Great Plains Medicare Advantage (HMO I-SNP)

Great Plains Medicare Advantage (HMO I-SNP) H7511-001

SUMMARY OF BENEFITS

January 1, 2026 - December 31, 2026

This is a summary of drug and health services covered by Great Plains Medicare Advantage (HMO I-SNP).

Great Plains Medicare Advantage (HMO I-SNP) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Medicare contract. Enrollment in the Plan depends on contract renewal.

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, please call Member Services and request the "Evidence of Coverage" or access it online at www.greatplainsmedicareadvantage.com.

To Reach a Member Services Representatives:

- Current members please call 1-877-492-5189 (TTY 711) for more information.
- Prospective members please call 1-877-701-0784 (TTY 711).
- For Medicare Part D drug coverage information, call 1-844-642-9090.
- Hours are 7 days a week, 8 a.m. to 8 p.m., Oct. 1-March 31; and Monday through Friday, 8 a.m. to 8 p.m., April 1-Sept. 30. This call is free.

  If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. Member Services also has free language interpreter services available for non-English speakers.

To join Great Plains Medicare Advantage (HMO I-SNP) you must:

- be entitled to Medicare Part A,
- *and* be enrolled in Medicare Part B,
- *and* live in our service area,
- *and* reside in one of our participating basic care or assisted living communities and meet a nursing facility level of care, or nursing facilities for greater than 90 days. The plan's Provider Directory has a list of participating assisted living communities or nursing facilities; you can access this list on our website www.greatplainsmedicareadvantage.com or call Member Services and ask us to send you a list.

The service area includes these counties in:

- **Nebraska:** Adams, Antelope, Boone, Boyd, Brown, Buffalo, Burt, Butler, Cass, Cedar, Clay, Colfax, Cuming, Custer, Dakota, Dixon, Dodge, Douglas, Fillmore, Franklin, Furnas, Gage, Gosper, Hall, Hamilton, Harlan, Holt, Howard, Jefferson, Johnson, Kearney, Knox, Lancaster, Madison, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Phelps, Pierce, Platte, Polk, Rock, Saline, Sarpy, Saunders, Seward, Sherman, Stanton, Valley, Washington, Wayne, Webster, and York.

Great Plains Medicare Advantage has a network of doctors, hospitals, pharmacies, and other providers. 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.

Benefits, premium, deductible, and/or copayments (copay)/coinsurance may change on January 1 of each year.

Limitations, copays, and restrictions may apply.

You must continue to pay your Medicare Part B premium.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You 2026" handbook. View it online at https://www.medicare.gov or get 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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Benefits and Premiums	You Pay
* Referral required + Your provider must obtain prior authorization from our plan	
Monthly Plan Premium	$33.90 You must continue to pay the Medicare Part B premium.
Deductible	The Part B deductible was $257. This is the 2025 cost-sharing amount and may change in 2026. Great Plains Medicare Advantage (HMO I-SNP) will provide updated rates as soon as they are released. The Part A deductible was $1,676. This is the 2025 cost-sharing amount and may change in 2026. Great Plains Medicare Advantage (HMO I-SNP) will provide updated rates as soon as they are released.
Maximum Out-of-Pocket Amount *Does Not Include Part D Prescription Drugs*	$9,070 per year
Inpatient Hospital Coverage	This is the 2025 cost-sharing amount and may change in 2026. $1,676 deductible for each benefit period. Days 1-60: $0 copay for each benefit period. Days 61-90: $419 copay per day of each benefit period. Days 91 and beyond: $838copay for each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs.
Outpatient Hospital Services+	20% coinsurance per visit
Outpatient Hospital Observation Services	$100 copay per stay
Ambulatory Surgical Center (ASC) Services+	20% coinsurance per visit
Doctor Visits Primary Care Providers Specialists	 $0 copay per visit 20% coinsurance per visit

