OBJECTIVES

The 2025 SNP MOC Training will cover the following:

1. Overview of Special Needs Plans (SNPs)
    - Model of Care (MOC)
    - SNP Types
    - Eligibility Criteria
2. SNP Model of Care Requirements
    - MOC Requirements
    - MOC Goals
    - MOC Structure
        - SNP MOC Population Description
        - Care Coordination
        - Provider Network
        - MOC Performance and Quality Outcomes
3. Alignment C-SNP Programs by State
4. Alignment D-SNP Programs by State
5. Provider Responsibilities

SPECIAL NEEDS PLAN OVERVIEW

SPECIAL NEEDS PLAN (SNP) OVERVIEW

SPECIAL NEEDS PLAN OVERVIEW

- The Medicare Act of 2003 established a Medicare Advantage coordinated care plan (CCP) that is designed to provide targeted care to individuals with special needs and certain vulnerable groups of Medicare beneficiaries
- Special Needs Plans (SNPs) are a type of Medicare Advantage plan that includes Part C (medical) and Part D (drug) coverage
- A SNP can be any type of MA CCP including a health maintenance organization (HMO) plan, an HMO point of service (HMO-POS) plan or a local or regional preferred Provider organization (i.e., LPPO or RPPO).
- SNPs provide coverage for at risk populations who have multiple conditions and barriers to participating in self-care management
- SNPs provide Members with guidance and resources that help provide access to benefits and information
- Medicare mandates that the health plan provides initial and annual training to Providers and employees who deliver care to Alignment SNP Members

SPECIAL NEEDS PLAN (SNP) TYPES

CMS OFFERS THREE TYPES OF SPECIAL NEEDS PLANS:

Dually Eligible (D-SNP or DE-SNP)	Members who qualify for both Medicare and Medicaid coverage.
Chronic Condition (C-SNP)	Members with specific severe or disabling chronic conditions such as cardiovascular disease, diabetes, congestive heart failure, osteoarthritis, mental disorders, ESRD, or HIV/AIDS
Institutional (I-SNP)	Beneficiaries who reside, or are expected to reside, for 90 days or longer in a long-term care facility – defined as skilled nursing facility (SNF) nursing facility (NF), intermediate care facility (ICF) or inpatient psychiatric facility OR those who live in the community but require an equivalent level of care to those who reside in a long-term care facility.

ALIGNMENT'S C-SNP ELIGIBILITY

CHRONIC CONDITION SPECIAL NEEDS PLANS

Alignment C-SNP programs are available to eligible Members who meet the qualifying conditions which include:

1. Must reside within the program's identified service areas
2. Must have a **qualifying chronic condition** confirmed by their Provider within 60 days of enrollment
3. Qualifying conditions for a C-SNPs must include at least one following confirmed conditions:

Heart & Diabetes C-SNP

- Diabetes Mellitus
- Chronic Heart Failure
- Cardiovascular Diagnoses
  - Cardiac Arrhythmias
  - Coronary Artery Disease
  - Peripheral Vascular Disease
  - Chronic Venous Thromboembolic Disorder

End Stage Renal Disease (ESRD) C-SNP

- Kidneys cease functioning
  - Regular course for long-term dialysis
- Kidney transplant to maintain life

Chronic Lung Disease (COPD) C-SNP

- Asthma
- COPD
- Emphysema
- Pulmonary Hypertension
- Pulmonary Fibrosis

Chronic, Disabling Mental Health (CDMH) Condition C-SNP

- Bipolar disorder
- Major depressive disorder
- Paranoid disorder
- Schizophrenia
- Schizoaffective disorder

DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP) ELIGIBILITY

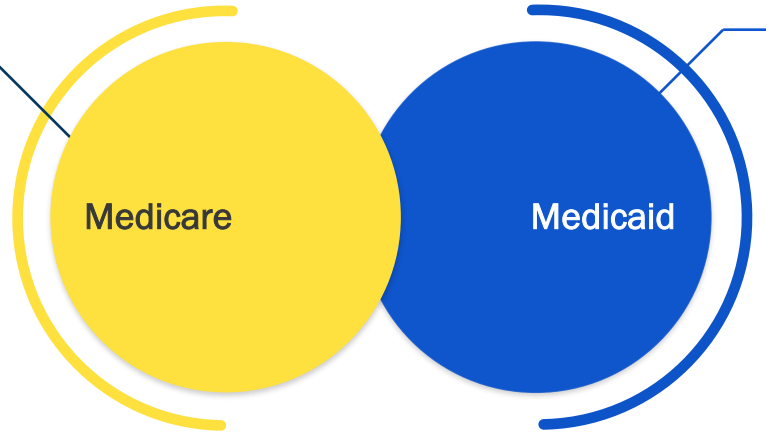
DUAL ELIGIBLE SPECIAL NEEDS PROGRAMS

A Dual Eligible Special Needs Plan (D-SNP) is available **to qualified seniors and individuals with disabilities** who meet the qualifying criteria listed below:

1. **Meet dual eligibility** status requirements
   - ❑ enrollment in a federally administered Medicare program based on age and/or disability status
   - ❑ The state-administered Medicaid program based on low income and assets
2. Reside within the program's identified service areas
3. Qualify for **BOTH** Medicare **and** Medicaid Benefits
4. Must verify Medicaid eligibility on a monthly basis after enrollment

Eligibility Criteria

- Age 65 or older
- Under 65 with a disability (intellectual/ developmental, cognitive, physical, behavioral health needs or chronic medical conditions)
- Any age with End Stage Renal disease



Eligibility Criteria

- Meet income and asset requirements

  AND
- Member of an eligible group
- Adults with disabilities
- Older adults
- Children and families
- People who are pregnant

DUAL ELIGIBLE SPECIAL NEEDS PLANS (CONT.)

DUAL ELIGIBLE SPECIAL NEEDS PROGRAMS

- Medicare coverage is primary; Medicaid coverage supplements Medicare coverage
- D-SNP Members are "cost-share protected" meaning the state Medicaid program pays the Member's Medicare (Parts A and B) cost share (copayments, deductibles, coinsurance).
- A D-SNP Member is not responsible for any costs and the Provider cannot balance bill the Member.
- Some D-SNPs are "integrated," meaning the Health Plan administers both Medicare and Medicaid benefits
- D-SNPs must have a State Medicaid Agency Contract (SMAC) that lists all the requirements imposed by the state including at least certain federal minimum requirements
- All D-SNPs must assist Members with Care Coordination and accessing both Medicare and Medicaid benefits, even if the DSNP does not administer the Medicaid benefit

D-SNP MEDICAID ELIGIBILITY REQUIREMENTS

MEDICAID ELIGIBILITY CATEGORIES

QUALIFIED MEDICARE BENEFICIARY (QMB)

- Medicaid covers Medicare Part A and B premiums, deductibles, coinsurance and copayment amounts
- Not otherwise eligible for any Medicaid benefits
- Cost Share Protected

QUALIFIED MEDICARE BENEFICIARY PLUS (QMB+)

- Medicaid covers Medicare Part A and B premiums, deductible, coinsurance and copayment amounts
- Also eligible for full Medicaid benefits, secondary to Medicare coverage
- Cost Share Protected

SPECIFIED LOW INCOME MEDICARE BENEFICIARY PLUS (SLMB+)

- Medicaid covers Medicare Part B premiums
- Also eligible for full Medicaid benefits

FULL MEDICAID ONLY (OTHER FULL BENEFIT DUAL ELIGIBLE OR FBDE)

- Eligible for full Medicaid benefits but not for the QMB program
- Medicaid may provide some assistance with Medicare cost-sharing
- Generally, cost share is $0 when the service is covered by both Medicare and Medicaid. May be instances where member must pay Medicare cost-sharing if services/benefit not covered by Medicaid

ALIGNMENT SUMMARY OF SNPS 2025

IN 2025, ALIGNMENT WILL OFFER BOTH CHRONIC AND DUAL SNPS

C- SNPS

- Chronic Condition SNP (C-SNP) for Diabetes, Congestive Heart Failure & Cardiovascular Disease
  - California
  - Nevada
  - Arizona
  - North Carolina
  - Texas
- Chronic Condition SNP (C-SNP) for End Stage Renal Disease
  - California
- Chronic Condition SNP (C-SNP) for Chronic Lung Conditions
  - California
- Chronic Condition SNP (C-SNP) for Chronic Disabling Mental Health Conditions
  - California

NEW FOR 2025

NEW FOR 2025

NEW FOR 2025

D-SNPS

- Dual Eligible SNPs (D-SNPs)
  - California
  - North Carolina
  - Nevada
  - Texas

NEW FOR 2025

SNP MODEL OF CARE (MOC) REQUIREMENTS

SNP MODEL OF CARE REQUIREMENTS

- The Model of Care (MOC) is a document that Alignment submits to Medicare to describe how Alignment works to successfully deliver care and services to the SNP Members
- The MOC is a fundamental component of SNP Quality Improvement, so CMS requires the National Committee for Quality Assurance (NCQA®) to review and approve all SNP MOCs based on standards and scoring criteria established by CMS.
- The Model of Care outlines extra, and unique services offered to the Special Needs population
- A Model of Care is required for each SNP type
- The Model of Care includes how Alignment measures the effectiveness of the MOC and the care provided to the SNP Members

