Align powered by Sanford Health Plan

Align ChoiceElite (PPO) H3186-001

SUMMARY OF BENEFITS

January 1, 2025 - December 31, 2025

This booklet gives you a summary of drug and health services covered by Align powered by Sanford Health Plan for Align ChoiceElite (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 our customer service and request the "Evidence of Coverage" or access it online at align.sanfordhealthplan.com.

Align ChoiceElite (PPO) is a Medicare Advantage PPO plan 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 powered by Sanford Health Plan does not require a referral to see a specialist.
- **Prior Authorizations** – Align powered by Sanford Health Plan offers 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:

- Current members please call 1-888-278-6485 (TTY 1-888-279-1549) for more information.
- Prospective members please call 1-888-605-9277.
- For Medicare Part D drug coverage information, call 1-844-642-9090.
- Hours of operation: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1st through March 31st, and Monday to Friday (except holidays) from April 1st through September 30th.

  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) you must:

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

The Align powered by Sanford Health Plan service area includes these counties in:

- **Iowa**: Lyon, O'Brien, Osceola, and Sioux.
- **Minnesota**: Becker, Beltrami, Big Stone, Clay, Clearwater, Hubbard, Lac qui Parle, Mahnomen, Marshall, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Red Lake, Rock, Traverse and Wilkin.
- **North Dakota**: Barnes, Burleigh, Cass, Grand Forks, Griggs, McLean, Mercer, Morton, Nelson, Oliver, Ramsey, Ransom, Richland, Steele, Stutsman, Traill and Walsh.
- **South Dakota**: Brookings, Clark, Clay, Day, Deuel, Douglas, Hanson, Hutchinson, Kingsbury, Lake, Lincoln, Marshall, McCook, Miner, Minnehaha, Moody, Roberts, Sanborn and Turner.

Align powered by Sanford Health Plan has 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 (PPO) 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.

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
* Referral required + Your provider must obtain prior authorization from our plan		
Monthly Plan Premium	$79 You must continue to pay the Medicare Part B premium.	
Deductible Medical Part D Prescription Drugs	 $0 $0 per year for Tier 1, Tier 2, Tier 6 $200 per year for Tier 3, Tier 4, Tier 5	
Maximum Out-of-Pocket Amount *Does not include costs related to prescription drugs*	$2,750 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+	$150 copay per day for days 1-4; $0 copay per day for days 5-90	$300 copay per day for days 1-4; $0 copay per day for days 5-90
Outpatient Hospital Services+	$150 copay per visit	20% Coinsurance per visit
Outpatient Hospital Observation Services+	$125 copay per stay	$250 copay per stay
Ambulatory Surgical Center (ASC) Services+	$100 copay per visit	20% Coinsurance per visit
Doctor Visits Primary Care Providers Specialists	 $0 copay per visit $0 to $25 copay per visit	 $10 copay per visit $45 copay per visit

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Preventive Care Such as immunizations, wellness visits, and diabetic screenings. See your Evidence of Coverage for a full list of covered services.	$0 copay per visit	$0 copay per visit
Emergency Care	$90 copay per visit *ER cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*	$90 copay per visit *ER cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*
Urgently Needed Services	$30 copay per visit *Urgently needed care services cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*	$30 copay per visit *Urgently needed care services cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*
Diagnostic Services / Labs / Imaging+ Lab Services, Diagnostic Tests and Procedures	$0 copay per visit	$10 copay per visit
Diagnostic Radiology Services (e.g. MRI, CAT Scan)	$0 to $250 copay per visit $0 for peripheral vascular disease ultrasounds only. $250 for complex diagnostic services. All other services $140.	20% Coinsurance per visit
Therapeutic Radiology Services	$60 copay per visit	20% Coinsurance per visit
Outpatient X-rays	$15 copay per visit	$30 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 you receive multiple services at the same location on the same day, only the maximum copay applies.*	

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Hearing Services		
Medicare-Covered Hearing Exam	$0 copay per visit	0% to 50% of the total cost per visit
Supplemental Benefits		
Routine Hearing Exam	$0 copay per visit 1 exam every year	0% to 50% of the total cost per visit 1 exam every year
Hearing Aids	$1,000 maximum plan coverage amount every year (for both ears combined) for in- and out-of-network prescription hearing aids.	$1,000 maximum plan coverage amount every year (for both ears combined) for in- and out-of-network prescription hearing aids.
	Your Healthy Benefits+ Flex Card will provide you with an annual allowance for hearing and vision out-of-pocket costs for additional covered services. See your plan's Evidence of Coverage for additional details.	

