



## **SUMMARY OF BENEFITS**

**JANUARY 1, 2026 – DECEMBER 31, 2026**

SECUR Health Plan is an HMO I-SNP with a Medicare contract. Enrollment in SECUR Health Plan depends on contract renewal.

The benefit information provided 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 1.833.767.3287 (TTY 711) and request the "Evidence of Coverage" or access it online at [www.securhealthplan.com](http://www.securhealthplan.com).

To join SECUR Health Plan, you must be entitled to Medicare Part A, be enrolled in Part B, live in the plans service area, and have institutional needs. The service area includes the counties listed in the first row of the chart below for each plan.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or get a copy by calling 1.800.MEDICARE (1.800.633.4227), 7 days a week, 24 hours a day. TTY users should call 1.877.486.2048.

This document is available in other formats such as braille, large print, or audio.

For more information, please call us at 1.833.767.3287 (TTY users should call 711) 7 days a week, 8 a.m. to 8 p.m. or visit us at [www.securhealthplan.com](http://www.securhealthplan.com).

## Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

### Benefit Coverage

Services with a <sup>1</sup> may require prior authorization.

**H3048-001**

**SECUR Advantage (HMO I-SNP)**

*(Residing in a facility)*

*Citrus, Hernando, Hillsborough, Pasco, and Pinellas counties*

### PREMIUMS, DEDUCTIBLES & MAXIMUM OUT-OF-POCKET (MOOP)

<b>Monthly Plan Premium</b> <i>(includes both medical and drugs)</i>	You pay \$4.80. If you receive "Extra Help," you may pay \$0.
<b>Deductible</b>	See Part D Prescription Drug section for Part D deductible.
<b>Maximum Out-of-Pocket Responsibility (In-Network)</b> <i>(does not include Part D prescription drugs)</i>	You pay no more than \$8,300 annually for in-network Medicare-covered services.

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### INPATIENT & OUTPATIENT HOSPITAL COVERAGE

#### Inpatient Hospital<sup>1</sup>

You pay a \$1,676<sup>2</sup> deductible per benefit period.

You pay:

- \$0 copay for days 1-60.
- \$419<sup>2</sup> copay per day for days 61-90.
- \$838<sup>2</sup> copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- 100%<sup>2</sup> of all costs beyond the lifetime reserve days.

These are 2025 cost-sharing amounts and may change for 2026. SECUR Health Plan will update these rates on its website ([www.securhealthplan.com](http://www.securhealthplan.com)) once available.

<sup>2</sup>If you have Medicaid benefits, your costs may be less.

#### Outpatient Hospital<sup>1</sup>

You may pay up to 20%<sup>2</sup> of the cost per visit.

#### Ambulatory Surgical Center (ASC)<sup>1</sup>

You may pay up to 20%<sup>2</sup> of the cost per visit.

### DOCTOR VISITS

#### Doctor Visits

- **Primary Care Provider**
- **Specialists**

You pay \$0 copay per visit.

You may pay 20%<sup>2</sup> of the cost per visit.

### PREVENTIVE CARE

#### Preventive Care

(e.g., flu vaccine, diabetic screenings)

You pay \$0 copay.

Other preventive services are available. There may be some covered services, such as diagnostic tests, that have a cost.

### EMERGENCY CARE

#### Emergency Care

You pay \$95<sup>2</sup> copay per visit.

If admitted to the hospital within 24 hours of ER visit, the emergency cost share is waived.

#### Urgently Needed Services

You may pay up to 20%<sup>2</sup> of the cost with a maximum limit of \$40<sup>2</sup> copay per visit.

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## DIAGNOSTIC SERVICES/LABS/IMAGING

### Diagnostic Services/ Labs/Imaging

- **Diagnostic Tests and Procedures<sup>1</sup>** If a member receives multiple services on the same day, only the maximum copay applies.
- **Lab Services<sup>1</sup>** If a member receives multiple services on the same day, only the maximum copay applies.
- **MRI, CAT Scan<sup>1</sup>** If a member receives multiple services on the same day, only the maximum copay applies.
- **X-Rays<sup>1</sup>** If a member receives multiple services on the same day, only the maximum copay applies.

You may pay up to 20%<sup>2</sup> of the cost for diagnostic tests and procedures.

You pay \$0 copay for lab services.

You may pay up to 20%<sup>2</sup> of the cost for MRI, CAT scans.

You may pay up to 20%<sup>2</sup> of the cost for x-rays.

<sup>2</sup>If you have Medicaid benefits, your costs may be less.

*Prior authorization may be required*

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## HEARING SERVICES

### Hearing Services

- Medicare Covered Services

You may pay up to 20%<sup>2</sup> of the cost for Medicare covered services.  
**<sup>2</sup>If you have Medicaid benefits, your costs may be less.**

- Routine Hearing Exam\*

You pay \$0 copay for:

- Unlimited routine hearing exams every two (2) years; and
- Unlimited fitting and evaluation for hearing aids every two (2) years.

