INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2019 - December 31, 2019

This booklet gives you a summary of what we cover and what you pay. It doesn't 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 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 a **Senior Care Plus Freedom PPO Plan:**

- **Freedom Basic-008 (PPO)**
- **Freedom Rx-007 (PPO)**
- **Freedom Rx Enhanced-006 (PPO)**
- **Freedom Rx Select-005 (PPO)**

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Senior Care Plus: Freedom Basic-008 (PPO), Freedom Rx-007 (PPO), Freedom Rx Enhanced-006 (PPO), or Freedom Rx Select-005 (PPO)** 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 http://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 http://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 **Senior Care Plus: Freedom Basic-008 (PPO), Freedom Rx-007 (PPO), Freedom Rx Enhanced-006 (PPO), and Freedom Rx Select-005 (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefit

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

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1- 888-775-7003 7003 (TTY users should call 711 – State Relay Service), Monday through Sunday,

7 am to 8 pm (PST), or you may visit www.SeniorCarePlus.com. We will be closed on all federal holidays except New Year's Day.

Este documento puede estar disponible en un idioma que no sea inglés. Para obtener información adicional, llame al número gratuito 888-775-7003 o 775-982-3112 (TTY 711).

Things to Know About Senior Care Plus: Freedom Basic-008 (PPO), Freedom Rx-007 (PPO), Freedom Rx Enhanced-006 (PPO), and Freedom Rx Select-005 (PPO)

Customer Service Hours of Operation

You can call us 7 days a week from 7:00 a.m. to 8:00 p.m. Pacific Time. We will be closed on all federal holidays except New Year's Day. TTY users should call 711.

Senior Care Plus Phone Numbers and Website

If you are a member of this plan, please call toll-free 888-775-7003 or 775-982-3112 (TTY 711).
If you are not a member of this plan, please call toll-free 888-775-7003 or 775-982-3158 (TTY 711).
You may also visit our website (www.SeniorCarePlus.com) for more information.

Who can join?

To join **Senior Care Plus: Freedom Basic-008 (PPO), Freedom Rx-007 (PPO), Freedom Rx Enhanced-006 (PPO), or Freedom Rx Select-005 (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Nevada: Churchill, Douglas, Lyon, and Storey counties.

Which doctors, hospitals, and pharmacies can I use?

Senior Care Plus: Freedom Basic-008 (PPO), Freedom Rx-007 (PPO), Freedom Rx Enhanced-006 (PPO), and Freedom Rx Select-005 (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider and pharmacy directory at our website (www.SeniorCarePlus.com). Or, call us and we will send you a copy of the *Provider and Pharmacy Directory*.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

Our plan members also get *more than what is* covered by Original Medicare. Some of the extra benefits are outlined in this booklet.

Senior Care Plus: Freedom Basic Plan covers Part B drugs including chemotherapy and some drugs administered by your provider. However, this plan does **not** cover Part D prescription drugs.

Senior Care Plus: Freedom Rx, Freedom Rx Enhanced and Freedom Rx Select Plans cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website: www.SeniorCarePlus.com. You can also call us and we will send you a copy of the formulary.

How will I determine how much my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate which tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

SUMMARY OF BENEFITS				
January 1, 2019 - December 31, 2019				
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
Monthly Plan Premium	**$0** per month. In addition, you must keep paying your Medicare Part B premium.	**$55** per month. In addition, you must keep paying your Medicare Part B premium.	**$130** per month. In addition, you must keep paying your Medicare Part B premium.	**$220** per month. In addition, you must keep paying your Medicare Part B premium.
Medicare Part B Premium Rebate	Senior Care Plus will reduce your Medicare Part B premium by up to **$20**.	This plan does not offer a Part B rebate.	This plan does not offer a Part B rebate.	This plan does not offer a Part B rebate.
Deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	Your yearly limit(s) in this plan: • **$3,400** for services you receive from in-network providers. • **$5,100** for services you receive from out-of-network providers. • **$5,100** for services you receive from any provider. Your limit for services received from in-network and out-of-network providers will count toward this limit.	Your yearly limit(s) in this plan: • **$3,400** for services you receive from in-network providers. • **$5,100** for services you receive from out-of-network providers. • **$5,100** for services you receive from any provider. Your limit for services received from in-network and out-of-network providers will count toward this limit.	Your yearly limit(s) in this plan: • **$3,400** for services you receive from in-network providers. • **$5,100** for services you receive from out-of-network providers. • **$5,100** for services you receive from any provider. Your limit for services received from in-network and out-of-network providers will count toward this limit.	Your yearly limit(s) in this plan: • **$3,000** for services you receive from in-network providers. • **$5,100** for services you receive from out-of-network providers. • **$5,100** for services you receive from any provider. Your limit for services received from in-network and out-of-network providers will count toward this limit.
COVERED MEDICAL AND HOSPITAL BENEFITS				
Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.				

