Alignment Health Plan®

2027 SUMMARY OF BENEFITS

Alignment Health My Choice 001 (PPO)
Alignment Health Balance 006 (PPO)
Alignment Health Balance Plus 004 (PPO)

San Diego
San Joaquin
Santa Cruz
Stanislaus

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 My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
Monthly Plan Premium • Part C	**$149.00**	**$93.00**	**$7.30** or **$0.00** if you receive "Extra Help"*
Deductible	**$0.00**	**$0.00**	**$0.00**
Maximum Out-of-Pocket Responsibility (does not include prescription drugs) In-Network	**$4,200.00**	**$2,850.00**	**$9,850.00**
Out-of-Network	**$6,000.00** combined	**$5,150.00** combined	**$11,950.00** combined
Inpatient Hospital [1, 2] In-Network	**$300.00** per day, days 1-5 **$0.00** per day, days 6-90 **$0.00** per day, days 91-999 (unlimited days per admission)	**$75.00** per day, days 1-3 **$0.00** per day, days 4-90 **$0.00** per day, days 91-999 (unlimited days per admission)	**$1,736.00** deductible for each benefit period Days 1-60: **$0.00** per day of each benefit period Days 61-90: **$434.00** per day of each benefit period Days 91 and beyond: **$868.00** per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) Beyond lifetime reserve days: all costs These costs are for 2026 and may change for 2027.*
Out-of-Network	**30%** coinsurance	**20%** coinsurance	**20%** coinsurance*

PREMIUMS AND BENEFITS	Alignment Health My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
Outpatient Hospital [1, 2] In-Network			
• Hospital Services	**$295.00**	**$200.00**	**20%** coinsurance*
• Observation Services	**$100.00**	**$0.00**	**20%** coinsurance*
Out-of-Network	**25%** coinsurance	**25%** coinsurance	**20%** coinsurance*
Ambulatory Surgical Center [1, 2] In-Network	**$0.00**	**$100.00**	**20%** coinsurance*
Out-of-Network	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
Doctor Visits In-Network			
• Primary	**$5.00**	**$0.00**	**20%** coinsurance*
• Specialists [1, 2]	**$35.00**	**$0.00**	**20%** coinsurance*
Out-of-Network			
• Primary	**25%** coinsurance	**$25.00**	**20%** coinsurance*
• Specialists [1, 2]	**30%** coinsurance	**$25.00**	**20%** coinsurance*
Preventive Care (e.g., flu vaccine, diabetic screenings) In-Network	**$0.00**	**$0.00**	**$0.00**
Out-of-Network	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
Emergency Care In and Out-of-Network	**$150.00** (not waived if admitted)	**$150.00** (not waived if admitted)	**20%** coinsurance* (waived if admitted within 3 days)
Urgently Needed Services In and Out-of-Network	**$0.00**	**$0.00**	**$0.00**

PREMIUMS AND BENEFITS	Alignment Health My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
Outpatient Diagnostic [1, 2] In-Network			
• Procedures, tests, lab services	**$0.00**	**$0.00**	**20%** coinsurance*
• X-Ray	**$15.00**	**$0.00**	**20%** coinsurance*
• Diagnostic	**$150.00**	**$0.00**	**20%** coinsurance*
• Therapeutic radiology services (such as radiation treatment for cancer)	**20%** coinsurance	**20%** coinsurance	**20%** coinsurance*
Out-of-Network	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
Hearing Services In-Network			
• 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
• Hearing aids	Not covered	Not covered	**$0.00** per hearing aid, 2 hearing aids every year
Out-of-Network			
• Routine hearing exam	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
• Hearing aids	Not covered	Not covered	**20%** coinsurance*
Dental Services [1] In-Network Diagnostic and preventive:	**$0.00** for Medicare-covered services	**$0.00** for Medicare-covered services	**20%** coinsurance* for Medicare-covered services
• Exam & Cleaning	**50%** coinsurance	**50%** coinsurance	**$0.00** for 1 every six months
• Fluoride treatment	**50%** coinsurance	**50%** coinsurance	**$0.00** for 1 every year
• X-Ray	**50%** coinsurance	**50%** coinsurance	**$0.00** for 1 every year

