Alignment Health Plan®

# 2027 SUMMARY OF BENEFITS

**Alignment Health Sutter Advantage +More (HMO)**

| | |
|---|---|
| Placer | Santa Clara |
| Sacramento | Santa Cruz |
| San Francisco | Sonoma |
| San Mateo | Yolo |

This is a summary of drug and health services benefits covered by Alignment Health Plan for January 1, 2027 - December 31, 2027.

**AlignmentHealthPlan.com**

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| PREMIUMS AND BENEFITS | Alignment Health Sutter Advantage +More (HMO) 019<br>Placer, Sacramento, and Yolo counties | Alignment Health Sutter Advantage +More (HMO) 020<br>Santa Clara County | Alignment Health Sutter Advantage +More (HMO) 021<br>Santa Cruz County | Alignment Health Sutter Advantage +More (HMO) 023<br>San Francisco, San Mateo, and Sonoma counties |
|---|---|---|---|---|
| **Monthly Plan Premium**<br>• Part C & Part D | **$21.00** | **$51.00** | **$61.00** | **$50.00** |
| **Deductible** | **$0.00** | **$0.00** | **$0.00** | **$0.00** |
| **Maximum Out-of-Pocket Responsibility**<br>(does not include prescription drugs) | **$4,900.00** | **$4,900.00** | **$4,900.00** | **$4,900.00** |
| **Inpatient Hospital** [1, 2] | **$185.00** per day, days 1-5<br>**$0.00** per day, days 6-90<br>(unlimited days per admission) | **$275.00** per day, days 1-5<br>**$0.00** per day, days 6-90<br>(unlimited days per admission) | **$275.00** per day, days 1-5<br>**$0.00** per day, days 6-90<br>(unlimited days per admission) | **$275.00** per day, days 1-5<br>**$0.00** per day, days 6-90<br>(unlimited days per admission) |
| **Outpatient Hospital** [1, 2]<br>• Hospital Services | **$195.00** | **$325.00** | **$325.00** | **$250.00** |
| • Observation Services | **$0.00** | **$0.00** | **$0.00** | **$0.00** |
| **Ambulatory Surgical Center** [1, 2] | **$100.00** | **$100.00** | **$100.00** | **$100.00** |
| **Doctor Visits**<br>• Primary | **$5.00** | **$5.00** | **$5.00** | **$5.00** |
| • Specialists [1, 2] | **$25.00** | **$25.00** | **$25.00** | **$25.00** |
| **Preventive Care**<br>(e.g., flu vaccine, diabetic screenings) | **$0.00** | **$0.00** | **$0.00** | **$0.00** |
| **Emergency Care** | **$120.00**<br>(not waived if admitted) | **$120.00**<br>(not waived if admitted) | **$120.00**<br>(not waived if admitted) | **$120.00**<br>(not waived if admitted) |
| **Urgently Needed Services** | **$0.00** | **$0.00** | **$0.00** | **$0.00** |

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|---|---|---|---|---|
| **OUTPATIENT DIAGNOSTIC** [1, 2] | | | | |
| • Procedures, tests, lab services | **$0.00** | **$0.00** | **$0.00** | **$0.00** |
| • X-Ray | **$15.00** | **$15.00** | **$15.00** | **$15.00** |
| • Diagnostic | **$150.00** | **$150.00** | **$150.00** | **$150.00** |
| • Therapeutic radiology services (such as radiation treatment for cancer) | **20%** coinsurance | **20%** coinsurance | **20%** coinsurance | **20%** coinsurance |
| **Hearing Services** | | | | |
| • Routine hearing exam | **$0.00** Medicare-covered benefits and 1 exam/fitting/ evaluation every year | **$0.00** Medicare-covered benefits and 1 exam/fitting/ evaluation every year | **$0.00** Medicare-covered benefits and 1 exam/fitting/ evaluation every year | **$0.00** Medicare-covered benefits and 1 exam/ fitting/ evaluation every year |
| • Hearing aids | Not covered | Not covered | Not covered | Not covered |
| **Dental Services** [1, 2]<br>Diagnostic and preventive: | **$0.00** for Medicare-covered services | **$0.00** for Medicare-covered services | **$0.00** for Medicare-covered services | **$0.00** for Medicare-covered services |
| • Exam & Cleaning | **$0.00** for 1 every six months | **$0.00** for 1 every six months | **$0.00** for 1 every six months | **$0.00** for 1 every six months |
| • Fluoride treatment | **$0.00** for 1 every six months | **$0.00** for 1 every six months | **$0.00** for 1 every six months | **$0.00** for 1 every six months |
| • X-Ray | **$0.00** for 1 every three years | **$0.00** for 1 every three years | **$0.00** for 1 every three years | **$0.00** for 1 every three years |

