2023 Benefit Platter

NORTH CAROLINA

All plans available in:
Avery, Buncombe, Chatham, Davidson, Davie, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes

Alignment Health Plan

	ALIGNMENT HEALTH AVA (PPO) 001	ALIGNMENT HEALTH PLATINUM (HMO POS) 003
Monthly Premium	$0	$0
Annual Plan Deductible	$0	$0
Maximum Out of Pocket (MOOP)	In-Network: $3900 Out-of-Network: $7,900 (combined)	$2,499
PCP	In-Network: $5 copay Out-of-Network: $40 copay	$0 copay
Specialist	In-Network: $20 copay Out-of-Network: $50 copay	$3 copay
INPATIENT CARE		
Hospital	In-Network: $200 copay per day, days 1-6 $0 copay per day, days 7-90 (unlimited days per admission) Out-of-Network: 10% coinsurance	In-Network: $175 copay per day, days 1-6 $0 copay per day, days 7-90 unlimited days Out-of-Network: $295 copay per day, days 1-6 / $0 copay per day, days 7-90
Inpatient Mental Health	In-Network: $120 copay per days 1-10 $0 copay per day, days 11-90 $0 copay per day, days 91-130 (40 additional day limit) $0 copay 60-days Lifetime Reserve Out-of-Network: 10% coinsurance	$295 copay per day, days 1-6 $0 copay per day, days 7-90 limit in a Psychiatric facility
Skilled Nursing (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: 30% coinsurance	Plan covers up to 100-days in a SNF. $0 copay per day, days 1-20 $178 copay per day, days 21-100
OUTPATIENT CARE		
Ambulatory Surgical Center	In-Network: $100 copay Out-of-Network: 30% coinsurance	$100 copay
Annual Physical Exam	In-Network: $0 copay Out-of-Network: 30% coinsurance	$0 copay
Emergency	$85 copay (not waived if admitted)	$80 copay (waived if admitted within 24 hours)
Ground and Air Ambulance Services	In-Network: $250 copay (waived if admitted) Out-of-Network: 30% coinsurance	$200 copay (not waived if admitted)
Home Health	In-Network: $0 copay Out-of-Network: 30% coinsurance	$0 copay
Hospital and Observation Services	In-Network: $165 copay Hospital Services $0 copay for Observation Services Out-of-Network: 25% coinsurance	$200 copay Hospital Services $0 copay for Observation Services
Outpatient Blood Services	$0 copay (3 pt. deductible waived)	$0 copay (3 pt. deductible waived)
Physical and Speech Therapy	In-Network: $0 copay Out-of-Network: 30% coinsurance	$10 copay
Outpatient Substance Abuse (Individual/Group)	In-Network: $40 copay Out-of-Network: 30% coinsurance	$35 copay
Podiatry	In-Network: $0 copay Out-of-Network: 30% coinsurance	$35 copay Medicare covered $10 copay for 6 Routine visits per year
Urgently Needed Care	$20 copay (waived if admitted within 24 hours)	$0 copay
Worldwide Emergency/ Urgent Coverage	$0 copay $10,000 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 Out-of-Network: 30% coinsurance	20% coinsurance
Diabetes Supplies	In-Network: 0% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic shoes or inserts Out-of-Network: 30% coinsurance	0% coinsurance for Diabetic supplies 20% coinsurance for Diabetic Therapeutic shoes or inserts
Outpatient Diagnostic (Procedures/Tests/ Lab Services)	In-Network: $0 copay Out-of-Network: 30% coinsurance	$0 copay
Outpatient Radiology (X-Ray/Diagnostic/ Therapeutic)	In-Network: $15 copay (X) $150 copay (D) 20% coinsurance (T) Out-of-Network: 30% coinsurance	$0 copay (X/D) 20% coinsurance (T)
Outpatient Mental Health Specialty	In-Network: $0 copay Out-of-Network: 30% coinsurance	$35 copay
Psychiatric Services (Individual/Group)	In-Network: $40 copay Out-of-Network: 30% coinsurance	$35 copay
Preventive Care (Medicare Covered)	In-Network: $0 copay Out-of-Network: 30% coinsurance	$0 copay
Prosthetic/ Medical Supplies	In-Network: 20% coinsurance Out-of-Network: 30% coinsurance	20% coinsurance
VISION, HEARING & DENTAL BENEFITS		
Eye Exams	In-Network: $0 copay for Medicare covered eye exams and 1 routine eye exam per year Out-of-Network: 30% coinsurance	$35 Medicare covered eye exams and $0 copay for Routine eye exam per year (Additional coverage available through FLEX Allowance)
Eyewear	In-Network: $150 coverage limit for glasses/contacts per 2 years Out-of-Network: 50% coinsurance	$0 copay for glasses/contacts with FLEX Allowance
Dental Services (Preventive)	In-Network: $0 copay Medicare covered only	$0 copay for: Oral Exam Cleaning X-ray Fluoride treatment Dental services covered with FLEX Allowance
Dental Services (Comprehensive)	In-Network: $0 copay Medicare covered only Out-of-Network: 30% coinsurance Medicare covered only	Diagnostic Services: $0 copay Restorative Services: $0 copay Endodontics: $0 copay Periodontics: $0 copay Extractions: $0 copay Prosthodontics: $0 copay Dental services covered with FLEX Allowance
Enhanced Dental Option	Premium: $54 **Options+ with FLEX Allowance** Up to $700 maximun coverage per year ($350 every 6 months) towards: Dental Service, Vision Services, Hearing Services, Acupuncture and Chiropractic Services In-Network: Diagnostic Services: 0% coinsurance Restorative: 0% coinsurance Endodontics: 0% coinsurance Periodontics: 0% coinsurance Extractions: 0% coinsurance Prosthodontics: 0% coinsurance Out-of-Network: Diagnostic Services: 0% coinsurance Restorative: 0% coinsurance Endodontics: 0% coinsurance Periodontics: 0% coinsurance Extractions: 0% coinsurance Prosthodontics: 0% coinsurance $700 maximum coverage per year Worldwide Emergency: Additional $25,000 OTC: $45 spending allowance per quarter (no rollover) $0 Personalized Emergency Response System (PERS)	not covered