OVERALL MODEL OF CARE GOALS

Improve Access to **Affordable Medical, Preventive, Mental Health and Social Services**

Improving Access to **Affordable Preventive Health Services**

Improving **Coordination of Care** Through a Central Point of Contact

Create **Seamless Transitions of Care** Across Health Care Settings, Provider and Health Services

Ensure **Appropriate Utilization** of Services

Improve Quality Through Early Intervention and Education

Improve Patient Health Outcomes

SNP MOC STRUCTURE

THE SNP MOC REQUIREMENTS BY NCQA® AND CMS COMPRISE THE FOLLOWING CLINICAL AND NON-CLINICAL STANDARDS:

SNP Population

- Documentation of how the health plan will determine, verify and track eligibility
- Detailed profile of medical, social, cognitive, environmental conditions, etc. associated with SNP population
- Health conditions impacting beneficiaries & plan for especially vulnerable beneficiaries

Care Coordination

- SNP staff structure, roles and training defined
- Health Risk Assessment (HRA)
- Individualized Care Plan (ICP)
- Face-to-Face Visit (F2F)
- Interdisciplinary Care Team (ICT)
- Care Transitions (CT)

Provider Network

- Specialized expertise available to SNP beneficiaries & how health plan evaluates competency of network
- Use of clinical practice guidelines & care transition protocols by Providers
- MOC training for Provider network

Quality Measurement & Performance

- Quality Measure Monitoring
- Measurable goals & health outcomes for the MOC
- Measure patient experience of care surveys and analyze integrated results
- SNP Model of Care Program Evaluation (annual)
- Quality Improvement Plan

SNP POPULATION DESCRIPTION

DESCRIPTION OF THE ALIGNMENT'S C-SNP POPULATION

DESCRIPTION OF THE ALIGNMENT C-SNP POPULATION

Most Vulnerable Members

- Alignment SNP focuses on the vulnerable sub-population of Members who are at highest risk of poor outcomes
- The Members are identified using Alignment Health Plan's proprietary software that is algorithm based and identifies census information, gaps in care, pharmacy information, HEDIS® information, and predicts risk scores for Alignment Members

Overall SNP Population

- A Population Assessment was conducted to build a Model of Care that will properly serve Alignment Members' needs. Factors we identified include but are not limited to:
  - Age of current Alignment C-SNP Members range from 18-103 years old
  - There are slightly more females than males enrolled in the Alignment C-SNPS
  - Hispanic, Caucasian and Native American/ Native Alaskan are top 3 ethnicities within the Alignment C-SNPS
  - English and Spanish are preferred languages

DESCRIPTION OF THE ALIGNMENT D-SNP POPULATION

Populations at greatest risk are identified in order to direct resources towards those with increased need for care management services:

- Complex and multiple chronic conditions – patients with multiple chronic diagnoses that require increased assistance with disease management and navigating health care systems
- Disabled – patients unable to perform key functional activities (walking, eating, toileting) independently such as those with amputation and/or blindness due to diabetes
- Frail – may include the elderly over 85 years and/or diagnoses such as osteoporosis, rheumatoid arthritis, COPD, CHF
- Dementia – patients at risk due to moderate/severe memory loss or forgetfulness
- End-of-life – patients with terminal diagnosis such as end-stage cancers, heart or lung disease

CARE COORDINATION

THE HEALTH RISK ASSESSMENT (HRA)

THE HEALTH RISK ASSESSMENT (HRA)

- A Health Risk Assessment (HRA) is required for **all** Members enrolled in a SNP
- The HRA is a tool used to identify Member risk levels including but not limited to Health, Functional, Cognitive, Psychosocial / Mental Health
- Alignment uses HRA risk leveling to identify Member needs to provide better coordination of care and to improve health outcomes while reducing overall cost.
- Alignment attempts to complete the HRA within 90 days of initial enrollment and annually, or when there is a change in the patient's condition
- Results of the HRA are communicated to the Member and Member's Provider (ICT)
- Patients have the right to refuse to complete the HRA
- HRA completion rates (initial and reassessments) are CMS STAR Measures!
- HRAs can be completed via telephone, e-mail, paper, virtually or in-person
- An HRA assesses needs related to:

HEALTH RISK ASSESSMENT KEY ELEMENTS

THE HEALTH RISK ASSESSMENT (HRA)

- The HRA is a Medicare requirement for all C-SNP and D-SNP Members
- HRA assessments must include:
  - Demographic data (e.g., age, gender, race)
  - Self-assessment of health status and activities of daily living (ADLs)
  - Functional status and pain assessment
  - Medical diseases/conditions and history
  - Biometric values (e.g., BMI, BP, glucose)
  - Psychosocial risks (e.g., depression, stress, fatigue)
  - Behavioral risks (e.g., tobacco use, nutrition, physical activity)
  - Social Needs assessment including housing stability, food insecurities and access to transportation

HRAT RISK LEVELING

HRAT RISK LEVELING

Alignment uses AVA™ risk categories to identify Member needs to provide better coordination of care and to improve health outcomes while reducing overall cost

The HRA is stratified into high risk, moderate risk, low risk or unknown to assess the Member's needs and to identify appropriate interventions.