- Fitting and Evaluation for Hearing Aids\*

- Hearing Aids\*<sup>1</sup>

You receive a \$3,600 benefit allowance toward hearing aids for both ears combined every two (2) years.

## DENTAL SERVICES

### Dental Services

You receive a \$2,600 benefit allowance every year for preventive and comprehensive dental benefits combined.

- Medicare-covered Dental Services<sup>1</sup>

You pay 20%<sup>2</sup> of the cost for Medicare-covered dental services

- Routine (Preventive) Dental Services\*

You pay a \$0 copay for unlimited routine dental services, including:

- Oral exams
- Prophylaxis (cleaning)
- Fluoride treatments
- X-rays
- Other diagnostic and preventive dental services

- Comprehensive Dental Services\*<sup>1</sup>

You pay \$0 copay for unlimited comprehensive dental services, including:

- Diagnostic services (exams, x-rays)
- Restorative services (crowns)
- Endodontics (root canals)
- Periodontics (scaling/root planning)
- Prosthodontics and other oral/maxillofacial surgery (dentures or fixed prosthetics and partials)
- Implants
- Orthodontics
- Adjunctive general services

## VISION SERVICES

# Benefit Coverage

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### Vision Services

- Medicare Covered Eye Exams
- Routine Eye Exams\*
- Medicare Covered Eyewear
- Routine Eyewear\*

You may pay 20%<sup>2</sup> of the cost for Medicare covered vision exams.

You pay \$0 copay for unlimited eye exams.

You pay \$0 copay for Medicare covered eyewear.

You pay \$0 copay for routine eyewear. You receive a \$360 benefit allowance toward eyeglass (lenses and frames), eyeglass lenses, eyeglass frames, upgrades, and a pair of contacts every two (2) years.

<sup>2</sup>If you have Medicaid benefits, your costs may be less.

### MENTAL HEALTH SERVICES

#### Inpatient Mental Health Services<sup>1</sup>

You pay a \$1,676<sup>2</sup> deductible per benefit period.

You pay:

- \$0 copay for days 1-60.
- \$419<sup>2</sup> copay per day for days 61-90.
- \$838<sup>2</sup> copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- Part A only pays for up to 190 days of inpatient psychiatric care for lifetime.

These are 2025 cost-sharing amounts and may change for 2026. SECUR Health Plan will update these rates on its website ([www.securhealthplan.com](http://www.securhealthplan.com)) once available.

<sup>2</sup>If you have Medicaid benefits, your costs could be less.

#### Outpatient Mental Health Services

- Outpatient Group and Individual Therapy Sessions

You may pay up to 20%<sup>2</sup> of the cost per session.

## Benefit Coverage

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#### SKILLED NURSING

##### Skilled Nursing Facility<sup>1</sup>

You pay:

- \$0 copay for days 1 through 20.
- \$209.50<sup>2</sup> copay per day for days 21 through 100.
- All costs for each day after day 100 of the benefit period.

These are 2025 cost-sharing amounts and may change for 2026. SECUR Health Plan will provide updated rates on its website ([www.securhealthplan.com](http://www.securhealthplan.com)) once available.

<sup>2</sup>If you have Medicaid benefits, your costs could be less.

#### REHABILITATION SERVICES

##### Physical Therapy/ Speech Therapy

You pay \$0 copay per visit.

##### Occupational Therapy

You pay \$0 copay per visit.

##### Cardiac Rehabilitation<sup>1</sup>

- Intensive Cardiac Rehabilitation<sup>1</sup>

You may pay up to 20%<sup>2</sup> of the cost per visit.

*Prior authorization may be required for cardiac rehabilitation services.*

#### AMBULANCE

##### Ambulance (Ground)<sup>1</sup>

You may pay up to 20%<sup>2</sup> of the cost.

##### Ambulance (Air)<sup>1</sup>

Coinsurance is waived if you are admitted to a hospital.

*Prior authorization applies only to non-emergency transports*

#### TRANSPORTATION

##### Transportation (Non-Emergency)\*<sup>1</sup>

You pay \$0 for 60 one-way trips per year to plan approved health-related locations.

#### MEDICARE PART B DRUGS

##### Medicare Part B Drugs<sup>1</sup>

<sup>2</sup>If you have Medicaid benefits, your costs may be less.

You pay 0% to 20%<sup>2</sup> of the cost for Part B drugs.

- Insulin<sup>1</sup>

You pay 0% to 20%<sup>2</sup> of the cost for insulin not to exceed \$35<sup>2</sup>.

- Chemotherapy and Other Drugs<sup>1</sup>

You pay 0% to 20%<sup>2</sup> of the cost for chemotherapy and other Part B drugs.

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#### **FOOT CARE**

##### **Podiatry Visit (Medicare Covered)<sup>1</sup>**

You may pay up to 20%<sup>2</sup> of the cost per Medicare-covered visit.

