2027

MEDIMORE

Summary of Benefits

January 1st - December 31st



LEON HEALTH®

H4286_SUMBEN003_2027_M

2027 Summary of Benefits

Leon MediMore (HMO)

Leon Health, Inc. – H4286, Plan 003

January 1, 2027 – December 31, 2027

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

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 give us a call to request a copy.

Can I join this plan?

To join Leon MediMore (HMO), you must:

- Be entitled to Medicare Part A.
- Be enrolled in Medicare Part B.
- Live in Miami-Dade County, Florida.

Check if your PCP is part of our plan's network

Leon MediMore (HMO) has a network of doctors, hospitals, pharmacies, and other providers. Except in emergency situations, if you use the providers that are not in our network, we 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.

Check if your prescription drugs are covered

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).

How can I learn about Original Medicare?

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 (1-800-6334227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

For additional information and assistance…

Call Leon Health Member Services Department at 1-844-969-5366 (TTY: 711) or visit us online 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.

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

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Premium, Deductible and Maximum-Out-of-Pocket	What You Should Know
Monthly Plan Premium	**$0** You must keep paying your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
Part B Premium Refund	Leon Health. Inc. will cover **$202.90** 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 **Days 91+:** **$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	

Benefits Information	What You Pay	What You Should Know
Doctor Visits		
Primary Care Physician (PCP)	**$0** copay	Includes Medicare-covered telehealth (virtual) doctor visits.
Specialist	**$0** copay	Includes Medicare-covered telehealth (virtual) doctor visits. Referral and/or prior authorization is required.
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	**$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 is required for any service. *Prior authorization and referral are required for Glaucoma screening.

Benefits Information	What You Pay	What You Should Know
• Smoking and tobacco cessation counseling • "Welcome to Medicare" preventive visit		
Emergency Care and Urgently Needed Services		
Emergency Care Services	**$120** copay per visit	Copayment is waived if patient is admitted to hospital.
Worldwide Coverage	**Worldwide Emergency and Urgent Care:** **$100** copay per visit	- The copayment is waived if the patient is admitted to a hospital for a worldwide emergency. - The copayment for worldwide urgent care is not waived if the patient is admitted to a hospital. - Coverage provided through direct member reimbursement after plan approval of supporting documentation. The plan will reimburse Medicare allowable rates.
Urgent Care Services	**$0** copay	
Diagnostic Services / Lab / Imaging		
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%** of the cost	
Outpatient X-Ray Services	**$0** copay	
Diagnostic Radiological Services (such as MRI, CT scans)	**$0** copay	

Benefits Information	What You Pay	What You Should Know
Hearing Services		
Hearing Services (Medicare-covered) - Exam to diagnose and treat hearing and balance issues.	**$0** copay	Referral is required.
Routine Hearing Exams (**1** every year)	**$0** copay	
Hearing Aid Evaluation/Fitting (**1** every **3** years)	**$0** copay	
Hearing Aids	**$0** copay	Up to **$1,050** allowance per hearing aid per ear (**$2,100** maximum) every three (**3**) years. A referral is required.
Dental Services		
Dental Services (Medicare-covered) - Limited dental services (excludes services in connection with care, treatment, filling, removal, or replacement of teeth).	**$0** copay	Referral and/or prior authorization is required.

Benefits Information	What You Pay	What You Should Know
Preventive Dental Services: • Cleaning (**1** every **6** months) • Dental X-Ray(s) (**1** every **6** months) • Fluoride treatment (**1** every year) • Oral Exam (**1** every **6** months)	**$0** copay	Up to **$5,600** *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. Unused amounts expire at the end of each year. For a complete list of covered dental services and limitations, refer to the 2027 Dental Schedule of Benefits.
Comprehensive Dental Services: • Non-Routine Services • Diagnostic services • Restorative services (Fillings) • Endodontics • Periodontics (Gum and Bone treatment) • Prosthodontics (Dentures) • Dental Implants (**2** every year) • Oral and Maxillofacial Surgery (Extractions)		
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 is required.
Routine Eye Exam (**1** every year)	**$0** copay	Referral and/or prior authorization is 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 year. Vision services are only available for Leon Medical Centers' on-site optical center. Referral and/or prior authorization is required. Some restrictions apply.