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|---|---|---|---|---|
| Comprehensive: | | | | |
| • Restorative | **$20 - $400** | **$20 - $400** | **$20 - $400** | **$20 - $400** |
| • Endodontics | **$25 - $350** | **$25 - $350** | **$25 - $350** | **$25 - $350** |
| • Periodontics | **$15 - $550** | **$15 - $550** | **$15 - $550** | **$15 - $550** |
| • Removable Prosthodontics | **$20 - $570** | **$20 - $570** | **$20 - $570** | **$20 - $570** |
| • Fixed Prosthodontics | **$40 - $400** | **$40 - $400** | **$40 - $400** | **$40 - $400** |
| • Oral and Maxillofacial Surgery | **$25 - $250** | **$25 - $250** | **$25 - $250** | **$25 - $250** |
| **Vision Services** | | | | |
| • Routine exam | **$0.00** Medicare-covered eye exams/1 routine eye exam every year | **$0.00** Medicare-covered eye exams/1 routine eye exam every year | **$0.00** Medicare-covered eye exams/1 routine eye exam every year | **$0.00** Medicare-covered eye exams/1 routine eye exam every year |
| • Eyewear | **$100.00** coverage limit for glasses/ contacts every two years | **$100.00** coverage limit for glasses/ contacts every two years | **$100.00** coverage limit for glasses/ contacts every two years | **$100.00** coverage limit for glasses/ contacts every two years |
| **Mental Health Services** [1, 2] | | | | |
| • Inpatient hospital | **$120.00** per day, days 1-10<br>**$0.00** per day, days 11-90<br>**$0.00** for 40 additional day limit<br>**$0.00** for 60 “lifetime reserve days” | **$120.00** per day, days 1-10<br>**$0.00** per day, days 11-90<br>**$0.00** for 40 additional day limit<br>**$0.00** for 60 “lifetime reserve days” | **$120.00** per day, days 1-10<br>**$0.00** per day, days 11-90<br>**$0.00** for 40 additional day limit<br>**$0.00** for 60 “lifetime reserve days” | **$120.00** per day, days 1-10<br>**$0.00** per day, days 11-90<br>**$0.00** for 40 additional day limit<br>**$0.00** for 60 “lifetime reserve days” |

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|---|---|---|---|---|
| • Mental health specialty (individual and group) | **$0.00** | **$0.00** | **$0.00** | **$0.00** |
| • Psychiatric services (individual and group) | **$40.00** | **$40.00** | **$40.00** | **$40.00** |
| **Skilled Nursing Facility** [1, 2] | **$10.00** per day, days 1-20<br>**$160.00** per day, days 21-51<br>**$0.00** per day, days 52-100<br>(no prior hospital stay required) | **$10.00** per day, days 1-20<br>**$160.00** per day, days 21-57<br>**$0.00** per day, days 58-100<br>(no prior hospital stay required) | **$10.00** per day, days 1-20<br>**$160.00** per day, days 21-62<br>**$0.00** per day, days 63-100<br>(no prior hospital stay required) | **$10.00** per day, days 1-20<br>**$160.00** per day, days 21-51<br>**$0.00** per day, days 52-100<br>(no prior hospital stay required) |
| **Physical and Speech Therapy** [1, 2] | **$0.00** | **$0.00** | **$0.00** | **$0.00** |
| **Ground and Air Ambulance Services** [1] | **$250.00**<br>(waived if admitted) | **$250.00**<br>(waived if admitted) | **$250.00**<br>(waived if admitted) | **$250.00**<br>(waived if admitted) |
| **Transportation** | Not covered | Not covered | Not covered | Not covered |
| **Medicare Part B Drugs** [1] | **0%** - **20%** coinsurance | **0%** - **20%** coinsurance | **0%** - **20%** coinsurance | **0%** - **20%** coinsurance |

