2027 Summary of Benefits

Michigan | H6832 | Plan 004

Premier Care (HMO-POS I-SNP)

January 1 – December 31, 2027

This document summarizes what the plan covers and what you may pay. It does not list every covered service, benefit, limitation, or exclusion. For complete details, review the Evidence of Coverage (EOC) or contact the plan for assistance.

Need Help?

Call: 1-855-855-0336 (TTY 711)
Visit: AlignSeniorCare.com

This document is also available in large print and braille.

If you are a member and have questions about how to use your benefits, reach out to your Care Ally, or learn more online at **AlignSeniorCare.com/Benefits-Hub**.

For terms and conditions, go to page 16.

Medical Benefits

Benefit category	Your plan benefits
Monthly plan premium	
The 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 (MOOP)	
MOOP *does not* include Part D prescription drugs	Your yearly costs for in- and out-of-network (POS) services combined will not exceed **$6,000**

Benefit category	Your plan benefits	
Inpatient hospital coverage		
In-network	**$230 copay per day** for days **1-6** **$0 copay per day** for days **7-90** **$0 copay** for **unlimited additional days**	Yes, prior authorization is required
Out-of-network (POS)	**$230 copay per day** for days **1-6** **$0 copay per day** for days **7-90**	Yes, prior authorization is required
Outpatient hospital coverage		
Outpatient hospital services		
In-network	**$0 copay** for diagnostic colonoscopy and polyp removal **$225 copay** for all other services	Yes, prior authorization is required
Out-of-network (POS)	**$0 copay** for diagnostic colonoscopy and polyp removal **$225 copay** for all other services	Yes, prior authorization is required
Outpatient hospital observation services		
In-network	**$100 copay**	Yes, prior authorization is required
Out-of-network (POS)	**$100 copay**	Yes, prior authorization is required
Ambulatory Surgical Center (ASC) services		
In-network	**20% coinsurance**	Yes, prior authorization is required
Out-of-network (POS)	**20% coinsurance**	Yes, prior authorization is required

Benefit category	Your plan benefits	
Doctor visits		
Primary Care Providers (PCP)		
In-network	**$0 copay**	**No prior authorization is required**
Out-of-network (POS)	**$0 copay**	**No prior authorization is required**
Specialists		
In-network	**$10 copay**	**No prior authorization is required**
Out-of-network (POS)	**$10 copay**	**No prior authorization is required**
Preventive care (e.g., flu vaccine, diabetic screenings)		
	$0 copay	**No prior authorization is required**
Emergency care		
	$90 copay You do not pay this amount if you are admitted to the hospital within 3 days.	**No prior authorization is required**
Urgently needed services		
	$40 copay You do not pay this amount if you are admitted to the hospital within 3 days.	**No prior authorization is required**

Benefit category	Your plan benefits	
Diagnostic services/labs/imaging		
Diagnostic tests and procedures		
In-network	**20% coinsurance**	Yes, **except** for services provided in a Nursing Facility or Physician Office
Out-of-network (POS)	**20% coinsurance**	Yes, **except** for services provided in a Nursing Facility or Physician Office
Diagnostic radiology services (e.g., MRI, CAT scan)		
In-network	**20% coinsurance**	Yes, prior authorization is required
Out-of-network (POS)	**20% coinsurance**	Yes, prior authorization is required
Lab services		
In-network	**$0 copay**	**No, except for genetic testing**
Out-of-network (POS)	**$0 copay**	**No, except for genetic testing**
Outpatient x-rays		
In-network	**$0 copay**	Yes, **except** for services provided in a Nursing Facility or Physician Office
Out-of-network (POS)	**$0 copay**	Yes, **except** for services provided in a Nursing Facility or Physician Office
Therapeutic radiology		
In-network	**20% coinsurance**	Yes, prior authorization is required
Out-of-network (POS)	**20% coinsurance**	Yes, prior authorization is required

