-Network: $5,150 combined	In-Network: $2,850 Out-of-Network: $5,150 combined
PCP	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: $25 copay
Specialist	In-Network: $20 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: $25 copay
INPATIENT CARE			
Inpatient Hospital-Acute	In-Network: $250 copay per day, days 1-3 $0 copay per day, days 4-90 $0 copay per day, days 91-999 (additional days) (unlimited days per admission) Out-of-Network: 40% coinsurance	In-Network: $75 copay per day, days 1-5 $0 copay per day, days 6-90 $0 copay per day, days 91-999 (additional days) (unlimited days per admission) Out-of-Network: 40% coinsurance	In-Network: $75 copay per day, days 1-3 $0 copay per day, days 4-90 $0 copay per day, days 91-999 (additional days) (unlimited days per admission) Out-of-Network: 20% coinsurance
Inpatient Hospital Psychiatric	In-Network: $120 copay per day, days 1-10 $0 copay per day, days 11-90 $0 copay for 40 additional day limit days 91-130 $0 copay 60-days Lifetime reserve Out-of-Network: 40% coinsurance	In-Network: $120 copay per day, days 1-10 $0 copay per day, days 11-90 $0 copay for 40 additional day limit, days 91-130 $0 copay 60-days Lifetime reserve Out-of-Network: 40% coinsurance	In-Network: $120 copay per day, days 1-10 $0 copay per day, days 11-90 $0 copay for 40 additional day limit, days 91-130 $0 copay 60-days Lifetime reserve Out-of-Network: 30% coinsurance
Skilled Nursing Facility (SNF)	In-Network: $0 copay per day, days 1-20 $100 copay per day, days 21-51 $0 copay per day, days 52-100 (no prior hospital stay required) Out-of-Network: 40% coinsurance	In-Network: $0 copay per day, days 1-20 $50 copay per day, days 21-100 (no prior hospital stay required) Out-of-Network: 40% coinsurance	In-Network: $0 copay per day, days 1-20 $50 copay per day, days 21-100 (no prior hospital stay required) Out-of-Network: 30% coinsurance
OUTPATIENT CARE			
Ambulatory Surgical Center	In-Network: $100 copay Out-of-Network: 40% coinsurance	In-Network: $100 copay Out-of-Network: 40% coinsurance	In-Network: $100 copay Out-of-Network: 30% coinsurance
Annual Physical Exam and Preventive Care (Medicare Covered)	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 30% coinsurance
Emergency Services	In-Network & Out-of-Network: $90 copay (not waived if admitted)	In-Network & Out-of-Network: $75 copay (not waived if admitted)	In-Network & Out-of-Network: $75 copay (not waived if admitted)
Ground and Air Ambulance Services	In-Network: $250 copay (waived if admitted) Out-of-Network: 40% coinsurance	In-Network: $100 copay (waived if admitted) Out-of-Network: 40% coinsurance	In-Network: $100 copay (waived if admitted) Out-of-Network: 30% coinsurance
Outpatient Hospital and Observation Services	In-Network: $200 copay Hospital Services $0 copay for Observation Services Out-of-Network: 40% coinsurance	In-Network: $200 copay Hospital Services $0 copay for Observation Services Out-of-Network: 40% coinsurance	In-Network: $200 copay Hospital Services $0 copay for Observation Services Out-of-Network: 25% coinsurance
Physical and Speech Therapy	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 30% coinsurance
Podiatry	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 30% coinsurance
Urgently Needed Services	In-Network & Out-of-Network: $20 copay (waived if admitted within 24 hours)	In-Network & Out-of-Network: $0 copay	In-Network & Out-of-Network: $0 copay
Worldwide Emergency/ Urgent Coverage	$0 copay $10,000 maximum coverage per year	$0 copay $25,000 maximum coverage per year	$0 copay $25,000 maximum coverage per year
OUTPATIENT MEDICAL SERVICES & SUPPLIES			
