

2024 Benefit Platter

NORTH CAROLINA

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



Alignment Health Plan®

	ALIGNMENT HEALTH PLATINUM (HMO POS) 003	ALIGNMENT HEALTH SMARTHMO (HMO) 006
Monthly Premium	\$0	\$0
Part B Rebate	\$0	\$150
Annual Plan Deductible	\$0	\$0
Maximum Out of Pocket (MOOP)	\$2,499	\$3,900
PCP	\$0 copay	\$0 copay
Specialist	In-Network: \$3 copay Out-of-Network: \$10 copay	\$15 copay
INPATIENT CARE		
Hospital	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	\$275 copay per day, days 1-6 \$0 copay per day, days 7-90 (unlimited days per admission)
Inpatient Mental Health	\$295 copay per day, days 1-6 \$0 copay per day, days 7-90 limit in a Psychiatric facility	\$120 copay per days 1-10 \$0 copay per day, days 11-90 \$0 copay for 40 additional day limit (91-130) \$0 copay 60-days Lifetime Reserve
Skilled Nursing (SNF)	\$0 copay per day, days 1-20 \$178 copay per day, days 21-100	\$20 copay per day, days 1-20 \$100 copay per day, days 21-100
OUTPATIENT CARE		
Ambulatory Surgical Center	\$100 copay	\$50 copay
Annual Physical Exam	\$0 copay	\$0 copay
Emergency	\$75 copay (waived if admitted within 24 hours)	\$120 copay (waived if admitted within 48 hours)
Ground and Air Ambulance Services	\$200 copay (not waived if admitted)	\$200 copay (waived if admitted)
Home Health	\$0 copay	\$0 copay
Hospital and Observation Services	\$200 copay Hospital Services \$0 copay for Observation Services	\$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	\$10 copay	\$0 copay
Outpatient Substance Abuse (Individual/Group)	\$35 copay	\$35 copay
Podiatry	\$0 copay Medicare covered Routine coverage available through FLEX Allowance	\$5 copay Medicare covered
Urgently Needed Care	\$0 copay	\$15 copay
Worldwide Emergency/Urgent Coverage	\$0 copay \$25,000 maximum coverage per year	\$0 copay \$25,000 maximum coverage per year
OUTPATIENT MEDICAL SERVICES & SUPPLIES		
Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance
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) \$0 copay (D) 20% coinsurance (T)
Outpatient Mental Health Specialty	\$35 copay	\$10 copay
Psychiatric Services (Individual/Group)	\$35 copay	\$20 copay
Preventive Care (Medicare Covered)	\$0 copay	\$0 copay
Prosthetic/Medical Supplies	20% coinsurance	20% coinsurance
VISION, HEARING & DENTAL BENEFITS		
Eye Exams	\$35 Medicare covered eye exams and \$0 copay for Routine eye exam per year (Additional coverage available through FLEX Allowance)	\$0 copay for Medicare covered eye exams and 1 routine eye exam per year
Eyewear	\$0 copay for glasses/contacts with FLEX Allowance	\$100 allowance for glasses/contacts per 2 years
Dental Services (Preventive)	\$0 copay for: Oral Exam Cleaning X-ray Fluoride treatment Dental services covered with FLEX Allowance	\$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
Dental Services (Comprehensive)	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	not covered
Optional Options+ Buy Up	not covered	Premium: \$64.90 Options+ In-Network: Diagnostic: 0% coinsurance Restorative: 50% coinsurance Endodontics: 50% coinsurance Periodontics: 0-50% coinsurance Extractions: 50% coinsurance Prosthodontics: 50% coinsurance \$1,500 maximum coverage per year \$5,000 coverage limit per year for Inpatient Hospital Copay reimbursement \$2,000 coverage limit, every 2 years for Hearing Care Anywhere for eligible members Additional \$75,000 per year for Emergency Worldwide Coverage \$0 for 24 one-way trips to plan approved locations (within a 30-mile radius) \$0 copay Personal Emergency Response System

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Hearing Aids	\$0 copay with FLEX Allowance	not covered
Hearing Exams/ Fitting and Evaluation for Hearing Aid	\$0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year (Additional coverage through FLEX Allowance)	\$0 copay for Medicare covered benefits and 1 exam/fitting/evaluation per year
ADDITIONAL BENEFITS - MORE THAN ORIGINAL MEDICARE!		
ACCESS On-Demand Black Card Benefits		
24/7 Concierge Service	\$0	\$0
FLEX Allowance	\$1,000 allowance every 6 months (up to \$2,000 annually) towards: Dental Services Vision Services Hearing Services Acupuncture Routine visits Chiropractic Routine visits Podiatry Routine Services	not covered
Over-the-Counter (OTC)	\$115 spending allowance every 3 months (no rollover)	not covered
Acupuncture	\$0 copay for Medicare covered Routine visits covered with FLEX Allowance	\$0 copay for Medicare covered
Chiropractic Services	\$0 copay for Medicare covered Routine visits covered with FLEX Allowance	\$0 copay for Medicare covered
Dialysis Services	20% coinsurance	20% coinsurance
Fitness	\$0 copay	\$0 copay
Chronic & Re-admission Meals	\$0 copay for 28 days, 56 meals per year (28 meals over 14 days, twice per year)	not covered
Personalized Health Risk Screening	\$75 copay every 2 years	not covered
Telehealth	\$0 copay for all benefit services	\$0 copay for all benefit services
Transportation	28 one-way trips to approved locations per year (within a 30-mile radius)	not covered
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	\$0 copay for 7 boarding days or 14 walks a year	\$0 copay for 7 boarding days or 14 walks a year
PRESCRIPTION DRUG COVERAGE		
Part D Deductible	None	\$545 tiers 4 & 5
Part D Out of Pocket Threshold	\$8,000	\$8,000
Initial Coverage Limit	\$5,030	\$5,030
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 \$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 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 \$45 copay 30-day supply / \$90 copay 60-day supply \$135 copay 100-day supply Mail Order Standard \$45 copay 30-day supply / \$90 copay 60-day supply \$135 copay 100-day supply Out-of-Network \$45 copay 30-day supply Long Term Care \$45 copay 31-day supply
Tier 4: Non-Preferred 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 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 Preferred/Standard 25% coinsurance / 30-day supply Mail Order Standard 25% coinsurance / 30-day supply Out-of-Network 25% coinsurance / 30-day supply Long Term Care 25% 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 \$0 copay 30-day supply Long Term Care \$0 copay 31-day supply
Gap Coverage	Tier 1 and Tier 6: All Drugs	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.	

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, Florida, Nevada and North Carolina 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.

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