



2025 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) from January 1 – December 31, 2025.

Premier Care (HMO-POS I-SNP) is a Medicare Advantage HMO-POS plan with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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 number: 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:

- Have both Medicare Part A and Medicare Part B,
- -- *and* -- live in our geographic service area,
- -- *and* -- be a United States citizen or be lawfully present in the United States,
- -- *and* -- meet the special eligibility requirements: Our plan is designed to meet the specialized needs of people who need a level of care that is usually provided in a nursing home. To be eligible for our plan, you must 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 at 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. Your plan includes a Point-of-Service (POS) benefit which means that you can use providers outside the plan's network for certain services. See table below for additional detail.

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 *Medicare & You 2025* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Medical Benefits

Benefit category	Your plan benefits
Monthly plan premium <i>(includes both medical and drug coverage)</i>	\$0 You must continue to pay your Medicare Part B premium.
Deductible	\$0 This plan does not have a medical deductible.
Maximum out-of-pocket amount <i>(does not include Part D prescription drugs)</i>	\$3,100 combined for in- and out-of-network services
Inpatient hospital coverage	<p>In-Network: \$150 copayment per day for days 1-10 \$0 copayment per day for days 11-90 Per admission or per stay benefit period applies. <i>Prior authorization is required.</i></p> <p>\$0 for unlimited additional days <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): \$150 copayment per day for days 1-10 \$0 copayment per day for days 11-90 Per admission or per stay benefit period applies. <i>Prior authorization is required.</i></p>

Benefit category	Your plan benefits
<p>Outpatient hospital coverage</p> <p>Outpatient hospital services</p> <p>Outpatient hospital observation services</p>	<p>In-Network: \$0-\$225 copayment \$0 copayment for diagnostic colonoscopy and polyp removal \$225 copayment for all other services <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): \$0-\$225 copayment \$0 copayment for preventive services \$225 copayment for all other services <i>Prior authorization is required.</i></p> <p>In-Network: \$100 copayment <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): \$100 copayment <i>Prior authorization is required.</i></p>
<p>Ambulatory Surgical Center (ASC) services</p>	<p>In-Network: 20% coinsurance <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): 20% coinsurance <i>Prior authorization is required.</i></p>

Benefit category	Your plan benefits
<p>Doctor visits</p> <p>Primary care providers</p> <p>Specialists</p>	<p>In-Network: \$0 copayment</p> <p>Out-of-Network (POS): \$0 copayment</p> <p>In-Network: \$5 copayment</p> <p>Out-of-Network (POS): \$5 copayment</p>
<p>Preventive care (e.g., flu vaccine, diabetic screenings)</p>	<p>\$0 copayment</p>
<p>Emergency care</p>	<p>\$90 copayment You do not pay this amount if you are admitted to the hospital within 3 days.</p>
<p>Urgently needed services</p>	<p>\$55 copayment per visit You do not pay this amount if you are admitted to the hospital within 3 days.</p>

Benefit category	Your plan benefits
<p>Diagnostic services/labs/imaging</p> <p>Diagnostic tests and procedures</p> <p>Diagnostic radiology services (e.g., MRI, CAT scan)</p> <p>Lab services</p>	<p>In-Network: 20% coinsurance <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): 20% coinsurance <i>Prior authorization is required.</i></p> <p>In-Network: 20% coinsurance <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): 20% coinsurance <i>Prior authorization is required.</i></p> <p>In-Network: \$0 copayment <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): \$0 copayment <i>Prior authorization is required.</i></p>

Benefit category	Your plan benefits
<p>Outpatient x-rays</p> <p>Therapeutic radiology</p>	<p>In-Network: \$0 copayment <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): \$0 copayment <i>Prior authorization is required.</i></p> <p>In-Network: 20% coinsurance <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): 20% coinsurance <i>Prior authorization is required.</i></p>
<p>Hearing services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Hearing services (Supplemental)</p> <p>Routine hearing exam</p> <p>Fitting/evaluation(s) for hearing aids</p> <p>Hearing aids</p>	<p>20% coinsurance</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$1,200 every year for both ears combined</p> <p>Benefit is administered by NationsBenefits.</p>