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MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
Inpatient Hospital Coverage[1,2]	**In-network**: • **$375** copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 **Out-of-network**: • **$500** copay or **30%** of the cost per stay, depending on the service	**In-network:** • **$350** copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 **Out-of-network:** • **$500** copay or **30%** of the cost per stay, depending on the service	**In-network:** • **$325** copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 **Out-of-network:** • **$500** copay or **30%** of the cost per stay, depending on the service	**In-network:** • **$275** copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 **Out-of-network:** • **$500** copay or **30%** of the cost per stay, depending on the service
	Our plan covers an unlimited number of days for an inpatient hospital stay.	Our plan covers an unlimited number of days for an inpatient hospital stay.	Our plan covers an unlimited number of days for an inpatient hospital stay.	Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient Hospital	**In-Network:** **$375** copay **Out-of-network:** **30%** coinsurance	**In-Network:** **$350** copay **Out-of-network:** **30%** coinsurance	**In-Network:** **$325** copay **Out-of-network:** **30%** coinsurance	**In-Network:** **$275** copay **Out-of-network:** **30%** coinsurance
Doctor Visits ○ Primary Care	**In-network**: **$20** copay for visits to in-network primary care physicians. **Out-of-network:** **$35** copay	**In-network:** **$20** copay for visits to in-network primary care physicians. **Out-of-network**: **$35** copay	**In-network:** **$15** copay for visits to in-network primary care physicians. **Out-of-network:** **$35** copay	**In-network:** **$10** copay for visits to all other in-network primary care physicians. **Out-of-network**: **$25** copay
○ Specialists	**In-network:** **$50** copay	**In-network** **$50** copay	**In-network:** **$50** copay	**In-network:** **$40** copay

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MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
	Out-of-network: **$75** copay	**Out-of-network:** **$75** copay	**Out-of-network:** **$65** copay	**Out-of-network:** **$65** copay
Preventative Care	**In-network:** You pay nothing **Out-of-network:** **30%** of the cost	**In-network:** You pay nothing **Out-of-network:** **30%** of the cost	**In-network:** You pay nothing **Out-of-network:** **30%** of the cost	**In-network:** You pay nothing **Out-of-network:** **30%** of the cost
	Any additional preventive services approved by Medicare during the contract year will be covered.	Any additional preventive services approved by Medicare during the contract year will be covered.	Any additional preventive services approved by Medicare during the contract year will be covered.	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	**$120** copay	**$120** copay	**$120** copay	**$120** copay
	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. *See "Inpatient Hospital Coverage" section of this booklet for other costs.*	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. *See "Inpatient Hospital Coverage" section of this booklet for other costs.*	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. *See "Inpatient Hospital Coverage" section of this booklet for other costs.*	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. *See "Inpatient Hospital Coverage" section of this booklet for other costs.*
Urgently Needed Services	**$30-$65** copay, depending on the service	**$30-$65** copay, depending on the service	**$25-$65** copay, depending on the service	**$15-$35** copay, depending on the service
	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services.	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services.	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services.	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services.

