

INTRODUCTION TO SUMMARY OF BENEFITS

January 1, 2021 - December 31, 2021

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

1. One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
2. Another choice is to get your Medicare benefits by joining a Medicare health plan such as a **Senior Care Plus HMO Plan**:
 - **Patriot Plan - 009 (HMO)**
 - **Essential Plan - 012 (HMO)**
 - **Select Plan - 018 (HMO)**
 - **Renown Preferred Plan by Senior Care Plus - 023 (HMO)**

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what the **Patriot Plan-009 (HMO)**, **Essential Plan-012 (HMO)**, **Select Plan-018 (HMO)**, or **Renown Preferred Plan by Senior Care Plus-023 (HMO)** covers and what you pay.

If you want to compare our plans 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 **Patriot Plan-009 (HMO)**, **Essential Plan-012 (HMO)**, **Select Plan-018 (HMO)**, or **Renown Preferred Plan by Senior Care Plus-023 (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefit
- Optional Benefits (you must pay an extra premium for these benefits)

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 Monday-Sunday, 7am-8pm (October 1st - March 31st); and Monday-Friday, 7am-8pm (April 1st - Sept 30th). TTY users should dial 711. We will be closed on all Federal holidays.

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 Patriot Plan-009 (HMO), Essential Plan-012 (HMO), Select Plan-018 (HMO), or Renown Preferred Plan by Senior Care Plus-023 (HMO)

Customer Service Hours of Operation

You can call us Monday-Sunday, 7am-8pm (October 1st - March 31st); and Monday-Friday, 7am-8pm (April 1st - Sept 30th). We will be closed on all Federal holidays.

Senior Care Plus Phone Numbers and Website

If you are a member of this plan, call toll-free 888-775-7003 or 775-982-3112 (TTY 711).
If you are not a member of this plan, 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 **Patriot Plan-009 (HMO), Essential Plan-012 (HMO), Select Plan-018 (HMO), or Renown Preferred Plan by Senior Care Plus-023 (HMO)** 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 county in Nevada: Carson City and Washoe counties.

Which doctors, hospitals, and pharmacies can I use?

Patriot Plan-009 (HMO), Essential Plan-012 (HMO), Select Plan-018 (HMO), or Renown Preferred Plan by Senior Care Plus-023 (HMO) 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: Patriot Plan (HMO) 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: Essential, Select, and Renown Preferred Plans (HMO) covers 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 my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what 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.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
SUMMARY OF BENEFITS				
January 1, 2021 - December 31, 2021				
Premiums and Benefits	Patriot Plan (HMO)	Essential Plan (HMO)	Select Plan (HMO)	Renown Preferred Plan (HMO)
Monthly Plan Premium	\$0 per month. In addition, you must keep paying your Medicare Part B premium.	\$0 per month. In addition, you must keep paying your Medicare Part B premium.	\$180 per month. In addition, you must keep paying your Medicare Part B premium.	\$0 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 \$50.	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.	Your yearly limit(s) in this plan: \$3,400 for services you receive from in-network providers.	Your yearly limit(s) in this plan: \$2,500 for services you receive from in-network providers.	Your yearly limit(s) in this plan: \$3,400 for services you receive from in-network providers.
COVERED MEDICAL AND HOSPITAL BENEFITS				
Services with a ¹ may require prior authorization. Services with a ² may require a referral from your doctor.				
Inpatient Hospital Coverage ^{1,2}	<ul style="list-style-type: none"> • Preferred: \$275 copay per day for days 1 through 6, you pay nothing per day for days 7 through 90. • Non-Preferred: \$440 copay per day or days 1 through 5, you pay nothing per day for days 6 through 90. 	<ul style="list-style-type: none"> • Preferred: \$275 copay per day for days 1 through 5, you pay nothing per day for days 6 through 90. • Non-Preferred: \$440 copay per day or days 1 through 5, you pay nothing per day for days 6 through 90. 	<ul style="list-style-type: none"> • Preferred: \$225 copay per day for days 1 through 4, you pay nothing per day for days 5 through 90. • Non-Preferred: \$440 copay per day or days 1 through 5, you pay nothing per day for days 6 through 90. 	<ul style="list-style-type: none"> • Preferred: \$275 copay per day for days 1 through 5, you pay nothing per day for days 5 through 90. • Non-Preferred: \$440 copay per day or days 1 through 5, you pay nothing per day for days 6 through 90.

