Align powered by Sanford Health Plan

ChoiceElite (PPO) H8385-002

ChoicePlus (PPO) H8385-004

SUMMARY OF BENEFITS

January 1, 2023 - December 31, 2023

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 plans 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—

- **North Dakota**: Barnes, Burleigh, Cass, Grand Forks, Griggs, McLean, Mercer, Morton, Nelson, Oliver, Ramsey, Ransom, Richland, Steele, Stutsman, Traill, and Walsh.

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 Choice Elite	Align Choice Plus
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 and 2. $150 per year for tiers 3, 4, and 5	$0 $0 per year for tiers 1 and 2. $150 per year for tiers 3, 4, and 5
Maximum Out-of-Pocket Amount (Does not include costs related to prescription drugs)	$4,000 yearly limit for combined in-network and out-of-network services	$5,500 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* *(In-network)* **Prior authorization is required.*	**In-network:** $350 copayment per stay **Out-of-network:** You pay the 2023 Original Medicare cost-sharing amounts. These are the 2022 cost-sharing amounts and may change for 2023. • Deductible $1,556 • Days 1-60: $0 copayment • Days 61-90: $389 copayment per day • Days 91 and beyond: $778 copayment per each "lifetime reserve day" after day 90 for each benefit period (up to 60	**In-network:** $450 copayment per stay **Out-of-network:** You pay the 2023 Original Medicare cost-sharing amounts. These are the 2022 cost-sharing amounts and may change for 2023. • $Deductible $1,556 • Days 1-60: $0 copayment • Days 61-90: $389 copayment per day • Days 91 and beyond: $778 copayment 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	days over your lifetime) Each day after lifetime reserve days: All costs
Outpatient Hospital Coverage * Outpatient Hospital Services **Prior authorization is required.* Outpatient Hospital Observation Services	**In-network:** $200 copayment for surgery **Out-of-network:** 20% coinsurance **In-network:** $150 copay per stay **Out-of-network:** $450 copay per visit	**In-network:** $200 copayment for surgery **Out-of-network:** 20% coinsurance **In-network:** $450 copayment per stay **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 *(In-network)* Primary Care Providers* Specialists* *Note: For mental health services see Mental Health section*	**In-network:** • $0 copayment • $0 copayment **Out-of-network:** • $10 copayment • $20 copayment	• $0 copayment • $0 copayment **Out-of-network:** • $15 copayment • $30 copayment
Preventive Care *(In-network and Out-of-network)*	You pay nothing.	You pay nothing.

Emergency Care *(In-network and Out-of-network)*	$75 copayment Copayment is waived if you are admitted to a hospital within 3 days.	$90 copayment Copayment is waived if you are admitted to a hospital within 3 days.
Urgently Needed Services *(In-network and Out-of-network)*	$30 copayment Copayment is waived if you are admitted to a hospital within 3 days.	$35 copayment Copayment is waived if you are admitted to a hospital within 3 days.
Diagnostic Services/Labs/Imaging Diagnostic Tests and Procedures Lab Services Diagnostic Radiology Services (e.g. MRI, CAT Scan) Therapeutic Radiology Services	*Authorization required for high-end imaging and genetic testing.* • $0 copayment *Prior authorization is required.* • $0 copayment *No authorization required for lab services rendered in any place of service, except for Genetic Testing, which does require authorization.* • $0 copayment for peripheral vascular disease ultrasounds $140 copayment for other diagnostic services *Prior authorization is required.* • $60 copayment *Prior authorization is required.*	• $0 copayment *Prior authorization is required.* • $0 copayment *No authorization required for lab services rendered in any place of service, except for Genetic Testing, which does require authorization.* • $0 copayment for peripheral vascular disease ultrasounds $325 copayment for other diagnostic services *Prior authorization is required.* • $60 copayment *Prior authorization is required.*