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January 1, 2019 - December 31, 2019				
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
	See "Inpatient Hospital Coverage" section of this booklet for other costs.	*See "Inpatient Hospital Coverage" section of this booklet for other costs.*	*See "Inpatient Hospital Coverage" section of this booklet for other costs.*	*See "Inpatient Hospital Coverage" section of this booklet for other costs.*
Diagnostic Services/Labs/Imaging[1,2]	Costs for these services may vary based on place of service.	Costs for these services may vary based on place of service.	Costs for these services may vary based on place of service.	Costs for these services may vary based on place of service.
○ Diagnostic radiology services (e.g., MRI)	**In-network:** **$140-$180** copay, depending on the service **Out-of-network:** **30%** of the cost	**In-network:** **$140-$180** copay, depending on the service **Out-of-network:** **30%** of the cost	**In-network:** **$125-$160** copay, depending on the service **Out-of-network:** **30%** of the cost	**In-network:** **$75-$100** copay, depending on the service **Out-of-network:** **30%** of the cost
○ Lab Services	**In-network:** **$0-$130** copay, depending on the service **Out-of-network**: **30%** of the cost	**In-network:** **$0-$130** copay, depending on the service **Out-of-network:** **30%** of the cost	**In-network:** **$0-$120** copay, depending on the service **Out-of-network:** **30%** of the cost	**In-network:** **$0-$80** copay, depending on the service **Out-of-network:** **30%** of the cost
○ Diagnostic Tests & Procedures	**In-network:** **$0-$375** copay, depending on the service **Out-of-network:** **30%** of the cost	**In-network:** **$0-$350** copay, depending on the service **Out-of-network:** **30%** of the cost	**In-network:** **$0-$325** copay, depending on the service **Out-of-network:** **30%** of the cost	**In-network:** **$0-$275** copay, depending on the service **Out-of-network:** **30%** of the cost
○ Outpatient X-Rays	**In-network:** **$100** copay **Out-of-network:** **30%** of the cost	**In-network:** **$100** copay **Out-of-network:** **30%** of the cost	**In-network:** **$90** copay **Out-of-network:** **30%** of the cost	**In-network:** **$50** copay **Out-of-network:** **30%** of the cost

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○ Therapeutic Radiology Services (e.g., radiation treatment for cancer)	**In-network:** **$60** copay **Out-of-network:** **30%** of the cost	**In-network:** **$60** copay **Out-of-network:** **30%** of the cost	**In-network:** **$60** copay **Out-of-network:** **30%** of the cost	**In-network:** **$60** copay **Out-of-network:** **30%** of the cost
Hearing Services ○ Routine Hearing Exam	**In-network:** **$45** copay **Out-of-network:** **$45** copay *Limited to 1 routine hearing exam per year. Must see TruHearing provider to use benefit.*	**In-network:** **$45** copay **Out-of-network:** **$45** copay *Limited to 1 routine hearing exam per year. Must see TruHearing provider to use benefit.*	**In-network:** **$45** copay **Out-of-network:** **$45** copay *Limited to 1 routine hearing exam per year. Must see TruHearing provider to use benefit.*	**In-network:** **$45** copay **Out-of-network:** **$45** copay *Limited to 1 routine hearing exam per year. Must see TruHearing provider to use benefit.*
○ Diagnostic Hearing Exam	**In-network:** **$50** copayment for Medicare-covered diagnostic hearing and balance exams when medically necessary. **Out-of-network:** **30%** coinsurance for Medicare-covered diagnostic hearing and balance exams when medically necessary.	**In-network:** **$50** copayment for Medicare-covered diagnostic hearing and balance exams when medically necessary. **Out-of-network:** **30%** coinsurance for Medicare-covered diagnostic hearing and balance exams when medically necessary.	**In-network:** **$50** copayment for Medicare-covered diagnostic hearing and balance exams when medically necessary. **Out-of-network:** **30%** coinsurance for Medicare-covered diagnostic hearing and balance exams when medically necessary.	**In-network:** **$40** copayment for Medicare-covered diagnostic hearing and balance exams when medically necessary. **Out-of-network:** **30%** coinsurance for Medicare-covered diagnostic hearing and balance exams when medically necessary.