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January 1, 2021 - December 31, 2021				
Premiums and Benefits	Patriot Plan (HMO)	Essential Plan (HMO)	Select Plan (HMO)	Renown Preferred Plan (HMO)
	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	Preferred: \$275 copay Non-Preferred: \$440 copay	Preferred: \$275 copay Non-Preferred: \$440 copay	Preferred: \$225 copay Non-Preferred: \$440 copay	Preferred: \$275 copay Non-Preferred: \$440 copay
Doctor Visits	\$0 copay for visits to preferred in-network primary care physicians. \$10 copay for visits to non-preferred in-network primary care physicians	\$0 copay for visits to preferred in-network primary care physicians. \$10 copay for visits to non-preferred in-network primary care physicians.	\$0 copay for visits to preferred in-network primary care physicians. \$10 copay for visits to non-preferred in-network primary care physicians.	\$0 copay for visits to in-network primary care physicians.
o Primary Care Visits				
o Specialists	\$40 copay	\$50 copay	\$25 copay	\$45 copay
Preventative Care	You pay nothing	You pay nothing	You pay nothing	You pay nothing
	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.
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.	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES				
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January 1, 2021 - December 31, 2021				
Premiums and Benefits	Patriot Plan (HMO)	Essential Plan (HMO)	Select Plan (HMO)	Renown Preferred Plan (HMO)
	<i>See "Inpatient Hospital Coverage" section of this booklet for other costs.</i>	<i>See "Inpatient Hospital Coverage" section of this booklet for other costs.</i>	<i>See "Inpatient Hospital Coverage" section of this booklet for other costs.</i>	<i>See "Inpatient Hospital Coverage" section of this booklet for other costs.</i>
Urgently Needed Services	\$30 copay, depending on location of the service	\$30 copay, depending on location of the service	\$20 copay, depending on location of the service	\$30 copay, depending on location of 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. <i>See the "Inpatient Hospital Care" section of this booklet for other costs.</i>	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services. <i>See the "Inpatient Hospital Care" section of this booklet for other costs.</i>	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services. <i>See the "Inpatient Hospital Care" section of this booklet for other costs.</i>	If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services. <i>See the "Inpatient Hospital Care" section of this booklet for other costs.</i>
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)	\$130 copay, depending on the service	\$135 copay, depending on the service	\$90 copay, depending on the service	\$125 copay, depending on the service
○ Lab Services	\$0 copay, depending on the service	\$0 copay, depending on the service	\$0 copay, depending on the service	\$0 copay, depending on the service
○ Diagnostic Tests & Procedures	\$0 copay, depending on the service	\$0 copay, depending on the service	\$0 copay, depending on the service	\$0 copay, depending on the service
○ Outpatient X-Rays	\$60 copay	\$70 copay	\$45 copay	\$60 copay

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January 1, 2021 - December 31, 2021				
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<ul style="list-style-type: none"> Therapeutic Radiology Services (e.g., radiation treatment for cancer) 	\$50 copay	\$60 copay	\$50 copay	\$50 copay
Hearing Services <ul style="list-style-type: none"> Hearing Exam 	In-network: \$45 copay <i>Limited to 1 routine hearing exam per year.</i>	In-network: \$45 copay <i>Limited to 1 routine hearing exam per year.</i>	In-network: \$45 copay <i>Limited to 1 routine hearing exam per year.</i>	In-network: \$45 copay <i>Limited to 1 routine hearing exam per year.</i>
<ul style="list-style-type: none"> Hearing Aids (<i>Max 2 aids per year; Benefit is limited to the TruHearing Advanced and Premium hearing aids</i>) 	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) 341-9614 to schedule an appointment.	You must see a TruHearing provider to use this benefit. Call 1-(844) 341-9614 to schedule an appointment.	You must see a TruHearing provider to use this benefit. Call 1-(844) 341-9614 to schedule an appointment.	You must see a TruHearing provider to use this benefit. Call 1-(844) 341-9614 to schedule an appointment.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