Benefits and Premiums	You Pay
Preventive Care Such as immunizations, wellness visits, and diabetic screenings. See your Evidence of Coverage for a full list of covered services.	$0 copay per visit for Medicare covered Preventive Care.
Emergency Care	$90 copay per visit *ER cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*
Urgently Needed Services	20% coinsurance, up to a $40 maximum per visit *Urgently needed care services cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*
Diagnostic Services / Labs / Imaging+ Diagnostic Tests and Procedures+	20% coinsurance *Prior authorization is required for outpatient diagnostic procedures and tests.*
Lab Services+	$0 copay per visit *No authorization required for lab services rendered in any place of service, except for Genetic Testing, which does require authorization.*
Diagnostic Radiology Services (e.g. MRI, CAT Scan) +	20% coinsurance *Prior authorization is required for outpatient diagnostic radiology services.*
Therapeutic Radiology Services+	20% coinsurance per visit *Prior authorization is required for outpatient therapeutic radiology services.*
Outpatient X-rays+	20% coinsurance per visit *Authorization only required for high-end imaging.*

Benefits and Premiums	You Pay
Hearing Services Medicare-Covered Hearing Exam	20% coinsurance per visit
Supplemental Benefits Routine Hearing Exam	$0 copay for 1 routine hearing exam every year, unlimited fitting and evaluation for hearing aids.
Hearing Aids	$2,000 maximum plan coverage amount every year (for both ears combined) for prescription hearing aids.
Dental Services Medicare-Covered Dental Services	20% of the total cost per visit
Supplemental Benefits Preventive Dental Services	$0 copay for the following preventive dental services: • 2 oral exams every year • 2 cleanings every year • 1 bitewing x-ray per year; 1 full mouth x-ray every 5 years.
Comprehensive Dental Services	$2,000 maximum plan coverage amount every year for non-Medicare-covered comprehensive dental services. <u>Comprehensive Dental</u> Services include – Restorative Service: $500 Limit for Non-Routine Services, Diagnostic Services, Restorative Services, Endodontics, Periodontics, and Extractions. Endodontics and Periodontics: unlimited visits every year up to limit
Dentures	1 visit; a $1,500 limit may be used towards services related to the provision of dentures, covering one set of dentures every two years.

Benefits and Premiums	You Pay
Vision Care	
Medicare-Covered Eye Exams	20% coinsurance
Supplemental Benefits	
Routine Eye Exam	$0 copay for one routine eye exam every year
Eyewear: Eyeglasses & Contacts (lenses and frames), Upgrades	$100 allowance applies to fitting evaluation and contact lenses. Contact lenses are in lieu of eyeglasses (lenses and frames). Visually Necessary contact lenses are covered in full in lieu of glasses. $300 allowance for glasses (lenses and frames). All base eyeglass lenses (single vision, lined bifocal, lined trifocal, and lenticular) and frames are covered up to the $300 allowance. Upgrades: Standard progressives are covered in full.
Mental Health Services	
Inpatient Psychiatric	This is the 2025 cost-sharing amount and may change in 2026. $1,676 deductible for each benefit period. Days 1-60: $0 copay for each benefit period. Days 61-90: $419 copay per day of each benefit period. Days 91 and beyond: $838 copay for each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: all costs.
Outpatient: Individual Visits Group Therapy Visits	 20% coinsurance per visit 20% coinsurance per visit
Ambulance Services	
Ground Ambulance	20% coinsurance per trip
Air Ambulance	20% coinsurance per trip

Benefits and Premiums	You Pay
Foot Care (Podiatry Services)	
Foot exams and treatment	20% coinsurance for Medicare-Covered services, diabetic foot care.
Supplemental benefits Routine Foot Care	$0 copay for 6 routine foot care visits per year.
Cardiac Rehab	20% coinsurance
Pulmonary Rehab	20% coinsurance
Occupational Therapy	20% coinsurance
Physical Therapy	20% coinsurance
Speech Therapy	20% coinsurance
Transportation (Additional Routine)	$0 copay for 34 one-way trips every year to plan-approved health-related locations
Skilled Nursing Facility (SNF) Care	You pay the 2026 Original Medicare cost-sharing amounts. These are the 2025 cost-sharing amounts and may change for 2026. Days 1-20: $0 copay for each benefit period. Days 21-100: $209.50 copay per day of each benefit period. Days 101 and beyond: You pay all costs. *No prior authorization required for Medicare-covered SNF stays.*
Medicare Part B Prescription Drugs+	
Insulin	0-20% coinsurance limited to $35 for a one-month supply.
Part B covered drugs and biologicals including chemotherapy drugs+	Up to 20% coinsurance *Prior authorization is required for some medications.*

