2025 Summary of Benefits

PruittHealth Premier Advantage (HMO I-SNP)

H3291, Plan 003

This is a summary of drug and health services covered by PruittHealth Premier Advantage (HMO I-SNP) from January 1 – December 31, 2025.

PruittHealth Premier Advantage (HMO I-SNP) is a Medicare Advantage HMO 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 1-855-855-0668, 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 PruittHealthPremier.com, or call Member Services and request the *Evidence of Coverage*.

To reach our Member Services Representatives:

- Toll-free number: 1-855-855-0668, 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 PruittHealth Premier Advantage (HMO 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 PruittHealthPremier.com or call Member Services and ask us to send you a list.

Our service area includes these counties in Georgia: Baldwin, Bartow, Ben Hill, Berrien, Bibb, Bryan, Butts, Carroll, Catoosa, Chatham, Chattooga, Cherokee, Clarke, Clinch, Cobb, Colquitt, Columbia, Dawson, De Kalb, Dooly, Dougherty, Echols, Elbert, Emanuel, Fannin, Floyd, Forsyth, Fulton, Glascock, Gwinnett, Habersham, Hall, Hancock, Haralson, Heard, Henry, Houston, Irwin, Jefferson, Jenkins, Lincoln, Long, Lowndes, Lumpkin, Mc Intosh, Meriwether, Monroe, Newton, Pickens, Pike, Polk, Pulaski, Richmond, Schley, Screven, Spalding, Stephens, Taliaferro, Toombs, Turner, Twiggs, Walker, Warren, Washington, Webster, Wilkes, Wilkinson, and Worth.

PruittHealth Premier Advantage (HMO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at PruittHealthPremier.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 2025* 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.

Medical Benefits

Benefit category	Your plan benefits
Monthly plan premium *(includes both medical and drug coverage)*	$7.00 You must continue to pay your Medicare Part B premium.
Deductible	The Part A deductible is $0. You pay the 2025 Original Medicare cost-sharing amounts. The Part B deductible is $257.
Maximum out-of-pocket amount *(does not include Part D prescription drugs)*	$5,900 for in-network services
Inpatient hospital coverage	$311 copayment per day for days 1-7 $0 copayment per day for days 8-90 Original Medicare benefit period applies. *Prior authorization is required.*
Outpatient hospital coverage	
Outpatient hospital services	$40-$298 copayment $298 copayment for OP Hospital surgery $40 copayment for all other services *Prior authorization is required.*
Outpatient hospital observation services	$100 copayment *Prior authorization is required.*
Ambulatory Surgical Center (ASC) services	$298 copayment *Prior authorization is required.*
Doctor visits	
Primary care providers	$0 copayment
Specialists	$15 copayment

Benefit category	Your plan benefits
Preventive care (e.g., flu vaccine, diabetic screenings)	$0 copayment
Emergency care	$90 copayment You do not pay this amount if you are admitted to the hospital within 3 days.
Urgently needed services	$45 copayment per visit You do not pay this amount if you are admitted to the hospital within 3 days.
Diagnostic services/labs/imaging	
Diagnostic tests and procedures	$95 copayment *Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.*
Diagnostic radiology services (e.g., MRI, CAT scan)	$225 copayment *Prior authorization is required except for ultrasounds.*
Lab services	$0 copayment *Prior authorization is required only for genetic testing.*
Outpatient x-rays	$15 copayment
Therapeutic radiology	20% coinsurance *Prior authorization is required.*

Benefit category	Your plan benefits
Hearing services (Medicare-covered)	
Medicare-covered services	20% coinsurance
Hearing services (Supplemental)	
Routine hearing exam	$0 copayment Limit 1 visit every year
Fitting/evaluation(s) for hearing aids	$0 copayment
Hearing aids	$2,500 every 2 years for both ears combined Benefit is administered by NationsBenefits.
Dental services (Medicare-covered)	
Medicare-covered services	$0 copayment *Prior authorization is required.*
Dental services (Supplemental)	
Preventive and comprehensive services	$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 *Evidence of Coverage* for Dental x-rays limitations. Maximum: $2,500 every year for preventive services and comprehensive services All services must be provided by **Liberty Dental**. To locate a network provider, you may call Member Services, or search the Liberty Dental provider directory online at libertydentalplan.com/pruitthealthpremier.