SUMMARY OF BENEFITS

January 1, 2021 - December 31, 2021

<i>Premiums and Benefits</i>	<i>Patriot Plan (HMO)</i>	<i>Essential Plan (HMO)</i>	<i>Select Plan (HMO)</i>	<i>Renown Preferred Plan (HMO)</i>
Dental Services <ul style="list-style-type: none"> ○ Medicare Covered Services 	<p>In-network: \$50 copay</p> <p><i>This does not include services in connection with care, treatment, filling, removal, or replacement of teeth</i></p>	<p>In-network: \$45 copay</p> <p><i>This does not include services in connection with care, treatment, filling, removal, or replacement of teeth</i></p>	<p>In-network: \$40 copay</p> <p><i>This does not include services in connection with care, treatment, filling, removal, or replacement of teeth</i></p>	<p>In-network: \$45 copay</p> <p><i>This does not include services in connection with care, treatment, filling, removal, or replacement of teeth</i></p>
<ul style="list-style-type: none"> ○ Preventive Dental Services (<i>includes 2 cleanings, 2 exams, and 2 sets of bite-wing x-rays per year</i>) 	<p>In-network: You pay nothing</p> <p>Out-of-network: You pay nothing*</p> <p>*Out-of-Network dentists may “balance bill” you for costs above Delta Dental’s allowed amount.</p>	<p>In-network: You pay nothing</p> <p>Out-of-network: You pay nothing*</p> <p>*Out-of-Network dentists may “balance bill” you for costs above Delta Dental’s allowed amount.</p>	<p>Comprehensive Dental Services are included in this plan at no additional premium. Please see below.</p>	<p>In-network: You pay nothing</p> <p>Out-of-network: You pay nothing*</p> <p>*Out-of-Network dentists may “balance bill” you for costs above Delta Dental’s allowed amount.</p>
<ul style="list-style-type: none"> ○ Comprehensive Dental Services 	<p>Comprehensive Dental Services are not included in this plan.</p>	<p>Comprehensive Dental Services are not included in this plan.</p>	<p>In-Network: There is no copayment for diagnostic and preventive dental services (maximum of 2 visits per year).</p> <p>30% coinsurance for non-routine, diagnostic, and restorative services.</p> <p>30% coinsurance for endodontics, periodontics, and extractions.</p>	<p>In-Network: There is no copayment for diagnostic and preventive dental services (maximum of 2 visits per year).</p> <p>30% coinsurance for non-routine, diagnostic, and restorative services.</p> <p>30% coinsurance for endodontics, periodontics, and extractions.</p>

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January 1, 2021 - December 31, 2021				
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			50% coinsurance for prosthodontics and oral/maxillofacial surgery. \$40 copay for Medicare-covered dental services.	50% coinsurance for prosthodontics and oral/maxillofacial surgery. \$45 copay for Medicare-covered dental services
Vision Services ¹ <ul style="list-style-type: none"> 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	In-Network: \$20 copay	In-Network: \$20 copay	In-Network: \$20 copay
<ul style="list-style-type: none"> Routine Vision (Limited to 1 routine eye exam per year) 	In-Network: \$25 copay Includes \$150 yearly allowance for full set of eyeglasses or contact lenses.	In-Network: \$25 copay Includes \$150 yearly allowance for full set of eyeglasses or contact lenses.	In-Network: \$25 copay Includes \$150 yearly allowance for full set of eyeglasses or contact lenses.	In-Network: \$ 25 copay Includes \$150 yearly allowance for full set of eyeglasses or contact lenses.
Mental Health Services <ul style="list-style-type: none"> Inpatient visit 	Preferred: \$275 copay per day for days 1 through 6. You pay nothing per day for days 7 through 90. Non-Preferred: \$440 copay per day for days 1	Preferred: \$275 copay per day for days 1 through 5. You pay nothing per day for days 6 through 90. Non-Preferred: \$440 copay per day for days 1	Preferred: \$225 copay per day for days 1 through 4. You pay nothing per day for days 5 through 90. Non-Preferred: \$440 copay per day for days 1	Preferred: \$275 copay per day for days 1 through 5. You pay nothing per day for days 5 through 90. Non-Preferred: \$440 copay per day for days 1