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MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
○ Hearing Aids *(Max 2 aids every year (one per ear per year); Benefit is limited to the TruHearing Advanced and Premium hearing aids)*	**Advanced:** **$699** copay per aid **Premium:** **$999** copay per aid **Hearing aid purchases includes:** 3 provider visits within first year of hearing aid purchase; 45 day trial period; 3 year extended warranty; 48 batteries per aid	**Advanced:** $**699** copay per aid **Premium:** **$999** copay per aid **Hearing aid purchases includes:** 3 provider visits within first year of hearing aid purchase; 45 day trial period; 3 year extended warranty; 48 batteries per aid	**Advanced:** **$699** copay per aid **Premium:** **$999** copay per aid **Hearing aid purchases includes:** 3 provider visits within first year of hearing aid purchase; 45 day trial period; 3 year extended warranty; 48 batteries per aid	**Advanced:** **$699** copay per aid **Premium:** **$999** copay per aid **Hearing aid purchases includes:** 3 provider visits within first year of hearing aid purchase; 45 day trial period; 3 year extended warranty; 48 batteries per aid
	You must see a TruHearing provider to use this benefit. Call 1-844-341-9611 to schedule an appointment.	**You must see a TruHearing provider to use this benefit.** Call 1-844-341-9611 to schedule an appointment.	**You must see a TruHearing provider to use this benefit.** Call 1-844-341-9611 to schedule an appointment.	**You must see a TruHearing provider to use this benefit.** Call 1-844-341-9611 to schedule an appointment.
Dental Services ○ Medicare Covered Services	**In-network:** **$50** copay **Out-of-network:** **30%** of the cost *This does **not** include services in connection with care, treatment,*	**In-network:** **$50** copay **Out-of-network:** **30%** of the cost *This does **not** include services in connection with care, treatment,*	**In-network:** **$50** copay **Out-of-network:** **30%** of the cost *This does **not** include services in connection with care, treatment,*	**In-network:** **$40** copay **Out-of-network:** **30%** of the cost *This does **not** include services in connection with care, treatment,*

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MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
	filling, removal, or replacement of teeth.	*filling, removal, or replacement of teeth.*	*filling, removal, or replacement of teeth.*	*filling, removal, or replacement of teeth.*
○ Preventive Dental Services *(includes 2 cleanings, 2 exams, and 2 sets of bite-wing x-rays per year)*	**Preventive dental is not included in this plan.**	**Preventive dental is not included in this plan.**	**In-network:** You pay nothing **Out-of-network:** You pay nothing Non-preferred ("out-of-network") dental providers may "balance bill" for services above the maximum allowed amount.	**Comprehensive Dental services are included (please see below).**
○ Comprehensive Dental Services (*includes preventive dental services, and coverage for basic, major, and restorative services)*	**Comprehensive Dental Services are not included in this plan.**	**Comprehensive Dental Services are not included in this plan.**	**Comprehensive Dental Services are not included in this plan.**	**In-Network & Out-of-Network:** There is no copay for preventive dental services. **30%** coinsurance for the following services: oral surgery, general anesthesia, endodontics, periodontics, palliative, basic restorative and special consultations. **50%** coinsurance for the following services: crowns, inlays/onlays,

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Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
				prosthodontics, major restorative, and denture repairs. Non-preferred ("out-of-network") dental providers may "balance bill" for services above the maximum allowed amount.
Vision Services[1] ○ Medicare Covered Services *(1 yearly eye exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening))*	**In-Network:** **$20** copay **Out-of-Network:** **30%** of the cost	**In-Network:** **$20** copay **Out-of-Network:** **30%** of the cost	**In-Network:** **$20** copay **Out-of-Network:** **30%** of the cost	**In-Network:** **$20** copay **Out-of-Network:** **30%** of the cost
○ Routine Vision *(Limited to 1 routine eye exam per year)*	**In-Network:** **$25** copay **Out-of-Network:** **$25** copay Includes **$150 yearly allowance** for full set of	**In-Network:** **$25** copay **Out-of-Network:** **$25** copay Includes **$150 yearly allowance** for full set of	**In-Network:** **$25** copay **Out-of-Network:** **$25** copay Includes **$150 yearly allowance** for full set of	**In-Network:** **$25** copay **Out-of-Network:** **$25** copay Includes **$150 yearly allowance** for full set of