Benefits Information	What You Pay	What You Should Know
Mental Health Services	**Day(s) 1-5:** **$50** copay per day **Days 6-90:** **$0** copay **Lifetime reserve days:** **$0** copay (up to 60 days per lifetime) **Beyond lifetime reserve day:** Member is responsible for all costs.	**Mental Health Services:** Leon MediMore covers up to 90 days of inpatient hospital care per benefit period. A benefit period begins when you are admitted to a hospital and ends after 60 consecutive days without inpatient hospital care. Benefit periods are not tied to the calendar year, and there is no limit to the number of benefit periods you can have. Our plan also covers 60 lifetime reserve days, which can be used only once during your lifetime. After these days are exhausted, you are responsible for inpatient hospital costs after day 90 of a benefit period. A 190-day lifetime limit applies to inpatient mental health care in a freestanding psychiatric hospital. This limit does not apply to mental health care received in a psychiatric unit of a general hospital. **Inpatient Psychiatric Hospital Services:** Leon MediMore covers up to 190 days of inpatient mental health care in a freestanding psychiatric hospital during your lifetime. If you receive inpatient mental health care in a psychiatric unit of a general hospital, those days do not count toward the 190-day lifetime limit. Referral and/or prior authorization is required.

Benefits Information	What You Pay	What You Should Know
Mental Health Care - Outpatient individual and group therapy sessions	**$0** copay	Referral and/or prior authorization is required.
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. A benefit period begins the day you enter a SNF and ends when you have not received Medicare-covered skilled care in a SNF for 60 days in a row. The benefit period is not tied to the calendar year. Referral and/or prior authorization is required.
Physical Therapy	**$0** copay	Referral and/or prior authorization is required.
Ambulance		
Ground Service	**$100** copay	Copayment is not waived for ground or air ambulance services, even if the patient is admitted to the hospital. Prior authorization rules may apply for non-emergency services.
Air Service	**20%** of the cost	
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.

Benefits Information	What You Pay	What You Should Know
Medicare Part B Drugs	**$0** copay for Hyaluronate Sodium Injection, Intravitreal Bevacizumab (Avastin) Injection, Enoxaparin Injection, and inhalation drugs via nebulizer. **0% - 20%** of the cost for all other Part B drugs and Part B vaccines. **0% - 20%** of the cost for chemotherapy/ radiation drugs. You pay no more than **$35** for a one-month (up to 30-day) supply of each covered insulin product. **$0** copay for Flu shot, Pneumonia, Hepatitis B and COVID vaccines.	Prior authorization may be 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. For certain rebatable Part B drugs, you might pay nothing (0% coinsurance), and never more than 20% of the cost. The drugs that qualify can change every 3 months.

Additional Benefits with your plan Leon MediMore (HMO)

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%** of the cost	Referral and/or prior authorization is required. Self-dialysis training does not require prior authorization.
Self-dialysis Training	**$0** copay	
Kidney Disease Education	**$0** copay	
Outpatient Surgery	**$40** copay	Referral and/or prior authorization is required.

Benefits Information	What You Pay	What You Should Know
Fitness and Wellness Program		
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 The benefit includes access to exercise equipment and group exercise classes, where available. Fitness services that require additional fees are not part of the fitness benefit and will not be reimbursed.
Home Health Services	**$0** copay	Referral and/or prior authorization is required.
Hospice Care		
Medicare-certified Hospice Program	Your hospice services are paid by Original Medicare, not by our plan.	You may receive care from any Medicare certified hospice program.
Hospice Consultation Services	**$0** copay	Our plan covers hospice consultation services (one time only) before you select hospice.

Benefits Information	What You Pay	What You Should Know
Meals – Post Discharge	**$0** copay	You may be eligible to receive **14** nutritious meals delivered to your home (**2** meals per day for **7** days) following discharge from an inpatient hospital stay or skilled nursing facility stay. This benefit is available up to **3** times per year, for a maximum of **42** meals annually. A participating provider will contact you to schedule the meal delivery. Observation stays and behavioral health stays are not eligible for this benefit.
Medical Equipment & Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.)	**0% of the cost** for durable medical equipment (DME) obtained from plan-approved vendors. **20% of the cost** applies to necessary and reasonable comfort DME items obtained from member-requested vendors that are not on the plan's approved list. Coinsurance amount varies per item.	Prior authorization is required. Leon Health has preferred vendors/manufactures for DME.
Prosthetic Devices (braces, artificial limbs, etc.) and related Medical Supplies	**$0** copay	Prior authorization is required.
Diabetes Supplies & Services	**$0** copay	Leon MediMore limits diabetic supplies to True Metrix, Prodigy, Smartmeter, FreeStyle, Glucocard, and Easy Touch exclusively.

