



2025 Summary of Benefits

AgeRight Advantage Health Plan (HMO I-SNP)

H1372, Plan 001

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

AgeRight Advantage Health Plan (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 1-844-854-6885, 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 AgeRightAdvantage.com, or call Member Services and request the *Evidence of Coverage*.

To reach our Member Services Representatives:

- Toll-free number: 1-844-854-6885, 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 AgeRight Advantage Health Plan (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 [AgeRightAdvantage.com](https://www.AgeRightAdvantage.com) or call Member Services and ask us to send you a list.

Our service area includes these counties in Oregon: Benton, Clackamas, Jackson, Josephine, Klamath, Lane, Linn, Marion, Multnomah, Washington, and Yamhill.

AgeRight Advantage Health Plan (HMO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at [AgeRightAdvantage.com](https://www.AgeRightAdvantage.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 <i>(includes both medical and drug coverage)</i>	\$26.20 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>	\$7,000 for in-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> \$100 copayment <i>Prior authorization is required.</i>
Ambulatory Surgical Center (ASC) services	20% coinsurance <i>Prior authorization is required.</i>

Benefit category	Your plan benefits
Doctor visits Primary care providers Specialists	\$0 copayment \$30 copayment
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	20% coinsurance (not to exceed \$45 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 Diagnostic radiology services (e.g., MRI, CAT scan) Lab services Outpatient x-rays Therapeutic radiology	20% coinsurance <i>Prior authorization is required.</i> 20% coinsurance <i>Prior authorization is required.</i> \$0 copayment <i>Prior authorization is required only for genetic testing.</i> 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.</i>

Benefit category	Your plan benefits
<p>Hearing services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Hearing services (Supplemental)</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>\$1,800 every 2 years for both ears combined</p> <p>Benefit is administered by NationsBenefits.</p>
<p>Dental services (Medicare-covered)</p> <p>Medicare-covered services</p> <p>Dental services (Supplemental)</p> <p>Preventive and comprehensive 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: \$700 every year for preventive services and comprehensive 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/agerightadvantage.</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>\$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>
<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>20% coinsurance</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 is required.</i></p>
Physical therapy	<p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p>
Ambulance Ground ambulance Air ambulance	<p>20% coinsurance <i>Prior authorization is required for non-emergency Medicare services.</i></p> <p>20% coinsurance <i>Prior authorization is required for non-emergency Medicare services.</i></p>
Transportation <i>(non-emergency)</i> <ul style="list-style-type: none"> • Plan approved health-related location 	<p>\$0 copayment Limit 32 one-way rides every year Each ride is limited to 20 miles</p> <p>Benefit is administered by NationsBenefits.</p>
Medicare Part B prescription drugs Chemotherapy/Radiation drugs Other Part B drugs	<p>0%-20% coinsurance Cost-sharing is dependent on the drug administered.</p> <p><i>Prior authorization is required for some medications. For chemotherapy, prior authorization is required for the initial drug approval only.</i></p> <p>0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum</p> <p><i>Prior authorization is required for some medications.</i></p>

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>
Occupational therapy	20% coinsurance <i>Prior authorization is required.</i>

Benefit category	Your plan benefits
<p>Podiatry services (Foot care)</p> <p>Medicare-covered services</p> <p>Routine foot care</p>	<p>20% coinsurance</p> <p>\$0 copayment Limit 6 visits every year</p>
<p>Speech therapy</p>	<p>20% coinsurance</p> <p><i>Prior authorization is required.</i></p>