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January 1, 2021 - December 31, 2021				
<i>Premiums and Benefits</i>	<i>Patriot Plan (HMO)</i>	<i>Essential Plan (HMO)</i>	<i>Select Plan (HMO)</i>	<i>Renown Preferred Plan (HMO)</i>
	through 5. You pay nothing per day for days 6 through 90	through 5. You pay nothing per day for days 6 through 90	through 5. You pay nothing per day for days 6 through 90	through 5. You pay nothing per day for days 6 through 90
○ Outpatient group therapy visit	\$40 copay	\$40 copay	\$35 copay	\$40 copay
○ Outpatient individual therapy visit	\$40 copay	\$40 copay	\$35 copay	\$40 copay
Skilled Nursing Facility (SNF)	\$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	\$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	\$20 copay per day for days 1 through 20; \$100 copay per day for days 21 through 34. You pay nothing per day for days 35 through 100	\$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
Outpatient Rehabilitation Services	\$15 copay	\$15 copay	\$15 copay	\$15 copay
○ Cardiac Rehab				
○ Occupational Therapy	\$20 copay	\$20 copay	\$15 copay	\$20 copay
○ Physical therapy and speech and language therapy	\$20 copay	\$20 copay	\$15 copay	\$20 copay
Ambulance	\$250 copay	\$250 copay	\$250 copay	\$250 copay
Transportation ^{1,2}	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Medicare Part B Drugs Chemotherapy Drugs ¹	20% of the cost	20% of the cost	20% of the cost	20% of the cost
Other Part B Drugs ¹	20% of the cost	20% of the cost	20% of the cost	20% of the cost

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January 1, 2021 - December 31, 2021				
<i>Premiums and Benefits</i>	<i>Patriot Plan (HMO)</i>	<i>Essential Plan (HMO)</i>	<i>Select Plan (HMO)</i>	<i>Renown Preferred Plan (HMO)</i>
Ambulatory Surgery Center	Preferred: \$275 per visit Non-Preferred: \$440 per visit	Preferred: \$275 copay Non-Preferred: \$440 copay	Preferred: \$225 copay Non-Preferred: \$440 copay	Preferred: \$275 copay Non-Preferred: \$440 copay
Foot Care (podiatry services) <ul style="list-style-type: none"> ○ Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions 	\$40 copay	\$50 copay	\$25 copay	\$45 copay
Medical Equipment/Supplies <ul style="list-style-type: none"> ○ Durable Medical Equipment¹ (e.g., wheelchairs, oxygen) 	20% of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.	20% of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.	10% of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.	20% 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	20% of the cost, depending on the supply	20% of the cost, depending on the supply	10% of the cost, depending on the supply	20% of the cost, depending on the supply
○ Diabetes self-management training	You pay nothing	You pay nothing	You pay nothing	You pay nothing
○ Therapeutic Shoes or Inserts	20% of the cost	20% of the cost	10% of the cost	20% of the cost
○ Prosthetic Devices (braces, artificial limbs, etc.) ¹	20% of the cost	20% of the cost	10% of the cost	20% of the cost
Wellness Programs	In-Network:	In-Network:	In-Network:	In-Network:

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<ul style="list-style-type: none"> ○ Health Education and Wellness 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs.</p> <p><i>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 management. In addition you will have access to the Hometown Health Hotline.</i></p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs.</p> <p><i>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 management. In addition you will have access to the Hometown Health Hotline.</i></p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs.</p> <p><i>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 management. In addition you will have access to the Hometown Health Hotline.</i></p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered health and wellness programs.</p> <p><i>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 management. In addition you will have access to the Hometown Health Hotline.</i></p>
<ul style="list-style-type: none"> ○ Fitness 	<p>Senior Care Plus offers a gym membership at select gym facilities in our service area for active members enrolled in the Patriot Plan.</p> <p>Please visit SeniorCarePlus.com for information on signing up</p>	<p>Senior Care Plus offers a gym membership at select gym facilities in our service area for active members enrolled in the Essential Plan.</p> <p>Please visit SeniorCarePlus.com for information on signing up</p>	<p>Senior Care Plus offers a gym membership at select gym facilities in our service area for active members enrolled in the Select Plan.</p> <p>Please visit SeniorCarePlus.com for information on signing up</p>	<p>Senior Care Plus offers a gym membership at select gym facilities in our service area for active members enrolled in the Renown Plan.</p> <p>Please visit SeniorCarePlus.com for information on signing up</p>

