2025 Summary of Benefits

Perennial Advantage Strive (HMO I-SNP)

H3419, Plan 001

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

Perennial Advantage Strive (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 1-844-788-6959, 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 PerennialAdvantage.com, or call Member Services and request the *Evidence of Coverage*.

To reach our Member Services Representatives:

- Toll-free number: 1-844-788-6959, 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 Perennial Advantage Strive (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 PerennialAdvantage.com or call Member Services and ask us to send you a list.

Our service area includes these counties in Colorado: Adams, Arapahoe, Boulder, Broomfield, Denver, and Jefferson.

Perennial Advantage Strive (HMO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at PerennialAdvantage.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 *(includes both medical and drug coverage)*	$37.00 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 *(does not include Part D prescription drugs)*	$9,350 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) *Prior authorization is required.*
Outpatient hospital coverage	
Outpatient hospital services	0%-20% coinsurance 0% coinsurance for preventive services 20% coinsurance for all other services *Prior authorization is required.*
Outpatient hospital observation services	$100 copayment *Prior authorization is required.*
Ambulatory Surgical Center (ASC) services	20% coinsurance *Prior authorization is required.*

Benefit category	Your plan benefits
Doctor visits	
Primary care providers	$0 copayment
Specialists	0%-20% coinsurance
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 copayment; 20% coinsurance (not to exceed $45 per visit) $20 copayment per visit for in-community urgent care 20% coinsurance for all other places of service (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	20% coinsurance *Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.*
Diagnostic radiology services (e.g., MRI, CAT scan)	20% coinsurance *Prior authorization is required.*
Lab services	$0 copayment *Prior authorization is required only for genetic testing.*
Outpatient x-rays	$0 copayment *Prior authorization is required except for services rendered in a Nursing Facility or Physician Office.*
Therapeutic radiology	20% coinsurance *Prior authorization is required.*

Benefit category	Your plan benefits
Hearing services (Medicare-covered)	
Medicare-covered services	20% coinsurance
Hearing services (Supplemental)	
Routine hearing exam	$0 copayment Limit 1 visit every 2 years
Fitting/evaluation(s) for hearing aids	$0 copayment Limit 1 visit every 2 years
Hearing aids	$2,000 every 2 years for both ears combined Benefit is administered by NationsBenefits.
Dental services (Medicare-covered)	
Medicare-covered services	20% coinsurance *Prior authorization is required.*
Dental services (Supplemental)	
Preventive and comprehensive services	$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 *Evidence of Coverage* for Dental x-rays limitations. Maximum: $2,300 every year for preventive services and comprehensive services 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/perennialadvantage.

Benefit category	Your plan benefits
Vision services (Medicare-covered)	
Exam to diagnose and treat diseases and conditions of the eye	20% coinsurance
For people with diabetes, screening for diabetic retinopathy is covered once per year	20% coinsurance
Eyewear after cataract surgery	20% coinsurance
Glaucoma screening	$0 copayment
Vision services (Supplemental)	
Routine eye exam	$0 copayment Limit 1 visit every year
Additional routine eyewear	$180 every year for lenses, frames or eyewear upgrades
Mental health services	
Inpatient visit	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) *Prior authorization is required.*
Outpatient group therapy visit	20% coinsurance
Outpatient individual therapy visit	20% coinsurance

Benefit category	Your plan benefits
Skilled Nursing Facility (SNF)	$0 copayment per day for days 1-20 $100 copayment per day for days 21-100 Original Medicare benefit period applies. *Prior authorization may be required. Please contact the plan for additional details.*
Physical therapy	20% coinsurance *Prior authorization may be required. Please contact the plan for additional details.*
Ambulance	
Ground ambulance	20% coinsurance
Air ambulance	20% coinsurance *Prior authorization is required for non-emergency Medicare services.*
Transportation *(non-emergency)*	Not covered
Medicare Part B prescription drugs	
Chemotherapy/Radiation drugs	0%-20% coinsurance Cost-sharing is dependent on the drug administered. *Prior authorization is required.*
Other Part B drugs	0%-20% coinsurance 0% coinsurance is the minimum possible for a Part B rebatable drug 20% coinsurance is the maximum *Prior authorization is required.*

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% coinsurance
Dialysis services	20% coinsurance
Durable Medical Equipment (DME)	20% coinsurance *Prior authorization is required.*

Benefit category	Your plan benefits
In-home support services (Support With Daily Tasks)	$0 copayment Limited to 60 hours annually Members have access to an In-Home Support Services benefit that may include support with ADLs or IADLs including personal hygiene needs, light housekeeping, laundry tasks, meal preparation, feeding, bathing, and toileting.
Occupational therapy	20% coinsurance *Prior authorization may be required. Please contact the plan for additional details.*
Over-The-Counter (OTC) benefit	$225 every 3 months to spend towards OTC Products. Funds rollover each period until the end of the year. One wheelchair cushion is available to each member free of cost once per year.
Podiatry services (Foot care)	
Medicare-covered services	20% coinsurance
Routine foot care	$0 copayment Limit 8 visits every year
Speech therapy	20% coinsurance *Prior authorization may be required. Please contact the plan for additional details.*