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Dental Services Medicare-Covered Dental Services	20% of the total cost per visit	20% of the total cost per visit
Supplemental Benefits Preventive Dental Services	$0 copay for the following preventive dental services: • 2 oral exams every year • 2 cleanings every year • 1 bitewing x-ray per year; 1 full mouth x-ray every 5 years.	$0 copay for the following preventive dental services: • 2 oral exams every year • 2 cleanings every year • 1 bitewing x-ray per year; 1 full mouth x-ray every 5 years.
Comprehensive Dental Services	$1,000 maximum plan coverage amount every year for in- and out-of-network non-Medicare-covered comprehensive dental services. <u>Comprehensive Dental</u> Services include – Restorative Service: 1 visit every 2 years Endodontics: 1 visit; root canal therapy - 1 per lifetime Periodontics: 1 visit every 3 years	$1,000 maximum plan coverage amount every year for in- and out-of-network non-Medicare-covered comprehensive dental services. <u>Comprehensive Dental</u> Services include – Restorative Service: 1 visit every 2 years Endodontics: 1 visit; root canal therapy - 1 per lifetime Periodontics: 1 visit every 3 years
	Your Healthy Benefits+ Flex Card will provide you with an annual allowance for dental out-of-pocket costs for additional covered services. See your plan's Evidence of Coverage for additional details.	

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Vision Care Medicare-Covered Eye Exams	20% of the total cost	0% to 50% of the total cost
Supplemental Benefits Routine Eye Exam	$0 copay for one routine eye exam every year	0% to 50% of the total cost for one routine eye exam every year
Eyewear: Eyeglasses & Contacts (lenses and frames), Upgrades	Contact lenses are in lieu of eyeglasses (lenses and frames) and allowance applies to fitting evaluation and contacts. Visually Necessary contact lenses are covered in full in lieu of glasses. All base eyeglass lenses (single vision, lined bifocal, lined trifocal, and lenticular) and frames are covered in full. Upgrades: Standard progressives are covered in full.	Contact lenses are in lieu of eyeglasses (lenses and frames) and allowance applies to fitting evaluation and contacts. Visually Necessary contact lenses are covered in full in lieu of glasses. All base eyeglass lenses (single vision, lined bifocal, lined trifocal, and lenticular) and frames are covered in full. Upgrades: Standard progressives are covered in full.
	Your Healthy Benefits+ Flex Card will provide you with an annual allowance for hearing and vision out-of-pocket costs for additional covered services. See your plan's Evidence of Coverage for additional details.	
Mental Health Services Inpatient Psychiatric	$150 copay per day for days 1-4; $0 copay per day for days 5-90 *Prior authorization is required for Medicare-covered inpatient mental health stays.*	$300 copay per day for days 1-4; $0 copay per day for days 5-90 *Prior authorization is required for Medicare-covered inpatient mental health stays.*
Outpatient Individual Visits	$0 copay per visit	$20 copay per visit
Outpatient Group Therapy Visits	$0 copay per visit	$20 copay per visit

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Ambulance Services		
Ground Ambulance	$200 copay per trip	$200 copay per trip
Air Ambulance	$200 copay per trip	$200 copay per trip
Skilled Nursing Facility (SNF) Care	Days 1-20: $0 copay for each benefit period. Days 21-100: $204 copay per day of each benefit period. Days 101 and beyond: all costs. *Prior authorization is required for Medicare-covered SNF stays.*	Days 1-20: $0 copay for each benefit period. Days 21-100: $204 copay per day of each benefit period. Days 101 and beyond: all costs. *Prior authorization is required for Medicare-covered SNF stays.*
Physical Therapy & Speech Therapy	$25 copay per visit	$50 copay per visit
Occupational Speech Therapy	$25 copay per visit	$50 copay per visit
Transportation	Not covered	Not covered
Worldwide Emergent/Urgent Coverage	$250 maximum plan benefit coverage amount every year for the worldwide benefit.	$250 maximum plan benefit coverage amount every year for the worldwide benefit.
Medicare Part B Prescription Drugs*		
Chemotherapy Drugs	20% of the total cost	0% to 20% of the total cost
Other Part B Drugs	0% to 20% of the total cost 0% coinsurance applies to rebatable drugs under the IRA, 20% applies in all other cases.	0% to 20% of the total cost 0% coinsurance applies to rebatable drugs under the IRA, 20% applies in all other cases.
	**Prior Authorization is required for some medications. Select Part B drugs are subject to step therapy restrictions.*	