PREMIUMS AND BENEFITS	Alignment Health My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
Comprehensive: • Restorative • Endodontics • Periodontics • Removable Prosthodontics • Fixed Prosthodontics • Oral and Maxillofacial Surgery	**$0.00** for Medicare-covered services	**$0.00** for Medicare-covered services	**$0.00** **$0.00** **$0.00** **$0.00** **$0.00** **$0.00** **$175.00** coverage limit every three months for comprehensive only
Out-of-Network Diagnostic and preventive: • Exam & Cleaning • Fluoride treatment • X-Ray	**60%** coinsurance **60%** coinsurance **60%** coinsurance	**60%** coinsurance **60%** coinsurance **60%** coinsurance	**20%** coinsurance*
Comprehensive:	**30%** coinsurance for Medicare-covered services	**30%** coinsurance for Medicare-covered services	**20%** coinsurance* **$175.00** coverage limit every three months for comprehensive only
Vision Services In-Network • 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
• Eyewear	**$150.00** coverage limit for glasses/ contacts every two years	**$200.00** coverage limit for glasses/ contacts every year	**$500.00** coverage limit for glasses/ contacts every two years

PREMIUMS AND BENEFITS	Alignment Health My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
Out-of-Network			
• Routine exam	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
• Eyewear	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
Mental Health Services [1, 2]			
• Inpatient hospital	**$120.00** per day, days 1-10 **$0.00** per day, days 11-90 **$0.00** for 40 additional day limit **$0.00** for 60 "lifetime reserve days"	**$120.00** per day, days 1-10 **$0.00** per day, days 11-90 **$0.00** for 40 additional day limit **$0.00** for 60 "lifetime reserve days"	**$1,736.00** deductible for each benefit period Days 1-60: **$0.00** per day of each benefit period Days 61-90: **$434.00** per day of each benefit period Days 91 and beyond: **$868.00** per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) Beyond lifetime reserve days: all costs These costs are for 2026 and may change for 2027.*
• Mental health specialty (individual and group)	**$20.00**	**$20.00**	**20%** coinsurance*
• Psychiatric services (individual and group)	**$40.00**	**$40.00**	**20%** coinsurance*
Out-of-Network			
• Inpatient hospital	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
• Mental health specialty (individual and group)	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*

PREMIUMS AND BENEFITS	Alignment Health My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
• Psychiatric services (individual and group)	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
Skilled Nursing Facility [1, 2] In-Network	**$0.00** per day, days 1-20 **$160.00** per day, days 21-51 **$0.00** per day, days 52-100 (no prior hospital stay required)	**$0.00** per day, days 1-20 **$50.00** per day, days 21-100 (no prior hospital stay required)	**$0.00** per day, days 1-20 **$217.00** per day, days 21-100 Days 101 and beyond: All costs These costs are for 2026 and may change for 2027.*
Out-of-Network	**30%** coinsurance*	**30%** coinsurance*	**20%** coinsurance*
Physical and Speech Therapy [1, 2] In-Network	**$0.00**	**$0.00**	**20%** coinsurance*
Out-of-Network	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
Ground and Air Ambulance Services [1] In-Network	**$250.00** (waived if admitted)	**$100.00** (waived if admitted)	**20%** coinsurance* (not waived if admitted)
Out-of-Network	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance* (not waived if admitted)
Transportation [1] In-Network	Not covered	**$0.00** 26 one-way trips to plan approved locations every year (within a 50-mile radius)	**$0.00** 50 one-way trips to plan approved locations every year (within a 50-mile radius)

