2023

January 1st - December 31st

# Summary of Benefits

## Leon MediMore

LEON HEALTH

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

H4286_SUMBEN0032023_M

# 2023 Summary of Benefits

## Leon MediMore

**Leon Health, Inc.**

**H4286, Plan 003**

This Summary of Benefits gives you a summary of what Leon Health, Inc. (HMO) covers and what you pay. It doesn't 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.

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

**January 1, 2023 - December 31, 2023.**

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

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join Leon Health, Inc. (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our Service area includes **Miami-Dade**.

Leon Health, Inc. (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.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. 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). 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 users should call 711) or visit us at www.leonhealth.com.

| Premiums and Benefits Information | Leon Health, Inc. HMO | What You Should Know |
|---|---|---|
| **Monthly Plan Premium** | **$0** monthly plan premium.<br>In addition, you must keep paying your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).<br>*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** | This plan does not have a medical deductible. | |
| **Maximum Out-of-Pocket Responsibility (does not include prescription drugs)** | Your maximum out-of-pocket limit in this plan is: **$3,450** for covered services you receive from in-network providers.<br>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.<br>You will still need to pay your monthly premiums and cost sharing for your Part D prescription drugs. | |
| **Inpatient Hospital**<br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. | Copayments are as follows:<br>Day 1-5:<br>You pay **$50**<br>Day 6 and 90:<br>You pay **$0** | Referral and/or prior authorization is required. |
| **Outpatient Hospital Services** | You pay **$50**<br>You pay **$0** for transfusions | |
| **Outpatient Observation** | You pay **$120** | |
| **Outpatient Surgery** | You pay **$40** | |
| **Ambulatory Surgical Center (ASC)** | You pay **$30** | |

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

| Premiums and Benefits Information | Leon Health, Inc. HMO | What You Should Know |
|---|---|---|
| **Emergency Care** | | |
| **Emergency Care Services** | You pay **$120** | Copayment for benefit is waived if patient is admitted to hospital. |
| **Worldwide Emergency/Urgent Coverage/Emergency Transportation** | You pay **$120** for Worldwide Emergency<br>**$100** Urgent Care<br>You pay **$100** for Worldwide Emergency Ground Transportation<br>You pay **20%** coinsurance for Worldwide Emergency Air Transportation | Coverage provided through direct member reimbursement after plan approval of supporting documentation up to the Medicare allowable rates.<br>Copayment for Worldwide Emergency benefit only is waived if patient is admitted to hospital. |
| **Urgently Needed Services** | | |
| Urgent Care Services | You pay **$0** | |
| **Diagnostic Services/Lab/Imaging**<br>(Costs for these services may vary based on place of service or type of service) | | |
| Diagnostic Procedures and Tests | You pay **$0** | Referral and/or prior authorization is required. |
| Lab Services<br>For COVID-19 testing a prior authorization is not required. | You pay **$0** | |
| Therapeutic Radiological Services | You pay **20%** coinsurance | |
| Outpatient X-Ray Services | You pay **$0** | |
| Diagnostic Radiological Services (such as MRIs, CT Scans) | You pay **$0** | |
| **Hearing Services** | | |
| Routine Hearing Exams (one every year) | You pay **$0** | Referral is required. |
| Hearing Aid Evaluation/Fitting (one every three years) | You pay **$0** | |

| Premiums and Benefits Information | Leon Health, Inc. HMO | What You Should Know |
|---|---|---|
| Hearing Aids | You pay **$0** | Referral is required.<br>The plan covers up to **$1,050** per hearing aid per ear (**$2,100** maximum benefit) every three years. |
| **Dental Services** | | |
| Medicare-covered Dental Services<br>Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth). | You pay **$0** | Authorization and Referral is required for non-emergency Medicare covered services.<br>Maximum yearly allowable is **$4,000** combined for preventive and comprehensive benefit. 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 routine or comprehensive dental services. Unused amounts do not rollover.<br>For a complete list of covered dental services and limitations, refer to the 2023 Dental Schedule of Benefits. |
| **Preventive Dental Services:**<br>• Cleaning (up to 1 every 6 month)<br>• Dental X-Ray(s) (up to 1 every 6 month)<br>• Fluoride treatment (1 every year)<br>• Oral Exam (up to 1 every 6 month) | You pay **$0** | |
| **Comprehensive Dental Services:**<br>• Non-Routine Services<br>• Diagnostic services<br>• Restorative services (Fillings)<br>• Endodontics (Root Canals)<br>• Periodontics (Gum and Bone treatment)<br>• Prosthodontics (Dentures)<br>• Dental Implants<br>• Oral and Maxillofacial Surgery (Extractions) | You pay **$0** | |
| **Vision Services** | | |
| Eye Exam (Medicare-covered) | You pay **$0** | Diagnosis and treatment of diseases and injuries of the eye, including treatment for age- related macular Degeneration.<br>Diabetic Retinopathy Screening (once a year).<br>Referral and/or prior authorization is required. |

