LEON HEALTH

Summary of Benefits

MEDIMORE

2024

January 1st - December 31st

Leon Health is an HMO plan with a Medicare Contract. Enrollment in Leon Health, Inc. depends on contract renewal.

Leon Health Inc.'s pharmacy network offers limited access to pharmacies with preferred cost sharing in Miami-Dade, FL. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 1-844-969-5366 (TTY: 711) or consult the online pharmacy directory at www.LeonHealth.com.

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Leon MediMore (HMO) offered by Leon Health, Inc.

2024 Summary of Benefits

January 1, 2024 – December 31, 2024.

This is a summary of drug and health services covered by Leon Health, Inc. (HMO)

This booklet gives you a summary of what ***Leon MediMore*** **(HMO)** covers and what you pay. This Summary of Benefits does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, refer to the plan's Evidence of Coverage (EOC) online at www.LeonHealth.com, or call us to request a copy.

To join ***Leon MediMore*** **(HMO)**, the following must apply to you:

- You are entitled to Medicare Part A.
- You are enrolled in Medicare Part B
- You live in Miami-Dade County, Florida.

Leon MediMore **(HMO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. To find out which providers and pharmacies are part of the plan's network, consult the Provider and Pharmacy Directory. This directory is available on our website, or you can get a copy by calling us.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. For a complete list of covered drugs and any restrictions, visit our website or call us to request the Formulary (List of Covered Drugs).

Leon Health Inc.'s pharmacy network offers limited access to pharmacies with preferred cost sharing in Miami-Dade, FL. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 1-844-969-5366 (TTY: 711) or consult the online pharmacy directory at www.LeonHealth.com.

Leon Health, Inc. is a Medicare Advantage HMO plan with a Medicare Contract. Enrollment in the plan depends on contract renewal.

For coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille, large print, or audio.

For more information, please call us at 1-844-969-5366 (TTY: 711) or visit us at *www.LeonHealth.com.* Hours are Monday – Sunday 8 a.m. – 8 p.m. from October to March, and Monday – Friday 8 a.m. – 8 p.m. from April to September. This call is free.

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Premium, Deductible and Maximum-Out-of-Pocket	What You Should Know
Monthly Plan Premium	**$0** per month. You must keep paying your Medicare Part B premium* (unless your Part B premium is paid for you by Medicaid or another third party). *Leon Health, Inc. will cover $110 of your Part B premium. You will receive the premium refund amount back on your monthly Social Security check. This process usually takes 90 days to go into effect.
Medical Deductible	**$0** *Leon MediMore* does not have a medical deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	**$3,450** per year for covered services you receive from in-network providers. This amount is the most you pay for copayments, coinsurance, and other costs for covered Medicare Part A (hospital) and Part B (medical) services for the year. Once you reach this limit, we will pay the full cost of your covered services in our plan for the rest of the year. You will still need to pay your cost sharing for your Part D prescription drugs.

Benefits Information	What You Pay	What You Should Know
Inpatient Hospital Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services.	Day(s) 1 - 5: **$50** copay per day Days 6 - 90: **$0** copay	Referral and/or prior authorization is required.
Outpatient Hospital Services	**$50** copay **$0** copay for transfusions	
Outpatient Observation	**$120** copay per stay	
Ambulatory Surgical Center (ASC)	**$30** copay	
Doctor Visits		
Primary Care Physician (PCP)	**$0** copay	Includes Medicare-covered telehealth (virtual) doctor visits.
Specialist	**$0** copay	Referral and/or prior authorization is required. Includes Medicare-covered telehealth (virtual) doctor visits.

Benefits Information	What You Pay	What You Should Know
Preventive Care		
• Abdominal aortic aneurysm screening • Alcohol misuse screening • Annual wellness visit • Bone mass measurement (bone density) • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit • Cardiovascular disease testing • Cervical and vaginal cancer screening (pap test) • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma screening* • HIV screening • Immunizations (Flu shot, Pneumonia, Hepatitis B, COVID-19 Vaccines) • Medical Nutrition Therapy • Medicare Diabetes Prevention Program (MDPP) • Lung cancer screening (Low Dose Computed Tomography) • Obesity screening and therapy • Prostate cancer screening • Sexually Transmitted Infection (STI) screening & counseling • Smoking and tobacco cessation counseling • "Welcome to Medicare" preventive visit	**$0** copay	Any additional preventive services approved by Medicare during the benefit year will be covered. Please see our Evidence of Coverage (EOC) for frequency of covered services. * Referral and/or prior authorization is required for Glaucoma screening.

