Align powered by Sanford Health Plan

ChoiceElite (PPO) H8385-001
ChoicePlus (PPO) H8385-003

SUMMARY OF BENEFITS

January 1, 2024 - December 31, 2024

This booklet gives you a summary of drug and health services covered by Align powered by Sanford Health Plan for ChoiceElite (PPO) and ChoicePlus (PPO). It is an overview of what we cover and what you pay. The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call one of our customer service and request the "Evidence of Coverage" or access it online at www.sanfordhealthplan.com/align.

Align ChoiceElite and Align ChoicePlus are Medicare Advantage PPO plans with a Medicare contract. Enrollment in the plan depends on the contract renewal.

- **Primary Care Physician (PCP)** – We encourage you to choose a primary care physician. Your health is better supported when we know who your doctor is.
- **Referrals** – Align ChoiceElite and Align ChoicePlus do not require a referral to see a specialist.
- **Prior Authorizations** – Align ChoiceElite and Align ChoicePlus offer Direct Access for Sanford providers. This means your Sanford doctor does not have to get approval before you receive services. We depend on their expertise to drive your healthcare options. Restrictions may apply.

To Reach Our Customer Services Representatives:

- For current members, please call (888) 278-6485, TTY (888) 279-1549 for more information. For prospective members, please call (888) 605-9277, TTY 711. For Medicare Part D drug coverage information, call (855) 800-8872, TTY 711.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
- If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. Customer Service also has free language interpreter services available for non-English speakers.

To join Align ChoiceElite (PPO) or Align ChoicePlus (PPO), you must:

- be entitled to Medicare Part A,
- *and* be enrolled in Medicare Part B,
- *and* live in our service area.

Align ChoiceElite (PPO) service area and Align ChoicePlus (PPO) service area includes these counties in —

- **Iowa**: Lyon, O'Brien, Osceola, and Sioux;
- **South Dakota**: Brookings, Clark, Clay, Day, Deuel, Douglas, Hanson, Hutchinson, Kingsbury, Lake, Lincoln, Marshall, McCook, Miner, Minnehaha, Moody, Roberts, Sanborn, and Turner.

Align ChoiceElite and Align ChoicePlus have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services; but if you want to, you can also use providers that are not in our network. You can choose to see either in-network or out-of-network providers. You will pay less for covered services through an in-network provider. Please note out-of-network/non-contracted providers are under no obligation to treat Align ChoiceElite or Align ChoicePlus members, except in emergency situations.

• You can choose from a variety of pharmacies (i.e. standard or preferred Pharmacies) to fill your prescriptions for covered Part D drugs.

• You can see our plan's provider directory at our website align.sanfordhealthplan.com.

• You can see our plan's pharmacy directory at our website align.sanfordhealthplan.com.

• Or, call us and we will send you a copy of the provider and pharmacy directories. The pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call our customer service number.

Premiums and Benefits	Align ChoiceElite	Align ChoicePlus
Monthly Plan Premium	$49	$0
	Member must continue to pay the Medicare Part B premium	
Deductible Medical Part D Prescription Drugs	$0 $0 per year for tiers 1 & 2 $150 per year for tiers 3, 4, 5 & 6	$0 $0 per year for tiers 1 and 2 $200 per year for tiers 3, 4, 5 & 6
Maximum Out-of-Pocket Amount* *Does not include costs related to prescription drugs	$3,000 yearly limit for combined In-network and Out-of-network services	$4,000 yearly limit for combined In-network and Out-of-network services
	If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your Medicare Part B premium, your plan premium and any cost sharing for your Part D prescription drugs.	
Inpatient Hospital Coverage* **Prior Authorization required*	**In-network:** • Days 1-4: $100 copay per day • Days 5-90: $0 copay per day **Out-of-network:** You pay the 2024 Original Medicare cost-sharing amounts. • Deductible: $1,632 • Days 1-60: $0 copay • Days 61-90: $408 copay per day • Days 91 and beyond: $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Each day after lifetime reserve days: All costs	**In-network:** • Days 1-4: $125 copay per day • Days 5-90: $0 copay per day **Out-of-network:** You pay the 2024 Original Medicare cost-sharing amounts. • Deductible: $1,632 • Days 1-60: $0 copay • Days 61-90: $408 copay per day • Days 91 and beyond: $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Each day after lifetime reserve days: All costs