Benefit category	Your plan benefits
Vision services (Medicare-covered)	
Exam to diagnose and treat diseases and conditions of the eye	$10 copayment
For people with diabetes, screening for diabetic retinopathy is covered once per year	$10 copayment
Eyewear after cataract surgery	$0 copayment
Glaucoma screening	$0 copayment
Vision services (Supplemental)	
Routine eye exam	$0 copayment Limit 1 visit every year
Additional routine eyewear	$500 every year for lenses, frames, contacts or eyewear upgrades
Mental health services	
Inpatient visit	$311 copayment per day for days 1-7 $0 copayment per day for days 8-90 Original Medicare benefit period applies. *Prior authorization is required.*
Outpatient group therapy visit	$10 copayment
Outpatient individual therapy visit	$10 copayment
Skilled Nursing Facility (SNF)	$0 per stay Per admission or per stay benefit period applies. *Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.*

Benefit category	Your plan benefits
Physical therapy	$15 copayment *Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.*
Ambulance Ground ambulance Air ambulance	 $285 copayment 20% coinsurance
Transportation *(non-emergency)* • Plan approved health-related location	$0 copayment Limit 48 one-way rides every year
Medicare Part B prescription drugs Chemotherapy/Radiation drugs Other Part B drugs	 0%-20% coinsurance Cost-sharing is dependent on the drug administered. *Prior authorization is required for some medications. For chemotherapy, prior authorization is required for the initial drug approval only.* 0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum *Prior authorization is required.*

Outpatient Prescription Drugs

Prescription drug payment stages	Your plan benefits		
Prescription drug deductible	$0 This plan does not have a prescription drug deductible. Your coverage starts in the Initial Coverage stage.		
Initial coverage	You stay in the Initial Coverage stage until your total out-of-pocket costs reach $2,000. 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)
Tier 1 (Preferred Generic)	$0 copayment	$0 copayment	$0 copayment
Tier 2 (Generic)	$7 copayment	$21 copayment	$7 copayment
Tier 3 (Preferred Brand)	$45 copayment	$135 copayment	$45 copayment
Tier 4 (Non-Preferred Brand)	$95 copayment	$285 copayment	$95 copayment
Tier 5 (Specialty Tier)	33% coinsurance	Not covered	33% coinsurance
Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,000, 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
Diabetic monitoring supplies	$0 copayment
Dialysis services	20% coinsurance
Durable Medical Equipment (DME)	20% coinsurance *Prior authorization is required.*
Healthy Living Flex Card • Fitness • Groceries* • Over-The-Counter (OTC) benefit	$200 every 3 months to spend towards OTC Products, Fitness, and Groceries *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
In-home support services (Support With Daily Tasks)	$0 copayment Limited to 30 hours annually
Occupational therapy	$15 copayment *Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.*
Podiatry services (Foot care)	
Medicare-covered services	$10 copayment
Routine foot care	$0 copayment Limit 6 visits every year
Speech therapy	$15 copayment *Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.*

*The benefits mentioned are part of a special supplemental program for the chronically ill. Not all members qualify. 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 Intellectual Disabilities
- Chronic Malnutrition Including Failure To Thrive
- Chronic alcohol and other drug dependence
- Chronic and disabling mental health conditions
- Chronic heart failure
- Chronic lung disorders
- Dementia
- Diabetes
- End-stage liver disease
- End-stage renal disease (ESRD)
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Neurologic disorders
- Osteoarthritis
- Severe hematologic disorders
- Stroke