Benefits Information	What You Pay	What You Should Know
Emergency Care and Urgently Needed Services		
Emergency Care Services	**$120** copay	Copayment is waived if patient is admitted to hospital.
Worldwide Emergency/Urgent Coverage/Emergency Transportation	**$120** copay for Worldwide Emergency **$100** copay for Worldwide Urgent Care **$100** copay for Worldwide Emergency Ground Transportation **20%** coinsurance for Worldwide Emergency Air Transportation	Copayment is waived for Worldwide Emergency Coverage if patient is admitted to hospital.
Urgent Care Services	**$0** copay	
Diagnostic Services/Lab/Imaging (Costs for these services may vary based on place of service or type of service)		
Diagnostic Procedures and Tests	**$0** copay	Referral and/or prior authorization is required. Prior authorization is not required for COVID-19 related testing.
Lab Services	**$0** copay	
Therapeutic Radiological Services	**20%** coinsurance	
Outpatient X-Ray Services	**$0** copay	
Diagnostic Radiological Services (such as MRI, CT scans)	**$0** copay	
Hearing Services		
Medicare-covered Hearing Services - Exam to diagnose and treat hearing and balance issues.	**$0** copay	Referral is required.
Routine Hearing Exams (**1** every year)	**$0** copay	Referral is required.

Benefits Information	What You Pay	What You Should Know
Hearing Aid Evaluation/Fitting (**1** every **3** years)	**$0** copay	Referral is required.
Hearing Aids	**$0** copay	**$1,050** allowance per hearing aid per ear (**$2,100** maximum) every three **(3)** years. A referral is required.
Dental Services		
Medicare-covered Dental Services - Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth).	**$0** copay	Up to **$5,000** yearly allowance for combined preventive and comprehensive benefits. Member cost sharing is **zero** for services up to the maximum plan benefit coverage amount. After the maximum plan benefit amount is exhausted, the member is liable for any additional costs for preventive or comprehensive dental services. Referral and/or prior authorization is required. Authorization is required for non-emergency Medicare covered services. Unused amounts expire at the end of each benefit year. For a complete list of covered dental services and limitations, refer to the 2024 *Dental Schedule of Benefits.*
Preventive Dental Services: • Cleaning (**1** every **6** month) • Dental X-Ray(s) (**1** every **6** month) • Fluoride treatment (**1** every year) • Oral Exam (**1** every **6** month)	**$0** copay	
Comprehensive Dental Services: • Non-Routine Services • Diagnostic services • Restorative services (Fillings) • Endodontics • Periodontics (Gum and Bone treatment) • Prosthodontics (Dentures) • Dental Implants • Oral and Maxillofacial Surgery (Extractions)	**$0** copay	
Vision Services		
Eye Exam (Medicare-covered)	**$0** copay	Diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Diabetic Retinopathy Screening (once a year). Referral and/or prior authorization may be required.
Routine Eye Exam (**1** every year)	**$0** copay	Referral and/or prior authorization may be required.