Outpatient X-rays	• $15 copayment *Authorization only required for high-end imaging.* If receiving multiple services at the same location on the same day, only the maximum copayment	• $15 copayment *Authorization only required for high-end imaging.* If receiving multiple services at the same location on the same day, only the maximum copayment
Diagnostic Services/Labs/Imaging *(Out-of-network)*	*Authorization required for high-end imaging and genetic testing.*	*Authorization required for high-end imaging and genetic testing.*
Diagnostic Tests and Procedures	• $10 copayment per visit *Prior authorization is required.*	• $10 copayment per visit *Prior authorization is required.*
Lab Services	• $10 copayment *No authorization required for lab services rendered in any place of service, except for Genetic Testing, which does require authorization.*	• $10 copayment *No authorization required for lab services rendered in any place of service, except for Genetic Testing, which does require authorization.*
Diagnostic Radiology Services (e.g. MRI, CAT Scan)	• 20% coinsurance *Prior authorization is required.*	• 20% coinsurance *Prior authorization is required.*
Therapeutic Radiology Services	• 20% coinsurance *Prior authorization is required.*	• 20% coinsurance *Prior authorization is required.*
Outpatient X-rays	• $30 copayment	• $40 copayment

Hearing Services *(In-network)* Hearing Exam *Supplemental Benefits* Routine Hearing Exam Hearing Aids	• 20% coinsurance for Medicare covered services • $0 copayment for 1 routine hearing exam every year. • $1,000 in credit for both ears combined every year. *(In-network and Out-of-Network combined)*	• 20% coinsurance for Medicare covered services • $0 copayment for 1 routine hearing exam every year. • $1,000 in credit for both ears combined every year. *(In-network and Out-of-Network combined)*
Hearing Services *(Out-of-network)* Hearing Exam *Supplemental Benefits* Routine Hearing Exam Hearing Aids	• 20% coinsurance • 50% coinsurance for 1 hearing exam per year • 50% coinsurance and $1,000 in credit for both ears combined every year.	• 20% coinsurance • 50% coinsurance for 1 hearing exam per year • 50% coinsurance and $1,000 in credit for both ears combined every year.
Dental Services *(In-network and Out-of-network)* Medicare-covered Dental *Supplemental Benefits* Preventive Dental Services	○ 20% coinsurance for Medicare-covered services. • $0 copayment (In-network) /50% coinsurance (Out-of-network) for the following preventive dental services: -2 Oral Exams every year -2 Prophylaxis (Cleanings)	• 20% coinsurance for Medicare-covered services. • $0 copayment (In-network) /50% coinsurance (Out-of-network) for the following preventive dental services: -2 Oral Exams every year -2 Prophylaxis (Cleanings)

	every year -1 Bitewing X-ray per year. -1 full mouth X-ray every 5 years.	every year -1 Bitewing X-ray per year. -1 full mouth X-ray every 5 years.
Comprehensive* Dental Services	*A maximum amount of $1,300 for Comprehensive dental services every year. *(In-network and Out-of-Network combined)* • 50% coinsurance (In-network and Out-of-network) for the following comprehensive dental services: -Restorative service: 1 filling every 2 years (24 months) -Endodontics: 1 root canal therapy per lifetime -Periodontics: 1 scaling and root planning every 3 years (36 months) -Extractions are unlimited -Prosthodontics, other oral/maxillofacial surgery, and other services: ▪ Crowns: 1 every 5 years ▪ 1 oral surgery (alveoplasty, osseous, osteoperiosteal, or cartilage graft) per lifetime	*A maximum amount of $1,000 for Comprehensive dental services every year. *(In-network and Out-of-Network combined)* • 50% coinsurance (In-network and Out-of-network) for the following comprehensive dental services: -Restorative service: 1 filling every 2 years (24 months) -Endodontics: 1 root canal therapy per lifetime -Periodontics: 1 scaling and root planning every 3 years (36 months) -Extractions are unlimited -Prosthodontics, other oral/maxillofacial surgery, and other services: o Crowns: 1 every 5 years o 1 oral surgery (alveoplasty, osseous, osteoperiosteal, or cartilage graft) per lifetime