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Hearing Aids	not covered	$0 copay with FLEX Allowance
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: 30% coinsurance	$0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year (Additional coverage through FLEX Allowance)
ADDITIONAL BENEFITS - MORE THAN ORIGINAL MEDICARE!		
ACCESS On-Demand Black Card Benefits		
24/7 Concierge Service	$0	$0
FLEX Allowance	not covered	Up to $2000 maximum coverage per ear ($500 every 3 months) towards: Dental Services Vision Services Hearing Services Acupuncture Routine visits Chiropractic Routine visits
Over-the-Counter (OTC)	$50 spending allowance every 3 months (no rollover)	$115 spending allowance every 3 months (no rollover)
Acupuncture	$0 copay for Medicare covered	$0 copay for Medicare covered Routine visits covered with FLEX Allowance
Chiropractic Services	In-Network: $0 copay for Medicare covered Out-of-Network: 30% coinsurance for Medicare covered	$0 copay for Medicare covered Routine visits covered with FLEX Allowance
Dialysis Services	In-Network: 20% coinsurance Out-of-Network: 30% coinsurance	20% coinsurance
Fitness	$0 copay	$0 copay
Readmission Prevention/Post Discharge Meals	not covered	$0 copay for 20 days, 40 meals per year (20 meals over 10 days, twice per year)
Personalized Health Risk Screening	not covered	$100 copay every 2 years
Telehealth	In-Network: $0 copay for all benefit services	$0 copay for all benefit services
Transportation	not covered	28 one-way trips to approved locations per year (within a 30-mile radius)
SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL (SSBCI) Qualifying chronic conditions include congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), dementia, diabetes, and stroke. Other chronic conditions may apply. Medical records will be used to establish qualification for the benefit.		
Pet Services	not covered	$0 copay for 7 boarding days or 14 walks a year
PRESCRIPTION DRUG COVERAGE		
Part D Deductible	None	None
Part D Out of Pocket Threshold	$7,400	$7,400
Initial Coverage Limit	$4,660	$4,660
Tier 1: Preferred Generic Drugs	**Retail Standard** $0 copay 30-day supply / $0 copay 60-day supply $0 copay 100-day supply **Mail Order Standard** $0 copay 30-day supply / $0 copay 60-day supply $0 copay 100-day supply **Out-of-Network** $0 copay 30-day supply **Long Term Care** $0 copay 31-day supply	**Retail Standard** $0 copay 30-day supply / $0 copay 60-day supply $0 copay 100-day supply **Mail Order Standard** $0 copay 30-day supply / $0 copay 60-day supply $0 copay 100-day supply **Out-of-Network** $0 copay 30-day supply **Long Term Care** $0 copay 31-day supply
