



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.

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 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.

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

Benefit Coverage

Services with a ¹ may require prior authorization.

H3048-003

SECUR Edge (HMO I-SNP)

(Residing in the community)

Citrus, Hernando, Hillsborough, Pasco, and Pinellas counties

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

Monthly Plan Premium *(includes both medical and drugs)*

You pay \$0.00.

Deductible

See Part D Prescription Drug section for Part D deductible.

Maximum Out-of- Pocket Responsibility (In-Network) *(does not include Part D prescription drugs)*

You pay no more than \$3,400 annually for in-network Medicare-covered services.

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INPATIENT & OUTPATIENT HOSPITAL COVERAGE

Inpatient Hospital¹

You pay a \$1,676² deductible per benefit period.

You pay:

- \$0 copay for days 1-60.
- \$419² copay per day for days 61-90.
- \$838² copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- 100%² 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) once available.

²If you have Medicaid benefits, your costs may be less.

Outpatient Hospital¹

You may pay \$50² copay per visit.

Ambulatory Surgical Center (ASC)¹

You may pay \$50² copay per visit.

DOCTOR VISITS

Doctor Visits

- **Primary Care Provider**

You pay \$0 copay per visit.

- **Specialists¹**

You may pay \$25 copay 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 that may have a cost.

EMERGENCY CARE

Emergency Care

You pay \$90² 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 \$0 copay per visit.

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DIAGNOSTIC SERVICES/LABS/IMAGING

Diagnostic Services/ Labs/Imaging

- **Diagnostic Tests and Procedures¹** If a member receives multiple services on the same day, only the maximum copay applies.
- **Lab Services¹**
If a member receives multiple services on the same day, only the maximum copay applies.
- **MRI, CAT Scan¹**
If a member receives multiple services on the same day, only the maximum copay applies.
- **X-Rays¹**
If a member receives multiple services on the same day, only the maximum copay applies.

You may pay up \$0 copay for diagnostic tests and procedures.

You pay \$0 copay for lab services.

You may pay \$50² copay for MRI, CAT scans.

You may pay \$0 copay for x-rays.

²If you have Medicaid benefits, your costs may be less.

HEARING SERVICES

Hearing Services

- **Medicare Covered Services¹**
- **Routine Hearing Exam*¹**
- **Fitting and Evaluation for Hearing Aids*¹**
- **Hearing Aids*¹**

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

You pay \$0 for:

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

You receive a \$2,000 benefit allowance toward hearing aids for both ears combined every two (2) years.

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DENTAL SERVICES

Dental Services

- **Medicare-covered services¹**
- **Routine (Preventive) Dental Services***
- **Comprehensive Dental Services*¹**

You receive a \$1,500 benefit allowance every year for preventive and comprehensive dental benefits combined.

You pay \$0 copay for Medicare-covered 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

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

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

VISION SERVICES

Vision Services

- **Medicare Covered Eye Exams¹**
- **Routine Eye Exams*¹**
- **Medicare Covered Eyewear**
- **Routine Eyewear***

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

You pay \$0 for unlimited eye exams.

You pay \$0 for Medicare-covered eyewear.

You pay \$0 for routine eyewear. You receive a \$250 benefit allowance toward eyeglass (lenses and frames), eyeglass lenses, eyeglass frames, upgrades, and a pair of contacts every two (2) years.

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MENTAL HEALTH SERVICES

Inpatient Mental Health Services¹

You pay a \$1,676² deductible per benefit period.

You pay:

- \$0 copay for days 1-60.
- \$419² copay per day for days 61-90.
- \$838² 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) once available.

²If you have Medicaid benefits, your costs could be less.

Outpatient Mental Health Services

- **Outpatient Group and Individual Therapy Sessions¹**

You may pay \$0 copay per session.

SKILLED NURSING

Skilled Nursing Facility¹

You pay:

- \$0 copay for days 1 through 20.
- \$150.00² copay per day for days 21 through 100.
- All costs for each day after day 100 of the benefit period.

²If you have Medicaid benefits, your costs could be less.

REHABILITATION SERVICES

Physical Therapy/ Speech Therapy¹

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

Occupational Therapy¹

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

Cardiac Rehabilitation¹

- **Intensive Cardiac Rehabilitation¹**

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

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AMBULANCE

Ambulance (Ground)¹

You may pay \$175² copay for Medicare-covered ground ambulance services

Ambulance (Air)¹

You pay 20%² of the cost for Medicare-covered air ambulance services

Prior authorization applies only to non-emergency ground and air transports.

TRANSPORTATION

Transportation (Non-Emergency)*

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

Rides must be scheduled at least 40 hours in advance of appointment date/time.

