2023
Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Senior Care Plus Extensive Duals Plan (HMO)

January 1, 2023 – December 31, 2023

Senior Care Plus

A Medicare Advantage Plan from Hometown Health.

H2960_2023_SummeryBenefits_024_M

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, http://www.seniorcareplus.com.

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 Senior Care Plus Extensive Duals Plan (HMO D-SNP).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what Senior Care Plus Extensive Duals Plan (HMO D-SNP) 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 Senior Care Plus Extensive Duals Plan (HMO D-SNP).
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.
- Prescription Drug 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 1-800-681-9585 (TTY: 711).

Things to Know About Senior Care Plus Extensive Duals Plan (HMO D-SNP)

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.
- If you are a member of this plan, call us at 1-888-775-7003, TTY: 711.
- If you are not a member of this plan, call us at 1-888-775-7003, TTY: 711.
- Our website: http://www.seniorcareplus.com.

Who can join?

To join Senior Care Plus Extensive Duals Plan (HMO D-SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area and receive any level of assistance from the Nevada Medicaid. If you receive both Medicare and Medicaid benefits, this means you are a dual-eligible beneficiary. Our service area includes these counties in Nevada: Carson City and Washoe.

Senior Care Plus Extensive Duals Plan (HMO D-SNP) may enroll dual-eligibles who are ["QMB", "QMB+", "FBDE"].

Which doctors, hospitals, and pharmacies can I use?

Senior Care Plus Extensive Duals Plan (HMO D-SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

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 (http://www.seniorcareplus.com).

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

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 D drugs. In addition, we cover Part B drugs including 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, http://www.seniorcareplus.com.
- Or, 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 5 "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.

If you have any questions about this plan's benefits or costs,
please contact Senior Care Plus

2 SECTION II - SUMMARY OF BENEFITS

Senior Care Plus Extensive Duals Plan (HMO D-SNP)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$32.50 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: $505
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $8,300 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
COVERED MEDICAL AND HOSPITAL BENEFITS If you are QMB, QMB+ or FBDE you pay $0 cost share for the services below.	
Inpatient Hospital	You pay $0 Copay. May require prior authorization.
Outpatient Hospital	Outpatient hospital: 20% Coinsurance. May require prior authorization.
Ambulatory Surgical Center	Ambulatory Surgical Center: 20% Coinsurance. May require prior authorization.
Doctor's Office Visits	Primary care physician visit: 20% Coinsurance. Specialist visit: 20% Coinsurance. May require prior authorization.

Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay nothing 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	20% Coinsurance per visit. If you are admitted to the hospital within 3Days, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: 20% Coinsurance.
Urgently Needed Services	20% Coinsurance per visit.
Diagnostic Services / Labs/ Imaging	Diagnostic tests and procedures: 20% Coinsurance. Lab services: 0% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 20% Coinsurance. X-rays: 20% Coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. May require prior authorization.
Hearing Services	Exam to diagnose and treat hearing and balance issues: 20% Coinsurance. Routine hearing exam (for up to 1 Every year): $0 Copay. Hearing Aid (up to 2 hearing aids every year): $495 - $1,970 Copay.
Dental Services	Medicare Covered: $40 Copay. Preventive dental services: • Oral exam (up to 1 visits every year): You Pay Nothing. • Cleaning (up to 2 visits every year): You Pay Nothing. • Dental X-rays (up to 1 visits Other, Describe): You Pay Nothing. Comprehensive dental services: • Diagnostic Services: 0% Coinsurance. • Restorative Services: 0% Coinsurance. • Extractions: 0% Coinsurance.

	• Endodontics: 0% Coinsurance. • Periodontics: 0% Coinsurance. • Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 0% Coinsurance. This dental plan will pay up to $2,000 maximum per calendar year.
Vision Services	Routine eye exam (up to 1 visits every year): $0 Copay. Our plan pays up to $250 every year for full set of eyeglasses or contact lenses.
Mental Health Care	Outpatient group therapy visit: 20% Coinsurance. Individual therapy visit: 20% Coinsurance.
Skilled Nursing Facility (SNF)	May require prior authorization.
Outpatient Rehabilitation	Occupational therapy visit: 20% Coinsurance. Physical therapy and speech and language therapy visit: 20% Coinsurance. May require prior authorization.
Ambulance	Ground Ambulance: 20% Coinsurance. Air Ambulance: 20% Coinsurance. May require prior authorization.
Transportation	$0 Copay. 36 One-way trips Every year to Plan-approved Location May require prior authorization.
Medicare Part B Drugs	For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. May require prior authorization.
PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: Not Applicable.
Initial Coverage	You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing			
Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive
Tier 2 (Generic)	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive
Tier 3 (Preferred Generic)	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive
Tier 4 (Non-Preferred Brand)	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive
Tier 5 (Specialty Tier)	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive
Preferred Retail Cost-Sharing			
Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive
Tier 2 (Generic)	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive
Tier 3 (Preferred Generic)	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive
Tier 4 (Non-Preferred Brand)	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive	$0 - $10.35 copay, depending on the level of "Extra Help" you receive

<table>
<tr><td></td><td>
<table>
<tr><td>Tier 5 (Specialty Tier)</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td></tr>
<tr><td colspan="4">Standard Mail Order</td></tr>
<tr><td>Tier</td><td>One-month supply</td><td>Two-month supply</td><td>Three-month supply</td></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 - $4.15 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $4.15 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $4.15 copay, depending on the level of “Extra Help” you receive</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 - $4.15 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $4.15 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $4.15 copay, depending on the level of “Extra Help” you receive</td></tr>
<tr><td>Tier 3 (Preferred Generic)</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td><td>$0 - $10.35 copay, depending on the level of “Extra Help” you receive</td></tr>
</table>
Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to days) of a drug.
Please call us or see the plan’s “Evidence of Coverage” on our website (http://www.seniorcareplus.com) for complete information about your costs for covered drugs.
</td></tr>
<tr><td>Coverage Gap</td><td>
The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660.
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 $7,400, which is the end of the coverage gap.
</td></tr>
</table>

	Our plan covers Tier 1 s in the coverage gap.
Catastrophic Amount	After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: • $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs, or • 5% of the cost.

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 **775-982-3242** (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al **775-982-3242** (TTY: 711).

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

This information is not a complete description of benefits. Call **888-775-7003** (TTY 711) 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 formulary, pharmacy network, and/or 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 Senior Care Plus 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 Member Services 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 Hometown Health Plan, Inc..