Benefit category	Your plan benefits	
Hearing services		
Hearing services (Medicare-covered)		
	20% coinsurance	**No prior authorization is required**
Hearing services (additional benefits)		
Routine hearing exam	**$0 copay** for up to **1 visit every year**	**No prior authorization is required**
Fitting/evaluation(s) for hearing aids	**$0 copay** for up to **1 visit every year**	**No prior authorization is required**
Hearing aids	Up to **$1,560 allowance every 2 years** for prescription hearing aids for both ears combined. This benefit is administered by NationsHearing. After your hearing exam, hearing aids can be ordered online through the NationsHearing portal. Your Care Ally can help you create your account, schedule a hearing exam, locate an in-network provider, or review your hearing benefits and current allowance. For all other inquiries, visit **AlignSeniorCare.NationsBenefits.com/Hearing**, call NationsHearing at 1-833-689-1751, or reach out to our Member Services team at 1-855-855-0336 for assistance.	**No prior authorization is required**

Benefit category	Your plan benefits	
Dental services		
Dental services (Medicare-covered)		
	20% coinsurance	Yes, prior authorization is required
Dental services (additional benefits)		
Preventive and comprehensive dental services	**$0 copay** for: • oral exams (up to **2 per year**), • cleanings (up to **2 per year**), • fluoride treatments (up to **1 every 6 months**) Dental x-ray limits apply Up to **$3,500 allowance every year** for comprehensive services Preventive dental services are not subject to a yearly dollar maximum To find a preferred provider, search the Liberty Dental network of providers. Your Care Ally can help you create your account, schedule a dental exam, locate an in-network provider, or view your dental benefits and current allowance. For all other inquiries, visit **LibertyDentalPlan.com/AlignSeniorCare**, call Liberty Dental at 1-866-544-1942, or reach out to our Member Services team at 1-855-855-0336 for assistance.	**No prior authorization is required**

Benefit category	Your plan benefits	
Vision services		
Vision services (Medicare-covered)		
Eye exams to diagnose and treat eye diseases and conditions	**20% coinsurance**	**No prior authorization is required**
Diabetic retinopathy screening	**20% coinsurance** for **1 screening per year** for members with diabetes	**No prior authorization is required**
Eyewear following cataract surgery	**20% coinsurance**	**No prior authorization is required**
Glaucoma screening	**$0 copay**	**No prior authorization is required**
Vision services (additional benefits)		
Routine vision exam	**$0 copay** for up to **1 visit every year**	**No prior authorization is required**
Additional routine eyewear	Up to **$200 per year** for lenses, frames, contacts, and eyewear upgrades. To find a preferred provider, search our plan's network of providers. Your Care Ally can help you schedule a vision exam, locate an in-network provider, or view your vision benefits and current allowance. For all other inquiries, reach out to our Member Services team at 1-855-855-0336 for assistance.	**No prior authorization is required**

Benefit category	Your plan benefits	
Mental health services		
Inpatient visit		
In-network	**$230 copay per day** for days **1-6** **$0 copay per day** for days **7-90** **$868 copay per day** for up to **60 additional days** over your lifetime	Yes, prior authorization is required
Out-of-network (POS)	**$230 copay per day** for days **1-6** **$0 copay per day** for days **7-90**	Yes, prior authorization is required
Outpatient group therapy visit		
	$10 copay	**No prior authorization is required**
Outpatient individual therapy visit		
	$20 copay	**No prior authorization is required**
Skilled Nursing Facility (SNF)		
	You pay the 2027 Original Medicare cost-sharing amounts. These are the 2026 cost-sharing amounts and may change for 2027. The plan will provide updated rates as soon as they are released. **$0 copay per day** for days **1-20** **$217 copay per day** for days **21-100**	May require authorization depending on the provider and their contract with our plan
Physical therapy		
	$0 copay	May require authorization depending on the provider and their contract with our plan

Benefit category	Your plan benefits	
Ambulance		
Ground ambulance	**$250 copay**	**No prior authorization is required, except** for non-emergency Medicare services
Air ambulance	**20% coinsurance**	**No prior authorization is required, except** for non-emergency Medicare services
Transportation		
Non-emergency	**$0 copay** for up to **24 one-way rides per year** to any health-related location **Additional benefit for eligible members (SSBCI)*:** *Some members may be eligible for transportation to any location with a qualifying chronic condition. You must use The Helper Bees network providers for transportation services to be covered. Your Care Ally can help you create your account, schedule a ride, or review your benefit. For all other inquiries, visit **AlignSeniorCare.TheHelperBeesPortal.com**, call The Helper Bees at 1-833-284-2434, or reach out to our Member Services team at 1-855-855-0336 for assistance. ***Important:** This additional benefit is part of the Special Supplemental Benefits for the Chronically Ill (SSBCI). Only members who qualify will receive this additional benefit. See page 18 for a list of qualifying chronic conditions.	**No prior authorization is required**