MEDICARE PART B DRUGS

Medicare Part B Drugs¹

²**If you have Medicaid benefits, your costs may be less.**

You pay 0% to 20%² of the cost for Part B drugs.

- **Insulin¹**

You pay 0% to 20%² of the cost for insulin not to exceed \$35² per month supply.

- **Chemotherapy and Other Drugs¹**

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

FOOT CARE

Podiatry Visit (Medicare Covered)

You may pay up to 20%² of the cost for Medicare-covered services.

Podiatry Visit (Routine Foot Care)*

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

MEDICAL EQUIPMENT/SUPPLIES

Durable Medical Equipment¹

- **Prosthetics¹**

You may pay up to 20%² of the cost.

Diabetes Supplies and Services

You may pay up to 20%² of the cost.

- **Diabetic Therapeutic Shoes or Inserts**

You may pay up to 20%² of the cost.

- **Diabetes Self-Management Training**

You pay \$0 copay.

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CHIROPRACTIC CARE & ACUPUNCTURE

Chiropractic Visit¹ (Medicare Covered)

You may pay \$0 copay per visit.

Acupuncture Visit (Medicare Covered)

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

HOME HEALTH CARE

Home Health Care¹ (Medicare Covered)

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

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.

OUTPATIENT SUBSTANCE ABUSE

Individual and Group Therapy Sessions¹

You may pay \$0 copay per session.

Opioid Treatment Program¹

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

RENAL DIALYSIS

Renal Dialysis

You may pay \$0 copay.

Kidney Disease Education Services

You pay \$0 copay

FLEX CARD

Flex Card*

You pay \$0 for a \$115 monthly combined allowance to use for any of the following:

- Over-the-Counter (OTC) items
- Meals (you must have one of the qualifying chronic conditions to use the Flex Card for meals. See your Evidence of Coverage for details.)
- Home and Bathroom Safety Devices and Modifications (such as, grab bar, bath bench, temporary ramp)
- Support for Caregivers of the Enrollee (respite care)

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IN-HOME SERVICES

In-Home Support Services*	You pay \$0 copay for up to 30 hours per year of assistance with activities for daily living.
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In-Home Safety Assessment*	You pay \$0 copay.
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In-Home Medication Reconciliation (post-discharge)*	You pay \$0 copay.
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HEALTH EDUCATION

Health Education*	You pay \$0 copay.
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ENHANCED DISEASE MANAGEMENT

Enhanced Disease Management Program*	You pay \$0 copay.
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COUNSELING SERVICES

Counseling Services (individual and group sessions)*	You pay \$0 for up to six (6) 30-minute sessions per year.
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Nutritional/Dietary Counseling (individual and group sessions)	You pay \$0 for unlimited nutritional/dietary counseling sessions.
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REMOTE ACCESS TECHNOLOGIES

24/7 Nurse Hotline*	You pay \$0 copay.
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Telemonitoring Services*	You pay \$0 copay.
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PERSONAL EMERGENCY RESPONSE SYSTEM

Personal Emergency Response System*	You pay \$0 copay.
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HOME BASED PALLIATIVE CARE

Home-based Palliative Care*	You pay \$0 for services providing relief from complex symptoms, pain, and stress of a serious illness.
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RE-ADMISSION PREVENTION

Re-admission Prevention*	You pay \$0 for up to two (2) meals for up to 14 calendar days after each inpatient facility discharge or outpatient surgery. This benefit can be used up to four (4) times per year.
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ANNUAL PHYSICAL EXAM

Annual Physical Exam*	You pay \$0 copay for a routine annual physical exam. There may be costs associated with any diagnostic radiology services associated with the annual exam.
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NOTE ABOUT MEDICAID ASSISTANCE

²Medicare 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[^]. The deductible does not apply to drugs on Tier 1 or Tier 2.

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.

PART D PRESCRIPTION DRUGS

Drug Tiers	Retail (30 days)	Retail (90 days)	Mail Order (90 days)
Tier 1: Preferred Generic Insulins	\$0 \$0	\$0 \$0	\$0 \$0
Tier 2: Generic Insulins	\$0 \$0	\$0 \$0	\$0 \$0
Tier 3: Preferred Brand Insulins	\$47 \$35	Long term supply not available	Long term supply not available
Tier 4: Non-Preferred Drug Insulins	25% \$35	Long term supply not available	Long term supply not available
Tier 5: Specialty Tier Insulins	25% \$35	Long term supply not available	Long term supply not available

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 25% of the cost or \$35 for a one-month supply of each insulin product covered by our plan (whichever is less), 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.

[^]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.