2026 Summary of Benefits

ProCare Advantage - Kidney Care (HMO-POS C-SNP)

H3467, Plan 002

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

ProCare Advantage - Kidney Care (HMO-POS C-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 - Kidney Care (HMO-POS C-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 have certain medical conditions. To be eligible for our plan, you must have Chronic kidney disease (CKD).

Our service area includes these counties in Texas: Collin, Dallas, Denton, and Tarrant.

ProCare Advantage - Kidney Care (HMO-POS C-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 copayment
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	$0 copayment *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
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: $1,000 every year 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.

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	$325 every year for lenses, frames or contacts
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.*

Benefit category	Your plan benefits
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	**In-Network:** $0 copayment *Prior authorization is required.* **Out-of-Network (POS):** 20% coinsurance
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.*
Transportation *(non-emergency)* • Plan approved health-related location	$0 copayment Limit 100 one-way trips every year Each ride is limited to 20 miles

Benefit category	Your plan benefits
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	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 $2,100, 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	$0 copayment
Dialysis services	20% coinsurance
Durable Medical Equipment (DME)	20% coinsurance *Prior authorization is required.*
Healthy Living Flex Card • Fitness • General supports for living* • Groceries* • Over-The-Counter (OTC) items	$155 every 3 months to spend towards Fitness, Groceries, OTC Items, and Utilities This benefit is administered by The Helper Bees. See your Evidence of Coverage for more details. *Some benefits have additional eligibility requirements. See section after the benefits chart for additional information.
Occupational therapy	**In-Network:** 20% coinsurance *Prior authorization is required.* **Out-of-Network (POS):** 20% coinsurance
Podiatry services (Foot care)	
Medicare-covered services	20% coinsurance
Routine foot care	$0 copayment Limit 8 visits every year

Benefit category	Your plan benefits
Speech therapy	**In-Network:** $0 copayment *Prior authorization is required.* **Out-of-Network (POS):** 20% coinsurance

*Special supplemental benefits for the chronically ill (SSBCI) are only available to members with certain chronic conditions. You may be eligible if you have one of the following conditions:

- Chronic kidney disease (CKD)