Tier 2: Generic Drugs	**Retail Standard** $5 copay 30-day supply / $10 copay 60-day supply $15 copay 100-day supply **Mail Order Standard** $5 copay 30-day supply / $10 copay 60-day supply $15 copay 100-day supply **Out-of-Network** $5 copay 30-day supply **Long Term Care** $5 copay 31-day supply	**Retail Standard** $0 copay 30-day supply / $0 copay 60-day supply $0 copay 100-day supply **Mail Order Standard** $0 copay 30-day supply / $0 copay 60-day supply $0 copay 100-day supply **Out-of-Network** $0 copay 30-day supply **Long Term Care** $0 copay 31-day supply
Tier 3: Preferred Brand Drugs	**Retail Standard** $40 copay 30-day supply / $80 copay 60-day supply $120 copay 100-day supply **Mail Order Standard** $40 copay 30-day supply / $80 copay 60-day supply $120 copay 100-day supply **Out-of-Network** $40 copay 30-day supply **Long Term Care** $40 copay 31-day supply	**Retail Standard** $40 copay 30-day supply / $80 copay 60-day supply $120 copay 100-day supply **Mail Order Standard** $40 copay 30-day supply / $80 copay 60-day supply $120 copay 100-day supply **Out-of-Network** $40 copay 30-day supply **Long Term Care** $40 copay 31-day supply
Tier 4: Non-Preferred Brand Drugs	**Retail Standard** $100 copay 30-day supply / $200 copay 60-day supply $300 copay 100-day supply **Mail Order Standard** $100 copay 30-day supply / $200 copay 60-day supply $300 copay 100-day supply **Out-of-Network** $100 copay 30-day supply **Long Term Care** $100 copay 31-day supply	**Retail Standard** $100 copay 30-day supply / $200 copay 60-day supply $300 copay 100-day supply **Mail Order Standard** $100 copay 30-day supply / $200 copay 60-day supply $300 copay 100-day supply **Out-of-Network** $100 copay 30-day supply **Long Term Care** $100 copay 31-day supply
Tier 5: Specialty Tier Drugs	**Retail Preferred/Standard** 33% coinsurance / 30-day supply **Mail Order Standard** 33% coinsurance / 30-day supply **Out-of-Network** 33% coinsurance / 30-day supply **Long Term Care** 33% coinsurance / 31-day supply	**Retail Standard** 33% coinsurance / 30-day supply **Mail Order Standard** 33% coinsurance / 30-day supply **Out-of-Network** 33% coinsurance / 30-day supply **Long Term Care** 33% coinsurance / 31-day supply
Tier 6: Select Care Drugs	**Retail Standard** $5 copay 30-day supply / $10 copay 60-day supply $0 copay 100-day supply **Mail Order Standard** $5 copay 30-day supply / $10 copay 60-day supply $0 copay 100-day supply **Out-of-Network** $5 copay 30-day supply **Long Term Care** $5 copay 31-day supply	**Retail Standard** $5 copay 30-day supply / $10 copay 60-day supply $0 copay 100-day supply **Mail Order Standard** $5 copay 30-day supply / $10 copay 60-day supply $0 copay 100-day supply **Out-of-Network** $5 copay 30-day supply **Long Term Care** $5 copay 31-day supply
Gap Coverage	Tier 6: All Drugs	Tier 1 and Tier 6: All Drugs
Ways To Save on Prescriptions	Pay $0 for a 100-day supply for Tier 1 and Tier 6 drugs	Pay $0 for a 100-day supply for Tier 1 and Tier 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). 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.	
Vaccines	Our plan covers most Part D vaccines at no cost to you.	