PREMIUMS AND BENEFITS	**Alignment Health My Choice 001 (PPO)** Santa Cruz and Stanislaus counties	**Alignment Health Balance 006 (PPO)** San Joaquin and Stanislaus counties	**Alignment Health Balance Plus 004 (PPO)** San Diego, San Joaquin, and Stanislaus counties
Out-of-Network	Not covered	**30%** coinsurance	**20%** coinsurance*
Medicare Part B Drugs [1]			
In-Network	**0%** - **20%** coinsurance	**0%** - **20%** coinsurance	**0%** - **20%** coinsurance*
Out-of-Network	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*

Outpatient Prescription Drugs		
ALIGNMENT HEALTH MY CHOICE 001 (PPO) Santa Cruz and Stanislaus 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**

ALIGNMENT HEALTH BALANCE 006 (PPO) San Joaquin and Stanislaus 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):	**$3.00**	**$9.00**
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):	**$3.00**	**$0.00**

ALIGNMENT HEALTH BALANCE PLUS 004 (PPO)
San Diego, San Joaquin, and Stanislaus counties

Part D Deductible	**$700.00** for Tier 3, Tier 4, and Tier 5 or **$0.00** if you receive "Extra Help"	
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):	**25%** coinsurance	**25%** coinsurance
Tier 3 (Preferred Brand Drugs):	**25%** coinsurance	**25%** coinsurance
Tier 4 (Non-Preferred Drugs):	**28%** coinsurance	**28%** coinsurance
Tier 5 (Specialty Tier):	**25%** coinsurance	Not covered
Tier 6 (Select Care Drugs):	**$5.00**	**$0.00**

UNDERSTANDING YOUR DRUG COVERAGE	**Alignment Health My Choice 001 (PPO)** Santa Cruz and Stanislaus counties	**Alignment Health Balance 006 (PPO)** San Joaquin and Stanislaus counties	**Alignment Health Balance Plus 004 (PPO)** San Diego, San Joaquin, and Stanislaus counties
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		Bonus Drugs coverage <u>not</u> available.

UNDERSTANDING YOUR DRUG COVERAGE	Alignment Health My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
	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.		
Vaccines	Our plan covers most Part D vaccines at no cost to you.		

EXTRA BENEFITS YOU GET WITH ALIGNMENT HEALTH PLAN	Alignment Health My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
ACCESS On-Demand Concierge Card Provides access to OTC benefits and Healthy Rewards	Included	Included	Included
Enhanced Dental Option [1, 2]			
Monthly Premium	**$40.00**	**$40.00**	Not covered
Coverage			
In-Network			
• Diagnostic	**0%** coinsurance	**0%** coinsurance	Not covered
• Restorative	**50%** coinsurance	**50%** coinsurance	
• Endodontics	**50%** coinsurance	**50%** coinsurance	
• Periodontics	**0%-50%** coinsurance	**0%-50%** coinsurance	
• Removable Prosthodontics	**50%** coinsurance	**50%** coinsurance	
• Fixed Prosthodontics	**50%** coinsurance	**50%** coinsurance	
• Oral and Maxillofacial Surgery	**50%** coinsurance	**50%** coinsurance	
Out-of-Network			
• Diagnostic	**50%** coinsurance	**50%** coinsurance	
• Restorative	**50%** coinsurance	**50%** coinsurance	
• Endodontics	**50%** coinsurance	**50%** coinsurance	
• Periodontics	**50%** coinsurance	**50%** coinsurance	
• Removable Prosthodontics	**50%** coinsurance	**50%** coinsurance	
• Fixed Prosthodontics	**50%** coinsurance	**50%** coinsurance	
• Oral and Maxillofacial Surgery	**50%** coinsurance	**50%** coinsurance	
	$1,500.00 coverage limit per year in-network and out-of-network every year	**$1,500.00** coverage limit per year in-network and out-of-network every year	
Fitness (membership(s) at participating fitness centers)	**$0.00**	**$0.00**	**$0.00**