##### **Podiatry Visit (Routine Foot Care)\*<sup>1</sup>**

You pay \$0 for up to four (4) visits per year for routine foot care.

#### **MEDICAL EQUIPMENT/SUPPLIES**

##### **Durable Medical Equipment (DME)<sup>1</sup>**

You may pay up to 20%<sup>2</sup> of the cost.

- Prosthetics<sup>1</sup>

##### **Diabetes Supplies and Services**

You may pay up to 20%<sup>2</sup> of the cost.

- Diabetic Therapeutic Shoes or Inserts

You may pay up to 20%<sup>2</sup> of the cost.

- Diabetes Self-Management Training

You pay \$0 copay.

#### **CHIROPRACTIC CARE & ACUPUNCTURE**

##### **Chiropractic Visit (Medicare Covered)**

You may pay up to 20%<sup>2</sup> of the cost per visit.

##### **Acupuncture Visit (Medicare Covered)**

You may pay up to 20%<sup>2</sup> of the cost per visit.

#### **HOME HEALTH CARE**

##### **Home Health Care<sup>1</sup> (Medicare Covered)**

You pay \$0 per visit.

#### **HOSPICE**

##### **Hospice Care**

Hospice services are covered by Original Medicare. You must get your care from a Medicare-certified hospice provider. You may pay part of the cost for outpatient drugs.

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#### **OUTPATIENT SUBSTANCE ABUSE**

##### **Individual and Group Therapy Visit<sup>1</sup>**

You may pay up to 20%<sup>2</sup> coinsurance per visit.

<sup>2</sup>**If you have Medicaid benefits, your costs may be less.**

##### **Opioid Treatment Program<sup>1</sup>**

You pay \$0 copay for Medicare-covered services.

#### **RENAL DIALYSIS**

##### **Renal Dialysis**

You may pay up to 20%<sup>2</sup> of the cost.

##### **Kidney Disease Education Services**

You pay \$0 copay.

#### **HEALTH EDUCATION**

##### **Health Education\***

You pay \$0 copay.

#### **ENHANCED DISEASE MANAGEMENT**

##### **Enhanced Disease Management Program\***

You pay \$0 copay.

#### **COUNSELING SERVICES**

##### **Counseling Services (individual and group sessions)\***

You pay \$0 copay for up to six (6) 30-minute sessions per year.

#### **RE-ADMISSION PREVENTION**

##### **Re-Admission Prevention\***

You pay \$0 copay for post-discharge medication reconciliation to prevent drug-to-drug interaction readmissions.

##### **Over-the-Counter Items Allowance\***

You pay \$0 and receive a \$100 monthly allowance to use for over-the-counter items, including Nicotine Replacement Therapy items.

Unused funds do not roll over to next month.

#### **NOTE ABOUT MEDICAID ASSISTANCE**

##### **<sup>2</sup>Medicare Cost Sharing**

**If you have full Medicaid benefits or are a Qualified Medicare Beneficiary, you will pay \$0 for your Medicare-covered services as noted by the cost sharing in this chart.**

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### PART D PRESCRIPTION DRUGS

**Phase 1:  
Deductible Stage** You pay \$615<sup>^</sup>.

**Phase 2:  
Initial Coverage Stage** **You are in the Initial Coverage Stage until your total yearly drug costs reach \$2,100.**  
Total yearly drug costs are the total drug costs paid both by you and the plan.  
Once you've reached this amount, you enter the Catastrophic Coverage Stage.

The below coinsurance amounts are for prescriptions purchased from network pharmacies. Cost will differ based on whether the prescriptions are filled at a standard pharmacy or mail-order pharmacy. Cost will also differ based on the number of days' supply. Long-term care (LTC) pharmacies can fill up to a 31-day supply at the 30-day coinsurance listed below.

#### Standard Retail Benefits (30 days/60 days/90 days)

**Tier 1 – All Drugs** 25% / 25% / 25%<sup>^</sup> of the cost  
**If you have Extra Help, your cost will be:**  
Generics: \$0 / \$1.60 / \$5.10 copay  
Brands: \$0 / \$4.90 / \$12.65 copay

#### Mail-order

**Tier 1 – All Drugs** No mail order.

**Phase 3:  
Catastrophic  
Coverage Stage** The plan pays the full cost for your covered Part D drugs. You pay nothing.

Cost sharing may change depending on point-of-service (mail-order, retail, LTC, home infusion), the pharmacy you choose and when you enter a new phase of the drug stages.

**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, even if you haven't paid your deductible.

**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.

**<sup>^</sup>Your cost share may differ depending on when you enter another phase of the drug benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1.800.772.1213 Monday through Friday, 7 a.m. – 7 p.m. TTY users should call 1.800.325.0778.**

For more information on additional pharmacy specific cost-share and the drug coverage stages, please call our Customer Service department or access our "Evidence of Coverage" online or request one by mail.