SUMMARY OF BENEFITS				
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Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
	eyeglasses or contact lenses.	eyeglasses or contact lenses.	eyeglasses or contact lenses.	eyeglasses or contact lenses.
Mental Health Services ○ Inpatient visit	**In-network:** **$375** copay per day for days 1 through 5. You pay nothing per day for days 6 through 90. **Out-of-network:** **$500** copay or **30%** of the cost per stay, depending on the service	**In-network:** **$350** copay per day for days 1 through 5. You pay nothing per day for days 6 through 90. **Out-of-network:** **$500** copay or **30%** of the cost per stay, depending on the service	**In-network:** **$325** copay per day for days 1 through 5. You pay nothing per day for days 6 through 90. **Out-of-network:** **$500** copay or **30%** of the cost per stay, depending on the service	**In-network:** **$275** copay per day for days 1 through 6. You pay nothing per day for days 7 through 90. **Out-of-network:** **$500** copay or **30%** of the cost per stay, depending on the service
○ Outpatient group therapy visit	**In-network:** **$40** copay **Out-of-network:** **$75** copay	**In-network:** **$40** copay **Out-of-network:** **$75** copay	**In-network:** **$40** copay **Out-of-network:** **$65** copay	**In-network:** **$40** copay **Out-of-network:** **$65** copay
○ Outpatient individual therapy visit	**In-network:** **$40** copay **Out-of-network:** **$75** copay	**In-network:** **$40** copay **Out-of-network:** **$75** copay	**In-network:** **$40** copay **Out-of-network:** **$65** copay	**In-network:** **$40** copay **Out-of-network:** **$65** copay
Skilled Nursing Facility (SNF)	**In-network:** **$20** copay per day for days 1 through 20; **$150** copay per day for days 21 through 34. You pay nothing per day for days 35 through 100.	**In-network:** **$20** copay per day for days 1 through 20; **$150** copay per day for days 21 through 34. You pay nothing per day for days 35 through 100.	**In-network:** **$20** copay per day for days 1 through 20; **$150** copay per day for days 21 through 34. You pay nothing per day for days 35 through 100.	**In-network:** **$20** copay per day for days 1 through 20; **$90** copay per day for days 21 through 34. You pay nothing per day for days 35 through 100.

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Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
	Out-of-network: **30%** of the cost per stay	**Out-of-network:** **30%** of the cost per stay	**Out-of-network:** **30%** of the cost per stay	**Out-of-network:** **30%** of the cost per stay
Outpatient Rehabilitation Services ○ Cardiac Rehab	**In-network:** **$15** copay **Out-of-network:** **30%** of the cost	**In-network:** **$15** copay **Out-of-network:** **30%** of the cost	**In-network:** **$15** copay **Out-of-network:** **30%** of the cost	**In-network:** **$15** copay **Out-of-network:** **30%** of the cost
○ Occupational Therapy	**In-network:** **$25** copay **Out-of-network:** **30%** of the cost	**In-network:** **$25** copay **Out-of-network:** **30%** of the cost	**In-network:** **$20** copay **Out-of-network:** **30%** of the cost	**In-network:** **$15** copay **Out-of-network:** **30%** of the cost
○ Physical therapy and speech-language therapy	**In-network:** **$25** copay **Out-of-network:** **30%** of the cost	**In-network:** **$25** copay **Out-of-network:** **30%** of the cost	**In-network:** **$20** copay **Out-of-network:** **30%** of the cost	**In-network:** **$15** copay **Out-of-network:** **30%** of the cost
Ambulance	**In-network:** **$250** copay **Out-of-network:** **30%** of the cost	**In-network:** **$250** copay **Out-of-network:** **30%** of the cost	**In-network:** **$200** copay **Out-of-network:** **30%** of the cost	**In-network:** **$200** copay **Out-of-network:** **30%** of the cost
Transportation[1,2]	**In-network:** You pay nothing **Out-of-network:** You pay nothing	**In-network:** You pay nothing **Out-of-network:** You pay nothing	**In-network:** You pay nothing **Out-of-network:** You pay nothing	**In-network:** You pay nothing **Out-of-network:** You pay nothing