EXTRA BENEFITS YOU GET WITH ALIGNMENT HEALTH PLAN	Alignment Health My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
Personal Emergency Response System (PERS) [1, 2]	Not covered	Not covered	**$0.00**
Personalized Health Risk Screening In-Network	Not covered	**$75.00** 1 screening every two years	Not covered
Out-of-Network	Not covered	**30%** coinsurance	Not covered
Chiropractic Services [1, 2] In-Network	**$0.00** Medicare-covered	**$0.00** Medicare-covered	**20%** coinsurance* Medicare-covered **$0.00** for 12 routine visits every year (combined with Acupuncture)
Out-of-Network	**30%** coinsurance Medicare-covered	**30%** coinsurance Medicare-covered	**20%** coinsurance* Medicare-covered
Acupuncture [1, 2] In-Network	**$0.00** Medicare-covered	**$0.00** Medicare-covered	**$0.00** Medicare-covered **$0.00** for 12 routine visits every year (combined with Chiropractic)
Out-of-Network	**30%** coinsurance Medicare-covered	**30%** coinsurance Medicare-covered	**20%** coinsurance* Medicare-covered
Podiatry Services [1, 2] In-Network	**$0.00** Medicare-covered	**$0.00** Medicare-covered	**20%** coinsurance* Medicare-covered
Out-of-Network	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*

EXTRA BENEFITS YOU GET WITH ALIGNMENT HEALTH PLAN	**Alignment Health My Choice 001 (PPO)** Santa Cruz and Stanislaus counties	**Alignment Health Balance 006 (PPO)** San Joaquin and Stanislaus counties	**Alignment Health Balance Plus 004 (PPO)** San Diego, San Joaquin, and Stanislaus counties
Over-the-Counter (OTC)	Not covered	**$20.00** spending allowance every month (no rollover)	Not covered
Telehealth In and Out-of-Network	**$0.00** for primary care provider services **$20.00** for mental health specialty and psychiatric services	**$0.00** for primary care provider services **$20.00** for mental health specialty and psychiatric services	**$0.00** for primary care provider services **$20.00*** for mental health specialty and psychiatric services
Worldwide Emergency/ Urgent Care	**$0.00** **$25,000.00** coverage limit every year	**$0.00** **$25,000.00** coverage limit every year	**$0.00** **$25,000.00** coverage limit every year
Durable Medical Equipment (DME) [1] In-Network	**0%** coinsurance for items **$350.00** or less **20%** coinsurance for items **$350.01** or more	**0%** coinsurance for items **$350.00** or less **20%** coinsurance for items **$350.01** or more	**20%** coinsurance*
Out-of-Network	**30%** coinsurance	**30%** coinsurance	**20%** coinsurance*
Re-admission and Chronic Meals	Not covered	Not covered	**$0.00** for 28 meals over 14 days, twice per year

Extra Benefits for those with Qualifying Condition (SSBCI)

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. For Alignment Health Balance 006 (PPO) and Alignment Health Balance Plus 004 (PPO), qualifying condition is limited to end stage renal disease (ESRD). 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.

EXTRA BENEFITS YOU GET WITH ALIGNMENT HEALTH PLAN	Alignment Health My Choice 001 (PPO) Santa Cruz and Stanislaus counties	Alignment Health Balance 006 (PPO) San Joaquin and Stanislaus counties	Alignment Health Balance Plus 004 (PPO) San Diego, San Joaquin, and Stanislaus counties
Essentials Allowance For qualifying members to assist with groceries, utilities, and home safety.	Not covered	**$150.00** spending allowance every month (no rollover)	**$200.00** spending allowance every month (no rollover)
Pet Services For members who have hospital procedures or emergencies and need pet care while they are away.	**$0.00** 7 boarding days or 14 walks every year	**$0.00** 7 boarding days or 14 walks every year	**$0.00** 7 boarding days or 14 walks every year
Pest Control Annual pest eradication for covered pests to ensure the health, welfare, and safety of members.	**$0.00** **$500.00** coverage limit for 1 service every year	**$0.00** **$500.00** coverage limit for 1 service every year	**$0.00** **$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:** Seven days a week from 8:00 a.m. to 8:00 p.m. except Thanksgiving and Christmas Day **April 1 – September 30:** Monday through Friday (except holidays) from 8:00 a.m. to 8:00 p.m.
Website	alignmenthealthplan.com

This plan(s) allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

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.

