2024 Summary of Benefits

Premier Care (HMO-POS I-SNP)

H1277, Plan 001

This is a summary of drug and health services covered by Premier Care (HMO-POS I-SNP) January 1, 2024 - December 31, 2024.

Premier Care (HMO-POS I-SNP) is a Medicare Advantage HMO-POS I-SNP Plan (HMO stands for Health Maintenance Organization) (I-SNP stands for Institutional Special Needs Plan) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

This information is not a complete description of benefits. Call 1-855-855-0489, TTY should call 711, for more information.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, visit our website at AlignSeniorCare.com, or call Member Services and request the *Evidence of Coverage*.

To Reach Our Member Services Representatives:

- Toll Free 1-855-855-0489, TTY/TDD should call 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.

To join Premier Care (HMO-POS I-SNP), you must:

- be entitled to Medicare Part A,
- -- *and* -- be enrolled in Medicare Part B,
- -- *and* -- live in our service area,
- -- *and* -- reside in one of our participating nursing facilities for greater than 90 days or live in a community setting (including in an assisted living or independent living community) and meet

the institutional level of care. The plan's *Provider Directory* has a list of participating nursing facilities. You can access this list on our website AlignSeniorCare.com or call Member Services and ask us to send you a list.

Our service area includes these counties in Virginia: Albemarle, Charlottesville City, Chesapeake City, Chesterfield, Hampton City, Henrico, Hopewell City, Norfolk City, Portsmouth City, Richmond City, Suffolk City, and Virginia Beach City.

Premier Care (HMO-POS I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at AlignSeniorCare.com. If you use providers that are not in our network, the plan may not pay for these services.

This document is also available in braille and in large print.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You 2024"** handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

	Premier Care (HMO-POS I-SNP)
Monthly Plan Premium *(includes both medical and drugs)*	$0 You must continue to pay your Medicare Part B premium.
Deductible	The Part B deductible was $226. This is the 2023 cost sharing amount and may change in 2024. Premier Care (HMO-POS I-SNP) will provide updated rates at AlignSeniorCare.com as soon as they are released. The Part A deductible is $0.
Maximum out-of-pocket amount (does not include Part D Prescription drugs)	From network providers: $3,900 From out-of-network providers: Not Applicable From network and out-of-network providers combined: $3,900
Inpatient Hospital coverage	**In-Network** $150 copayment each day for days 1 to 10 and $0 copayment each day for days 11 to 90 for Medicare-covered hospital care. $0 copayment for additional Medicare-covered days. Members have a Point-of-Service option for Inpatient Hospital Services. "Point-of-Service" means you can use providers outside the plan's network. $0 copayment for additional lifetime reserve days. Per stay benefit period. *Prior authorization is required.* **Out-of-Network** $150 copayment each day for days 1 to 10 and $0 copayment each day for days 11 to 90 for Medicare-covered hospital care. *Prior authorization is required.*

	Premier Care (HMO-POS I-SNP)
Outpatient Hospital coverage	
Outpatient hospital services	**In-Network** 20% coinsurance Members have a Point-of-Service option for Outpatient Hospital Services. "Point-of-Service" means you can use providers outside the plan's network. *Prior authorization is required.* **Out-of-Network** 20% coinsurance *Prior authorization is required.*
Outpatient hospital observation services	**In-Network** $100 copayment per stay Members have a Point-of-Service option for Outpatient Observation Services. "Point-of-Service" means you can use providers outside the plan's network. *Prior authorization is required.* **Out-of-Network** $100 copayment *Prior authorization is required.*
Ambulatory Surgical Center (ASC)	**In-Network** 20% coinsurance Members have a Point-of-Service option for Ambulatory Surgical Center Services. "Point-of-Service" means you can use providers outside the plan's network. *Prior authorization is required.* **Out-of-Network** 20% coinsurance *Prior authorization is required.*

	Premier Care (HMO-POS I-SNP)
Doctor Visits	
Primary Care Providers	**In-Network** $0 copayment Members have a Point-of-Service option for Primary Care Physician services. "Point-of-Service" means you can use providers outside the plan's network. **Out-of-Network** $0 copayment
Specialists	**In-Network** $10 copayment Members have a Point-of-Service option for Physician Specialist services. "Point-of-Service" means you can use providers outside the plan's network. **Out-of-Network** $10 copayment
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay nothing.
Emergency care	$90 copayment Copayment is waived if you are admitted to a hospital within 3 days.
Urgently needed services	$55 copayment Copayment is waived if you are admitted to a hospital within 3 days.