Outpatient Hospital Coverage Outpatient Hospital Services***** ***Prior Authorization required*** Outpatient Hospital Observation Services	**In-network:** $150 copay per visit for surgery **Out-of-network:** 20% coinsurance **In-network:** $0 copay per visit **Out-of-network:** $450 copay per visit	**In-network:** $200 copay per visit for surgery **Out-of-network:** 20% coinsurance **In-network:** $400 copay per visit **Out-of-network:** $600 copay per visit
Ambulatory Surgical Center (ASC) Services* **Prior Authorization required for certain surgeries*	**In-network:** $150 copay per visit **Out-of-network:** 20% coinsurance	**In-network:** $300 copay per visit **Out-of-network:** 20% coinsurance
Doctor Visits Primary Care Providers Specialists* Primary Care Providers Specialists* *****<u>For Mental Health Services</u>, *See Mental Health section below*	**In-network:** • $0 copay • $0 copay **Out-of-network:** • $10 copay • $20 copay	**In-network:** • $0 copay • $0 copay **Out-of-network:** • $15 copay • $30 copay

<table>
<tr><td>Preventive Care</td><td>In-network and
Out-of-network
You pay $0</td><td>In-network and
Out-of-network
You pay $0</td></tr>
<tr><td colspan="3">Our plans cover many preventive services, including...
Abdominal aortic aneurysm screening
Alcohol misuse counseling
Annual physical exam
Annual wellness visit
Bone mass measurement
Breast cancer screening (mammogram)
Cardiovascular disease risk reduction visit
Cardiovascular disease testing
Cervical and vaginal cancer screening
Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
Depression screening
Diabetes screenings
Glaucoma screening
HIV screening
Immunizations, including COVID-19 vaccine, flu shots, hepatitis B shots, pneumococcal shots
Medical nutrition therapy services
Medicare Diabetes Prevention Program (MDPP)
Obesity screening and counseling
Prostate cancer screenings (PSA)
Screening for lung cancer with low-dose computed tomography (LDCT)
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)
“Welcome to Medicare” preventive visit (one-time)
Any additional preventive services approved by Medicare during the contract year will be covered</td></tr>
<tr><td>Emergency Care*</td><td>In-network and
Out-of-network
You pay $75 copay</td><td>In-network and
Out-of-network
You pay $90 copay</td></tr>
<tr><td colspan="3">* Emergency Care copay is waived if you are admitted to a hospital within 3 days.</td></tr>
<tr><td>Urgently Needed Services*</td><td>In-network and
Out-of-network
You pay $30 copay</td><td>In-network and
Out-of-network
You pay $30 copay</td></tr>
<tr><td colspan="3">* Urgent Care Services copay is waived if you are admitted to a hospital within 3 days</td></tr>
</table>

Diagnostic Services / Labs / Imaging Lab Services, Diagnostic Tests and Procedures*****	**In-network:** $0 copay per visit **Out-of-network:** $10 copay per visit	**In-network:** $0 copay per visit **Out-of-network:** $10 copay per visit
Diagnostic Radiology Services (e.g. MRI, CAT Scan)*****	**In-network:** • $0 copay for peripheral vascular disease ultrasounds • $165 copay for other diagnostic services **Out-of-network:** • 20% coinsurance	**In-network:** • $0 copay for peripheral vascular disease ultrasounds • $325 copay for other diagnostic services **Out-of-network:** • 20% coinsurance
Therapeutic Radiology Services*****	**In-network:** $60 copay per visit **Out-of-network:** 20% coinsurance	**In-network:** $60 copay per visit **Out-of-network:** 20% coinsurance
Outpatient X-rays*****	**In-network:** $15 copay per visit **Out-of-network:** $30 copay per visit	**In-network:** $20 copay per visit **Out-of-network:** $40 copay per visit
**Prior Authorization is not required for lab services rendered in any place of service; however, Prior Authorization is required for Genetic Testing and for High-End Imaging.*	If receiving multiple services at the same location on the same day, only the maximum copay applies.	If receiving multiple services at the same location on the same day, only the maximum copay applies.
Hearing Services Medicare-Covered Hearing Exam	**In-network:** 20% coinsurance **Out-of-network:** 20% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 20% coinsurance