*For those with full Medi-Cal, the copay for services may be paid in part or in full by Medi-Cal, or a third party.

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.

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.

Dental Benefits | CA

Alignment Health Plan®

Dental Benefit & Service California	Alignment Health My Choice 001 (PPO)	Alignment Health My Choice 001 (PPO) Enhanced Dental Option
Monthly Premium	**$0**	**$40**
Network	In-Network: LIBERTY Dental Plan & Dental Guard Preferred Select Out-of-Network*	In-Network: LIBERTY Dental Plan & Dental Guard Preferred Select Out-of-Network*
Calendar Year Maximum	Not applicable	****Calendar Year Maximum (Preventive & Comprehensive)** $1,500
Covered Services, Member Cost Share, Benefit Limitations		
DIAGNOSTIC & PREVENTIVE		
• Oral Exam	**50%**, in-network **60%**, out-of-network	**0%**, in-network, **50%**, out-of-network, one per six months
• Routine Cleaning (Prophy)	**50%**, in-network **60%**, out-of-network	**0%**, in-network, **50%**, out-of-network, one per six months
• Fluoride Treatment	**50%**, in-network **60%**, out-of-network	**0%**, in-network, **50%**, out-of-network, one per six months
• X-Ray (Full Mouth or Pano)	**50%**, in-network **60%**, out-of-network	**0%**, in-network, **50%**, out-of-network, one per three years
RESTORATIVE (***Prior authorization may be required for services)		
• Amalgam Restoration (Silver Filling)	Not covered	**50%**, one per tooth every two years
• Composite Resin Restoration (White Filling)	Not covered	**50%**, one per tooth every two years
• Crown	Not covered	**50%**, one per tooth every five years, with a maximum of two crowns per calendar year
ENDODONTICS		
• Root Canal Therapy	Not covered	**50%**, one per tooth per lifetime

Dental Benefit & Service California	Alignment Health My Choice 001 (PPO)	Alignment Health My Choice 001 (PPO) Enhanced Dental Option
PERIODONTICS (***Prior authorization may be required for services)		
• Periodontal Maintenance	Not covered	**0%**, in-network, **50%**, out-of-network, one per three months
• Scaling and Root Planing (Deep Cleaning)	Not covered	**0%**, in-network, **50%**, out-of-network, one per quadrant every two years
PROSTHODONTICS (***Prior authorization may be required for services)		
• Complete Denture	Not covered	**50%**, one per five years
• Partial Denture	Not covered	**50%**, one per five years
• Retainer Crown	Not covered	**50%**, one per tooth every five years, with a maximum of two crowns per calendar year
ORAL & MAXILLOFACIAL SURGERY (***Prior authorization may be required for services)		
• Extraction	Not covered	**50%**, one per tooth per lifetime

Dental Benefit & Service California	**Alignment Health Balance Plus 004 (PPO)**	**Alignment Health Balance 006 (PPO)**	**Alignment Health Balance 006 (PPO)** Enhanced Dental Option
Monthly Premium	**$0**	**$0**	**$40**
Network	In-Network: LIBERTY Dental Plan & Dental Guard Preferred Select Out-of-Network*	In-Network: LIBERTY Dental Plan & Dental Guard Preferred Select Out-of-Network*	In-Network: LIBERTY Dental Plan & Dental Guard Preferred Select Out-of-Network*
Calendar Year Maximum	****Quarterly Allowance (Comprehensive)** $175	Not applicable	****Calendar Year Maximum (Preventive & Comprehensive)** $1,500
Covered Services, Member Cost Share, Benefit Limitations			
DIAGNOSTIC & PREVENTIVE			
• Oral Exam	**$0**, in-network, **20%**, out-of-network, one per six months	**50%**, in-network **60%**, out-of-network	**0%**, in-network, **50%**, out-of-network, one per six months
• Routine Cleaning (Prophy)	**$0**, in-network, **20%**, out-of-network, one per six months	**50%**, in-network **60%**, out-of-network	**0%**, in-network, **50%**, out-of-network, one per six months
• Fluoride Treatment	**$0**, in-network, **20%**, out-of-network, one per six months	**50%**, in-network **60%**, out-of-network	**0%**, in-network, **50%**, out-of-network, one per six months
• X-Ray (Full Mouth or Pano)	**$0**, in-network, **20%**, out-of-network, one every calendar year	**50%**, in-network **60%**, out-of-network	**0%**, in-network, **50%**, out-of-network, one per six months

