2027 Summary of Benefits

Medicare Advantage Plan

Health First Secure H1099-009 (HMO)

January 1, 2027 – December 31, 2027

Y0089_EL1105288_M, Accepted 08/25/2026

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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, call us and ask for the "**Evidence of Coverage**." You can also see the Evidence of Coverage on our website, https://www.hf.org/healthplans.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Health First Secure H1099-009 (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Health First Secure H1099-009 (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** 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.

Sections in this booklet

- Things to Know About **Health First Secure H1099-009 (HMO)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-800-716-7737 (TTY: 1-800-955-8771).

Things to Know About Health First Secure H1099-009 (HMO)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday and Saturday from 8:00 a.m. – noon.
- If you are a member of this plan, call us at 1-800-716-7737, TTY: 1-800-955-8771.
- If you are not a member of this plan, call us at 1-800-716-7737, TTY: 1-800-955-8771.
- Our website: https://www.hf.org/healthplans.

Who can join?

To join **Health First Secure H1099-009 (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Florida: Brevard and Indian River.

Which doctors and hospitals can I use?

Health First Secure H1099-009 (HMO) has a network of doctors, hospitals, and other providers. If you use the providers that are not in our network, the plan may not pay for these services **if you do not have out of network coverage.**

You can see our plan's provider directory at our website (https://www.hf.org/healthplans).

Or, call us and we will send you a copy of the provider directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part B drugs including chemotherapy and some drugs administered by your provider.

If you have any questions about this plan's benefits or costs, please contact Health First Health Plans, Inc.

2 SECTION II - SUMMARY OF BENEFITS

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Premiums and Benefits	**Health First Secure H1099-009 (HMO)**
Monthly Plan Premium	You do not pay a separate monthly plan premium for Health First Secure H1099-009 (HMO). You must continue to pay your Medicare Part B premium.
Part B premium reduction amount	This plan does not have a Part B premium reduction amount.
Deductible	Medical Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) in this plan: • $3,900 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Health First Secure H1099-009 (HMO)**
Inpatient Hospital Coverage (PA)	**In-Network:** Days 1-7: $180 copay per day for each admission. Days 8-90: $0 copay per day. Days 91-100: $0 copay per additional day.
Outpatient Hospital Coverage (PA)	**In-Network:** Outpatient hospital observation: $150 copay. Outpatient hospital surgery: $0 - $150 copay.
Ambulatory Surgical Center (ASC) Services (PA)	**In-Network:** Ambulatory surgical center: $0 - $150 copay.
Doctor Visits (Primary Care Providers and Specialists) (PA)	**In-Network:** Primary care physician visit: $0 copay. Specialist visit: $20 copay.
Preventive Care (PA)	**In-Network:** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	**In-Network:** Emergency care: $150 copay per visit. Worldwide emergency coverage: $150 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.
Urgently Needed Services	**In-Network:** Urgently needed services: $25 copay per visit. Worldwide urgent coverage: $150 copay.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Health First Secure H1099-009 (HMO)**
	Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.
Diagnostic Services/Labs/Imaging (PA)	**In-Network:** Diagnostic tests and procedures: $20 copay. Lab services: $0 copay. Diagnostic radiology services (such as MRI, CAT Scan): $125 copay. X-rays: $20 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost.
Hearing Services	**In-Network:** Medicare-covered hearing exam (diagnostic hearing exam): $15 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing aids (up to 2 hearing aids every year): $0 - $1,395 copay. Fitting/Evaluation (up to 1 visit(s) every year): $0 copay.
Dental Services (PA)	**In-Network:** Medicare-covered dental benefits: $15 copay. Dental maximum benefit coverage amount: $1,000 allowance per year. Diagnostic and preventive dental services: • Oral exam (up to 2 every year). • Cleaning (up to 2 every year). • Fluoride treatment (up to 1 every year). • Dental X-rays (up to 1 every 12 - 36 months, depending on the procedure). Comprehensive dental services: • Restorative services (up to 1 every 2 years per surface per tooth for fillings and 5 years for crowns). • Periodontics (up to 1 every 6 - 36 months).