Vision Care *(In-network)* Eye Exams *Supplemental Benefits* Routine Eye Exam Eyewear: eyeglasses (lenses and frames), upgrades, contacts	• 20% coinsurance for Medicare-covered services. • $0 copayment for 1 routine eye exam every year. • Contacts: $100 limit to cover fitting evaluation and 1 pair of contact lenses every year in lieu of eyeglasses (lenses and frames) visually necessary contact lenses are covered in full in lieu of eyeglasses. *(In-network and Out-of-Network combined)* Eyeglasses: $200 limit for eyeglasses (lenses and frames) every year. *(In-network and Out-of-Network combined)* Upgrades: Standard progressives are covered in full	• 20% coinsurance for Medicare-covered services. • $0 copayment for 1 routine eye exam every year. • Contacts: $100 limit to cover fitting evaluation and 1 pair of contact lenses every year in lieu of eyeglasses (lenses and frames) visually necessary contact lenses are covered in full in lieu of eyeglasses. *(In-network and Out-of-Network combined)* Eyeglasses: $100 limit for eyeglasses (lenses and frames) every year. *(In-network and Out-of-Network combined)* Upgrades: Standard progressives are covered in full
Vision Care *(Out-of-network)* Eye Exams *Supplemental Benefits* Routine Eye Exam Eyewear: eyeglasses (lenses and frames), upgrades, contacts	Routine vision services do not count towards out-of-pocket maximum. • 20% coinsurance for Medicare-covered services. • 50% coinsurance for 1 routine eye exam per year • Eyeglasses: 50% coinsurance for lenses; and 0% coinsurance with a $200 limit for frames each	Routine vision services do not count towards out-of-pocket maximum. • 20% coinsurance for Medicare-covered services. • 50% coinsurance for 1 routine eye exam per year • Eyeglasses: 50% coinsurance for lenses; and 0% coinsurance with a $100 limit for frames each

	year. *(In-network and Out-of-Network $200 limit is combined)* Contacts: 0% coinsurance and $100 limit for contacts and a fitting exam in lieu of eyeglasses (lenses and frames); and 50% coinsurance for visually necessary contact lenses in lieu of eyeglasses annually *(In-network and Out-of-Network $100 limit is combined)* Upgrades not covered	year. *(In-network and Out-of-Network $100 limit is combined)* Contacts: 0% coinsurance and $100 limit for contacts and a fitting exam in lieu of eyeglasses (lenses and frames); and 50% coinsurance for visually necessary contact lenses in lieu of eyeglasses annually *(In-network and Out-of-Network $100 limit is combined)* Upgrades not covered
Mental Health Services *(In-network)* Inpatient Psychiatric Outpatient Group Therapy Visit Outpatient Individual Therapy Visit	• $350 copayment per stay *Prior authorization is required.* • $15 copayment • $15 copayment	• $450 copayment per stay *Prior authorization is required.* • $20 copayment • $20 copayment
Mental Health Services *(Out-of-network)* Inpatient Psychiatric	• You pay the 2023 Original Medicare cost-sharing amounts. These are the 2022 cost-sharing amounts and may change for 2023. • Deductible:$1,556 • Days 1-60: $0 copayment per day	• You pay the 2023 Original Medicare cost-sharing amounts. These are the 2022 cost-sharing amounts and may change for 2023. • Deductible $1,556 • Days 1-60: $0 copayment per day

	• Days 61-90 $389 copayment per day • Days 91 and beyond: $778 copayment 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. • *Prior authorization is required.*	• Days 61-90 $389 copayment per day • Days 91 and beyond: $778 copayment 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. • *Prior authorization is required.*
Outpatient Group Therapy Visit	• $20 copayment per visit	• $40 copayment per visit
Outpatient Individual Therapy Visit	• $20 copayment per visit	• $40 copayment per visit
Skilled Nursing Facility (SNF) Care *(In-network and Out-of Network)*	Up to 100 days in a SNF is covered: • Days 1-20: $0 copayment • Days 21-42: $184 copayment • Days 43-100: $0 copayment *Prior authorization is required.*	Up to 100 days in a SNF is covered: • Days 1-20: $0 copayment • Days 21-42: $184 copayment • Days 43-100: $0 copayment *Prior authorization is required.*
Physical Therapy & Speech Therapy *(In-network)*	$40 copayment per visit	$40 copayment per visit

Physical Therapy & Speech Therapy *(Out-of-network)*	$50 copayment per visit	$50 copayment per visit
Ambulance Services *(In-Network and Out-of-network)* Ground Ambulance Air Ambulance	• $150 copayment per trip • $150 copayment per trip	• $240 copayment per trip • $240 copayment per trip
Transportation (Non-covered)	• Not covered	• Not covered
Medicare Part B Prescription Drugs *(In-network & Out of Network)* Chemotherapy Drugs Other Part B Drugs	*Prior authorization is required for some Part B medications. Select Part B drugs are subject to step therapy restrictions.* • 20% coinsurance for other chemotherapy drugs • $100 copayment for Prolia • 20% coinsurance	*Prior authorization is required for some Part B medications. Select Part B drugs are subject to step therapy restrictions.* • 20% coinsurance for other chemotherapy drugs • $100 copayment for Prolia • 20% coinsurance.
Occupational Speech Therapy *(In-network)*	$25 copayment per visit	$40 copayment per visit
Occupational Speech Therapy *(Out-of-network)*	$45 copayment per visit	$50 copayment per visit
Fitness Program: Gym Membership (Silver & Fit) *(In-network only)*	You pay $0 or a discounted rate	You pay $0 or a discounted rate
Meal Benefit: Mom's Meals *(In-network and*	• You pay nothing for: 168 meals: 2 meals per	• You pay nothing for: 168 meals: 2 meals per