Benefit category	Your plan benefits
<p>Dental services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Dental services (Supplemental)</p> <p>Preventive and comprehensive services</p>	<p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>\$0 copayment for oral exam(s) (limit 2 every year), cleaning(s) (limit 2 every year), and Fluoride treatment(s) (limit 1 every 6 months). See <i>Evidence of Coverage</i> for Dental x-rays limitations.</p> <p>Maximum: \$3,000 every year for preventive services and comprehensive services</p> <p>All services must be provided by Liberty Dental. To locate a network provider, you may call Member Services, or search the Liberty Dental provider directory online at libertydentalplan.com/alignseniorcare.</p>
<p>Vision services (Medicare-covered)</p> <p>Exam to diagnose and treat diseases and conditions of the eye</p> <p>For people with diabetes, screening for diabetic retinopathy is covered once per year</p> <p>Eyewear after cataract surgery</p> <p>Glaucoma screening</p> <p>Vision services (Supplemental)</p> <p>Routine eye exam</p> <p>Additional routine eyewear</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>\$0 copayment</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$150 every year for lenses, frames, contacts or eyewear upgrades</p>

Benefit category	Your plan benefits
Transportation <i>(non-emergency)</i>	<u>Not</u> covered
Medicare Part B prescription drugs	
Chemotherapy/Radiation drugs	0%-20% coinsurance Cost-sharing is dependent on the drug administered. <i>Prior authorization is required for some medications. For chemotherapy, prior authorization is required for the initial drug approval only.</i>
Other Part B drugs	0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum <i>Prior authorization is required for some medications.</i>

Outpatient Prescription Drugs

Prescription drug payment stages	Your plan benefits		
Prescription drug deductible	\$0 This plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.		
Initial coverage	You stay in the Initial Coverage stage until your total out-of-pocket costs reach \$2,000. You then move on to the Catastrophic Coverage Stage.		
Tier drug coverage	Standard retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing (up to a 90-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)
Tier 1 (Preferred Generic)	\$2 copayment	\$6 copayment	\$2 copayment
Tier 2 (Generic)	\$15 copayment	\$45 copayment	\$15 copayment

Prescription drug payment stages	Your plan benefits		
Tier 3 (Preferred Brand)	\$45 copayment	\$135 copayment	\$45 copayment
Tier 4 (Non-Preferred Brand)	\$95 copayment	\$285 copayment	\$95 copayment
Tier 5 (Specialty Tier)	25% coinsurance	Not covered	25% coinsurance
Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,000, you pay nothing for your covered Part D prescription drugs.		

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

Benefit category	Your plan benefits
Diabetic monitoring supplies	\$0 copayment
Dialysis services	20% coinsurance
Durable Medical Equipment (DME)	20% coinsurance <i>Prior authorization is required.</i>
Healthy Living Flex Card <ul style="list-style-type: none"> • Electronic companion animal* • In-home support services • Over-The-Counter (OTC) Items 	\$275 every 3 months to spend towards OTC Products, In-Home Support Services, and an Electronic Companion Animal This benefit is administered by The Helper Bees. See your EOC for more details. *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.

Benefit category	Your plan benefits
Occupational therapy	\$0 copayment <i>Prior authorization may be required. Please contact the plan for additional details.</i>
Podiatry services (Foot care)	
Medicare-covered services	20% coinsurance
Routine foot care	\$0 copayment Limit 4 visits every year
Speech therapy	\$0 copayment <i>Prior authorization may be required. Please contact the plan for additional details.</i>

*The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify. Special supplemental benefits for the chronically ill (SSBCI) are only available to members with certain chronic conditions. You may be eligible if you have one of the following conditions:

- Autoimmune disorders
- Cancer
- Cardiovascular disorders
- Chronic alcohol and other drug dependence
- Chronic and disabling mental health conditions
- Chronic heart failure
- Chronic lung disorders
- COPD
- Dementia
- Diabetes
- End-stage liver disease
- End-stage renal disease (ESRD)
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Neurologic disorders
- Osteoarthritis
- Osteoporosis
- Severe hematologic disorders
- Stroke