Supplemental Benefits	You Pay
Fitness Program: **Gym Membership (Silver & Fit)**	$5 copay / month
Meal Benefit: **Mom's Meals*** ***Referral is required*	$0 copay for 56 meals / 28 days maximum. Benefit can be used 4 times per year. Meals are covered following inpatient hospitalization or SNF Part A Stay.
Over the Counter (OTC) Benefit	$80 maximum plan coverage amount every 3 months for OTC items. • 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	
Deductible	$0 per year for Tier 1 Preferred Generic, Tier 2 Generic, Tier 6 Select Care Drugs $200 per year for Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,000. 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 (31-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

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Preferred retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$2 copay	$0 copay	$2 copay	$2 copay	$2 copay
Cost-Sharing Tier 2 (Generic)	$10 copay	$4 copay	$10 copay	$10 copay	$10 copay
Cost-Sharing Tier 3 (Preferred Brand)	$47 copay	$42 copay	$47 copay	$47 copay	$47 copay
Cost-Sharing Tier 4 (Non-Preferred Drug)	50% of the total cost	50% of the total cost	50% of the total cost	50% of the total cost	50% of the total cost
Cost-Sharing Tier 5 (Specialty Tier)	30% of the total cost	30% of the total cost	30% of the total cost	30% of the total cost	30% of the total cost
Cost-Sharing Tier 6 (Select Care Drugs)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost sharing (in-network) (100-day supply)	Mail-order cost sharing (100-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$6 copay	$6 copay
Cost-Sharing Tier 2 (Generic)	$30 copay	$30 copay
Cost-Sharing Tier 3 (Preferred Brand)	$141 copay	$141 copay
Cost-Sharing Tier 4 (Non-Preferred Drug)	50% of the total cost	50% of the total cost
Cost-Sharing Tier 5 (Specialty Tier)	30% of the total cost	30% of the total cost
Cost-Sharing Tier 6 (Select Care Drugs)	$0 copay	$0 copay

Non-discrimination notice

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, please call us:
  Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549)
  Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549)
  Our customer service lines are available 8 a.m. to 8 p.m. CST, 7 days a week, October 1-March 31 except on Christmas and Thanksgiving, and Monday through Friday all other dates except on federal holidays.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with the Section 504 Coordinator at:

Mailing Address: Section 504 Coordinator, 2301 E. 60th Street, Sioux Falls, SD 57103
Telephone number: (877) 473-0911 (TTY: 711)
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by phone, mail, fax, or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Great Plains Medicare Advantage

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H1787_120-900-862GPMANon-discriminationNotice-PY2022-SD_C H7511_120-900-862GPMANon-discriminationNotice-PY2022-NE_C
H8967_120-900-862GPMANon-discriminationNotice- PY2022-ND_C H8385_120-900-862Non-DiscriminationNotice-PY2022-ND-SD_C
H3186_120-900-862Non-DiscriminationNotice-PY2022-MN_C 120-900-862 Rev. 7/22

Help in Other Languages

For help in any language other than English, call Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

Arabic – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (844) 637-4760: Great Plains Medicare Advantage (رقم هاتف الصم والبكم: (888) 279-1549) (888) 278-6485: Align Medicare Advantage (رقم هاتف الصم والبكم: (888) 279-1549)).

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ Great Plains Medicare Advantage: (844) 637-4760 (መስማት ለተሳናቸው: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (መስማት ለተሳናቸው: (888) 279-1549).

Chinese – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549) 。

Cushite (Oromo) – XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

Hmong – LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

Karen –ဟ်သူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ့ါ ကျိာ်အတ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549) 번으로 전화해 주십시오.

Laotian – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le Great Plains Medicare Advantage: (844) 637-4760 (ATS: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (ATS: (888) 279-1549).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните Great Plains Medicare Advantage: (844) 637-4760 (телетайп: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (телетайп: (888) 279-1549).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

Thai – เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Great Plains Medicare Advantage: (844) 637-4760 (TTY: (888) 279-1549); Align Medicare Advantage: (888) 278-6485 (TTY: (888) 279-1549).

Great Plains Medicare Advantage

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