Supplemental Benefits Routine Hearing Exam	**In-network:** $0 copay for one annual hearing exam **Out-of-network:** Healthy Benefits+ Flex Card will provide you an annual $2,000 allowance for dental, hearing and vision out-of-pocket costs for additional covered services.	**In-network:** $0 copay for one annual hearing exam **Out-of-network** Healthy Benefits+ Flex Card will provide you an annual $1,750 allowance for dental, hearing and vision out-of-pocket costs for additional covered services.
Hearing Aids	**In-network & Out-of-network:** Healthy Benefits+ Flex Card will provide you an annual $2,000 allowance for dental, hearing and vision out-of-pocket costs for additional covered services.	**In-network & Out-of-network:** Healthy Benefits+ Flex Card will provide you an annual $1,750 allowance for dental, hearing and vision out-of-pocket costs for additional covered services.
Dental Services Medicare-Covered Dental Services *Supplemental Benefits* Preventive Dental Services	**In-network:** 20% coinsurance **Out-of-network:** 20% coinsurance **In-network:** **$0 copay** <u>Preventive Dental</u> Services include: 2 Oral exams every year 2 Cleanings every year 1 set of bitewing x-rays annually 1 Panoramic x-ray every 5 years.	**In-network:** 20% coinsurance **Out-of-network:** 20% coinsurance **In-network:** **$0 copay** <u>Preventive Dental</u> Services include: 2 Oral exams every year 2 Cleanings every year 1 set of bitewing x-rays annually 1 Panoramic x-ray every 5 years.

Preventive Dental Services Comprehensive Dental Services	**Out of network:** Healthy Benefits+ Flex Card will provide you an annual $2,000 allowance for dental, hearing and vision out-of-pocket costs for additional covered services. **In & Out of-network** Healthy Benefits+ Flex Card will provide you an annual $2,000 allowance for dental, hearing and vision out-of-pocket costs for additional covered services. <u>Comprehensive Dental</u> Services include – Restorative Service: filling Endodontics: root canal therapy Periodontics: scaling and root planning Extractions: Prosthodontics, other oral/maxillofacial surgery, and other services: Crowns: Oral Surgery: alveoloplasty, osseous, osteoperiosteal, or cartilage graft	**Out of network:** Healthy Benefits+ Flex Card will provide you an annual $1,750 allowance for dental, hearing and vision out-of-pocket costs for additional covered services. **In-network & Out of network** Healthy Benefits+ Flex Card will provide you an annual $1,750 allowance for dental, hearing and vision out-of-pocket costs for additional covered services. <u>Comprehensive Dental</u> Services include – Restorative Service: filling Endodontics: root canal therapy Periodontics: scaling and root planning Extractions: Prosthodontics, other oral/maxillofacial surgery, and other services: Crowns: Oral Surgery: alveoloplasty, osseous, osteoperiosteal, or cartilage graft
Vision Care Medicare-Covered Eye Exams	**In-network:** 20% coinsurance **Out-of-network:** 20% coinsurance	**In-network:** 20% coinsurance **Out-of-network:** 20% coinsurance

Supplemental Benefits Routine Eye Exam	**In-network:** $0 copay for one routine eye exam every year **Out-of-network:** 50% coinsurance Healthy Benefits+ Flex Card will provide you an annual $2,000 allowance for dental, hearing and vision out-of-pocket costs for additional covered services.	**In-network:** $0 copay for one routine eye exam every year **Out-of-network:** 50% coinsurance Healthy Benefits+ Flex Card will provide you an annual $1,750 allowance for dental, hearing and vision out-of-pocket costs for additional covered services.
Eyewear*: Eyeglasses & Contacts (lenses and frames), Upgrades	**In-network:** $0 copay **Out-of-network:** 50% coinsurance *$200 maximum plan coverage amount allowed in-network and out-of-network for all non-Medicare-covered eyewear. Healthy Benefits+ Flex Card will provide you an annual $2,000 allowance for dental, hearing and vision out-of-pocket costs for additional covered services.	**In-network:** $0 copay **Out-of-network:** 50% coinsurance *$100 maximum plan coverage amount allowed in-network and out-of-network for all non-Medicare-covered eyewear. Healthy Benefits+ Flex Card will provide you an annual $1,750 allowance for dental, hearing and vision out-of-pocket costs for additional covered services.