Durable Medical Equipment (DME)	In-Network: 0% coinsurance for items $350 or less 20% coinsurance for items $350.01 or more 20% coinsurance for Continuous Glucose Monitors (CGM) Out-of-Network: 40% coinsurance	In-Network: 0% coinsurance for items $350 or less 20% coinsurance for items $350.01 or more 20% coinsurance for Continuous Glucose Monitors (CGM) Out-of-Network: 40% coinsurance	In-Network: 0% coinsurance for items $350 or less 20% coinsurance for items $350.01 or more 20% coinsurance for Continuous Glucose Monitors (CGM) Out-of-Network: 30% coinsurance
Diabetes Supplies	In-Network: 0% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic Shoes or Inserts Out-of-Network: 40% coinsurance	In-Network: 0% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic Shoes or Inserts Out-of-Network: 40% coinsurance	In-Network: 0% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic Shoes or Inserts Out-of-Network: 30% coinsurance
Outpatient Diagnostic (Procedures/Tests/Lab Services)	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 30% coinsurance
Outpatient Radiology (X-Ray/Diagnostic/Therapeutic)	In-Network: $15 copay (X) $150 copay (D) 20% coinsurance (T) Out-of-Network: 40% coinsurance	In-Network: $0 copay (X/D) 20% coinsurance (T) Out-of-Network: 40% coinsurance	In-Network: $0 copay (X/D) 20% coinsurance (T) Out-of-Network: 30% coinsurance
Mental Health Specialty Services (Individual/Group)	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 30% coinsurance
Psychiatric Services (Individual/Group)	In-Network: $40 copay Out-of-Network: 40% coinsurance	In-Network: $40 copay Out-of-Network: 40% coinsurance	In-Network: $40 copay Out-of-Network: 30% coinsurance
Prosthetic/Medical Supplies	In-Network: 20% coinsurance	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance	In-Network: 20% coinsurance Out-of-Network: 30% coinsurance
VISION, HEARING & DENTAL BENEFITS			
Eye Exams	In-Network: $0 copay for Medicare covered exams and 1 routine eye exam per year Out-of-Network: 40% coinsurance	In-Network: $0 copay for Medicare covered exams and 1 routine eye exam per year Out-of-Network: 40% coinsurance	In-Network: $0 copay for Medicare covered exams and 1 routine eye exam per year Out-of-Network: 30% coinsurance
Eyewear	In-Network: $150 coverage limit for glasses/contacts every 2 years Out-of-Network: 40% coinsurance	In-Network: $200 coverage limit for glasses/contacts per year Out-of-Network: 40% coinsurance	In-Network: $200 coverage limit for glasses/contacts per year Out-of-Network: 30% coinsurance
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	In-Network: $0 copay Medicare covered only	In-Network: Oral Exam: 50% coinsurance Cleaning: 50% coinsurance Fluoride treatment: 50% coinsurance X-ray: 50% coinsurance Out-of-Network: Oral Exam: 60% coinsurance Cleaning: 60% coinsurance Fluoride treatment: 60% coinsurance X-ray: 60% coinsurance

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Comprehensive Dental	In-Network & Out-of-Network: $0 copay for: Diagnostic Services Restorative Services Endodontics Periodontics Prosthodontics $1,000 coverage limit per year (Preventive and Comprehensive combined)	In-Network: $0 copay Medicare covered only Out-of-Network: 40% coinsurance Medicare covered only	In-Network: $0 copay Medicare covered only Out-of-Network: 30% coinsurance Medicare covered only
Optional Supplemental Benefits	Premium: $48 Options+ In-Network & Out-of-Network: $0 copay for: Diagnostic Services Restorative Services Endodontics Periodontics Prosthodontics Oral and Maxillofacial Surgery Annual Max Coverage: Additional $1,000 allowance for a total of $2,000 annual in-network & out-of-network maximum Additional $15,000 per year for Worldwide Emergency Coverage 12 one-way trips to plan approved locations per year (within a 30-mile radius) $195-$1,750 copay per hearing aid, 2 hearing aids per year Additional $15 over-the-counter allowance every month $0 copay Personal Emergency Response System	Premium: $36 Enhanced Dental Option In-Network: Diagnostic Services: 0% coinsurance Restorative: 50% coinsurance Endodontics: 50% coinsurance Periodontics: 0-50% coinsurance Prosthodontics: 50% coinsurance