



# 2026 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, 2026.**

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](https://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](http://AlignSeniorCare.com) or call Member Services and ask us to send you a list.

Our service area includes these counties in Michigan: Allegan, Genesee, Gratiot, Jackson, Kalamazoo, Kent, Lake, Livingston, Macomb, Mason, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ottawa, Sanilac, Tuscola, 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](http://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. Out-of-network/non-contracted providers are under no obligation to treat Plan 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.

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 2026* handbook. View it online at [www.medicare.gov](http://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
<b>Monthly plan premium</b> <i>(includes both medical and drug coverage)</i>	\$0 You must continue to pay your Medicare Part B premium.
<b>Deductible</b>	\$0 This plan does not have a medical deductible.
<b>Maximum out-of-pocket amount</b> <i>(does not include Part D prescription drugs)</i>	\$4,700 combined for in- and out-of-network services
<b>Inpatient hospital coverage</b>	<p><b>In-Network:</b>            \$230 copayment per day for days 1-6            \$0 copayment per day for days 7-90  <i>Prior authorization is required.</i></p> <p>\$0 for unlimited additional days  <i>Prior authorization is required.</i></p> <p><b>Out-of-Network (POS):</b>            \$230 copayment per day for days 1-6            \$0 copayment per day for days 7-90  <i>Prior authorization is required.</i></p>



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

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



Benefit category	Your plan benefits
<p><b>Dental services (Medicare-covered)</b></p> <p>Medicare-covered services</p> <p><b>Dental services (Supplemental)</b></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: No maximum for preventive services and \$3,500 every year for comprehensive services</p> <p>All services must be provided by <b>Liberty Dental</b>. To locate a network provider, you may call Member Services, or search the Liberty Dental provider directory online at <a href="http://libertydentalplan.com/alignseniorcare">libertydentalplan.com/alignseniorcare</a>.</p>
<p><b>Vision services (Medicare-covered)</b></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><b>Vision services (Supplemental)</b></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>\$200 every year for lenses, frames, contacts or eyewear upgrades</p>





Benefit category	Your plan benefits
<b>Ambulance</b>  Ground ambulance     Air ambulance	\$250 copayment  <i>Prior authorization is required for non-emergency Medicare services.</i>  20% coinsurance  <i>Prior authorization is required for non-emergency Medicare services.</i>
<b>Transportation</b> <i>(non-emergency)</i>  <ul style="list-style-type: none"> <li>Any health-related location</li> <li>Non-medical needs*</li> </ul>	\$0 copayment Limit 24 one-way rides every year  Benefit is administered by The Helper Bees  *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
<b>Medicare Part B prescription drugs</b>  Chemotherapy/Radiation drugs         Other Part B 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>  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		
<b>Prescription drug deductible</b>	\$615 Deductible applies to Tiers 3-5. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.		
<b>Initial coverage</b>	You stay in the Initial Coverage stage until your total out-of-pocket costs reach \$2,100. 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)
<b>Tier 1</b> (Preferred Generic)	\$2 copayment	\$6 copayment	\$2 copayment
<b>Tier 2</b> (Generic)	\$15 copayment	\$45 copayment	\$15 copayment
<b>Tier 3</b> (Preferred Brand)	\$45 copayment	\$135 copayment	\$45 copayment
<b>Tier 4</b> (Non-Preferred Drug)	\$95 copayment	\$285 copayment	\$95 copayment
<b>Tier 5</b> (Specialty Tier)	25% coinsurance	Not covered	25% coinsurance
<b>Catastrophic coverage</b>	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$2,100, 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
<b>Diabetic monitoring supplies</b>	\$0 copayment
<b>Dialysis services</b>	20% coinsurance
<b>Durable Medical Equipment (DME)</b>	20% coinsurance <i>Prior authorization is required.</i>
<b>Groceries*</b>	\$50 every month to spend towards food and produce. Funds roll over each period until the end of the year.  Benefit is administered by The Helper Bees  *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
<b>Healthy Living Flex Card</b> <ul style="list-style-type: none"> <li>• Electronic companion animal*</li> <li>• Over-The-Counter (OTC) items</li> <li>• Personal Emergency Response System (PERS)</li> </ul>	\$195 every 3 months to spend towards the purchase of an Electronic Companion Animal, OTC Items, and PERS Devices. Funds roll over each period until the end of the year.  Benefit is administered by The Helper Bees  *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
<b>In-home support services (Support With Daily Tasks)</b>	\$0 copayment Limited to 80 hours annually  Members have access to an In-Home Support Services benefit that may include support with ADLs or IADLs including personal hygiene needs, light housekeeping, laundry tasks, meal preparation, feeding, bathing, and toileting. This may also include general tasks such as errands, accompaniment to appointments, technology assistance, and setting appointments.  Benefit is administered by The Helper Bees

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

\*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 use disorder and other substance use disorders (SUDs)
- Chronic and disabling mental health conditions
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- Chronic gastrointestinal disease
- Chronic heart failure
- Chronic hyperlipidemia
- Chronic hypertension
- Chronic kidney disease (CKD)
- Chronic lung disorders
- Conditions associated with cognitive impairment
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- Conditions with functional challenges
- Dementia
- Diabetes mellitus
- HIV/AIDS
- Immunodeficiency and Immunosuppressive disorders
- Neurologic disorders
- Osteoporosis
- Overweight, obesity, and metabolic syndrome
- Post-organ transplantation
- Severe hematologic disorders
- Stroke