Align Health
PARTNERS

When it comes to affordable quality healthcare choices, we put our members first. We deliver the right care at the right time for the best price for our members.

Unlimited Open Network Plan

Our comprehensive Unlimited Open Network Plan allows you the freedom to choose the healthcare provider that is best for you. This plan combines unlimited access to Telemedicine in combination with a PPO copay for in-office primary care and specialist physician visits. Plan also includes the option to see any provider out-of-network at a special rate.

Plan includes pharmacy, lab, imaging, and mental health and provides 100% coverage for preventative services outlined by the Affordable Care Act (ACA) with the added benefits of worldwide emergency, surgery, and hospitalization cost protection.

HOW IT WORKS

1. **Contact and coordinate care through Align's care navigation team**
2. **Choose an in-network doctor or choose an out-of-network provider at a special rate. Engage telemedicine 24/7/365 when needed**
3. **Utilize your Rx, lab, imaging and behavioral health benefits**
4. **If emergency, hospitalization, or surgery is required, utilize your medical cost sharing benefit. (Requires your Initial Unshareable Amount (IUA) before cost protection begins)**

- *Meets Part A of the Affordable Care Act (ACA) Preventative Services Requirements*

Member Benefits - Unlimited Open Network Plan

General Benefits

- 100% coverage for preventative services as outlined by the Affordable Care Act
- Designated care navigator
- HIPAA/PHI compliant technology that brings personal care to you when you need it
- No deductibles or hidden costs or fees
- Member first approach to healthcare and health promotion
- Universal acceptance regardless of preexisting conditions
- Unlimited telemedicine 24/7/365 with no copay for general medical visits through Teladoc ®
- Discounts on specialists, prescriptions, labs, and imaging
- Live video chat
- Enroll or cancel by the 20th to be effective by the 1st of the following month
- Easy to use secure member portal with help desk

In-Office Physician Visits

Search for a network provider at Planstin.com/PHCS or call 800-922-4362. For out-of-network services, this plan employs a reference-based pricing (RBP) strategy. RBP payout amounts are 150% Medicare reimbursement rates. In the absence of a Medicare rate, your plan will pay the usual customary, and reasonable (UCR) industry rate for your geographic area.

- Preventative / Wellness covered at 100%
- Primary Care Visits - $20 copay in network and $50 copay out-of-network - Unlimited
- Specialist Visits - $50 copay in network and $100 copay out-of-network - Unlimited
- Urgent Care - $50 copay in network and $100 copay out-of-network - Unlimited

Pharmacy

- Tier 1: Low Cost - $10 copay up to $150 per month
- Tier 2: Generic - $25 copay up to $150 per month
- Tier 3: Preferred Brand - $50 up to $150 per month

Laboratory Services

Plan year begins June 1st. Copay limits reset every June 1st.

- Lab Work - $10 copay in network and $25 copay out-of-network ($100 max per lab, up to 15 per year)
- X-Rays - $50 copay in network and $100 copay out-of-network ($250 max per x-ray, up 5 per year)
- Catscan, MRI, Ultrasound CT - $200 copay in network and $400 copay out-of-network ($1000 max per visit, up to 2 tests per year)

Mental Wellness

- Clinical appropriate number of visits with no session fees
- Teladoc® mental health services via phone or video
  - Licensed Therapist - $90
  - Psychiatrist visit (ongoing) - $100 and Psychiatrist visit (evaluation) - $220

Member Benefits - Unlimited Open Network Plan

Emergency, Surgery, and Hospitalization Cost Protection [1]

- No co-pay, deductible, coinsurance, or max out of pocket
- No network restrictions
- No major medical caps
- Attentive to medical cost needs
- Simple responsible cost per medical event options
- Medical management
- Fair price negotiation
- Specialist and facility acceptance worldwide

[1] **Pre-Membership Condition Benefit Limitations and Maternity Information**

For more information, refer to the "Pre-Membership Medical Conditions & Maternity Needs Requests" section.

Member Pricing - Unlimited Open Network

The initial unshareable amount, or IUA, is the amount a member must pay before expenses related to a medical need become shareable with the medical cost sharing community. There are 3 IUA options: $1,000, $2,500, and $5,000.

After the IUA is met, additional eligible medical expenses are shareable with the community. There is no annual or lifetime limit on eligible expenses. Members do not need to pay another IUA for any given sharing request until they are symptom free for 12 months. Additionally, members will not be responsible for more than three IUAs in a rolling 12-month period.

Initial Unshareable Amount per Medical Event x3 per rolling 12-month period	$1000 IUA		$2500 IUA		$5000 IUA	
	Under 50	Over 50	Under 50	Over 50	Under 50	Over 50
Member Only	$519.00	$567.00	$463.00	$509.00	$429.00	$478.00
Member + Spouse	$819.00	$869.00	$699.00	$758.00	$667.00	$715.00
Member + Child(ren)	$824.00	$855.00	$697.00	$755.00	$671.00	$722.00
Member + Family	$1189.00	$1255.00	$1037.00	$1117.00	$949.00	$1029.00

Prices are current as of 06/2023 and are subject to change

**Smoker add $60

- *Meets Part A of the Affordable Care Act (ACA) Preventative Services Requirements*

Pre-Membership Medical Conditions & Maternity Needs Requests

To keep membership contributions low for all members, there is a waiting period for sharing of medical conditions that exist prior to membership enrollment. This section defines pre-membership medical conditions and outlines the sharing limitations.

Definition of Pre-Membership Medical Condition

A pre-membership medical condition is any illness or injury for which a person has

- been examined,
- been diagnosed,
- taken medication,
- had symptoms,
- or received medical treatment

within 24 months prior to the effective date of membership. Medical need requests related to conditions that existed prior to membership are only shareable if the condition was regarded as cured and did not require treatment or present symptoms for 24 months prior to the effective date of membership.

Pre-existing Condition Benefit Limitations

- Any illness or accident for which a person has been diagnosed, received medical treatment, been examined, taken medication, or had symptoms for 24 months prior to the effective date is considered a pre-membership condition.
- Pre-membership conditions limitations:
  - 1st Year of Membership - Waiting period for all pre-membership conditions
  - 2nd Year of Membership - Up to $25,000 of sharing for pre-membership conditions
  - 3rd Year of Membership - Up to $50,000 of sharing for pre-membership conditions
  - 4th Year of Membership and Beyond - Up to $125,000 of sharing for pre-membership conditions

Exceptions for High Blood Pressure, High Cholesterol, and Diabetes

High blood pressure, high cholesterol, and diabetes (types 1 and 2) will not be considered pre-membership medical conditions as long as the member has not been hospitalized for the condition in the 12 months prior to enrollment and is able to control it through medication or diet.

Maternity

As with any other medical need requests, expectant mothers pay a single IUA for all expenses related to their maternity need request. Shareable expenses may be related to miscarriage, prenatal care, postnatal care, and delivery. Please submit your maternity need request as soon as possible, but no later than 6 months from pregnancy confirmation so we can best assist you with your maternity need request.

Waiting Period - Pregnancy is considered to have existed prior to membership if conception occurs prior to or within the first 60 days of the membership. Conception that occurs prior to membership or within the first 60 days of membership is not shareable. The conception date will be confirmed by medical records.

Newborns who are not born as part of a shareable maternity need must be enrolled manually in a HealthShare membership. The newborn's membership will begin on the date of enrollment but can be no sooner than seven days after delivery. Any complications that the newborn may have, or any medical conditions present at birth, will be considered pre-membership medical conditions. Such conditions are subject to the same waiting periods as other pre-membership medical conditions.