RISK CATEGORIES

Stratification Level	Score	Outreach	Interventions	Minimal Call Frequency
High risk	**ARS 10+**	• RN Care Manager /CM Outreach specialist performs outreach after HRA completion to engage Member in CCM • Members will be referred to RN CM for assessment review and development of ICP • Ongoing follow-up will be scheduled with appropriate resources based on Member needs. • ICP is developed from HRA as well as comprehensive assessment responses and shared with Member and PCP at a minimum • ICP/ICT letter shared with PCP and Member • Social Worker is utilized for Social Determinates of Health (SDoH) needs	RN Care Manager CM Outreach Specialists/ Care Coordinator Social Work	Monthly or more frequent based on clinical judgment
At risk	**ARS 4-9**	• RN Care Manager /CM Outreach specialist performs outreach after HRA completion to engage Member in CCM • Members will be referred to RN CM for assessment review and development of ICP • Ongoing follow-up will be scheduled with appropriate resources based on Member needs. • ICP is developed from HRA as well as comprehensive assessment responses and shared with Member and PCP at a minimum • ICP/ICT letter shared with PCP and Member Social Worker is utilized for Social Determinates of Health (SDoH) needs	RN Care Manager CM Outreach Specialists/ Care Coordinator Social Work	Quarterly
Low Risk	**ARS 0-4**	• Members are provided ICP, and health education based on HRAT answers • ICP/ICT letter shared with PCP and Member • Case will remain in monitored status to assess for any change in conditions or transitions • Social Worker is utilized for Social Determinates of Health (SDoH) needs	RN Care Manager CM Outreach Specialist/ Care Coordinator	Minimum Annual or with change in condition
Unknown- *Member's acuity cannot be assessed*	**0**	• Outreach attempts exhausted • Member declined HRA completion • ICP/ICT letter shared with PCP and Member • ICPs based on CPGs for identified conditions using available info	CM Outreach Specialist/ Care Coordinator	Minimum Annual or with change in condition

CARE PLAN DEVELOPMENT

CARE PLAN DEVELOPMENT

- The HRA is the tool used for evaluating the Member's current health status. The Care Plan documents ongoing plan of action to address the Member's care needs with the Member and the ICT
- An initial care plan is developed from the HRA results within 30 calendar days of completion of the HRA and updated when a Member's health care needs change
- The HRA results are used to develop or update a Member's Basic (BCP) or Individualized Care Plan (ICP) and to stratify the Member into risk categories for Care Management and Coordination
- BCPs are created based on the practice guidelines for the Member's qualifying condition and other conditions identified through the HRA completion or information available at the time of care plan creation
- ICP is developed and maintained for each engaged/participating SNP Member and is created from the HRA and the comprehensive assessment to develop personalized interventions and goals

INTERDISCIPLINARY CARE TEAM (ICT)

INTERDISCIPLINARY CARE TEAM (ICT)

- The Interdisciplinary Care Team (ICT) is Member-centric and based on a collaborative approach.
- The ICTs overall care management role includes Member and caregiver evaluation, re-evaluation, care planning and plan implementation, Member advocacy, health support, health education, support of the Member's self-care management and ICP evaluation and modification as appropriate.
- Both C-SNP and D-SNP Members must have an Interdisciplinary Care Team that is based on the Member's medical and psychosocial needs as determined by the HRA and Care Plan
- The Member, the Care Manager and the PCP, at a minimum, make up the ICT, but might also include Social Workers, Pharmacists, Medical Director, Specialists or other treating Physicians
- ICT information is communicated through various methods including:
    - The CM system documentation
    - Telephonic communication with Member/caregiver and Provider
    - Written ICT meeting minutes
    - Documentation within the Member's ICP
- ICT meetings are conducted at least annually and more frequently based on the patient's needs. They can be virtual, in-person or by sharing the care plan by fax/email or regular mail

INTERDISCIPLINARY CARE TEAM- ICT

The Interdisciplinary Care Team is developed based on patient needs/requests and facilitates:

- Access to appropriate and person - centered care
- Multidisciplinary approach to support Integrated Care Management
- Development of a comprehensive plan of care
- Communication regarding individualized care plan

The Care Manager (CM)* leads and determines ICT Membership with the patient and can include:

- Patient/caregiver*
- Medical Expertise*
- Social Services Expertise
- Behavioral Health as indicated
- Pharmacist
- Nursing Facility Representative
- Discharge Planner
- PT/OT/ST
- Community agencies
- Other health care professionals

*Indicates minimum required

ICT MEETINGS

ICT Members participate based on the Member's needs

CMs keep the team updated with information involving the Member's care plan

ICT meetings are formally conducted at least annually and more frequently based on the patient's needs.