Mental Health Services Inpatient Psychiatric* **Prior Authorization required*	**In-network:** • Days 1-4: $100 copay per day • Days 5-90 $0 copay per day **Out-of-network:** You pay the 2024 Original Medicare cost-sharing amounts. • Deductible: $1,632 • Days 1-60: $0 copay per day • Days 61-90 $408 copay per day • Days 91 and beyond: $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Each day after lifetime reserve days: All costs • 20% of the Medicare-Approved Amount for mental health services you get from doctors and other providers while you're a hospital inpatient.	**In-network:** • Days 1-4: $125 copay per day • Days 5-90 $0 copay per day **Out-of-network:** You pay the 2024 Original Medicare cost-sharing amounts. • Deductible: $1,632 • Days 1-60: $0 copay per day • Days 61-90 $408 copay per day • Days 91 and beyond: $816 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Each day after lifetime reserve days: All costs • 20% of the Medicare-Approved Amount for mental health services you get from doctors and other providers while you're a hospital inpatient.
Outpatient Individual and Outpatient Group Therapy Visits	**In-network:** $10 copay per visit **Out-of-network:** $20 copay per visit	**In-network:** $20 copay per visit **Out-of-network:** $40 copay per visit
Skilled Nursing Facility (SNF) Care* **Prior Authorization required*	**In & Out of network:** You pay the 2024 Original Medicare cost-sharing amounts. • Days 1-20: $0 copay per day • Days 21-100: $204 copay per day	**In & Out of network:** You pay the 2024 Original Medicare cost-sharing amounts. • Days 1-20: $0 copay per day • Days 21-100: $204 copay per day

Physical Therapy & Speech Therapy	**In-network:** $30 copay per visit **Out-of-network:** $50 copay per visit	**In-network:** $30 copay per visit **Out-of-network:** $50 copay per visit
Ambulance Services Ground Ambulance or Air Ambulance	**In-network and Out-of-network** You pay $240 copay per trip	**In-network and Out-of-network** You pay $240 copay per trip
Transportation	Not covered	Not covered
Worldwide Emergent/Urgent Coverage	Up to $250 reimbursement amount for urgent or emergency care outside of the U.S.	Up to $250 reimbursement amount for urgent or emergency care outside of the U.S.
Medicare Part B Prescription Drugs*		
Chemotherapy Drugs	**In & Out of network:** • 0-20% coinsurance for chemotherapy drugs • $100 copay for Prolia • 0-20% coinsurance for other Part B Drugs	**In & Out of network:** • 0-20% coinsurance for chemotherapy drugs • $100 copay for Prolia • 0-20% coinsurance for other Part B Drugs
Other Part B Drugs	**Prior Authorization is required for some medications. Select Part B drugs are subject to step therapy restrictions.*	**Prior Authorization is required for some medications. Select Part B drugs are subject to step therapy restrictions.*
Occupational Speech Therapy	**In-network:** $30 copay per visit **Out-of-network:** $45 copay per visit	**In-network:** $30 copay per visit **Out-of-network:** $50 copay per visit
Fitness Program: **Gym Membership (Silver & Fit)**	**In-network:** You pay $0 or discounted rate	**In-network:** You pay $0 or discounted rate