Benefits Information	What You Pay	What You Should Know
Routine Eyewear • Eyeglasses (lenses and frames) • Contact lenses • Upgrades	**$0** copay	Up to two (**2**) pairs of eyeglasses each year, including upgrades, no limit per pair, for a maximum benefit amount of **$320**. or Up to four (**4**) boxes of soft contact lenses each year, not to exceed **$35** per box, for a maximum annual benefit of **$140**. One (**1**) pair of eyeglasses or contact lenses after each cataract surgery that includes the insertion of an intraocular lens. You are responsible for the cost above the maximum annual benefit amount. Unused amounts expire at the end of each benefit year. Vision services are only available for Leon Medical Centers' on-site optical center. Referral and/or prior authorization is required. Some restrictions apply.
Inpatient Mental Health Services	Day(s) 1 – 5: **$50** copay per day Days 6-90: **$0** copay Lifetime reserve days: **$0** copay	*Leon MediMore* covers **90** days for an inpatient mental health hospital stay. Our plan also covers **60** "lifetime reserve days". These are "extra" covered days. Our plan has a lifetime limit of **190** days for inpatient mental health care in a psychiatric hospital. Includes mental health specialty services: individual and group sessions. Referral and/or prior authorization is required.

Benefits Information	What You Pay	What You Should Know
Skilled Nursing Facility (SNF)	Day(s) 1 – 20: **$0** copay Days 21 – 100: **$20** copay per day	You are covered for up to **100** days in a Skilled Nursing Facility per benefit period. Referral and/or prior authorization is required.
Physical Therapy and Speech-Language Pathology Services	**$0** copay	Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Referral and/or prior authorization is required.
Ambulance		
Ground Service	**$100** copay	Prior authorization rules may apply for non-emergency services.
Air Service	**20%** coinsurance	
Transportation	**$0** copay	Transportation provided by Leon Health transportation services. Unlimited trips to in-network doctor appointments, medical facilities, and other approved locations. Transportation is only available to the closest geographically located center from the patient's home. Trips must be scheduled at least 48 hours in advance. Prior authorization is required for trips over 30 miles one-way.
Medicare Part B Drugs	**$0** copay for Hyaluronate Sodium Injection, Intravitreal Bevacizumab (Avastin) Injection, Enoxaparin Injection, and inhalation drugs via nebulizer. **20%** coinsurance for all other Part B drugs and Part B vaccines. **0% - 20%** coinsurance for chemotherapy/ radiation drugs. You won't pay more than **$35** for a one-month supply of each covered insulin product. **$0** copay for Flu shot, Pneumonia, Hepatitis B and COVID vaccines.	Prior authorization is required. Medicare Part B drugs may be subject to step therapy requirements. Step Therapy is a process that requires trying first another drug before the drug initially prescribed. Certain rebatable Part B drugs may be subject to a lower coinsurance. The specific drugs and potential savings change every quarter.

Benefits Information	What You Pay	What You Should Know
Cardiac and Pulmonary Rehabilitation Services	**$0** copay	Referral and/or prior authorization is required.
Dialysis (Kidney Disease Services)		
Outpatient/Inpatient Dialysis Treatments	**20%** coinsurance	Referral and/or prior authorization is required.
Self-dialysis Training	**$0** copay	
Kidney Disease Education	**$0** copay	
Outpatient Surgery	**$40** copay	Referral and/or prior authorization is required.
Fitness & Wellness Programs		
Fitness Program	**$0** copay	Leon Healthy Living Centers have strength and cardiovascular training equipment to help you reach your fitness goals. Leon Healthy Living Centers offer information on a number of health-related topics, as well as programs to aid in personal development. Enjoy health seminars on important issues that include: • Preventive Medicine • Diet and Nutrition • Diabetes • Fall prevention Benefit includes use of exercise equipment and access to group exercise classes where available.
Home Health Services	**$0** copay	Referral and/or prior authorization is required.
Hospice Care		
Medicare-certified Hospice Program	Your hospice services are paid for by Original Medicare, not our plan.	You may receive care from any Medicare certified hospice program.