- Virtual/Conference calls
- In-person meetings (Grand Rounds)
- Inpatient facility care conference
- Exchange of care plan via fax/mail when Member is non-participatory

FACE-TO-FACE ENCOUNTERS

- Face-to-Face (F2F) Encounters are required on at least an annual basis beginning within the first 12 months of enrollment.
- A face-to-face encounter must be either in-person or through a visual, real-time, interactive telehealth encounter. The face-to-face encounter is part of the overall care management strategy.
- The F2F encounter must be with a Member of the ICT or CM team
- Beginning in 2023, during outreach to the Member, Alignment will offer a virtual visit with a CM to conduct CM assessments or will assist with scheduling a F2F wellness visit with the PCP.
- Alignment's Care Anywhere Practitioners may provide medical or social support through face-to-face visits in the Member's home or through virtual visits when a Member is identified as high-risk and collaborate with the Member's PCP as needed

CARE TRANSITIONS

- A Care Transition is movement of a Member from one care setting to another when the Member's health status changes
- Care Transition settings include home, home health, acute care, skilled/custodial nursing facilities, rehabilitation facility, outpatient/ ambulatory care/ surgery centers
- Care Transitions are addressed by the Care Manager for both planned and unplanned transitions in order to maximize Member recovery and avoid preventable transitions
- All applicable ICT Members are informed of the Member's needs prior to, during and post transition from one care setting to another including the receiving facility

POST DISCHARGE CARE TRANSITION

The post-discharge program for C-SNP and D-SNP Members, includes phone calls or visits after being discharged home from the hospital. Members receive a post-hospital call within 10 business days of discharge. During these calls, the CM or Provider:

- Helps the Member understand discharge diagnosis and instructions
- Facilitates follow-up appointments
- Assists with needed home health and equipment
- Resolves barriers to obtaining medications
- Educates the Member on new or continuing medical conditions

PROVIDER NETWORK

ALIGNMENT PROVIDER PARTNERS RESPOND TO MEMBER'S NEEDS BY:

- Communicating With Care Coordination and Others in The Member's Care Team
- Attending ICT Meetings
- Supporting Care Transitions
- Assisting With Development and Updates to the ICP
- Reviewing and Responding to Patient Specific Information
- Completing Annual Wellness Exams
- Encouraging Medication Adherence
- Promoting Quality Improvement
- Understanding The MOC By Completing The Training

NETWORK OVERSIGHT:

- All Alignment Contracted Providers, Facilities and Ancillary Providers, undergo a Credentialing process to ensure they meet all Federal And State Credentialing Requirements
- All licensed Practitioners and Providers who have an independent relationship with Alignment Health Plan require credentialing
- Verification of credentialing information is performed by Alignment or its delegate initially prior to contracting and every 3 years after or sooner based on state requirements

CARE ANYWHERE/ALIGNMENT PRACTITIONERS

- Alignment supports the Member and the Primary Care Provider through the Alignment Care Anywhere Program
- The Alignment's Care Anywhere program is a physician led, Advance Practice Clinician (APC) driven model of care designed to support SNP Members who have been identified as benefiting from a comprehensive in-home assessment to address immediate, chronic, and social health care needs
- The CareAnywhere program delivers an extra layer of care services for targeted Members to not only reduce the unnecessary utilization of ER and inpatient services, but also to improve health outcomes and restore humanity in advanced care planning

PLAN PERFORMANCE AND QUALITY OUTCOMES

QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

- Alignment has a Quality Improvement Plan (QIP) that is specific to the C-SNP or D-SNP MOCs and designed to measure the effectiveness of each MOC
- Data is collected, analyzed and evaluated in order to report on the MOC quality performance improvement
- Specific HEDIS® health outcomes measures are identified in order to measure the impact the MOC has on all SNP Members
- All SNP Program Member satisfaction surveys are utilized to assess overall satisfaction with the MOC
- The results of surveys are used to modify the MOC QIP on an annual basis
- Each year, an annual evaluation of the MOC is performed and the results shared with the stakeholders through the Quality Improvement Committee (QIC)