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January 1, 2019 - December 31, 2019				
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
Foot Care (podiatry services) ○ Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions	**In-network:** **$50** copay **Out-of-network:** **$75** copay	**In-network:** **$50** copay **Out-of-network:** **$75** copay	**In-network:** **$50** copay **Out-of-network:** **$65** copay	**In-network:** **$40** copay **Out-of-network:** **$65** copay
Medical Equipment/Supplies ○ Durable Medical Equipment[1] (e.g., wheelchairs, oxygen)	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.	**In-network:** **10%** of the cost **Out-of-network:** **30%** of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.
○ Diabetes Monitoring Supplies	**In-network:** **0-20%** of the cost, depending on the supply **Out-of-network:** **30%** of the cost	**In-network:** **0-20%** of the cost, depending on the supply **Out-of-network:** **30%** of the cost	**In-network:** **0-20%** of the cost, depending on the supply **Out-of-network:** **30%** of the cost	**In-network:** **0-10%** of the cost, depending on the supply **Out-of-network:** **30%** of the cost
○ Diabetes self-management training	**In-network:** You pay nothing **Out-of-network:**	**In-network:** You pay nothing **Out-of-network:**	**In-network:** You pay nothing **Out-of-network:**	**In-network:** You pay nothing **Out-of-network:**

SUMMARY OF BENEFITS				
January 1, 2019 - December 31, 2019				
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
	30% of the cost	**30%** of the cost	**30%** of the cost	**30%** of the cost
○ Therapeutic Shoes or Inserts	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost	**In-network:** **10%** of the cost **Out-of-network:** **30%** of the cost
○ Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost	**In-network:** **10%** of the cost **Out-of-network:** **30%** of the cost
Wellness Programs ○ Health Education and Wellness	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs. *These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, special diets, and smoking cessation. Programs designed to enrich the health and lifestyles of members include weight management, and stress*	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs. *These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, special diets, and smoking cessation. Programs designed to enrich the health and lifestyles of members include weight management, and stress*	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs. *These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, special diets, and smoking cessation. Programs designed to enrich the health and lifestyles of members include weight management, and stress*	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs. *These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, special diets, and smoking cessation. Programs designed to enrich the health and lifestyles of members include weight management, and stress*

SUMMARY OF BENEFITS				
January 1, 2019 - December 31, 2019				
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
	management. In addition you will have access to the Hometown Health Hotline. **Out-of-network**: **30%** coinsurance for Medicare-covered health and wellness programs.	*management. In addition you will have access to the Hometown Health Hotline.* **Out-of-network**: **30%** coinsurance for Medicare-covered health and wellness programs.	*management. In addition you will have access to the Hometown Health Hotline.* **Out-of-network**: **30%** coinsurance for Medicare-covered health and wellness programs.	*management. In addition you will have access to the Hometown Health Hotline.* **Out-of-network**: **30%** coinsurance for Medicare-covered health and wellness programs.
○ Fitness	Fitness benefit is <u>not</u> included in this plan.	Senior Care Plus offers a gym membership at select gym facilities in our service area for active members enrolled in the Freedom Rx Plan. Please visit SeniorCarePlus.com for information on signing up for this benefit or contact Customer Service at 775-982-3112. Participating facilities may change throughout the plan year.	Senior Care Plus offers a gym membership at select gym facilities in our service area for active members enrolled in the Freedom Rx Enhanced Plan. Please visit SeniorCarePlus.com for information on signing up for this benefit or contact Customer Service at 775-982-3112. Participating facilities may change throughout the plan year.	Senior Care Plus offers a gym membership at select gym facilities in our service area for active members enrolled in the Freedom Rx Select Plan. Please visit SeniorCarePlus.com for information on signing up for this benefit or contact Customer Service at 775-982-3112. Participating facilities may change throughout the plan year.
Medicare Part B Drugs ○ Chemotherapy Drugs[1]	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost	**In-network:** **20%** of the cost **Out-of-network:** **30%** of the cost
○ Other Part B Drugs[1]	**In-network:**	**In-network:**	**In-network:**	**In-network:**

