



## 2025 Summary of Benefits

Align Kidney Care (HMO C-SNP)

H9917, Plan 003

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

Align Kidney Care (HMO C-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 1-844-788-8935, 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 [AlignSeniorCare.com](https://www.AlignSeniorCare.com), or call Member Services and request the *Evidence of Coverage*.

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

- Toll-free number: 1-844-788-8935, 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 Align Kidney Care (HMO 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 Florida: Alachua, Hillsborough, Lee, Orange, Pinellas, and Sumter.

Align Kidney Care (HMO C-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at [AlignSeniorCare.com](http://AlignSeniorCare.com). If you use providers that are not in our network, the plan may not pay for these services.

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](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>	\$20.30 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
<p><b>Doctor visits</b></p> <p>Primary care providers</p> <p>Specialists</p>	<p>\$0 copayment</p> <p>0%-20% coinsurance \$0 copayment for nephrologist 20% coinsurance for all other services</p>
<p><b>Preventive care (e.g., flu vaccine, diabetic screenings)</b></p>	<p>\$0 copayment</p>
<p><b>Emergency care</b></p>	<p>\$90 copayment You do not pay this amount if you are admitted to the hospital within 3 days.</p>
<p><b>Urgently needed services</b></p>	<p>\$25 copayment per visit You do not pay this amount if you are admitted to the hospital within 3 days.</p>
<p><b>Diagnostic services/labs/imaging</b></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>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>\$0 copayment</p> <p><i>Prior authorization is required only for genetic testing.</i></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>

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 2 years</p> <p>\$0 copayment Limit 1 visit every 2 years</p> <p>\$2,000 every 2 years for both ears combined</p> <p>Benefit is administered by NationsBenefits.</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</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: No maximum for preventive services and \$2,000 every year for comprehensive services</p> <p>All services must be provided by <b>Liberty Dental</b>. To locate a network provider, you may call Member Services, or search the Liberty Dental provider directory online at <a href="http://libertydentalplan.com/alignseniorcare">libertydentalplan.com/alignseniorcare</a>.</p>

Benefit category	Your plan benefits
<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>20% coinsurance</p> <p>\$0 copayment</p> <p>\$0 copayment Limit 1 visit every year</p> <p>\$150 every year for lenses, frames, contacts or eyewear upgrades</p>
<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>

Benefit category	Your plan benefits
<b>Skilled Nursing Facility (SNF)</b>	You pay the 2025 Original Medicare cost-sharing amounts.  \$0 copayment per day for days 1-20 \$209.50 copayment per day for days 21-100  <i>Prior authorization is required.</i>
<b>Physical therapy</b>	20% coinsurance  <i>Prior authorization is required.</i>
<b>Ambulance</b>  Ground ambulance   Air ambulance	20% coinsurance <i>Prior authorization is required for non-emergency Medicare services.</i>  20% coinsurance <i>Prior authorization is required for non-emergency Medicare services.</i>
<b>Transportation</b> <i>(non-emergency)</i> <ul style="list-style-type: none"> <li>• Any health-related location</li> <li>• Non-medical needs*</li> </ul>	\$0 copayment Limit 50 one-way rides every year Each ride is limited to 75 miles  *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
<b>Medicare Part B prescription drugs</b>  Chemotherapy/Radiation drugs   Other Part B 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>  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		
<b>Prescription drug deductible</b>	\$590 Deductible applies to Tiers 2-5. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.		
<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.		
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)
<b>Tier 1</b> (Preferred Generic)	\$2 copayment	\$6 copayment	\$2 copayment
<b>Tier 2</b> (Generic)	\$15 copayment	\$45 copayment	\$15 copayment
<b>Tier 3</b> (Preferred Brand)	\$45 copayment	\$135 copayment	\$45 copayment
<b>Tier 4</b> (Non-Preferred Brand)	\$95 copayment	\$285 copayment	\$95 copayment
<b>Tier 5</b> (Specialty Tier)	25% coinsurance	Not covered	25% coinsurance
<b>Tier 6</b> (Select Care Drugs)	\$0 copayment	\$0 copayment	\$0 copayment
<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>	\$0 copayment
<b>Dialysis services</b>	20% coinsurance
<b>Durable Medical Equipment (DME)</b>	20% coinsurance <i>Prior authorization is required.</i>
<b>Healthy Living Flex Card</b> <ul style="list-style-type: none"> <li>• General supports for living*</li> <li>• Groceries*</li> <li>• Over-The-Counter (OTC) benefit</li> </ul>	\$75 every month to spend towards OTC Products, Groceries, Utilities, and Rent/Mortgage. Funds rollover each period until the end of the year.  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.
<b>Meals</b>	\$0 copayment  The Plan provides up to 2 meals per day for 7 days following a discharge from an inpatient hospital or rehabilitation stay (this benefit is limited up to 4 weeks of meals annually).  The Plan also provides up to 2 meals per day for 30 days to members with a diagnosis of End-Stage Renal Disease (ESRD).
<b>Occupational therapy</b>	20% coinsurance <i>Prior authorization is required.</i>

Benefit category	Your plan benefits
<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>	20% coinsurance <i>Prior authorization is required.</i>

\*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 alcohol and other drug dependence
- Chronic and disabling mental health conditions
- Chronic heart failure
- Chronic lung disorders
- COPD
- Dementia
- Diabetes
- End-stage liver disease
- End-stage renal disease (ESRD)
- HIV/AIDS
- Hyperlipidemia
- Hypertension
- Neurologic disorders
- Osteoarthritis
- Osteoporosis
- Severe hematologic disorders
- Stroke