



## 2025 Summary of Benefits

PruittHealth Premier (HMO I-SNP)

H6345, Plan 002

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

PruittHealth Premier (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 1-855-855-0759, 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](https://www.PruittHealthPremier.com), or call Member Services and request the *Evidence of Coverage*.

### **To reach our Member Services Representatives:**

- Toll-free number: 1-855-855-0759, 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 (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](http://PruittHealthPremier.com) or call Member Services and ask us to send you a list.

Our service area includes these counties in South Carolina: Abbeville, Aiken, Bamberg, Barnwell, Berkeley, Colleton, Dillon, Fairfield, Hampton, Horry, Marion, Mc Cormick, Orangeburg, Pickens, Richland, Saluda, and York.

PruittHealth Premier (HMO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at [PruittHealthPremier.com](http://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](http://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
<b>Monthly plan premium</b> <i>(includes both medical and drug coverage)</i>	\$46.60 You must continue to pay your Medicare Part B premium.
<b>Deductible</b>	You pay the 2025 Original Medicare cost-sharing amounts. The Part A deductible is \$1,676. The Part B deductible is \$257.
<b>Maximum out-of-pocket amount</b> <i>(does not include Part D prescription drugs)</i>	\$9,350 for in-network services
<b>Inpatient hospital coverage</b>	You pay the 2025 Original Medicare cost-sharing amounts.  You pay a \$1,676 deductible for each Medicare-covered stay \$0 copayment per day for days 1-60 \$419 copayment per day for days 61-90 \$838 copayment per day for each lifetime reserve day (up to 60 days over your lifetime)  <i>Prior authorization is required.</i>
<b>Outpatient hospital coverage</b>  Outpatient hospital services   Outpatient hospital observation services	20% coinsurance  <i>Prior authorization is required.</i>  \$100 copayment  <i>Prior authorization is required.</i>
<b>Ambulatory Surgical Center (ASC) services</b>	20% coinsurance  <i>Prior authorization is required.</i>

Benefit category	Your plan benefits
<b>Doctor visits</b> Primary care providers  Specialists	\$0 copayment  \$35 copayment
<b>Preventive care (e.g., flu vaccine, diabetic screenings)</b>	\$0 copayment
<b>Emergency care</b>	\$90 copayment You do not pay this amount if you are admitted to the hospital within 3 days.
<b>Urgently needed services</b>	20% coinsurance (not to exceed \$45 per visit) You do not pay this amount if you are admitted to the hospital within 3 days.
<b>Diagnostic services/labs/imaging</b>  Diagnostic tests and procedures  Diagnostic radiology services (e.g., MRI, CAT scan)  Lab services  Outpatient x-rays  Therapeutic radiology	20% coinsurance  <i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i>  20% coinsurance  <i>Prior authorization is required except for ultrasounds.</i>  \$0 copayment  <i>Prior authorization is required only for genetic testing.</i>  20% coinsurance  20% coinsurance  <i>Prior authorization is required.</i>

Benefit category	Your plan benefits
<p><b>Hearing services (Medicare-covered)</b></p> <p>Medicare-covered services</p> <p><b>Hearing services (Supplemental)</b></p> <p>Routine hearing exam</p> <p>Fitting/evaluation(s) for hearing aids</p> <p>Hearing aids</p>	<p>20% coinsurance</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$0 copayment</p> <p>\$4,000 every 2 years for both ears combined</p>
<p><b>Dental services (Medicare-covered)</b></p> <p>Medicare-covered services</p> <p><b>Dental services (Supplemental)</b></p> <p>Preventive and comprehensive services</p>	<p>20% coinsurance <i>Prior authorization is required.</i></p> <p><u>Not</u> covered</p>
<p><b>Vision services (Medicare-covered)</b></p> <p>Exam to diagnose and treat diseases and conditions of the eye</p> <p>For people with diabetes, screening for diabetic retinopathy is covered once per year</p> <p>Eyewear after cataract surgery</p> <p>Glaucoma screening</p> <p><b>Vision services (Supplemental)</b></p> <p>Routine eye exam</p> <p>Additional routine eyewear</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>\$0 copayment</p> <p>\$0 copayment</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$300 every year for lenses, frames, contacts or eyewear upgrades</p>

Benefit category	Your plan benefits
<p><b>Mental health services</b></p> <p>Inpatient visit</p> <p>Outpatient group therapy visit</p> <p>Outpatient individual therapy visit</p>	<p>You pay the 2025 Original Medicare cost-sharing amounts.</p> <p>You pay a \$1,676 deductible for each Medicare-covered stay</p> <p>\$0 copayment per day for days 1-60</p> <p>\$419 copayment per day for days 61-90</p> <p>\$838 copayment per day for each lifetime reserve day (up to 60 days over your lifetime)</p> <p><i>Prior authorization is required.</i></p> <p>20% coinsurance</p> <p>20% coinsurance</p>
<p><b>Skilled Nursing Facility (SNF)</b></p>	<p>\$0 per stay</p> <p>Per admission or per stay benefit period applies.</p> <p><i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i></p>
<p><b>Physical therapy</b></p>	<p>5% coinsurance</p> <p><i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i></p>
<p><b>Ambulance</b></p> <p>Ground ambulance</p> <p>Air ambulance</p>	<p>20% coinsurance</p> <p>20% coinsurance</p>
<p><b>Transportation</b> (<i>non-emergency</i>)</p> <ul style="list-style-type: none"> <li>Plan approved health-related location</li> </ul>	<p>\$0 copayment</p> <p>Limit 24 one-way rides every year</p>

Benefit category	Your plan benefits
<b>Medicare Part B prescription drugs</b>	
Chemotherapy/Radiation drugs	0%-20% coinsurance Cost-sharing is dependent on the drug administered.  <i>Prior authorization is required for some medications. For chemotherapy, prior authorization is required for the initial drug approval only.</i>
Other Part B drugs	0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum  <i>Prior authorization is required.</i>

### Outpatient Prescription Drugs

Prescription drug payment stages	Your plan benefits		
<b>Prescription drug deductible</b>	\$590 Deductible applies.		
<b>Initial coverage</b>	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.		
<b>Drug coverage</b>	<b>Standard retail cost sharing</b> (in-network) (up to a 30-day supply)	<b>Mail-order cost sharing</b> (up to a 90-day supply)	<b>Long-term care (LTC) cost sharing</b> (up to a 31-day supply)
<b>Drug coverage</b>	25% coinsurance	Not covered	25% coinsurance
<b>Catastrophic coverage</b>	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
<b>Diabetic monitoring supplies</b>	20% coinsurance
<b>Dialysis services</b>	20% coinsurance
<b>Durable Medical Equipment (DME)</b>	20% coinsurance <i>Prior authorization is required.</i>
<b>Occupational therapy</b>	5% coinsurance  <i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i>
<b>Over-The-Counter (OTC) benefit</b>	\$105 every month (no benefit rollover) \$50 per month for OTC medications filled through PruittHealth Pharmacy; \$55 per month for OTC supplies filled through PruittHealth Med Supply; OTC benefit list of approved items provided by the Plan
<b>Podiatry services (Foot care)</b>  Medicare-covered services  Routine foot care	20% coinsurance  \$0 copayment Limit 6 visits every year
<b>Speech therapy</b>	5% coinsurance  <i>Prior authorization is required except for services rendered in PruittHealth Skilled Nursing Facility locations.</i>