Senior Care Plus

FOR THESE PLANS, BENEFICIARIES MUST RESIDE IN **WASHOE COUNTY** OR **CARSON CITY**.

Choose Your 2022 Plan

HMO Benefits	Original Medicare (2021 AMOUNTS)	Patriot Plan-009	Essential Plan-012	Select Plan-018	Renown Preferred Plan by Senior Care Plus-023
MONTHLY PLAN PREMIUM	**$0**	**$0**	**$0**	**$180**	**$0**
PART B REBATE	**N/A**	**$50**	**N/A**	**N/A**	**N/A**
Maximum Out-of-Pocket	No Maximum OOP	$2,500 per year	$3,400 per year	$2,500 per year	$3,400 per year
Out-of-Network Benefits	Medicare Assigned Provider	Not covered	Not covered	Not covered	Not covered
Primacy Care Physician (PCP)	$203 deductible / 20% per visit	$0 Per visit (Preferred PCP) $10 per visit (Non-Preferred PCP)	$0 per visit (Preferred PCP) $10 per visit (Non-Preferred PCP)	$0 Per visit (Preferred PCP) $10 per visit (Non-Preferred PCP)	$0 per visit
Specialist Office Visits	20% per visit	$40 per visit	$50 per visit	$25 per visit	$45 per visit
Inpatient Hospital	$1,484 deductible / $0 days 1-60 / $371 days 61-90	Preferred: $250 / 6 days per period Non-Preferred: $440 / 5 days per period	Preferred: $300 / 5 days per period Non-Preferred: $440 / 5 days per period	Preferred: $250 / 4 days per period Non-Preferred: $440 / 5 days per period	Preferred: $300 / 5 days per period Non-Preferred: $440 / 5 days per period
Outpatient Hospital Services	20% per visit	Preferred: $275 per visit / Non-Preferred: $440 per visit	Preferred: $275 per visit / Non-Preferred: $440 per visit	Preferred: $225 per visit / Non-Preferred: $440 per visit	Preferred: $275 per visit / Non-Preferred: $440 per visit
Skilled Nursing	$0 days 1-20 / $185.50 days 21-100	$20 days 1-20 / $150 days 21-34	$20 days 1-20 / $150 days 21-34	$20 days 1-20 / $100 days 21-34	$20 days 1-20 / $150 days 21-34
Emergency Room Care	20% per visit	$120 per visit	$120 per visit	$120 per visit	$120 per visit
Urgently Need Care	20% per visit	$30 / $65 per visit	$30 / $65 per visit	$20 / $45 per visit	$30 / $65 per visit
Teladoc	Not covered	$0 per visit	$0 per visit	$0 per visit	$0 per visit
Ambulance Services	20% per trip	$250 per trip	$250 per trip	$250 per trip	$250 per trip
Diagnostic Tests (X-ray, CT, MRI)	20% per test	$60 / $95 / $130 per visit	$70 / $100 / $135 per visit	$45 / $65 / $90 per visit	$60 / $90 / $125 per visit
Routine Lab Services	20% per test	$0 per visit	$0 per visit	$0 per visit	$0 per visit
Preventive Services	No copayment	$0 per visit	$0 per visit	$0 per visit	$0 per visit
Durable Medical Equipment	20% per item	20% per item	20% per item	10% per item	20% per item
Chiropractic Services	$203 deductible / 20% per visit	$20 per visit	$20 per visit	$20 per visit	$20 per visit
Vision (Routine Coverage)	Not covered	$25 per exam / $150 allowance	$25 per exam / $150 allowance	$25 per exam / $150 allowance	$25 per exam / $150 allowance
Hearing Exam / Hearing Aid Coverage	Diagnostic & Balance Exams - 20% coinsurance / Not covered	$45 per exam (yearly) / 2 TruHearing hearing aids per year; $699 / $999	$45 per exam (yearly) / 2 TruHearing hearing aids per year; $699 / $999	$45 per exam (yearly) / 2 TruHearing hearing aids per year; $699 / $999	$45 per exam (yearly) / 2 TruHearing hearing aids per year; $699 / $999
Fitness Benefit	Not covered / Not covered	Included – See list of gyms	Included – See list of gyms	Included – See list of gyms	Included – See list of gyms
Dental Coverage (Delta Dental)	Not covered / Not covered	Preventative Included	Preventative Included	$2,000 Comprehensive Included	$2,000 Comprehensive Included
OTC Benefit (FieldTex)	Not covered	$25 Quarter	$25 Quarter	$75 Quarter	$50 Quarter
Acupuncture (Low back pain only)	Not covered	$30 visit / max 20 visits	$30 visit / max 20 visits	$30 visit / max 20 visits	$30 visit / max 20 visits
Rx-Annual Deductible*	Not covered	N/A	N/A	N/A	N/A
Rx-Coverage in the Gap*	Not covered	Not covered	Preferred $2.50 (Tier 6) / Non-Preferred $8.50 (Tier 6)	$0 / $0/ $0 (Tiers 1,2,6)	Preferred $2.50 (Tier 6) / Non-Preferred $8.50 (Tier 6)
Rx-Preferred Generic (1)*	Not covered	Not covered	Preferred $5 / Non-Preferred $11	Preferred $0 / Non-Preferred $6	Preferred $5 / Non-Preferred $11
Rx-Non-Preferred Generic (2)*	Not covered	Not covered	Preferred $12 / Non-Preferred $20	Preferred $0 / Non-Preferred $8	Preferred $12 / Non-Preferred $20
Rx-Preferred Brand (3)*	Not covered	Not covered	Preferred $41 / Non-Preferred $47 / Senior Savings $35	Preferred $41 / Non-Preferred $47 / Senior Savings $35	Preferred $41 / Non-Preferred $47 / Senior Savings $35
Rx-Non-Preferred Brand (4)*	Not covered	Not covered	Preferred $94 / Non-Preferred $100	Preferred $94 / Non-Preferred $100	Preferred $94 / Non-Preferred $100
Rx-Specialty (5)*	Not covered	Not covered	33% coinsurance	33% coinsurance	33% coinsurance
Rx-Select Drug (6)*	Not covered	Not covered	Preferred $2.50 / Non-Preferred $8.50	Preferred $0 / Non-Preferred $6	Preferred $2.50 / Non-Preferred $8.50
Rx-90-Day Retail / Rx-90-Day Mail*	Not covered	Not covered	2.5 times 30-day / 2 times 30 day	2.5 times 30-day / 2 times 30-day	2.5 times 30-day / 2 times 30 day

**All copays are for a 30-day supply unless otherwise noted. / Preferred Pharmacies: Renown and CVS / Rx 90-day Retail you pay 2.5 times for a 30-day supply / Rx 90-day Mail order you pay 2 times a 30-day supply*

This is a partial list of benefits and should not be construed as a complete list. Please refer to the Evidence of Coverage for complete plan details. 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.

Hometown Health Renown HEALTH

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