SUMMARY OF BENEFITS				
January 1, 2019 - December 31, 2019				
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
Premiums and Benefits	***Freedom Basic (PPO)***	***Freedom Rx (PPO)***	***Freedom Rx Enhanced (PPO)***	***Freedom Rx Select (PPO)***
	20% of the cost **Out-of-network:** **30%** of the cost	**20%** of the cost **Out-of-network:** **30%** of the cost	**20%** of the cost **Out-of-network:** **30%** of the cost	**20%** of the cost **Out-of-network:** **30%** of the cost

PRESCRIPTION DRUG COVERAGE										
SUMMARY OF BENEFITS										
January 1, 2019 - December 31, 2019										
	Freedom Basic (PPO)	**Freedom Rx (PPO)**			**Freedom Rx Enhanced (PPO)**			**Freedom Select (PPO)**		
Deductible	No deductible	You pay a **$250 deductible** for Tiers 3, 4, and 5.			You pay a **$175 deductible** for Tiers 3, 4, and 5.			No deductible		
Initial Coverage	Our plan does not cover Part D prescription drugs.	You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			You pay the following until your total yearly drug costs reach **$3,820**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.		
		Standard Retail Cost-Sharing			**Standard Retail Cost-Sharing**			**Standard Retail Cost-Sharing**		
		Tier	**30-day supply**	**90-day supply**	**Tier**	**30-day supply**	**90-day supply**	**Tier**	**30-day supply**	**90-day supply**
		Tier 1 (Preferred Generic)	**$8** copay	**$20** copay	Tier 1 (Preferred Generic)	**$6** copay	**$15** copay	Tier 1 (Preferred Generic)	**$3** copay	**$7.50** copay

PRESCRIPTION DRUG COVERAGE									
SUMMARY OF BENEFITS									
January 1, 2019 - December 31, 2019									
	Freedom Basic (PPO)	**Freedom Rx (PPO)**			**Freedom Rx Enhanced (PPO)**			**Freedom Select (PPO)**	
		Tier 2 (Non-Preferred Generic)	**$16** copay	**$40** copay	Tier 2 (Non-Preferred Generic)	**$14** copay	**$35** copay	Tier 2 (Non-Preferred Generic)	**$12** copay	**$30** copay
		Tier 3 (Preferred Brand)	**$47** copay	**$117.50** copay	Tier 3 (Preferred Brand)	**$47** copay	**$117.50** copay	Tier 3 (Preferred Brand)	**$47** copay	**$117.50** copay
		Tier 4 (Non-Preferred Brand)	**$100** copay	**$250** copay	Tier 4 (Non-Preferred Brand)	**$100** copay	**$250** copay	Tier 4 (Non-Preferred Brand)	**$100** copay	**$250** copay
		Tier 5 (Specialty Tier)	**28%** of the cost	**28%** of the cost	Tier 5 (Specialty Tier)	**29%** of the cost	**29%** of the cost	Tier 5 (Specialty Tier)	**33%** of the cost	**33%** of the cost
		Tier 6 (Select Care Tier)	**$4** copay	**$10** copay	Tier 6 (Select Care Tier)	**$3** copay	**$7.50** copay	Tier 6 (Select Care Tier)	**$0** copay	**$0** copay
		Standard Mail Order Cost-Sharing			**Standard Mail Order Cost-Sharing**			**Standard Mail Order Cost-Sharing**	
		Tier		**90-day supply**	**Tier**		**90-day supply**	**Tier**		**90-day supply**
		Tier 1 (Preferred Generic)		**$16** copay	Tier 1 (Preferred Generic)		**$12** copay	Tier 1 (Preferred Generic)		**$6** copay
		Tier 2 (Non-Preferred Generic)		**$32** copay	Tier 2 (Non-Preferred Generic)		**$28** copay	Tier 2 (Non-Preferred Generic)		**$24** copay