Dental Benefit & Service California	Alignment Health Balance Plus 004 (PPO)	Alignment Health Balance 006 (PPO)	Alignment Health Balance 006 (PPO) Enhanced Dental Option
RESTORATIVE (***Prior authorization may be required for services)			
• Amalgam Restoration (Silver Filling)	**$0**, in-network, **20%**, out-of-network, one per tooth every two years	Not covered	**50%**, one per tooth every two years
• Composite Resin Restoration (White Filling)	**$0**, in-network, **20%**, out-of-network, one per tooth every two years	Not covered	**50%**, one per tooth every two years
• Crown	**$0**, in-network, **20%**, out-of-network, one per tooth every five years, with a maximum of two crowns per calendar year	Not covered	**50%**, one per tooth every five years
ENDODONTICS			
• Root Canal Therapy	**$0**, in-network, **20%**, out-of-network, one per tooth per lifetime	Not covered	**50%**, one per tooth per lifetime
PERIODONTICS (***Prior authorization may be required for services)			
• Periodontal Maintenance	**$0**, in-network, **20%**, out-of-network, one per six months	Not covered	**0%**, in-network, **50%**, out-of-network, one per three months
• Scaling and Root Planing (Deep Cleaning)	**$0**, in-network, **20%**, out-of-network, one per quadrant every three years	Not covered	**0%**, in-network, **50%**, out-of-network, one per quadrant every two years

Dental Benefit & Service California	Alignment Health Balance Plus 004 (PPO)	Alignment Health Balance 006 (PPO)	Alignment Health Balance 006 (PPO) Enhanced Dental Option
PROSTHODONTICS (***Prior authorization may be required for services)			
• Complete Denture	**$0**, in-network, **20%**, out-of-network, one per five years	Not covered	**50%**, one per five years
• Partial Denture	**$0**, in-network, **20%**, out-of-network, one per five years	Not covered	**50%**, one per five years
• Retainer Crown	**$0**, in-network, **20%**, out-of-network, one per tooth every five years, with a maximum of two crowns per calendar year	Not covered	**50%**, one per tooth every five years
ORAL & MAXILLOFACIAL SURGERY (***Prior authorization may be required for services)			
• Extraction	**$0**, in-network, **20%**, out-of-network, one per tooth per lifetime	Not covered	**50%**, one per tooth per lifetime

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 summary outlines the member cost-share portion (co-payment or co-insurance) for common dental procedures performed by an in-network dental provider. This plan may not cover all dental codes. For a complete list of dental codes and associated plan limitations, please refer to the Dental Guide. Any dental code which is not listed within the Dental Guide is not a covered service and is member responsibility. The Dental Guide can be found at alignmenthealthplan.com > Members > Member Forms & Resources.

*Out-of-network providers have not agreed to accept the plan's contracted provider rates and therefore may bill the member the difference between what the plan pays and the out-of-network provider's total billed charges.

**The member is responsible for any amount above the calendar year maximum for preventive and comprehensive services. Any unused amount remaining at the end of the year will expire.

***Prior authorization may be required for comprehensive (restorative, nonsurgical periodontal, prosthodontic (removable/fixed) and/or oral surgery) services.

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