Benefit category	Your plan benefits	
Medicare Part B prescription drugs		
Chemotherapy/Radiation drugs	**0%-20% coinsurance** depending on the drug you receive	Yes, prior authorization is required **for some medications** For chemotherapy, prior authorization is required only for initial drug approval
Other Part B drugs	**0%-20% coinsurance** depending on the drug you receive 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum	Yes, prior authorization is required **for some medications**

Part D: Prescription Drug Information

Part D Payment Drug Stages	Premier Care (HMO-POS I-SNP)
Deductible stage	**$700** Deductible applies to **Tiers 3-5**. For all other drugs, coverage applies immediately.
Initial coverage stage	You stay in this stage until your total out-of-pocket costs reach **$2,400**. See cost-sharing chart below for details.
Catastrophic coverage	Once your out-of-pocket drug costs reach **$2,400,** you pay **$0** for covered Part D drugs.

Drug Cost-Sharing During the Initial Coverage Stage

Drug Coverage	Standard Retail (in-network) *Up to a 30-day supply*	Mail Order *Up to a 90-day supply*	Long-Term Care (LTC) *Up to a 31-day supply*
Tier 1 (Preferred Generic)	**$2 copay**	**$6 copay**	**$2 copay**
Tier 2 (Generic)	**$15 copay**	**$45 copay**	**$15 copay**
Tier 3 (Preferred Brand)	**25% coinsurance**	**25% coinsurance**	**25% coinsurance**
Tier 4 (Non-Preferred Drug)	**25% coinsurance**	**25% coinsurance**	**25% coinsurance**
Tier 5 (Specialty Tier)	**25% coinsurance**	**Not covered**	**25% coinsurance**

Vaccines: Most Part D vaccines are covered at **$0**, even before the deductible.

Insulin: You pay no more than **$35 per month** for covered insulin, regardless of tier or deductible.

Extra Benefits

Benefit category	Your plan benefits	
Diabetic monitoring supplies		
	$0 copay	**No prior authorization is required**
Dialysis services		
	20% coinsurance	**No prior authorization is required**
Durable Medical Equipment (DME)		
	20% coinsurance	Yes, prior authorization is required
Foot care		
Podiatry services (Medicare-covered)	**$0 copay**	**No prior authorization is required**
Routine foot care	**$0 copay** for up to **4 visits every year**	**No prior authorization is required**

Benefit category	Your plan benefits	
Groceries*		
	$25 allowance every month to spend on food and produce. All items must be purchased through The Helper Bees. Allowance is preloaded to your card for use at approved retail locations or to order items online. Your Care Ally can help you create your account, review your current balance, find which items are covered, or place an order. For all other inquiries, visit **AlignSeniorCare.TheHelperBeesPortal.com**, call The Helper Bees at 1-833-284-2434, or reach out to our Member Services team at 1-855-855-0336 for assistance. ***Important:** This additional benefit is part of the Special Supplemental Benefits for the Chronically Ill (SSBCI). Only members who qualify will receive this additional benefit. See page 18 for a list of qualifying chronic conditions.	**No prior authorization is required**

Benefit category	Your plan benefits	
Healthy Living Allowance		
	$150 allowance every 3 months. Unused funds roll over each period until the end of the year. The allowance covers the following benefit categories: • Electronic companion animal* • General supports for living (essential & adaptive clothing)* • Over-the-Counter (OTC) hearing aids • Over-the-Counter (OTC) items • Personal Emergency Response System (PERS) • Personal hygiene items* All items must be purchased through The Helper Bees. Allowance is preloaded to your card for use at approved retail locations or to order items online. Your Care Ally can help you create your account, review your current balance, find which items are covered, or place an order. For all other inquiries, visit **AlignSeniorCare.TheHelperBeesPortal.com**, call The Helper Bees at 1-833-284-2434, or reach out to our Member Services team at 1-855-855-0336 for assistance. ***Important:** This additional benefit is part of the Special Supplemental Benefits for the Chronically Ill (SSBCI). Only members who qualify will receive this additional benefit. See page 18 for a list of qualifying chronic conditions.	**No prior authorization is required**