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January 1, 2021 - December 31, 2021				
Premiums and Benefits	Patriot Plan (HMO)	Essential Plan (HMO)	Select Plan (HMO)	Renown Preferred Plan (HMO)
	for this benefit or contact Customer Service at 775-982-3112. Participating facilities may change throughout the plan year.	for this benefit or contact Customer Service at 775-982-3112. Participating facilities may change throughout the plan year.	for this benefit or contact Customer Service at 775-982-3112. Participating facilities may change throughout the plan year.	for this benefit or contact Customer Service at 775-982-3112. Participating facilities may change throughout the plan year.
○ Teladoc Virtual Visits	\$0 copay	\$0 copay	\$0 copay	\$0 copay

SUMMARY OF BENEFITS										
January 1, 2021 - December 31, 2021										
	Patriot Plan (HMO)	Essential Plan (HMO)			Select Plan (HMO)			Renown Plan (HMO)		
PRESCRIPTION DRUG BENEFITS										
Initial Coverage	Our plan does not cover Part D prescription drug.	You pay the following until your total yearly drug costs reach \$4,130 . 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 \$4,130 . 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 \$4,130 . Total yearly drug costs are the total drug costs paid by both you and our Part D plan.		
		You may get your drugs at network retail pharmacies and mail order pharmacies.			You may get your drugs at network retail pharmacies and mail order pharmacies.			You may get your drugs at network retail pharmacies and mail order pharmacies.		
		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

SUMMARY OF BENEFITS

January 1, 2021 - December 31, 2021

	<i>Patriot Plan (HMO)</i>	<i>Essential Plan (HMO)</i>			<i>Select Plan (HMO)</i>			<i>Renown Plan (HMO)</i>		
PRESCRIPTION DRUG BENEFITS										
		Tier 1 (Preferred Generic) Standard / Preferred	\$11 / \$5 copay	\$27.50 / \$12.50 copay	Tier 1 (Preferred Generic)	\$6 / \$0 copay	\$15 / \$0 copay	Tier 1 (Preferred Generic)	\$11 / \$5 copay	\$27.50 / \$12.50 copay
		Tier 2 (Non-Preferred Generic) Standard / Preferred	\$20 / \$12 copay	\$50 / \$30 copay	Tier 2 (Non-Preferred Generic)	\$8 / \$0 copay	\$20 / \$0 copay	Tier 2 (Non-Preferred Generic)	\$20 / \$12 copay	\$50 / \$30 copay
		Tier 3 (Preferred Brand) Standard / Preferred	\$47 / \$41 copay	\$117.50 / \$102.50 copay	Tier 3 (Preferred Brand)	\$47 / \$41 copay	\$117.50 / \$102.50 copay	Tier 3 (Preferred Brand)	\$47 / \$41 copay	\$117.50 / \$102.50 copay
		Tier 4 (Non-Preferred Brand) Standard / Preferred	\$100 / \$94 copay	\$250 / \$235 copay	Tier 4 (Non-Preferred Brand)	\$100 / \$94 copay	\$250 / \$235 copay	Tier 4 (Non-Preferred Brand)	\$100 / \$94 copay	\$250 / \$235 copay
		Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost	33% of the cost
		Tier 6 (Select Care Tier) Standard / Preferred	\$8.50 / \$2.50 copay	\$21.25 / \$6.25 copay	Tier 6 (Select Care Tier)	\$6 / \$0 copay	\$15 / \$0 copay	Tier 6 (Select Care Tier)	\$8.50 / \$2.50 copay	\$21.25 / \$6.25 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	

SUMMARY OF BENEFITS

January 1, 2021 - December 31, 2021

	<i>Patriot Plan (HMO)</i>	<i>Essential Plan (HMO)</i>		<i>Select Plan (HMO)</i>		<i>Renown Plan (HMO)</i>	
PRESCRIPTION DRUG BENEFITS							
		Tier 1 (Preferred Generic)	\$10 copay	Tier 1 (Preferred Generic)	\$0 copay	Tier 1 (Preferred Generic)	\$10 copay
		Tier 2 (Non-Preferred Generic)	\$24 copay	Tier 2 (Non-Preferred Generic)	\$0 copay	Tier 2 (Non-Preferred Generic)	\$24 copay
		Tier 3 (Preferred Brand)	\$82 copay	Tier 3 (Preferred Brand)	\$82 copay	Tier 3 (Preferred Brand)	\$82 copay
		Tier 4 (Non-Preferred Brand)	\$188 copay	Tier 4 (Non-Preferred Brand)	\$188 copay	Tier 4 (Non-Preferred Brand)	\$188 copay
		Tier 5 (Specialty Tier)	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost	Tier 5 (Specialty Tier)	33% of the cost
		Tier 6 (Select Care Tier)	\$5 copay	Tier 6 (Select Care Tier)	\$0 copay	Tier 6 (Select Care Tier)	\$5 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 \$4,130 .		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		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 \$4,130 .	