	Premier Care (HMO-POS I-SNP)
Diagnostic Services/Labs/Imaging	
Diagnostic tests and procedures	**In-Network** 20% coinsurance Members have a Point-of-Service option for Diagnostic Procedures and Tests. "Point-of-Service" means you can use providers outside the plan's network. *Prior authorization is required.* **Out-of-Network** 20% coinsurance *Prior authorization is required.*
Diagnostic radiology services (e.g. MRI, CAT Scan)	**In-Network** 20% coinsurance Members have a Point-of-Service option for Diagnostic Radiological Services. "Point-of-Service" means you can use providers outside the plan's network. *Prior authorization is required.* **Out-of-Network** 20% coinsurance *Prior authorization is required.*
Lab services	**In-Network** $0 copayment Members have a Point-of-Service option for Lab Services. "Point-of-Service" means you can use providers outside the plan's network. *Prior authorization is required.* **Out-of-Network** $0 copayment *Prior authorization is required.*

	Premier Care (HMO-POS I-SNP)
Outpatient X-rays	**In-Network** $0 copayment Members have a Point-of-Service option for Outpatient X-Ray Services. "Point-of-Service" means you can use providers outside the plan's network. *Prior authorization is required.* **Out-of-Network** $0 copayment *Prior authorization is required.*
Therapeutic Radiology	**In-Network** 20% coinsurance Members have a Point-of-Service option for Therapeutic Radiological Services. "Point-of-Service" means you can use providers outside the plan's network. *Prior authorization is required.* **Out-of-Network** 20% coinsurance *Prior authorization is required.*
Hearing services Hearing exam *Supplemental benefits* Routine hearing exam Fitting-evaluation(s) for hearing aids **Hearing aids**	20% coinsurance for each Medicare-covered service. $0 copayment Limited to 1 visit every year $0 copayment Limited to 1 visit every year Up to a $1,000 credit for both ears combined every year for hearing aids.
Dental services Medicare-covered dental *Supplemental benefits*	20% coinsurance for each Medicare-covered service. *Prior authorization is only required for Medicare-covered comprehensive dental services.*

	Premier Care (HMO-POS I-SNP)
Preventive and comprehensive services	2 oral exam(s); 2 cleaning(s); 2 Fluoride treatments every year. Dental X-rays limitations are included in the *Evidence of Coverage.* $3,000 every year for use to access (non-Medicare and/or non-Medicaid covered services) supplemental preventive and comprehensive dental services combined. All services must be provided by **Liberty Dental**. Our plan partners with Liberty Dental to provide your dental benefits. To locate a network provider or to review Liberty Dental Plan's Clinical Guidelines, you may call Member Services at 1-866-544-1942 or search the Liberty Dental online provider directory at libertydentalplan.com/alignseniorcare. If you choose to use a provider outside of the network, the services you receive will not be covered. Additional Limitations and Exclusions may be found in the *Evidence of Coverage*.
Vision care	
Exam to diagnose and treat diseases and conditions of the eye	20% coinsurance for each Medicare-covered service.
For people with diabetes, screening for diabetic retinopathy is covered once per year.	20% coinsurance for each Medicare-covered service.
Eyewear after cataract surgery	20% coinsurance for each Medicare-covered service.
Glaucoma screening	$0 copayment for each Medicare-covered service.
Supplemental benefits	
Routine eye exam	$0 copayment Limited to 1 visit every year

	Premier Care (HMO-POS I-SNP)
Additional routine eyewear ○ Contact lenses ○ Eyeglass lenses ○ Eyeglass frames ○ Eyeglasses (lenses and frames) ○ Upgrades	Up to a $150 combined credit every year.
Mental Health Services	
Inpatient visit	**In-Network** $195 copayment each day for days 1 to 8 and $0 copayment each day for days 9 to 90 for Medicare-covered hospital care. $658 copayment each day for days 1 to 60 for additional lifetime reserve days. Members have a Point-of-Service option for Inpatient Mental Health Services. "Point-of-Service" means you can use providers outside the plan's network. *Prior authorization is required.* **Out-of-Network** $195 copayment each day for days 1 to 8 and $0 copayment each day for days 9 to 90 for Medicare-covered hospital care. *Prior authorization is required.*
Outpatient group therapy visit	$10 copayment
Outpatient individual therapy visit	$20 copayment
Skilled nursing facility (SNF) care	$0 copayment for each Medicare-covered skilled nursing facility stay. *Prior authorization may be required. Please contact the plan for additional details.*
Physical Therapy	$0 copayment *Prior authorization may be required. Please contact the plan for additional details.*

	Premier Care (HMO-POS I-SNP)
Ambulance services	
Ground Ambulance	20% coinsurance *Prior authorization is required for non-emergency Medicare services.*
Air Ambulance	20% coinsurance *Prior authorization is required for non-emergency Medicare services.*
Transportation (Non-Emergency)	Not covered
Medicare Part B prescription drugs	
Chemotherapy/ Radiation drugs	0% - 20% coinsurance *For chemotherapy, authorization is required for the initial drug approval only.*
Other Part B drugs	0% - 20% coinsurance *Prior authorization is required for some medications.*

