This is a summary of drug and health services covered in the SeniorCare Advantage HMO plan, offered by Scott and White Health Plan.

Summary of Benefits

January 1, 2019 - December 31, 2019

SeniorCare Advantage HMO is offered by Scott and White Health Plan, a Medicare Advantage organization with a Medicare contract. Enrollment in SeniorCare Advantage depends on contract renewal.

This booklet gives you 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, refer to the *Evidence of Coverage*, available on our website at advantage.swhp.org by October 15, 2018.

Tips for comparing your Medicare choices

This Summary of Benefits gives you a summary of what SeniorCare Advantage HMO covers and what you pay.

- If you want to compare our plan with other Medicare 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.

Things to know about SeniorCare Advantage HMO

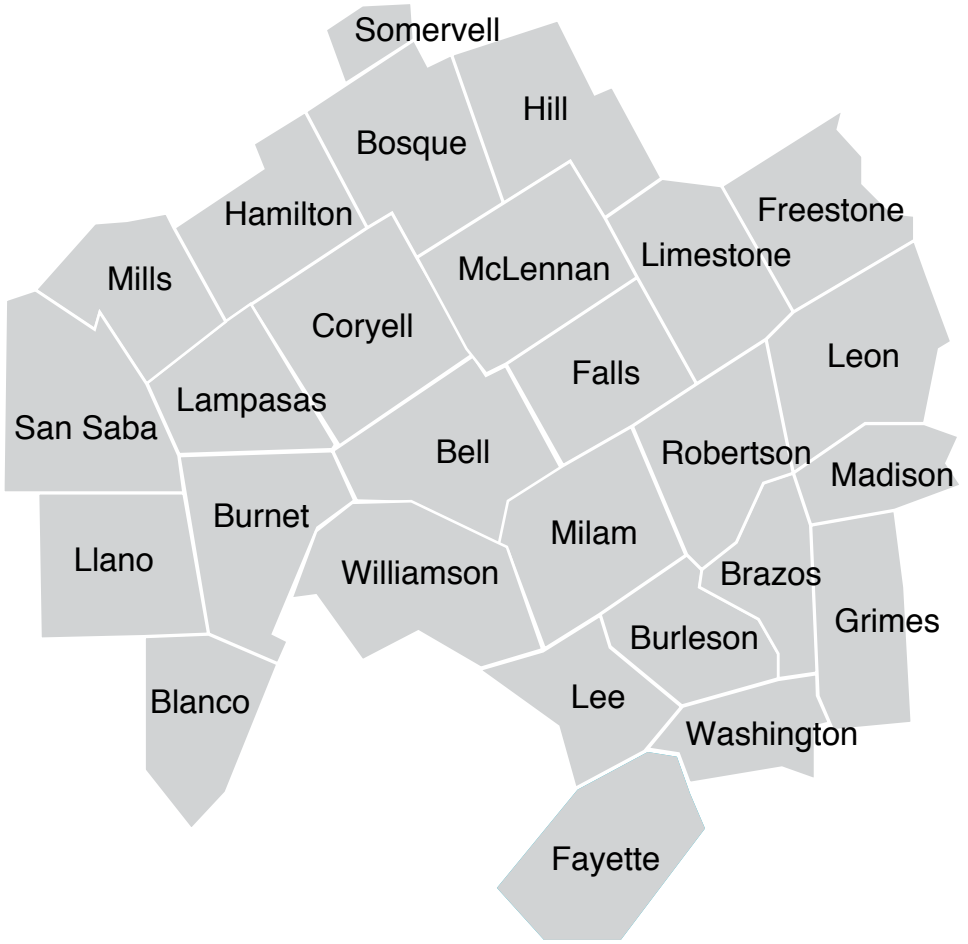
- You can call us 7 a.m. – 8 p.m., seven days a week.
- If you are a member of this plan, call toll free 1-866-334-3141 or TTY 711.
- If you are not a member of this plan, call toll-free 1-800-782-5068 or TTY 711.
- Our website: advantage.swhp.org

This document is available in other formats such as large print. The document may be available in a non-English language.