| Outpatient Prescription Drugs | | |
|---|---|---|
| **ALIGNMENT HEALTH SUTTER ADVANTAGE +MORE (HMO) 019, 020, 021 AND 023**<br>Placer, Sacramento, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, and Yolo counties | | |
| **Part D Deductible** | **$0.00** | |
| **Part D Out of Pocket Threshold** | **$2,400.00** | |
| **Initial Coverage** | Retail 30-day supply | Mail-order 100-day supply |
| Tier 1 (Preferred Generic Drugs): | **$0.00** | **$0.00** |
| Tier 2 (Generic Drugs): | **$5.00** | **$15.00** |
| Tier 3 (Preferred Brand Drugs): | **$40.00** | **$120.00** |
| Tier 4 (Non-Preferred Drugs): | **32%** coinsurance | **32%** coinsurance |
| Tier 5 (Specialty Tier): | **33%** coinsurance | Not covered |
| Tier 6 (Select Care Drugs): | **$5.00** | **$0.00** |

## UNDERSTANDING YOUR DRUG COVERAGE

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|---|---|
| **Cost-Sharing** | May vary depending on the pharmacy you choose and the payment stage of the Part D benefit you are in. If you reside in a long-term care facility, you will pay the same cost-sharing amount for a 31-day supply as you would for a 30-day supply at an in-network retail pharmacy. |
| **Catastrophic Coverage** | After your yearly out-of-pocket drug costs reach **$2,400.00**, you pay **$0.00** for plan-covered Part D drugs for the remainder of the year. For plans with excluded drug coverage under our enhanced benefit, you pay the same copayment as you did in the Initial Coverage Stage. |
| **Bonus Drugs** | Additional coverage of certain drugs that are not typically covered under Part D such as generic Viagra, and select drugs within the categories of prescription vitamins, hair loss, and cough and cold products. For a complete list of covered drugs and coverage details, please refer to the Drug List (Formulary). |
| **Insulin** | You won't pay more than **$35.00** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. |

| UNDERSTANDING YOUR DRUG COVERAGE | |
|---|---|
| **Vaccines** | Our plan covers most Part D vaccines at no cost to you. |

| EXTRA BENEFITS YOU GET WITH ALIGNMENT HEALTH PLAN | Alignment Health Sutter Advantage +More (HMO) 019<br>Placer, Sacramento, and Yolo counties | Alignment Health Sutter Advantage +More (HMO) 020<br>Santa Clara County | Alignment Health Sutter Advantage +More (HMO) 021<br>Santa Cruz County | Alignment Health Sutter Advantage +More (HMO) 023<br>San Francisco, San Mateo, and Sonoma counties |
|---|---|---|---|---|
| **ACCESS On-Demand Concierge Card**<br>Provides access to OTC benefits and Healthy Rewards | Included | Included | Included | Included |
| **Enhanced Dental Option** | | | | |
| **Monthly Premium** | **$36.00** | **$36.00** | **$36.00** | **$36.00** |
| **Coverage** | | | | |
| • Diagnostic | **0%** coinsurance | **0%** coinsurance | **0%** coinsurance | **0%** coinsurance |
| • Restorative | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance |
| • Endodontics | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance |
| • Periodontics | **0%-50%** coinsurance | **0%-50%** coinsurance | **0%-50%** coinsurance | **0%-50%** coinsurance |
| • Removable Prosthodontics | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance |
| • Fixed Prosthodontics | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance |
| • Oral and Maxillofacial Surgery | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance | **50%** coinsurance |
| | **$1,500.00** coverage limit per year | **$1,500.00** coverage limit per year | **$1,500.00** coverage limit per year | **$1,500.00** coverage limit per year |
| **Fitness**<br>(membership(s) at participating fitness centers) | **$0.00** | **$0.00** | **$0.00** | **$0.00** |
| **Chiropractic Services** [1, 2] | **$0.00** Medicare-covered | **$0.00** Medicare-covered | **$0.00** Medicare-covered | **$0.00** Medicare-covered |
| **Acupuncture** [1, 2] | **$0.00** Medicare-covered | **$0.00** Medicare-covered | **$0.00** Medicare-covered | **$0.00** Medicare-covered |