	Premier Care (HMO-POS I-SNP)		
Outpatient Prescription Drugs			
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Standard mail-order cost-sharing** (up to a 90-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)
Deductible	This plan has no deductible for Part D drugs, this payment stage doesn't apply.		
Tier 1 (Preferred Generic)	$2 copayment	$6 copayment	$2 copayment
Tier 2 (Generic)	$15 copayment	$45 copayment	$15 copayment
Tier 3 (Preferred Brand)	$45 copayment	$135 copayment	$45 copayment

	Premier Care (HMO-POS I-SNP)		
Outpatient Prescription Drugs			
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Standard mail-order cost-sharing** (up to a 90-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)
Tier 4 (Non-Preferred Brand)	$95 copayment	$285 copayment	$95 copayment
Tier 5 (Specialty Tier)	25% coinsurance	Not Available	25% coinsurance
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. Premier Care (HMO-POS I-SNP) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be copayment for a one-month supply.		
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $8,000, you pay nothing.		

You won’t pay more than $35 for tier 3 for a one-month supply, $70 for tier 3 for a two-month supply, and $105 for tier 3 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Cost-sharing may differ based on point-of-service (mail-order, 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).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

Important Message About What You Pay for Insulin - 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.

Additional Benefits

	Premier Care (HMO-POS I-SNP)
Chiropractic services	
Manual manipulation of the spine to correct subluxation	20% coinsurance for Medicare-covered services. *Prior authorization is only required for Medicare-covered chiropractic services.*
Routine chiropractic care	$30 copayment Limited to 12 visit(s) every year *Prior authorization is only required for Medicare-covered chiropractic services.*
Diabetic monitoring supplies	$0 copayment
Fitness program • **Physical fitness** • **Memory fitness** • **Activity tracker**	$0 copayment Members have access to an online physical fitness and exercise class subscription for the year. Members also have access to BrainHQ, an online subscription for the year that offers brain/mental exercises and games. Members receive $150 towards the purchase of a Fitbit activity tracker.
Grocery Card	$0 copayment Members will receive $25 a month to spend on food and groceries* at preferred online and retail locations. This benefit will be available to members via a pre-loaded "flex" card. Members will access their Over-the-Counter product benefit using the same "flex" card. *This benefit is available only to members with certain chronic conditions. See the list of conditions below to find out if you qualify: • Chronic alcohol and other drug dependence • Autoimmune disorders • Cancer • Cardiovascular disorders

	Premier Care (HMO-POS I-SNP)
	• Chronic heart failure • Dementia • Diabetes • End-stage liver disease • End-stage renal disease (ESRD) • Severe hematologic disorders • HIV/AIDS • Chronic lung disorders • Chronic and disabling mental health conditions • Neurological disorders • Stroke • Osteoarthritis • Hypertension • Hyperlipidemia
Occupational therapy	$0 copayment *Prior authorization may be required. Please contact the plan for additional details.*
Over-the-counter benefit	$0 copayment You are eligible for a $225 credit per quarter to be used toward the purchase of over-the-counter (OTC) health and wellness products. This benefit will be available to members via a pre-loaded "flex" card. Members will access their Grocery benefit using the same "flex" card. Please contact the plan for additional details. Credits carry forward to the next period if unused.
Podiatry services (Foot care) Foot exams and treatment *Supplemental Benefit* **Additional routine foot care**	 20% coinsurance for each Medicare-covered service. $0 copayment Limited to 4 visit(s) every year

Pre-Enrollment Checklist

Premier Care (HMO-POS I-SNP)
Memory Care (HMO-POS C-SNP)
Align Kidney Care (HMO-POS C-SNP)

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-855-855-0489 (TTY 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit AlignSeniorCare.com or call 1-855-855-0489 (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ **Effect on Current Coverage.** Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.
- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ **For I-SNP enrollees only:** This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a skilled nursing facility, a nursing facility, an intermediate care facility for individuals with intellectual and developmental disabilities, a psychiatric hospital or unit, a rehabilitation hospital or unit, a long-term care hospital, a swing-bed hospital, or a facility approved by CMS that furnishes similar services.
- ☐ **For C-SNP enrollees only:** This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- ☐ **For HMO-POS enrollees only:** Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services the provider must agree to treat you. Except in an emergency or urgent situation, noncontracted providers may deny care.

Pre-Enrollment Checklist

Premier Care (HMO-POS I-SNP)
Memory Care (HMO-POS C-SNP)
Align Kidney Care (HMO-POS C-SNP)

Align Senior Care is an HMO-POS I-SNP and HMO-POS C-SNP with a Medicare contract. Enrollment in Align Senior Care plans depend on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Align Senior Care members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services.

Align Senior Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-855-0489 (TTY 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-855-0489 (TTY 711).

Form Approved
OMB# 0938-1421

ALIGN SENIOR CARE

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-855-0489. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-855-0489. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-855-855-0489。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-855-855-0489。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-855-0489. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-855-0489. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-855-855-0489 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-855-0489. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-855-0489 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-855-0489. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-855-0489 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-855-0489 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-855-0489. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-855-0489. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-855-0489. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-855-0489. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-855-0489 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。