SUMMARY OF BENEFITS

January 1, 2021 - December 31, 2021

	<i>Patriot Plan (HMO)</i>	<i>Essential Plan (HMO)</i>	<i>Select Plan (HMO)</i>				<i>Renown Plan (HMO)</i>							
PRESCRIPTION DRUG BENEFITS														
			and what you have paid) reaches \$4,130.											
		<p>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>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.</p>	<p>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>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.</p>				<p>After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total \$6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>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.</p>							
Standard Retail Cost-Sharing														
		Tier	Drugs Covered	30-day supply	90-day supply	Tier	Drugs Covered	30-day supply	90-day supply	Tier	Drugs Covered	30-day supply	90-day supply	
		Tier 6 (Select Care) Standard /	All	\$8.50 / \$2.50 copay	\$21.50 / \$6.25 copay	Tier 1 (Preferred Generic)	All	\$6 / \$0 copay	\$15 / \$0 copay	Tier 6 (Select Care) Standard and Preferred	All	\$8.50 / \$2.50 copay	\$21.50 / \$6.25 copay	

SUMMARY OF BENEFITS

January 1, 2021 - December 31, 2021

	<i>Patriot Plan (HMO)</i>	<i>Essential Plan (HMO)</i>			<i>Select Plan (HMO)</i>			<i>Renown Plan (HMO)</i>			
PRESCRIPTION DRUG BENEFITS											
		Preferred									
					Tier 2 (Generic)	All	\$8 / \$0 copay	\$20 / \$0 copay			
					Tier 6 (Select Care)	All	\$6 / \$0 copay	\$15 / \$0 copay			
		Standard Mail Order Cost-Sharing									
		Tier	Drugs Covered	100-day supply	Tier	Drugs Covered	100-day supply	Tier	Drugs Covered	100-day supply	
		Tier 6 (Select Care)	All	\$0 copay	Tier 1 (Preferred Generic)	All	\$0 copay	Tier 1 (Preferred Generic)	All	\$0 copay	
					Tier 2 (Generic)	All	\$0 copay				
					Tier 6 (Select Care)	All	\$0 copay				
Catastrophic Coverage		After your yearly out-of-pocket drug costs (including drugs purchased			After your yearly out-of-pocket drug costs (including drugs purchased			After your yearly			

SUMMARY OF BENEFITS

January 1, 2021 - December 31, 2021

	<i>Patriot Plan (HMO)</i>	<i>Essential Plan (HMO)</i>	<i>Select Plan (HMO)</i>	<i>Renown Plan (HMO)</i>		
PRESCRIPTION DRUG BENEFITS						
		through your retail pharmacy and through mail order) reach \$6,550 , you pay the greater of:	through your retail pharmacy and through mail order) reach \$6,550 , you pay the greater of:	out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,550 , you pay the greater of:		
		5% of the cost, or \$3.70 copay for generic (including brand drugs treated as generic) and the greater of 5% of the cost, or \$9.20 copay for all other drugs.	5% of the cost, or \$3.70 copay for generic (including brand drugs treated as generic) and the greater of 5% of the cost, or \$9.20 copay for all other drugs.	5% of the cost, or \$3.70 copay for generic (including brand drugs treated as generic) and the		

SUMMARY OF BENEFITS

January 1, 2021 - December 31, 2021

	<i>Patriot Plan (HMO)</i>	<i>Essential Plan (HMO)</i>	<i>Select Plan (HMO)</i>	<i>Renown Plan (HMO)</i>		
PRESCRIPTION DRUG BENEFITS						
				greater of 5% of the cost, or \$9.20 copay for all other drugs.		

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

This information is not a complete description of benefits. Call 1- 888-775-7003 (711 TTY) for more information.

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>.