Benefit category	Your plan benefits	
In-home support services (support with daily tasks)		
	$0 copay for up to **84 hours per year** 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. You must use The Helper Bees network of providers for in-home support services to be covered. Your Care Ally can help you create your account, request a service, review covered services, and confirm remaining hours. For all other inquiries, visit **AlignSeniorCare.TheHelperBeesPortal.com**, call The Helper Bees at 1-833-284-2434, or reach out to our Member Services team at 1-855-855-0336 for assistance.	**No prior authorization is required**
Therapy		
Occupational therapy	**$0 copay**	May require authorization depending on the provider and their contract with our plan
Speech therapy	**$0 copay**	May require authorization depending on the provider and their contract with our plan

Premier Care (HMO-POS I-SNP)

Michigan | H6832 | Plan 004

This document explains the health care and prescription drug services covered by **Premier Care (HMO-POS I-SNP) valid from January 1 through December 31, 2027**.

Premier Care (HMO-POS I-SNP) by Align Senior Care MI, LLC is a Medicare Advantage plan with a contract with Medicare. Enrollment depends on the plan's yearly contract renewal with Medicare.

This Summary of Benefits explains:

- What services this plan covers
- What you may pay for those services

It does not list every service, benefit, limit, exclusion, or rule. For full details, visit **AlignSeniorCare.com/Plan-Documents** or call Member Services to request a copy of the Evidence of Coverage, which explains all benefits and plan rules.

Need Help?

Call: 1-855-855-0336 (TTY 711)
Visit: AlignSeniorCare.com

Our Hours of Operation
October 1 – March 31: 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas)

April 1 – September 30: 8 a.m. to 8 p.m., Monday through Friday (except holidays)

This document is also available in large print and braille.

Who Can Join This Plan

To enroll in **Premier Care (HMO-POS I-SNP)**, you must:

- Have **Medicare Part A and Part B**
- Live in the plan's **service area** (i.e., you must reside in a county served by our plan)
- Be a United States citizen, national, or an eligible noncitizen
- Meet special eligibility requirements detailed below

What are the special eligibility requirements? This plan is for people who need a level of care usually provided in a senior living community. You may qualify if you:

- Live in or intend to live in one of our participating senior living communities for more than 90 days, or
- Live in a community setting and meet the institutional level of care

A list of participating senior living communities is available in the Provider Directory on **AlignSeniorCare.com/Search-Our-Network**, or you can call Member Services to request a copy.

Our Service Area

Michigan: We service Allegan, Bay, Genesee, Gratiot, Huron, Ingham, Jackson, Kalamazoo, Kent, Lake, Lapeer, Livingston, Macomb, Mason, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ottawa, Saginaw, Sanilac, Tuscola, Washtenaw, and Wayne counties.

Providers and Network

This plan has a network of doctors, hospitals, pharmacies, and other providers. You can find the full list of providers in our online directory at **AlignSeniorCare.com/Search-Our-Network**.

This plan is an HMO-POS (Health Maintenance Organization with a Point-of-Service benefit). Generally, you are required to use providers in the plan's network. If you use providers outside the plan's network, the plan may not pay for those services. Care received outside the network is usually covered only in emergencies. If you do not see your doctor in-network, please contact Member Services to determine if there can be an exception. This plan also includes a Point of Service (POS) benefit which means that you may use out-of-network providers for certain services.

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.

Understanding your Medicare or Medicaid Coverage

Medicare Information

To learn more about Original Medicare coverage and costs, review the **Medicare & You 2027 handbook**. You can find it online at **www.medicare.gov** or request a copy by calling **1-800-MEDICARE (1-800-633-4227)**, available 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Medicaid Coverage and Cost-Sharing

If you are enrolled in Medicaid or other assistance programs, you may receive help paying for your plan premium and some out-of-pocket costs. Depending on your eligibility, you may not have to pay certain premiums, copays, or coinsurance amounts shown in this Summary of Benefits. Enrolling into this plan will not impact your assistance.