Benefits Information	What You Pay	What You Should Know
Hospice Consultation Services	**$0** copay	Our plan covers hospice consultation services (one time only) before you select hospice.
Meals – Post Discharge	**$0** copay	You may be eligible to receive **14** home delivered nutritious meals (**2** meals per day for **7** days) following discharge from an Inpatient Hospitalization or Skilled Nursing Facility Admission only. You are eligible to receive this benefit up to three (**3**) times per year for a total annual maximum benefit of **42** meals. Calls to schedule benefits will be scheduled by the plan provider.
Medical Equipment & Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.)	**0% - 20%** coinsurance. Coinsurance amount varies per item.	Prior authorization is required.
Prosthetic Devices (braces, artificial limbs, etc.) and related Medical Supplies	**$0** copay	Prior authorization is required.
Diabetes Supplies & Services	**$0** copay	*Leon MediMore* is limiting Diabetic Supplies to those provided by True Metrix, Prodigy, iGlucose, Freestyle, and Glucocard only.
Over-the-Counter (OTC) Items	**$0** copay	**$50** allowance per quarter in approved, non-prescription, over-the-counter drugs and health related items available through Leon Medical Center's pharmacies only. Unused amounts expire at the end of each month. Orders are limited to one per month.

Benefits Information	What You Pay	What You Should Know
Opioid Use Treatment Services	**$0** copay	Covered services include: - FDA-approved opioid agonist and antagonist treatment medications - Dispensing and administration of such medications, if applicable. - Substance use counseling. - Individual and group therapy, and toxicology testing. Referral and/or prior authorization is required.
Podiatry Services **Foot care** (Medicare-covered)	**$0** copay	Prior authorization is required.
Routine Foot Care	**$0** copay	Prior authorization is required. Routine foot care benefit is unlimited.

Part D Prescription Drug Benefits

See the Summary of 2024 prescription drug coverage to understand your plan's specific coverage for each stage.

This plan uses a list of covered drugs, called "Formulary". Check this guide to find out if your drugs are covered and know of any restrictions.

Covered *insulin* products by our plan for preferred and standard retail pharmacy: You won't pay more than **$35** for a *30-day* supply of each insulin product covered by our plan, regardless of the cost-sharing tier.

Refer to the Formulary to find all Part D insulins covered by our plan.

Deductible	**$0** - This plan does not have a Part D deductible.
Initial Coverage Limit (ICL)	**$5,030** is the plan's Initial Coverage Limit (ICL) You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments).

Preferred Retail Cost-Sharing			
Tier	30 days	60 days	90 days
Tier 1 - Generic	$0	$0	$0
Tier 2 - Preferred Brand	$47	$94	$141
Tier 3 - Non-Preferred Brand	$97	N/A	N/A
Tier 4 - Specialty Tier	33%	N/A	N/A

Standard Retail Cost-Sharing			
Tier	30 days	60 days	90 days
Tier 1 - Generic	$10	$20	$30
Tier 2 - Preferred Brand	$47	$94	$141
Tier 3 - Non-Preferred Brand	$100	N/A	N/A
Tier 4 - Specialty Tier	33%	N/A	N/A

Coverage Gap Stage	You enter this stage after your total drug costs reach **$5,030**. During the Coverage Gap Stage, only *Tier 1* drugs will be covered as follows: **Tier 1:** *Preferred Retail Cost-Sharing:* - **$0** for 30 day-supply - **$0** for 60 day-supply - **$0** for 90 day-supply *Standard Retail Cost-Sharing:* - **$10** for 30 day-supply - **$20** for 60 day-supply - **$30** for 90 day-supply
Catastrophic Coverage Stage	During this payment stage, the plan pays the full cost for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit. You pay nothing.

This information is not a complete description of benefits. To get a complete list of services we cover including any limitations or exclusions, refer to the plan's Evidence of Coverage (EOC) online at www.LeonHealth.com, or call us to request a copy at 1-844-969-5366 (TTY: 711) 8 a.m. to 8 p.m. seven days a week from October 1 – March 31 8 a.m. to 8 p.m. Monday- Friday from April 1 - September 30.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-969-5366 (TTY: 711).

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 1-844-969-5366. 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 1-844-969-5366. 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 1-844-969-5366。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 1-844-969-5366。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 1-844-969-5366. 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 1-844-969-5366. 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 1-844-969-5366 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 1-844-969-5366. 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 1-844-969-5366 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 1-844-969-5366. 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 1-844-969-5366 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 1-844-969-5366 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 1-844-969-5366. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 1-844-969-5366. 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 1-844-969-5366. 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 1-844-969-5366. 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 1-844-969-5366 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。

LEON HEALTH