



2025 Summary of Benefits

ProCare Advantage - Kidney Care (HMO-POS C-SNP)

H3467, Plan 002

This is a summary of drug and health services covered by ProCare Advantage - Kidney Care (HMO-POS C-SNP) from January 1 – December 31, 2025.

ProCare Advantage - Kidney Care (HMO-POS C-SNP) is a Medicare Advantage HMO-POS 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 1-844-206-3719, 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 ProCareAdvantagePlan.com, or call Member Services and request the *Evidence of Coverage*.

To reach our Member Services Representatives:

- Toll-free number: 1-844-206-3719, 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 ProCare Advantage - Kidney Care (HMO-POS C-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 have certain medical conditions. To be eligible for our plan, you must have End-Stage Renal Disease Requiring Dialysis (Any Mode of Dialysis).

Our service area includes these counties in Texas: Collin, Dallas, Denton, and Tarrant.

ProCare Advantage - Kidney Care (HMO-POS C-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at ProCareAdvantagePlan.com. If you use providers that are not in our network, the plan may not pay for these services. Your plan includes a Point-of-Service (POS) benefit which means that you can use providers outside the plan's network for certain services. See table below for additional detail.

This document is available for free in Spanish. (Este documento está disponible de forma gratuita en español).

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 <i>(includes both medical and drug coverage)</i>	\$17.10 You must continue to pay your Medicare Part B premium.
Deductible	You pay the 2025 Original Medicare cost-sharing amounts. The Part A deductible is \$1,676. The Part B deductible is \$257.
Maximum out-of-pocket amount <i>(does not include Part D prescription drugs)</i>	\$9,350 combined for in- and out-of-network services
Inpatient hospital coverage	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>
Outpatient hospital coverage Outpatient hospital services Outpatient hospital observation services	20% coinsurance <i>Prior authorization is required.</i> 20% coinsurance <i>Prior authorization is required.</i>
Ambulatory Surgical Center (ASC) services	20% coinsurance <i>Prior authorization is required.</i>

Benefit category	Your plan benefits
<p>Doctor visits</p> <p>Primary care providers</p> <p>Specialists</p>	<p>\$0 copayment</p> <p>In-Network: 20% coinsurance <i>Prior authorization is required.</i></p> <p>Out-of-Network (POS): 20% coinsurance <i>Prior authorization is required.</i></p>
<p>Preventive care (e.g., flu vaccine, diabetic screenings)</p>	<p>\$0 copayment</p>
<p>Emergency care</p>	<p>\$90 copayment You do not pay this amount if you are admitted to the hospital within 3 days.</p>
<p>Urgently needed services</p>	<p>20% coinsurance (not to exceed \$45 per visit) You do not pay this amount if you are admitted to the hospital within 3 days.</p>

Benefit category	Your plan benefits
<p>Diagnostic services/labs/imaging</p> <p>Diagnostic tests and procedures</p> <p>Diagnostic radiology services (e.g., MRI, CAT scan)</p> <p>Lab services</p> <p>Outpatient x-rays</p> <p>Therapeutic radiology</p>	<p>\$0 copayment</p> <p><i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i></p> <p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>\$0 copayment</p> <p><i>Prior authorization is required only for genetic testing.</i></p> <p>20% coinsurance</p> <p><i>Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.</i></p> <p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p>
<p>Hearing services (Medicare-covered)</p> <p>Medicare-covered services</p>	<p>20% coinsurance</p>
<p>Dental services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Dental services (Supplemental)</p> <p>Preventive services</p>	<p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p> <p>\$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 <i>Evidence of Coverage</i> for Dental x-rays limitations.</p> <p>Maximum: \$1,000 every year for preventive services</p> <p>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/procareadvantage.</p>

Benefit category	Your plan benefits
<p>Vision services (Medicare-covered)</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>Vision services (Supplemental)</p> <p>Routine eye exam</p> <p>Additional routine eyewear</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>\$0 copayment</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$300 every year for lenses, frames or contacts</p>
<p>Mental health services</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><i>Prior authorization is required.</i></p> <p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p>

Benefit category	Your plan benefits
Skilled Nursing Facility (SNF)	<p>You pay the 2025 Original Medicare cost-sharing amounts.</p> <p>\$0 copayment per day for days 1-20 \$209.50 copayment per day for days 21-100</p> <p><i>Prior authorization may be required. Please contact the plan for additional details.</i></p>
Physical therapy	<p>In-Network: \$0 copayment</p> <p><i>Prior authorization may be required. Please contact the plan for additional details.</i></p> <p>Out-of-Network (POS): 20% coinsurance</p>
<p>Ambulance</p> <p>Ground ambulance</p> <p>Air ambulance</p>	<p>20% coinsurance</p> <p><i>Prior authorization is required for non-emergency Medicare services.</i></p> <p>20% coinsurance</p> <p><i>Prior authorization is required for non-emergency Medicare services.</i></p>
<p>Transportation <i>(non-emergency)</i></p> <ul style="list-style-type: none"> Plan approved health-related location 	<p>\$0 copayment Limit 100 one-way rides every year Each ride is limited to 20 miles</p>

Benefit category	Your plan benefits
Medicare Part B prescription drugs	
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 for some medications.</i>

Outpatient Prescription Drugs

Prescription drug payment stages	Your plan benefits		
Prescription drug deductible	\$590 Deductible applies.		
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.		
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)
Drug coverage	25% coinsurance	25% coinsurance	25% 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 <i>Prior authorization is required.</i>
Healthy Living Flex Card <ul style="list-style-type: none"> • Fitness • General supports for living* • Groceries* • Over-The-Counter (OTC) benefit 	\$155 every 3 months to spend towards OTC Products, Fitness, Groceries, and Utilities This benefit is administered by The Helper Bees. See your EOC for more details. *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
Occupational therapy	In-Network: 20% coinsurance <i>Prior authorization may be required. Please contact the plan for additional details.</i> Out-of-Network (POS): 20% coinsurance
Podiatry services (Foot care) Medicare-covered services Routine foot care	20% coinsurance \$0 copayment Limit 8 visits every year

Benefit category	Your plan benefits
Speech therapy	<p>In-Network: \$0 copayment</p> <p><i>Prior authorization may be required. Please contact the plan for additional details.</i></p> <p>Out-of-Network (POS): 20% coinsurance</p>

*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:

- End-stage renal disease (ESRD)