Medicaid coverage and cost-sharing rules are set by the State and depend on your individual eligibility.

Special Supplemental Benefits for the Chronically Ill (SSBCI) benefits

Some extra benefits are available only to members with certain chronic conditions. These benefits are called Special Supplemental Benefits for the Chronically Ill (SSBCI).

Not all members qualify. To be eligible, a member must have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee, be determined by the plan and a healthcare provider to be at high risk for hospitalization or other adverse health outcomes, and require a high level of care coordination. Even if a member has a qualifying chronic condition, they may not receive these benefits. Coverage depends on the plan's specific eligibility criteria and clinical determination. Members may be required to complete an assessment with the plan's care team to confirm eligibility throughout the year.

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

Glossary

Coinsurance

The percentage of the plan-allowed amount you may have to pay for a covered service. This does not include the total cost of service. This usually applies after you pay your deductible.

- **Plan-allowed amount**: This is the amount the plan agrees to pay for a covered service. It is set by the plan, not the doctor or hospital.
- **Billed charges**: This is the amount the provider bills for the service. It can be higher than the plan-approved amount, but the plan does not use this amount to calculate what you pay.

Copayment (Copay)

A set dollar amount you pay for a covered service, such as a doctor visit or prescription.

Comprehensive Care

Care that covers a wide range of health needs. This extends beyond preventive care, and routine care to specialty care, and care for ongoing or complex health conditions.

Cost-sharing

The part of health care costs you may have to pay, such as copays, coinsurance, or deductibles. These amounts may be different if you have Medicaid.

Covered Services

Health care services that your plan includes and helps pay for, based on plan rules.

Deductible

The amount you pay for covered services before your plan starts to pay.

Dual Eligible

A person who qualifies for both Medicare and Medicaid. Coverage and costs may be different based on the level of Medicaid eligibility.

HMO (Health Maintenance Organization)

A type of health plan that usually requires you to use doctors and hospitals in the plan's network. You may need to choose a primary care provider and get referrals to see specialists. Care outside the network is usually covered only in emergencies.

Low-income Subsidy (LIS) / Extra Help

A federal program that helps people with limited income pay for Medicare prescription drug costs, such as premiums and copays.

Medicaid

A federal and state program that helps pay health care costs for people with limited income. Rules and benefits vary by state.

Medically Necessary

Care or supplies needed to diagnose or treat health conditions and that follow accepted medical standards.

Medicare

A federal health insurance program for people age 65 or older, and for some people under 65 with disabilities or certain medical conditions.

Medicare Advantage (Part C)

A Medicare health plan offered by a private insurance company that provides Medicare Part A and Part B benefits and usually includes prescription drug coverage.

Medicare Savings Programs (MSPs)

State programs that help pay Medicare premiums and, in some cases, other out-of-pocket costs for eligible individuals.

Network Provider

A doctor, hospital, or facility that works with the plan and agrees to set prices for services.

POS (Point of Service)

A plan feature that allows you to receive certain covered services from providers outside the plan's approved network. Using out-of-network providers may cost more and may require plan approval.

PPO (Preferred Provider Organization)

A type of health plan that allows you to see doctors and hospitals both in and out of the plan's network. Using network providers usually costs less. Referrals are not usually required.

Premium

The amount paid each month for health plan coverage. Some members may have premiums paid by Medicaid or other assistance programs, depending on eligibility.

Preventive Care

Health care that helps prevent illness or find health problems early. This may include checkups, screenings, vaccines, and wellness visits.

Primary Care Provider (PCP)

The doctor or health care provider you see for routine care and who helps manage your overall health care.

Prior Authorization

Written approval needed from the plan before certain services or medications are covered.

Routine Care

Health care provided on a regular or yearly basis to help maintain your health. This often includes yearly exams used to check your health when no illness or injury is present.

Specialist

A doctor who focuses on care for a specific condition or type of treatment.

SSBCI (Special Supplemental Benefits for the Chronically Ill)

Additional benefits that some Medicare Advantage plans may offer to certain members with chronic health conditions, when allowed by Medicare rules.

SSBCI benefits are not available to all members, require the member to meet specific eligibility criteria, and are offered at the plan's discretion. Not all plans offer SSBCI benefits.

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 Medicare & You 2027 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**.