Benefits and Premiums	You Pay
Medicare identifies Part B "rebatable" drugs that have a price increasing at a rate higher than the rate of inflation. Your cost for Part B rebatable drugs is limited to the cost under Original Medicare and will be no more than 20% coinsurance. However, your cost could change each quarter and will be between $0 and 20%. Medicare will notify Great Plains Medicare Advantage of your cost for these drugs on a quarterly basis. **Select Part B drugs are subject to step therapy restrictions.*	
Outpatient Prescription Drugs Deductible	$615 for all Part D drugs.
Cost-sharing for Covered Drugs	<u>Standard Retail Cost-Sharing</u> 30, 60 or 90-day supply all Tiers: 25% coinsurance <u>Long-Term Care (LTC) Cost-sharing</u> 31-day supply: 25% coinsurance
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through retail pharmacy) reach $2,100, you pay nothing for covered Part D drugs.
	Cost-sharing may differ based on point-of-service (retail, Long Term Care (LTC)), whether the pharmacy is in our standard network, or whether the prescription is a short-term supply (30-days) or long-term supply (90-days).

Benefits and Premiums	You Pay
	Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. 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.

Notice of Availability

English: Free interpretation services are available to you. Additional services and resources necessary to provide information on accessible formats are also available at no cost. Call 1-877-492-5189 (TTY: 711) or speak with your healthcare provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-492-5189 (TTY: 711) o hable con su proveedor.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-492-5189 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-492-5189 (Người khuyết tật: 711), hoặc trao đổi với người cung cấp dịch vụ của bạn."

Amharic: ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-877-492-5189 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

Oromo: HUBADHAA: Yoo afaan Oromoo dubbattu ta'e, tajaajilli gargaarsa afaanii bilisaa siniif ni argama. Gargaarsi gargaaraa fi tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbilaa 1-877-492-5189 (TTY: 711) yookiin dhiyeessaa kee waliin haasa'aa.

Arabic:

نبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (711) 1-877-492-5189 أو تحدث إلى مقدم الخدمة.

French: ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-492-5189 (TTY: 711) ou parlez à votre fournisseur.

Karen: ဆူ– နမ့်ကတိၤ ထၢနှာ်လီၤဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆီဉ်ထွဲမၤစၢၤ လၢတလာ် ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နှၢ်ဟူဝီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤန့ၢ်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-877-492-5189 (TTY: 711) မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပ့ၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတက့ၢ်.

Simplified Chinese: 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-492-5189（文本电话：711）或咨询您的服务提供商。

Swahili: MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-877-492-5189 (TTY: 711) au zungumza na mtoa huduma wako.

Nepali: सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-877-492-5189 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-492-5189 (TTY: 711) o makipag-usap sa iyong provider.

Yoruba: ÀKÍYÈSI: Tí o bá lè sọ èdè Yorùbá, àwọn ètò ìrànlọ́wọ́ èdè wà lọ́fẹ̀ẹ́ fún ọ. A ó tún pèsè àwọn ohun èlò ìrànlọ́wọ́ àti àwọn iṣẹ́ tó bá yẹ láti pèsè ìsọfúnni nípa àwọn ọ̀nà tí ó rọrùn láti lóye lọ́fẹ̀ẹ́. Pe 1-877-492-5189 (TTY: 711) tàbí kí o bá olùpèsè rẹ sọ̀rọ̀.

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-492-5189 (TTY: 711) или обратитесь к своему поставщику услуг.

Ukrainian: УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-877-492-5189 (TTY:711) або зверніться до свого постачальника».

Large print – If you require materials in large print, please call: 1-877-492-5189 (TTY: 711).

Notice of Nondiscrimination

Discrimination is against the law. Sanford Health complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Sanford Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, please contact Member Services at 1-877-492-5189 (TTY: 711)

If you believe that Sanford Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation, you can file a grievance with the Section 504 Coordinator at:

Mailing Address: Section 504 Coordinator, 2301 E. 60th Street, Sioux Falls, SD 57103
Telephone Number: (877) 473-0911 (TTY 711)
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW. Room 509F, HHH Building Washington, DC 20201
Phone: 1-800-368-1019 (TDD 800-537-7697)
More information is available at http://www.hhs.gov/ocr/index.html.