Oral & Maxillofacial Surgery: 50% coinsurance Out-of-Network: Diagnostic Services: 0% coinsurance Restorative: 50% coinsurance Endodontics: 50% coinsurance Periodontics: 50% coinsurance Prosthodontics: 50% coinsurance Oral & Maxillofacial Surgery: 50% coinsurance $1,500 maximum coverage per year	Premium: $36 Enhanced Dental Option In-Network: Diagnostic Services: 0% coinsurance Restorative: 50% coinsurance Endodontics: 50% coinsurance Periodontics: 0-50% coinsurance Prosthodontics: 50% coinsurance Oral & Maxillofacial Surgery: 50% coinsurance Out-of-Network: Diagnostic Services: 0% coinsurance Restorative: 50% coinsurance Endodontics: 50% coinsurance Periodontics: 50% coinsurance Prosthodontics: 50% coinsurance Oral & Maxillofacial Surgery: 50% coinsurance $1,500 maximum coverage per year
Hearing Exams/Fitting and Evaluation for Hearing Aid	In-Network: $0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year Out-of-Network: 40% coinsurance	In-Network: $0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year Out-of-Network: 40% coinsurance	In-Network: $0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year Out-of-Network: 30% coinsurance
ADDITIONAL BENEFITS - MORE THAN ORIGINAL MEDICARE WITH YOUR ACCESS ON-DEMAND CARD BENEFITS!			
24/7 Concierge Service	$0	$0	$0
Over-the-Counter (OTC)	$10 spending allowance per month (no rollover)	$20 spending allowance per month (no rollover)	$20 spending allowance per month (no rollover)
Acupuncture	$0 copay for Medicare covered	$0 copay for Medicare covered	$0 copay for Medicare covered
Chiropractic Services	In-Network: $0 copay for Medicare covered Out-of-Network: 40% coinsurance for Medicare covered	In-Network: $0 copay for Medicare covered Out-of-Network: 40% coinsurance for Medicare covered	In-Network: $0 copay for Medicare covered Out-of-Network: 30% coinsurance for Medicare covered
Dialysis Services	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 40% coinsurance	In-Network: $0 copay Out-of-Network: 30% coinsurance
Fitness membership(s) at participating fitness centers	$0 copay	$0 copay	$0 copay
Telehealth	In-Network: $0 copay for Primary Care/Mental Health Specialty/Psychiatric Services	In-Network: $0 copay for Primary Care/Mental Health Specialty/Psychiatric Services	In-Network: $0 copay for Primary Care/Mental Health Specialty/Psychiatric Services
Transportation	not covered	26 one-way trips to plan approved locations per year (within a 50-mile radius)	26 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.	not covered	not covered	$100 spending allowance per month (no rollover) (ESRD Condition Only)
Pet Services	$0 copay for 7 boarding days or 14 walks per year	$0 copay for 7 boarding days or 14 walks per year	$0 copay for 7 boarding days or 14 walks per year (ESRD Condition Only)
Pest Control	$0 copay for 1 service per year	$0 copay for 1 service per year	$0 copay for 1 service per year (ESRD Condition Only)
PRESCRIPTION DRUG COVERAGE			
Part D Deductible	$0	$0	$0
Part D Out of Pocket Threshold	$2,100	$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	**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** $5 copay 30-day supply $10 copay 60-day supply $15 copay 100-day supply	**Retail & Mail Order Standard** $3 copay 30-day supply $6 copay 60-day supply $9 copay 100-day supply	**Retail & Mail Order Standard** $3 copay 30-day supply $6 copay 60-day supply $9 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	**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** 32% coinsurance 30-day/60-day/100-day supply	**Retail & Mail Order Standard** 32% coinsurance 30-day/60-day/100-day supply	**Retail & Mail Order Standard** 32% coinsurance 30-day/60-day/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	**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	**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	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.