PERFORMANCE AND OUTCOME MONITORING SAMPLE MEASURES

PROCESS MEASURES	HEALTH OUTCOMES
Initial HRA Completed Timely (Initial HRA and Annual HRA)	Diabetics with controlled HbA1c
Annual HRA Completed Timely	Medication Adherence for Cholesterol (Statin)
HRA Completed Timely (Initial HRA and Annual HRA)	Care of Older Adult (66+): Pain Assessment
Individualized Care Plan Completion	Care of Older Adult (66+): Medication Review
Interdisciplinary Care Team Participation	Transition of Care follow-up after hospitalization
Face to Face Visits	Follow-up after hospitalization for Mental Illness
Member Engagement	Hospitalizations/1000 Members per year
Member Experience	Inpatient Readmission Rate
Member Access to Care	Emergency Room Rate/1000 Members per year
Member Complaints	Follow-up after ED visit for people with high-risk Chronic Conditions
Social Services Referrals	

**Measures may not be applicable to all SNP types*

ALIGNMENT HEALTH PLAN CHRONIC SPECIAL NEEDS PLANS

(C-SNP)

ALIGNMENT'S C-SNP PLANS FOR CALIFORNIA

PLAN NAME:

ALIGNMENT HEALTH HEART & DIABETES HMO C-SNP

ALIGNMENT HEALTH HEART & DIABETES CALPLUS HMO C-SNP

NEW FOR 2025

ALIGNMENT HEALTH BREATH EASY HMO C-SNP ★

ALIGNMENT HEALTH CLARITY HMO C-SNP ★

Available in: Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Clara, Stanislaus, Ventura, Yolo

ALIGNMENT'S ESRD C-SNP

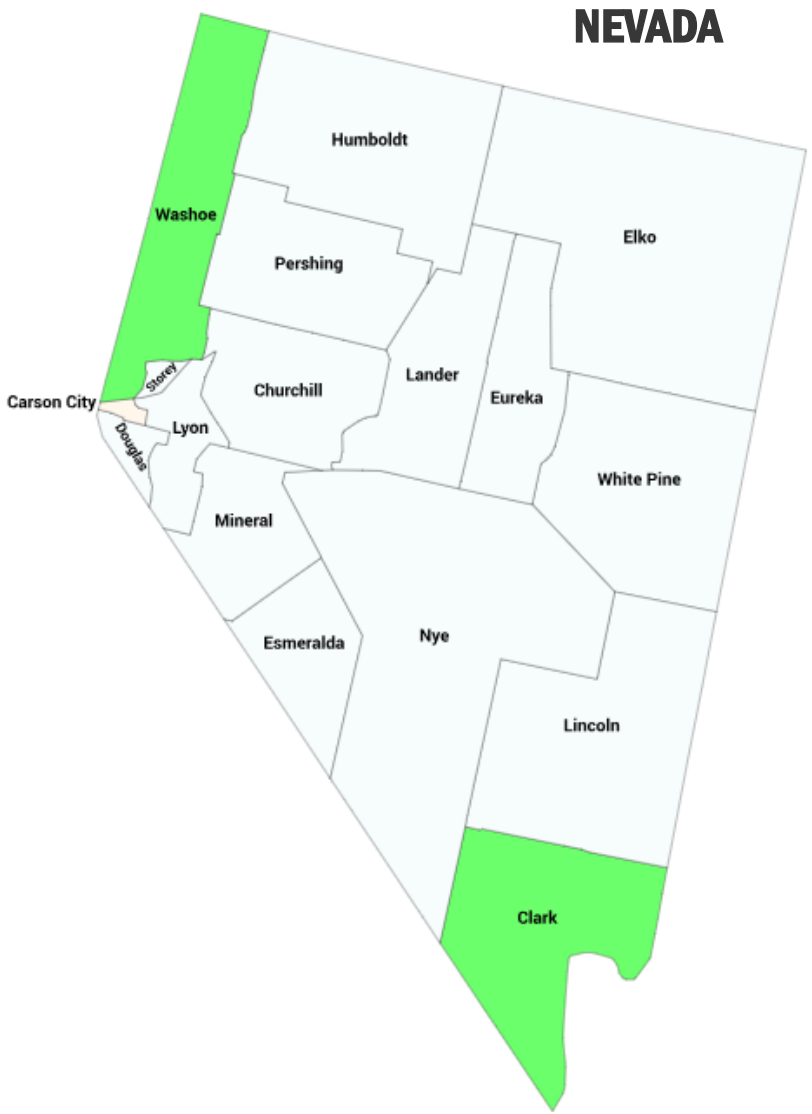
CALIFORNIA

PLAN NAME:

ALIGNMENT HEALTH ESRD BALANCE HMO C-SNP

Available in: Los Angeles and Orange Counties

ALIGNMENT'S C-SNP FOR NEVADA



PLAN NAME:

ALIGNMENT HEALTH HEART & DIABETES HMO C-SNP

Available in: Clark, and Washoe Counties

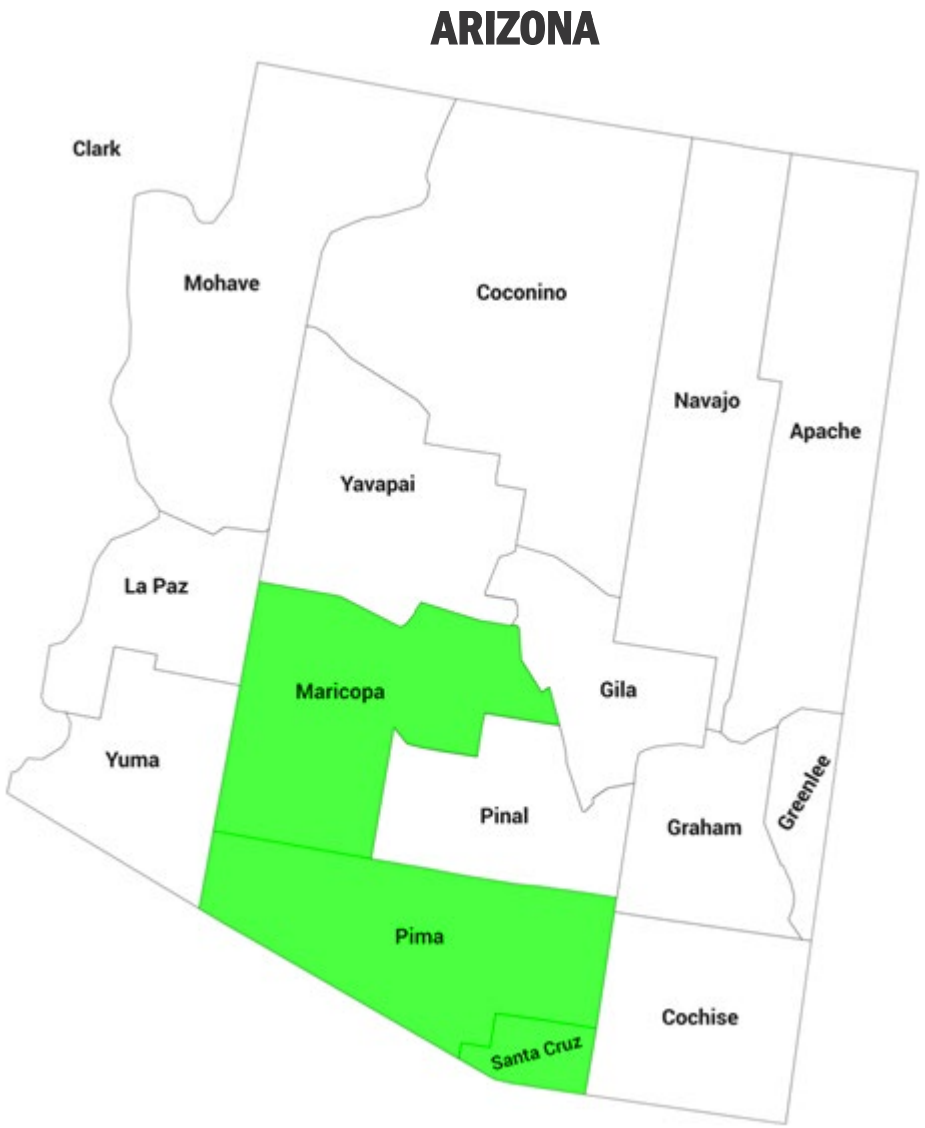
ALIGNMENT'S C-SNP FOR ARIZONA

PLAN NAME:

ALIGNMENT HEALTH HEART & DIABETES HMO C-SNP

ALIGNMENT HEALTH HEART & DIABETES PLUS HMO C-SNP

Available in: Maricopa, Pima and Santa Cruz Counties



ALIGNMENT'S C-SNP FOR NORTH CAROLINA

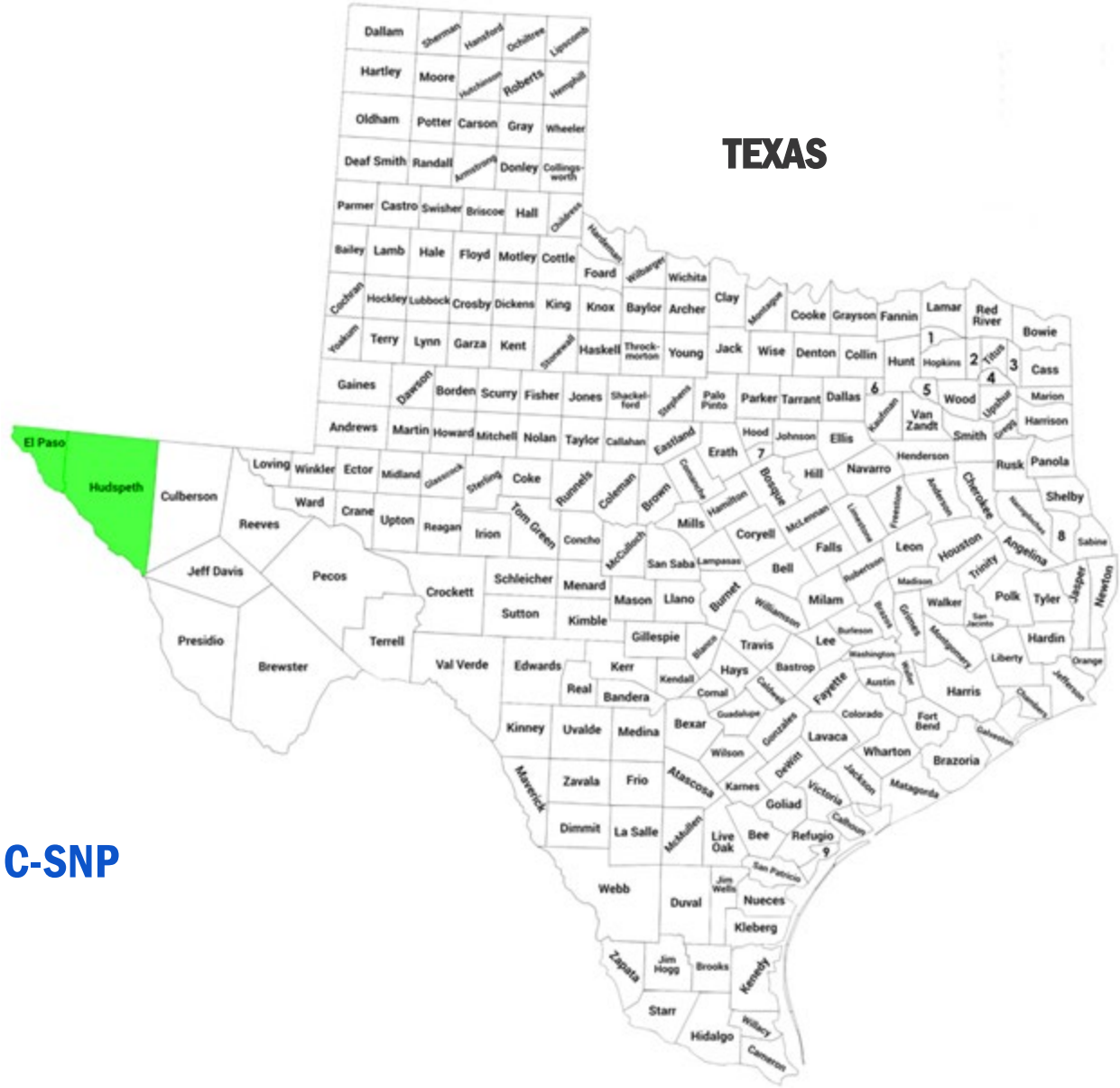
PLAN NAME:

ALIGNMENT HEALTH HEART & DIABETES HMO-POS C-SNP

Available in: Avery, Buncombe, Chatham, Davidson, Davie, Forsyth, Guilford, Henderson, Johnston, Madison, McDowell, Mitchell, Orange, Transylvania, Wake, Wilkes Counties, North Carolina

Clark and Washoe Counties, Nevada

ALIGNMENT'S C-SNP FOR TEXAS



PLAN NAME:

ALIGNMENT HEALTH HEART & DIABETES HMO-POS C-SNP

Available in: El Paso and Hudspeth

ADDITIONAL BENEFITS FOR C-SNPS MAY INCLUDE:

ALIGNMENT C-SNP BENEFIT SUMMARY

- Care Anywhere Evaluations- Annual Wellness Examination
- Preventive and Comprehensive Dental Services
- Routine vision exams and glasses or contact coverage
- Routine preventive screening
- Hearing exams
- Transportation
- Chronic & Readmission Meal Benefit
- Personal Emergency Response System (PERS)
- Fitness Benefit
- Healthy Rewards Program
- Telehealth
- Caregiver Reimbursement
- In Home Support
- Pet Services
- Pest Control
- Air Purifier/Humidifier
- Essentials For qualifying members to assist with Groceries, Gas, Utilities and Home Safety
- 24/7 ACCESS On-Demand Concierge team helps Members navigate the services and benefits available
- ACCESS On-Demand Concierge Black Card- gives access to concierge service 24 hours a day, 7 days a week and works like a debit card to pay for items, including over the counter (OTC), grocery and Alignment Health Plan healthy rewards
- Acupuncture
- Chiropractic Services
- Bonus Drug Coverage