Out-of-network)	day, 7 days a week for 12 weeks Available immediately following surgery or inpatient hospitalization, 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. *Referral is required.* • You pay nothing for: 56 meals for a 28 day maximum Available immediately following surgery or inpatient hospitalization. Benefit can be used for up to 4 times per year. *Referral is required.*	day, 7 days a week for 12 weeks Available immediately following surgery or inpatient hospitalization, 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. *Referral is required.* • You pay nothing for: 56 meals for a 28 day maximum Available immediately following surgery or inpatient hospitalization. Benefit can be used for up to 4 times per year. *Referral is required.*
Over the Counter (OTC) Benefit *(In-network and Out-of-network)*	$75 quarterly allowance Members must obtain OTC from plan-authorized vendor. Members may order OTC items from vendor via mail, phone or website. Members may access their OTC benefit through a program that delivers to their home	$55 quarterly allowance Members must obtain OTC from plan-authorized vendor. Members may order OTC items from vendor via mail, phone or website. Members may access their OTC benefit through a program that delivers to their home

Outpatient Prescription Drugs		
	Align Choice Elite	**Align Choice Plus**
Deductible	$0 per year for Tiers 1 and 2. $150 per year for Tiers 3, 4, and 5.	$0 per year for Tiers 1 and 2. $150 per year for Tiers 3, 4, and 5.
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $4,660. 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 (30-day supply) or long-term (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	

		Align Choice Elite	Align Choice Plus
Standard Pharmacy	**Tier 1** (Preferred Generic)	30 day supply: $4 copayment 60 day supply: $8 copayment 90 day supply: $12 copayment	30 day supply: $4 copayment 60 day supply: $8 copayment 90 day supply: $12 copayment
Preferred Pharmacy	**Tier 1** (Preferred Generic)	30, 60, or 90 day supply: $0 copayment	30, 60, or 90 day supply: $0 copayment
Standard Pharmacy	**Tier 2** (Generic)	30 day supply: $10 copayment 60 day supply: $20 copayment 90 day supply: $30 copayment	30 day supply: $10 copayment 60 day supply: $20 copayment 90 day supply: $30 copayment
Preferred Pharmacy	**Tier 2** (Generic)	30 day supply: $4 copayment 60 day supply: $8 copayment 90 day supply: $12 copayment	30 day supply: $4 copayment 60 day supply: $8 copayment 90 day supply: $12 copayment
Standard Pharmacy	**Tier 3** (Preferred Brand)	30 day supply: $47 copayment 60 day supply: $94 copayment 90 day supply: $141 copayment	30 day supply: $47 copayment 60 day supply: $94 copayment 90 day supply: $141 copayment
Preferred Pharmacy Tier 3 (Preferred Brand)	**Tier 3** (Preferred Brand)	30 day supply: $42 copayment 60 day supply: $84 copayment 90 day supply: $126 copayment	30 day supply: $42 copayment 60 day supply: $84 copayment 90 day supply: $126 copayment
Standard Pharmacy and Preferred Pharmacy	**Tier 4** (Non-Preferred Drug)	30 day supply: $100 copayment 60 day supply: $200 copayment 90 day supply: $300 copayment	30 day supply: $100 copayment 60 day supply: $200 copayment 90 day supply: $300 copayment
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

Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $4,660, 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 $7,400, you pay the greater of: • 5% coinsurance, or • $4.15 copayment for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs.	
Supplemental Benefit Senior Savings Model	Members receive access to a broad set of formulary insulins at a maximum $35.00 copayment per month's supply, throughout the deductible, initial coverage, and coverage gap phases of their Part D drug coverage	Member receive access to a broad set of formulary insulins at a maximum $35.00 copayment per month's supply, throughout the deductible, initial coverage, and coverage gap phases of their Part D drug coverage