| Premiums and Benefits Information | Leon Health, Inc. HMO | What You Should Know |
|---|---|---|
| Routine Eye Exam (1 every year) | You pay **$0** | Authorization and/or referral is required. |
| Routine Eyewear:<br>• Eyeglasses (lenses and frames)<br>• Contact Lenses<br>• Upgrades | You pay **$0** | Up to two (2) pairs of eyeglasses, each year selected eyeglasses must not exceed **$160** per pair of eyes- glasses including upgrades for a maximum benefit of **$320**<br>Or<br>Up to four (4) boxes of soft contact lenses each year not to exceed **$35/box** for a maximum annual benefit amount of **$140**<br>One pair of eyeglasses or contact lenses after each cataract surgery that includes the insertion of an intraocular lens.<br>Vision services are only available to Leon Medical Centers' on-site optical center.<br>Referral and/or prior authorization may be required |
| **Mental Health Services** | You pay **$0** | Our plan covers 90 days for an inpatient mental health hospital stay.<br>Our plan also covers 60 lifetime reserve days. The plan covers 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.<br>Includes mental health specialty services: individual and group sessions.<br>Referral and/or prior authorization is required. |
| **Skilled Nursing Facility** | You pay **$0** for days 1-20<br>You pay **$20** per day for days 21-100 | You are covered for up to 100 days in a Skilled Nursing Facility. Referral and/or prior-authorization is required. |

| Premiums and Benefits Information | Leon Health, Inc. HMO | What You Should Know |
|---|---|---|
| **Physical Therapy and Speech-Language Pathology Services** | You pay **$0** | Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).<br>Referral and/or prior authorization is required. |
| **Ambulance** | | |
| **Ground Service** | You pay **$100** | Prior authorization rules may apply for non-emergency services. |
| **Air Service** | You pay **20%** coinsurance | |
| **Transportation** | You pay **$0** | Transportation provided by Leon Health transportation services.<br>Unlimited trips to in-network doctor appointments, medical facilities, and other approved locations. Transportation only available to closest geographically located center from patient's home.<br>Trips must be scheduled at least 48 hours in advance.<br>Prior authorization is required for trips over 30 miles one-way. |
| **Medicare Part B Drugs** | You pay $0 for Hyaluronate Sodium Injection, Intravitreal Bevacizumab (Avastin) Injection, Enoxaparin Injection, and inhalation drugs via nebulizer.<br>20% for all other Part B drugs and Part B vaccines.<br>You pay **$0** for Flu shot, Pneumonia, Hepatitis B and Covid vaccines | Prior authorization may be required. |

| Premiums and Benefits Information | Leon Health, Inc. HMO | What You Should Know |
|---|---|---|
| **Cardiac and Pulmonary Rehabilitation Services** | You pay **$0** | 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 | You pay **$0** | |
| Kidney Disease Education | You pay **$0** | |
| **Fitness & Wellness Programs** | | |
| Fitness Program | You pay **$0** | 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.<br>Enjoy health seminars on important issues that include:<br>• Preventive Medicine<br>• Diet and Nutrition<br>• Diabetes<br>• Fall prevention<br>Benefit includes use of exercise equipment and access to group exercise classes where available. |
| **Home Health Services** | You pay **$0** | 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. |
| **Hospice Consultation Services** | You pay **$0** | |

| Premiums and Benefits Information | Leon Health, Inc. HMO | What You Should Know |
|---|---|---|
| **Meals** | You pay **$0** | After discharge from an acute inpatient hospital stay or skilled nursing facility, you may be eligible to receive 14 frozen nutritious meals (2 meals per day for 7 days) delivered to your home.<br>You are eligible to receive this benefit up to three (3) times per year for a total annual maximum benefit of 42 meals.<br>Calls to schedule benefits will be scheduled by plan provider. |
| **Medical Equipment & Supplies** | | |
| **Durable Medical Equipment (wheelchairs, oxygen, etc.)** | You pay **0-20%** coinsurance.<br>Coinsurance amount varies per item. | Prior authorization is required. |
| **Prosthetic Devices (braces, artificial limbs, etc.) and related Medical Supplies** | You pay **$0** | Prior authorization is required. |
| **Diabetes Supplies & Services** | You pay **$0** | Leon MediMore is limiting Diabetic Supplies to Diabetic Supplies provided by True Metrix; Prodigy; IGlucose, and Freestyle only. |
| **Over the Counter (OTC) Items** | You pay **$0** | This plan covers certain approved, non-prescription, over-the-counter drugs and health related items, up to $25 per quarter.<br>Unused OTC amounts do not roll over from month to month.<br>Orders are limited to one per month. |

| Premiums and Benefits Information | Leon Health, Inc. HMO | What You Should Know |
|---|---|---|
| **Opioid Use Treatment Services** | You pay **$0** | Covered services include: FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable.<br>Substance use counseling.<br>Individual and group therapy, and Toxicology testing.<br>Referral and/or prior authorization is required. |
| **Routine Foot Care** | You pay **$0** | |
| **Podiatry Services Foot care (Medicare-covered)** | You pay **$0** | Prior authorization is required. |

## Part D Prescription Drugs

| | | | |
|---|---|---|---|
| **Deductible** | $0 | | |
| **Initial Coverage Period (ICL)** | You stay in this stage until your year-to-date "total drug costs". (Your payments plus any Part D plan's payments) total $4,660. | | |
| **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 Drugs | 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 Drugs | 33% | N/A | N/A |
| **Coverage Gap Stage** | During the Coverage Gap Stage, Only Tier 1 drugs will be covered as follows:<br><br>**Tier 1:**<br><br>Preferred Retail Cost-Sharing:<br>$0 for 30 day-supply<br>$0 for 60 day-supply<br>$0 for 90 day-supply<br><br>Standard Retail Cost-Sharing<br>$10 for 30 day-supply<br>$20 for 60 day-supply<br>$30 for 90 day-supply | | |
| **Catastrophic Coverage Stage** | After your yearly out-of-pocket drug costs have reached $7,400, the plan will pay most of the cost for your drugs. Your share of the cost of covered drugs will be the greater of: 5% of the cost of the drug — or — $0.00 copay for generic drugs (including brand drugs treated as generic) and $10.35 copay for all other drugs. | | |

This information is not a complete description of benefits. Call 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 for more information.

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


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