2026 Summary of Benefits

ProCare Advantage (HMO-POS I-SNP)

H3467, Plan 001

This is a summary of drug and health services covered by ProCare Advantage (HMO-POS I-SNP) from January 1 – December 31, 2026.

ProCare Advantage (HMO-POS I-SNP) is a Medicare Advantage HMO-POS 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 1-844-206-3719, TTY users 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 ProCareAdvantagePlan.com, or call Member Services and request the *Evidence of Coverage*.

To reach our Member Services Representatives:

- Toll-free number: 1-844-206-3719, 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 ProCare Advantage (HMO-POS 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. The plan's *Provider Directory* has a list of participating nursing facilities. You can access this list on our website at ProCareAdvantagePlan.com or call Member Services and ask us to send you a list.

Our service area includes these counties in Texas: Atascosa, Austin, Bandera, Bee, Bexar, Blanco, Bosque, Brazoria, Burnet, Caldwell, Chambers, Cherokee, Clay, Collin, Colorado, Comal, Cooke, Dallas, Denton, El Paso, Ellis, Fannin, Fort Bend, Galveston, Goliad, Gonzales, Grimes, Guadalupe, Hamilton, Hardin, Harris, Hill, Hopkins, Hudspeth, Jack, Jefferson, Johnson, Kendall, La Salle, Lampasas, Lavaca, Lee, Liberty, Matagorda, McMullen, Medina, Mills, Montgomery, Orange, Palo Pinto, Parker, Real, Rockwall, San Jacinto, Somervell, Tarrant, Trinity, Tyler, Van Zandt, Wharton, Williamson, Wilson, and Wise.

ProCare Advantage (HMO-POS I-SNP) has a network of doctors, hospitals, pharmacies, and other providers that can be found on our website at ProCareAdvantagePlan.com. If you use providers that are not in our network, the plan may not pay for these services. Your plan includes a Point-of-Service (POS) benefit which means that you can use providers outside the plan's network for certain services. See table below for additional detail. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network 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 2026* 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)*	$4.80 You must continue to pay your Medicare Part B premium.
Deductible	You pay the 2026 Original Medicare cost-sharing amounts. The Part A deductible is $1,736. The Part B deductible is $283.
Maximum out-of-pocket amount *(does not include Part D prescription drugs)*	$9,250 combined for in- and out-of-network services
Inpatient hospital coverage	You pay the 2026 Original Medicare cost-sharing amounts. You pay a $1,736 deductible for each Medicare-covered stay $0 copayment per day for days 1-60 $434 copayment per day for days 61-90 $868 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	20% coinsurance *Prior authorization is required.*
Outpatient hospital observation services	20% coinsurance *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%-20% coinsurance $0 copayment for primary care visits in the Skilled Nursing Facility 20% coinsurance for all other places of service
Specialists	**In-Network:** 20% coinsurance *Prior authorization is required.* **Out-of-Network (POS):** 20% coinsurance *Prior authorization is required.*
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% coinsurance (not to exceed $40 per visit) You do not pay this amount if you are admitted to the hospital within 3 days.

Benefit category	Your plan benefits
Diagnostic services/labs/imaging	
Diagnostic tests and procedures	20% coinsurance *Prior authorization is required.*
Diagnostic radiology services (e.g., MRI, CAT scan)	20% coinsurance *Prior authorization is required.*
Lab services	$0 copayment *Prior authorization is required.*
Outpatient x-rays	20% coinsurance *Prior authorization is required.*
Therapeutic radiology	20% coinsurance *Prior authorization is required.*
Hearing services (Medicare-covered)	
Medicare-covered services	20% coinsurance
Hearing services (Supplemental)	
Hearing aids	$150 every 3 months to spend towards Prescription Hearing Aids (both ears combined) Allowance is included as part of your Healthy Living Flex Card and is shared with other benefits

Benefit category	Your plan benefits
Dental services (Medicare-covered)	
Medicare-covered services	20% coinsurance *Prior authorization is required.*
Dental services (Supplemental)	
Preventive 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: No dollar maximum for preventive 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/procareadvantage. Additional $150 every 3 months included as part of your Healthy Living Flex Card
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	$175 every year for lenses, frames or contacts Additional $150 every 3 months included as part of your Healthy Living Flex Card

Benefit category	Your plan benefits
Mental health services	
Inpatient visit	You pay the 2026 Original Medicare cost-sharing amounts. You pay a $1,736 deductible for each Medicare-covered stay $0 copayment per day for days 1-60 $434 copayment per day for days 61-90 $868 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 *Prior authorization is required.*
Outpatient individual therapy visit	20% coinsurance *Prior authorization is required.*
Skilled Nursing Facility (SNF)	You pay the 2026 Original Medicare cost-sharing amounts. $0 copayment per day for days 1-20 $217 copayment per day for days 21-100 *Prior authorization is required.*
Physical therapy	20% coinsurance *Prior authorization is required.*
Ambulance	
Ground ambulance	20% coinsurance *Prior authorization is required for non-emergency Medicare services.*
Air ambulance	20% coinsurance *Prior authorization is required for non-emergency Medicare services.*

Benefit category	Your plan benefits
Transportation *(non-emergency)* • Plan approved health-related location	$0 copayment Limit 30 one-way trips every year
Medicare Part B prescription drugs	
Chemotherapy/Radiation drugs	0%-20% coinsurance Cost-sharing is dependent on the drug administered. *Prior authorization is required for some medications. For chemotherapy, prior authorization is required for the initial drug approval only.*
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 for some medications.*

Outpatient Prescription Drugs

Prescription drug payment stages	**Your plan benefits**		
Prescription drug deductible	$615 Deductible applies.		
Initial coverage	You stay in the Initial Coverage stage until your total out-of-pocket costs reach $2,100. 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	Not covered	25% coinsurance
Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $2,100, 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	20% coinsurance
Dialysis services	20% coinsurance
Durable Medical Equipment (DME)	20% coinsurance *Prior authorization is required.*
Healthy Living Flex Card • Dental - Preventive services • Hearing - Prescription hearing aids • Over-The-Counter (OTC) items • Vision - Eyewear	$150 every 3 months to spend towards Eyewear, OTC Items, Prescription Hearing Aids, and Preventive Dental Services Benefit is administered by The Helper Bees
In-home support services (Support With Daily Tasks)	$420 every year 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. This may also include general tasks such as errands, accompaniment to appointments, technology assistance, and setting appointments.
Occupational therapy	20% coinsurance *Prior authorization is required.*
Podiatry services (Foot care) Medicare-covered services Routine foot care	 20% coinsurance $0 copayment Limit 4 visits every year
Speech therapy	20% coinsurance *Prior authorization is required.*