2025 Summary of Benefits

Premier Care (HMO-POS I-SNP)

H6832, Plan 004

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 1-855-855-0336, 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: 1-855-855-0336, 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 Michigan: Allegan, Genesee, Jackson, Kalamazoo, Kent, Livingston, Macomb, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ottawa, Washtenaw, and Wayne.

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 *(includes both medical and drug coverage)*	$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 *(does not include Part D prescription drugs)*	$4,700 combined for in- and out-of-network services
Inpatient hospital coverage	**In-Network:** $230 copayment per day for days 1-6 $0 copayment per day for days 7-90 Per admission or per stay benefit period applies. *Prior authorization is required.* $0 for unlimited additional days *Prior authorization is required.* **Out-of-Network (POS):** $230 copayment per day for days 1-6 $0 copayment per day for days 7-90 Per admission or per stay benefit period applies. *Prior authorization is required.*

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

Benefit category	Your plan benefits
Doctor visits	
Primary care providers	**In-Network:** $0 copayment **Out-of-Network (POS):** $0 copayment
Specialists	**In-Network:** $10 copayment **Out-of-Network (POS):** $10 copayment
Preventive care (e.g., flu vaccine, diabetic screenings)	$0 copayment
Emergency care	$90 copayment You do not pay this amount if you are admitted to the hospital within 3 days.
Urgently needed services	$40 copayment per visit You do not pay this amount if you are admitted to the hospital within 3 days.

Benefit category	Your plan benefits
Diagnostic services/labs/imaging	
Diagnostic tests and procedures	**In-Network:** 20% coinsurance *Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.* **Out-of-Network (POS):** 20% coinsurance *Prior authorization is required.*
Diagnostic radiology services (e.g., MRI, CAT scan)	**In-Network:** 20% coinsurance *Prior authorization is required.* **Out-of-Network (POS):** 20% coinsurance *Prior authorization is required.*
Lab services	**In-Network:** $0 copayment *Prior authorization is required only for genetic testing.* **Out-of-Network (POS):** $0 copayment *Prior authorization is required.*

Benefit category	Your plan benefits
Outpatient x-rays	**In-Network:** $0 copayment *Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.* **Out-of-Network (POS):** $0 copayment *Prior authorization is required.*
Therapeutic radiology	**In-Network:** 20% coinsurance *Prior authorization is required.* **Out-of-Network (POS):** 20% coinsurance *Prior authorization is required.*
Hearing services (Medicare-covered)	
Medicare-covered services	20% coinsurance
Hearing services (Supplemental)	
Routine hearing exam	$0 copayment Limit 1 visit every year
Fitting/evaluation(s) for hearing aids	$0 copayment Limit 1 visit every year
Hearing aids	$130 every month as part of a shared allowance with your Healthy Living Flex Card. See your EOC for more details.

Benefit category	Your plan benefits
Dental services (Medicare-covered)	
Medicare-covered services	20% coinsurance *Prior authorization is required.*
Dental services (Supplemental)	
Preventive and comprehensive services	$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 *Evidence of Coverage* for Dental x-rays limitations. Maximum: No maximum for preventive services and $3,000 every year for comprehensive services 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.
Vision services (Medicare-covered)	
Exam to diagnose and treat diseases and conditions of the eye	20% coinsurance
For people with diabetes, screening for diabetic retinopathy is covered once per year	20% coinsurance
Eyewear after cataract surgery	20% coinsurance
Glaucoma screening	$0 copayment
Vision services (Supplemental)	
Routine eye exam	$0 copayment Limit 1 visit every year
Additional routine eyewear	$130 every month as part of a shared allowance with your Healthy Living Flex Card. See your EOC for more details.

Benefit category	Your plan benefits
Mental health services	
Inpatient visit	**In-Network:** $230 copayment per day for days 1-6 $0 copayment per day for days 7-90 $816 copayment per day for each lifetime reserve day (up to 60 days over your lifetime) Per admission or per stay benefit period applies. *Prior authorization is required.* **Out-of-Network (POS):** $230 copayment per day for days 1-6 $0 copayment per day for days 7-90 Per admission or per stay benefit period applies. *Prior authorization is required.*
Outpatient group therapy visit	$10 copayment
Outpatient individual therapy visit	$20 copayment
Skilled Nursing Facility (SNF)	You pay the 2025 Original Medicare cost-sharing amounts. These are the 2024 cost-sharing amounts and may change for 2025. The plan will provide updated rates as soon as they are released. $0 copayment per day for days 1-20 $204 copayment per day for days 21-100 *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.*

Benefit category	Your plan benefits
Ambulance	
Ground ambulance	$250 copayment *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 Cost-sharing is dependent on the drug administered. *Prior authorization is required for some medications. For chemotherapy, prior authorization is required for the initial drug approval only.*
Other Part B drugs	0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum *Prior authorization is required for some medications.*

Outpatient Prescription Drugs

Prescription drug payment stages	Your plan benefits		
Prescription drug deductible	$590 Deductible applies to Tiers 3-5. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.		
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
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 *Prior authorization is required.*
Healthy Living Flex Card • Electronic companion animal* • Eyewear • Fitness • Hearing aids • In-home support services • Over-The-Counter (OTC) benefit • Personal Emergency Response System (PERS)	$130 every month to spend towards OTC Products, In-Home Support Services, Activity Tracker, Online Fitness Classes, Eyewear, Hearing Aids, Personal Emergency Response Device, and an Electronic Companion Animal. Funds rollover each period until the end of the year. See your EOC for more details. *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
Groceries*	$50 every month Eligible members may purchase covered grocery items with a Healthy Living Flex Card. *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
Occupational therapy	$0 copayment *Prior authorization may be required. Please contact the plan for additional details.*
Podiatry services (Foot care) Medicare-covered services Routine foot care	 20% coinsurance $0 copayment Limit 4 visits every year

Benefit category	Your plan benefits
Speech therapy	$0 copayment *Prior authorization may be required. Please contact the plan for additional details.*

*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