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|---|---|---|---|---|
| **Podiatry Services** [1, 2] | **$0.00** Medicare-covered | **$0.00** Medicare-covered | **$0.00** Medicare-covered | **$0.00** Medicare-covered |
| **Over-the-Counter (OTC)** | **$15.00** spending allowance every month (no rollover) | **$15.00** spending allowance every month (no rollover) | **$15.00** spending allowance every month (no rollover) | **$15.00** spending allowance every month (no rollover) |
| **Telehealth** | **$0.00** for primary care provider, mental health specialty, and psychiatric services | **$0.00** for primary care provider, mental health specialty, and psychiatric services | **$0.00** for primary care provider, mental health specialty, and psychiatric services | **$0.00** for primary care provider, mental health specialty, and psychiatric services |
| **Worldwide Emergency/ Urgent Care** | **$0.00**<br>**$7,500.00** coverage limit every year | **$0.00**<br>**$7,500.00** coverage limit every year | **$0.00**<br>**$7,500.00** coverage limit every year | **$0.00**<br>**$7,500.00** coverage limit every year |
| **Durable Medical Equipment (DME)** [1] | **0%** coinsurance for items **$350.00** or less<br>**20%** coinsurance for items **$350.01** or more | **0%** coinsurance for items **$350.00** or less<br>**20%** coinsurance for items **$350.01** or more | **0%** coinsurance for items **$350.00** or less<br>**20%** coinsurance for items **$350.01** or more | **0%** coinsurance for items **$350.00** or less<br>**20%** coinsurance for items **$350.01** or more |
| **Extra Benefits for those with Qualifying Condition (SSBCI)**<br>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. | | | | |
| **Pet Services**<br>For members who have hospital procedures or | **$0.00**<br>7 boarding days | **$0.00**<br>7 boarding days | **$0.00**<br>7 boarding days | **$0.00**<br>7 boarding days |

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|---|---|---|---|---|
| emergencies and need pet care while they are away. | or 14 walks every year | or 14 walks every year | or 14 walks every year | or 14 walks every year |
| **Pest Control**<br>Annual pest eradication for covered pests to ensure the health, welfare, and safety of members. | **$0.00**<br>**$500.00** coverage limit for 1 service every year | **$0.00**<br>**$500.00** coverage limit for 1 service every year | **$0.00**<br>**$500.00** coverage limit for 1 service every year | **$0.00**<br>**$500.00** coverage limit for 1 service every year |

| Understanding Your Plan | |
|---|---|
| **Who Can Join?** | **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.** |
| **Alignment Health Plan Members** | **1-866-634-2247 (TTY 711)** |
| **Prospective Members** | **1-888-979-2247 (TTY 711)** |
| **Hours of Operation** | **October 1 – March 31:**<br>Seven days a week from 8:00 a.m. to 8:00 p.m. except Thanksgiving and Christmas Day<br>**April 1 – September 30:**<br>Monday through Friday (except holidays) from 8:00 a.m. to 8:00 p.m. |
| **Website** | alignmenthealthplan.com |

Alignment Health Plan offers access to a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for the services. Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. To learn more about coverage and costs of Original Medicare, look at the "Medicare & You" handbook. You can view it online at medicare.gov or request a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. This information is not a complete description of benefits. For complete details, including limitations and exclusions, please refer to the Evidence of Coverage (EOC) or call 1-866-634-2247 (TTY 711) 24 hours a day, 7 days a week.

Services notated with a "1" may require prior authorization. Services notated with a "2" may require a referral from your doctor. 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 alignmenthealthplan.com.

This document is also available in other languages and formats.

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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.

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