Benefits Information	What You Pay	What You Should Know
Over-the-Counter (OTC) Items	**$0** copay	Leon MediMore offers a **$50 *monthly* allowance*** on approved, non-prescription, over-the-counter (OTC) items and health-related products available at Leon Medical Center (LMC) pharmacies or approved retail locations. If members choose to receive this benefit through LMC pharmacies, they must complete an OTC order form or contact Member Services each month to order eligible OTC items and health-related products. Eligible items are listed in the OTC catalog. Unused amounts expire at the end of each month. Orders are limited to one per month.
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 (Medicare-covered)	**$0** copay	Prior authorization is required.
Routine Foot Care	**$0** copay	Prior authorization is required. Unlimited routine foot care visits are allowed each year.

Benefits Information	What You Pay	What You Should Know
Routine Acupuncture	**$0** copay	Up to **six** (**6**) routine acupuncture visits per year for any health condition. Referral and/or prior authorization is required.

Part D Prescription Drug Benefits

✔ Refer to the Summary Chart of 2027 Prescription Drug Coverage below 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 such as quantity limitations, prior authorization or step therapy.

Deductible	This plan does not have a Part D deductible.		
Initial Coverage	During this stage, you pay your applicable copay or coinsurance for your covered drugs, and our plan pays the remaining share. You remain in this stage until your total yearly drug costs reach **$2,400.**		
Preferred Retail Cost-Sharing			
Tier	30 days	60 days	90 days
Tier 1 – Generics	$0	$0	$0
Tier 2 – Preferred Brands	$30	$60	$90
Tier 3 – Non-Preferred Drugs	$40	N/A	N/A
Tier 4 – Specialty Tier	33%	N/A	N/A
Tier 5 – Supplemental Drugs	$0	N/A	N/A
Standard Retail Cost-Sharing			
Tier	30 days	60 days	90 days
Tier 1 – Generics	$10	$20	$35
Tier 2 – Preferred Brands	$40	$80	$120
Tier 3 – Non-Preferred Drugs	$50	N/A	N/A
Tier 4 – Specialty Tier	33%	N/A	N/A
Tier 5 – Supplemental Drugs	$10	N/A	N/A

Catastrophic Coverage	If you reach the Catastrophic Coverage Stage, you pay **$0** for your covered Part D drugs. You may have cost-sharing for excluded drugs covered under our enhanced benefit. Generally, you remain in this stage for the rest of the calendar year.

Additional Part D Benefit Information

Insulin Coverage: covered insulin products by our plan for preferred and standard retail pharmacy: You pay no more than **$35** for a one-month (up to 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.

Excluded Drug Coverage: these are medications used to treat anorexia, weight loss, or weight gain; fertility treatments; drugs for cosmetic purposes or hair growth; and medications for erectile dysfunction. Additional drugs may also be excluded from Part D coverage.

Part D Vaccines: our plan covers most adult Part D vaccines at no cost to you. Refer to the Formulary or contact Member Services for coverage and cost-sharing details about specific vaccines.

Medicare Prescription Payment Plan: it is a new payment option that works with your drug coverage to help you manage your out-of-pocket costs for covered Part D drugs by spreading them across monthly payments throughout the calendar year. Participation is voluntary, there is no cost to participate, and it does not reduce your total drug costs. To learn more about this payment option, call us at 1-844-969-5366 (TTY users call 711) or visit www.Medicare.gov.

Disclaimers

Leon Health, Inc. is an HMO 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 Provider and Pharmacy Directory at www.leonhealth.com/directory/.

Benefits vary by plan benefit packages.

This information is not a complete description of benefits. Call Member Services at 1-844-9695366, TTY users call 711 for more information.

Leon Health, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-969-5366 (TTY: 711) or speak to your provider.



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