Meal Benefit: **Mom's Meals*** ***Referral is required*	**In-network and Out-of-network** You pay $0 for: 168 meals: 2 meals per day, 7 days a week for 12 weeks For a chronic illness, or for a medical condition or potential medical condition that requires the enrollee to remain at home for a period of time. You pay $0 for: 56 meals for a 28 day maximum Following surgery or post inpatient hospitalization. Benefit can be used for up to 4 times per year.	**In-network and Out-of-network** You pay $0 for: 168 meals: 2 meals per day, 7 days a week for 12 weeks For a chronic illness, or for a medical condition or potential medical condition that requires the enrollee to remain at home for a period of time. You pay nothing for: 56 meals for a 28 day maximum Following surgery or post inpatient hospitalization. Benefit can be used for up to 4 times per year.
Over the Counter (OTC) Benefit	**In-network and Out-of-network** • Up to $80 quarterly allowance for eligible Over-the-Counter (OTC) products • Members must obtain OTC from plan-authorized vendor. Members may order OTC items from vendor via mail, in-store shopping, phone, mobile phone app or website. Members may access their OTC benefit through a program that delivers to their home. Unused OTC Allowance dollars do not roll over to the next quarter or the next calendar year.	**In-network and Out-of-network** • Up to $65 quarterly allowance for eligible Over-the-Counter (OTC) products Members must obtain OTC from plan-authorized vendor. Members may order OTC items from vendor via mail, in-store shopping, phone, mobile phone app or website. Members may access their OTC benefit through a program that delivers to their home. Unused OTC Allowance dollars do not roll over to the next quarter or the next calendar year.

Outpatient Prescription Drugs		
	Align Choice Elite	**Align Choice Plus**
Deductible	$0 per year for Tiers 1 & 2 $150 per year for Tiers 3, 4, 5 & 6	$0 per year for Tiers 1 & 2 $200 per year for Tiers 3, 4, 5 & 6
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. • Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online. • This plan requires prior authorization and has quantity limit restrictions for certain drugs. Please refer to the formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website. • Cost sharing may differ based on point-of-service (retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our standard network, or whether the prescription is a short-term supply (30-day supply) or long-term supply (90-day supply). • You can choose from a variety of pharmacies (i.e. standard or preferred Pharmacies) to fill your prescriptions for covered Part D drugs. You may search for network providers and pharmacies on our website at align.sanfordhealthplan.com, or call us and we will send you a copy of the provider and pharmacy directories • Preferred Pharmacies Include: Sanford, Lewis Drug, CVS, Seip, Gateway, Thrifty White, and Optum Mail Order	

		Align Choice Elite	Align Choice Plus
Standard Pharmacy	**Tier 1** (Preferred Generic)	30 day supply: $2 copay 60 day supply: $4 copay 90 day supply: $6 copay	30 day supply: $3 copay 60 day supply: $6 copay 90 day supply: $9 copay
Preferred Pharmacy	**Tier 1** (Preferred Generic)	30, 60, or 90 day supply $0 copay	30, 60, or 90 day supply $0 copay
Standard Pharmacy	**Tier 2** (Generic)	30 day supply: $10 copay 60 day supply: $20 copay 90 day supply: $30 copay	30 day supply: $8 copay 60 day supply: $16 copay 90 day supply: $24 copay
Preferred Pharmacy	**Tier 2** (Generic)	30 day supply: $4 copay 60 day supply: $8 copay 90 day supply: $12 copay	30 day supply: $4 copay 60 day supply: $8 copay 90 day supply: $12 copay
Standard Pharmacy	**Tier 3** (Preferred Brand)	30 day supply: $47 copay 60 day supply: $94 copay 90 day supply: $141 copay	30 day supply: $47 copay 60 day supply: $94 copay 90 day supply: $141 copay
Preferred Pharmacy	**Tier 3** (Preferred Brand)	30 day supply: $42 copay 60 day supply: $84 copay 90 day supply: $126 copay	30 day supply: $42 copay 60 day supply: $84 copay 90 day supply: $126 copay
Standard Pharmacy *and* **Preferred Pharmacy**	**Tier 4** (Non-Preferred Drug)	30 day supply: $100 copay 60 day supply: $200 copay 90 day supply: $300 copay	30 day supply: $100 copay 60 day supply: $200 copay 90 day supply: $300 copay
Standard Pharmacy *and* **Preferred Pharmacy**	**Tier 5** (Specialty Tier)	30, 60 or 90 day supply 30% coinsurance	30, 60 or 90 day supply 30% coinsurance
Standard Pharmacy *and* **Preferred Pharmacy**	**Tier 6** (Select Care Drugs)	30, 60, or 90 day supply $0 copay	30, 60, or 90 day supply $0 copay
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $5,030, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.		

Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacy or mail order) reach $8,000, you pay nothing for covered Part D drugs.
	Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. 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.