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Health First Secure H1099-009 (HMO)**
	• Oral and maxillofacial surgery services (up to 1 every 60 months for oroantral fistula closure; extractions are unlimited). • Adjunctive general services (up to 1 every 0 - 12 months). You will also receive a preloaded debit card with $250 per calendar year for any supplemental diagnostic, preventive, or comprehensive dental service. Services paid for using the debit card are not subject to dental service frequency limits; however, coverage is limited to the annual amount available.
Vision Services (PA)	**In-Network:** Medicare-covered exam (diagnosis and treatment for diseases and conditions of the eye): $15 copay. Glaucoma screening: $0 copay. Routine vision exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Contact lenses: $0 copay. Eyeglasses (frames and lenses): $0 copay. Our plan pays up to $400 every year for supplemental eyewear.
Mental Health Services (PA)	**In-Network:** Outpatient group therapy visit: $20 copay. Individual therapy visit: $20 copay. Inpatient mental health care: Days 1-7: $180 copay per day for each admission. Days 8-90: $0 copay per day.
Skilled Nursing Facility (SNF) (PA)	**In-Network:** Days 1-20: $0 copay per day. Days 21-100: $100 copay per day.
Physical Therapy and other Rehabilitation Services	**In-Network:** Occupational therapy visit: $15 copay. Physical therapy, speech therapy, and language therapy visit: $15 copay.

COVERED MEDICAL AND HOSPITAL BENEFITS	
Benefits/Services	**Health First Secure H1099-009 (HMO)**
Ambulance (PA)	**In-Network:** Ground ambulance: $230 copay. Air ambulance: 20% of the total cost. Worldwide emergency transportation: $230 copay. Benefits for emergency care, urgent care, and emergency transportation received outside the United States and its territories are limited to a combined $50,000 maximum per calendar year.
Transportation	**In-Network:** $0 copay. 20 one-way trips every year to any health-related location.
Medicare Part B Drugs (PA)	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% of the total cost. Other Part B drugs: 0% - 20% of the total cost. You pay no more than $35 for a 30-day supply of Part B insulin furnished through an item such as an insulin pump.

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-716-7737 (TTY: 1-800-955-8771).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-716-7737 (TTY: 1-800-955-8771).

Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in **Health First Health Plans** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Health First Health Plans, Inc. members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.

Health coverage is offered by Health First Health Plans.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-800-716-7737 (TTY 1-800-955-8771).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit https://www.hf.org/healthplans or call 1-800-716-7737 (TTY 1-800-955-8771) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

Understanding Important Rules

- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2028.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

THANK YOU

Connect with us

Contact Information: 1-800-716-7737, TTY: 1-800-955-8771

Organization Name: Health First Health Plans, Inc.

Organization website: https://www.hf.org/healthplans

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services.

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-716-7737 (TTY: 1-800-955-8771) or speak to your provider.

Spanish (Español): 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 1-800-716-7737 (TTY: 1-800-955-8771) o hable con su proveedor.

Haitian Creole (Kreyòl Ayisyen): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-716-7737 (TTY: 1-800-955-8771) oswa pale avèk founisè w la.

Vietnamese (Việt): 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 1-800-716-7737 (TTY: 1-800-955-8771) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Brazilian Portuguese (Português do Brasil): ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-716-7737 (TTY: 1-800-955-8771) ou fale com seu provedor.

Traditional Chinese (中文): 注意：如果您說 中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-716-7737 (TTY: 1-800-955-8771) 或與您的提供者討論。」

French (Français): 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 1-800-716-7737 (TTY: 1-800-955-8771) ou parlez à votre fournisseur.

Tagalog (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 1-800-716-7737 (TTY: 1-800-955-8771) o makipag-usap sa iyong provider.

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Russian (РУССКИЙ): 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 1-800-716-7737 (TTY: 1-800-955-8771) или обратитесь к своему поставщику услуг.

Arabic (العربية): إذا كنت تتحدث اللغة العربية ، تتوفر لك خدمات مساعدة لغوية مجانية. كما تتوفر مجانًا وسائل مساعدة وخدمات مناسبة لتقديم المعلومات بتنسيقات سهلة الوصول. اتصل على الرقم 1-800-716-7737 (1-800-955-8771 TTY: 1) أو تواصل مع مقدم الخدمة.

Italian (Italiano): ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1-800-716-7737 (TTY: 1-800-955-8771) o parla con il tuo fornitore.

German (Deutsch): 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 1-800-716-7737 (TTY: 1-800-955-8771) an oder sprechen Sie mit Ihrem Provider.

Korean (한국어): 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-716-7737 (TTY: 1-800-955-8771) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Polish (POLSKI): UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-716-7737 (TTY: 1-800-955-8771) lub porozmawiaj ze swoim dostawcą.

Gujarati (ગુજરાતી): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-716-7737 (TTY: 1-800-955-8771) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Thai (ไทย): หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-716-7737 (TTY: 1-800-955-8771) หรือปรึกษาผู้ให้บริการของคุณ