SUMMARY OF BENEFITS

January 1st - December 31st

MEDIEXTRA

2025

LEON HEALTH

H4286_SUMBEN001_2025_M

2025 Summary of Benefits
Leon MediExtra (HMO)
Leon Health, Inc. – H4286, Plan 001

January 1, 2025 – December 31, 2025.

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 MediExtra (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 MediExtra (HMO)***, the following must apply to you:

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

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

Leon MediExtra (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 (1-800-633-4227), 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** 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).
Medical Deductible	**$0** *Leon MediExtra* does not have a medical deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	**$1,000** 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.	**$0** copay	Referral and/or prior authorization is required.
Outpatient Hospital Services	**$0** copay	
Outpatient Observation	**$0** copay	
Ambulatory Surgical Center (ASC)	**$0** copay	
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.

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 is required. *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	**$50** copay per visit	Copayment is waived if patient is admitted to hospital.
Worldwide Emergency/ Urgent Coverage/ Emergency Transportation	**Worldwide Emergency and Urgent Care:** **$50** copay per visit **Worldwide Emergency Air and Ground Transportation:** **$50** copay	Copayment is waived if patient is admitted to 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	**$0** copay	
Outpatient X-Ray Services	**$0** copay	
Diagnostic Radiological Services (such as MRI, CT scans)	**$0** copay	
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.

Benefits Information	What You Pay	What You Should Know
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.
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 **$7,250** 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 2025 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)	**$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 is required.

Benefits Information	What You Pay	What You Should Know
Routine Eye Exam (**1** every year)	**$0** copay	Referral and/or prior authorization is required.
Routine Eyewear: • Eyeglasses (lenses and frames) • Contact lenses • Upgrades	**$0** copay	Up to three (**3**) pairs of eyeglasses each year, including upgrades, no limit per pair, for a maximum benefit amount of **$500**. *or* Up to six (**6**) boxes of soft contact lenses each year, not to exceed **$35** per box, for a maximum annual benefit of **$210**. 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	**$0** copay	**Mental Health Services:** *Leon MediExtra* covers up to **90** days each benefit period for an inpatient mental health hospital care. A benefit period begins the day you enter a hospital and ends when you have not received inpatient hospital for 60 days in a row. The benefit period is not tied to the calendar year. Our plan also covers **60** "lifetime reserve days". These are "extra" covered days that can be used only once. Once you exhaust these additional 60 days, your coverage for inpatient hospital stays will be restricted to 90 days. **Inpatient Psychiatric Hospital Services:** *Leon MediExtra* has a lifetime limit of **190** days for inpatient mental health care in a psychiatric hospital. If you get inpatient mental health care in a psychiatric unit of a general hospital, it does not count toward your 190 days. Referral and/or prior authorization is required.
Mental Health Care - Outpatient individual and group therapy sessions	**$0** copay	Referral and/or prior authorization is required.

Benefits Information	What You Pay	What You Should Know
Skilled Nursing Facility (SNF)	**$0** copay	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	**$0** copay	Prior authorization rules may apply for non-emergency services.
Air Service	**$0** copay	
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. **20%** coinsurance for all other Part B drugs and Part B vaccines. **0% - 20%** coinsurance 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. Certain rebatable Part B drugs may be subject to a lower coinsurance. The specific drugs and potential savings change every quarter.

Additional Benefits with your plan *Leon MediExtra (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	**$0** copay	
Kidney Disease Education	**$0** copay	
Outpatient Surgery	**$0** copay	Referral and/or prior authorization is required.

Benefits Information	What You Pay	What You Should Know
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.
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.
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.

Benefits Information	What You Pay	What You Should Know
Medical Equipment & Supplies		
Durable Medical Equipment (wheelchairs, oxygen, etc.)	**$0** copay	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 MediExtra* limits diabetic supplies to True Metrix, Prodigy, iGlucose, Freestyle, and Glucocard exclusively.
Over-the-Counter (OTC) Items	**$0** copay	**$70** *monthly* allowance on approved, non-prescription, over-the-counter (OTC) items and health-related products available exclusively through Leon Medical Center's pharmacies. The eligible items are listed in the OTC catalog. Members are required to complete an OTC order form or call Member Services each month to receive their choice of eligible OTC items and health-related products. 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.

Benefits Information	What You Pay	What You Should Know
Podiatry Services (Medicare-covered)	**$0** copay	Prior authorization is required.
Routine Foot Care	**$0** copay	Prior authorization is required. Routine foot care visits are unlimited per year.
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 2025 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	**$0 –** This plan does not have a Part D deductible.		
Initial Coverage	**$2,000** During this period, you pay the copayment or coinsurance listed below until your total yearly drug costs for covered drugs reach $2,000. Total yearly drug costs are the total drug cost paid by both you and the plan.		
Preferred Retail Cost-Sharing			
Tier	30 days	60 days	90 days
Tier 1 – Generic	$0	$0	$0
Tier 2 – Preferred Brand	$0	$0	$0
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 – Generic	$5	$10	$15
Tier 2 – Preferred Brand	$20	$40	$60
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	**$0 –** If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.		

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: drugs to treat anorexia, weight loss, or weight gain; fertility drugs; cosmetic or hair growth drugs, erectile dysfunction drugs. (other drugs may 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: the Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). To learn more about this payment option, please contact us at 1-844-969-5366 or visit 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 pharmacy directory at www.leonhealth.com.

Benefits vary by plan benefit packages.

This information is not a complete description of benefits. Call Member Services at 1-844-969-5366, 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.

ATENCIÓN: Si usted habla español, los servicios gratuitos de asistencia lingüística están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-844-969-5366 (TTY: 711) o hable con su proveedor.

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。

2025

LEON HEALTH