PRESCRIPTION DRUG COVERAGE							
SUMMARY OF BENEFITS							
January 1, 2019 - December 31, 2019							
	Freedom Basic (PPO)	**Freedom Rx (PPO)**		**Freedom Rx Enhanced (PPO)**		**Freedom Select (PPO)**	
		Tier 3 (Preferred Brand)	**$94** copay	Tier 3 (Preferred Brand)	**$94** copay	Tier 3 (Preferred Brand)	**$94** copay
		Tier 4 (Non-Preferred Brand)	**$200** copay	Tier 4 (Non-Preferred Brand)	**$200** copay	Tier 4 (Non-Preferred Brand)	**$200** copay
		Tier 5 (Specialty Tier)	**28%** of the cost	Tier 5 (Specialty Tier)	**29%** of the cost	Tier 5 (Specialty Tier)	**33%** of the cost
		Tier 6 (Select Care Tier)	**$8** copay	Tier 6 (Select Care Tier)	**$6** copay	Tier 6 (Select Care Tier)	**$0** copay
		If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.		If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.		If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.	
Coverage Gap		Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$3,820**.		Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$3,820**.		Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$3,820**.	

PRESCRIPTION DRUG COVERAGE							
SUMMARY OF BENEFITS							
January 1, 2019 - December 31, 2019							
	Freedom Basic (PPO)	**Freedom Rx (PPO)**	**Freedom Rx Enhanced (PPO)**	**Freedom Select (PPO)**			
		After you enter the coverage gap, you pay **30%** of the plan's cost for covered brand name drugs and **37%** of the plan's cost for covered generic drugs until your costs total **$5,100,** which is the end of the coverage gap. Not everyone will enter the coverage gap.	After you enter the coverage gap, you pay **30%** of the plan's cost for covered brand name drugs and **37%** of the plan's cost for covered generic drugs until your costs total **$5,100**, which is the end of the coverage gap. Not everyone will enter the coverage gap.	After you enter the coverage gap, you pay **30%** of the plan's cost for covered brand name drugs and **37%** of the plan's cost for covered generic drugs until your costs total **$5,100**, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.			
				Standard Retail Cost-Sharing			
				Tier	**Covered Drugs**	**30-day supply**	**90-day supply**
				Tier 1 (Preferred Generic)	All	**$3** copay	**$7.50** copay
				Tier 2 (Non-Preferred Generic)	All	**$12** copay	**$30** copay
				Tier 6 (Select)	All	**$0** copay	**$0** copay
				Standard Mail Order Cost-Sharing			
				Tier	**Covered Drugs**		**90-day supply**

PRESCRIPTION DRUG COVERAGE						
SUMMARY OF BENEFITS						
January 1, 2019 - December 31, 2019						
	Freedom Basic (PPO)	**Freedom Rx (PPO)**	**Freedom Rx Enhanced (PPO)**	**Freedom Select (PPO)**		
				Tier 1 (Preferred Generic)	All	**$6** copay
				Tier 2 (Non-Preferred Generic)	All	**$24** copay
				Tier 6 (Select Care)	All	**$0** copay
Catastrophic Coverage		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,100**, you pay the greater of: **5%** of the cost, or **$3.40** copay for generic (including brand drugs treated as generic) and the greater of **5%** of the cost, or **$8.50** copay for all other drugs	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,100**, you pay the greater of: **5%** of the cost, or **$3.40** copay for generic (including brand drugs treated as generic) and the greater of **5%** of the cost, or **$8.50** copay for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$5,100**, you pay the greater of: **5%** of the cost, or **$3.40** copay for generic (including brand drugs treated as generic) and the greater of **5%** of the cost, or **$8.50** copay for all other drugs		

Senior Care Plus is a PPO Medicare Advantage plan with a Medicare contract. Enrollment in Senior Care Plus depends on contract renewal.

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements and Non-Discrimination Statement

Discrimination is against the law.

Senior Care Plus complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Senior Care Plus does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Senior Care Plus:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Compliance Officer.

If you believe that Senior Care Plus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Compliance Officer, 10315 Professional Circle, Reno, NV, 89521, 800-611-5097, (TTY: 1- 800-833-5833). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.