Who can join?

To join SeniorCare Advantage HMO, you must have Medicare Part A and Medicare Part B, and live in our service area. Our service area includes these counties in Texas: Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hill, Lampasas, Lee, Leon, Limestone, Llano, McLennan, Madison, Milam, Mills, Robertson, San Saba, Somervell, Washington, and Williamson.

What is the service area for **SeniorCare Advantage HMO?**



The counties in the service area are listed below:

Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington, Williamson

Which doctors, hospitals, and pharmacies can I use?

SeniorCare Advantage HMO has a network directory of doctors, hospitals, pharmacies, and other providers that can be found on our website at advantage.swhp.org. You must use network providers and pharmacies for covered services, unless authorized by the Plan.

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 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.

SeniorCare Advantage HMO covers Medicare Part B and Part D drugs. Certain limitations may apply.

How will I determine my drug costs?

Our plan groups each medication into one of five "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. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, advantage.swhp.org.

Premiums and Benefits	Select	Preferred	Premium
Monthly Plan Premium			
With Part D prescription drug coverage	You pay $0 per month.	You pay $130 per month.	You pay $240 per month.
Without Part D prescription drug coverage	You pay $0 per month.	You pay $90 per month.	You pay $199 per month.
You must continue to pay your Medicare Part B premium.			
Deductible	You pay nothing.	You pay nothing.	You pay nothing.
Maximum Out-of-Pocket Responsibility ***(does not include prescription drugs)***	You pay $5,300 annually.	You pay $3,400 annually.	You pay $3,400 annually.
Inpatient Hospital Coverage	Days 1-5: You pay $350 copay per day. Days 6-90: You pay nothing.	You pay $450 copay per stay.	You pay nothing.
Outpatient Hospital Coverage			
Ambulatory Surgical Center	You pay $275 copay.	You pay $100 copay.	You pay nothing.
Outpatient Hospital Services	You pay $350 copay.	You pay $15 copay.	You pay nothing.
Doctor Visits			
Primary Care Providers	You pay nothing per visit.	You pay $15 copay per visit.	You pay nothing per visit.
Specialists	You pay $40 copay per visit.	You pay $15 copay per visit.	You pay nothing per visit.
Preventive Care	You pay nothing.	You pay nothing.	You pay nothing.

Premiums and Benefits	Select	Preferred	Premium
Emergency Care	You pay $80 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.	You pay $120 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.	You pay $120 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.
Urgently Needed Services	You pay $50 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.	You pay $40 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.	You pay $40 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.
Diagnostic Services/Labs/Imaging			
Diagnostic Tests and Procedures	You pay nothing.	You pay $15 copay.	You pay nothing.
Lab Services	You pay nothing.	You pay $15 copay.	You pay nothing.
Diagnostic Radiology Services (e.g. MRI, CAT Scan)	You pay $75 - $300 copay per visit.	You pay $0 - $15 copay per visit.	You pay nothing.
Outpatient X-rays	You pay nothing.	You pay $15 copay.	You pay nothing.
Hearing Services			
Medicare-covered Hearing Exam	You pay $40 copay for Medicare covered hearing exam.	You pay $15 copay for Medicare covered hearing exam.	You pay nothing.
Routine Hearing Exam	You pay $40 copay. Limited to 1 visit every year.	You pay $15 copay. Limited to 1 visit every year.	You pay nothing. Unlimited visits every year.

Premiums and Benefits	Select	Preferred	Premium
Hearing Aids	Hearing aids covered up to $1,000 every three years.	Not covered.	Hearing aids covered up to $1,000 every three years.
Dental Services			
Yearly Benefit Maximum	$1,500	$1,500	$1,500
Deductible	You pay nothing.	You pay nothing.	You pay nothing.
Oral Exams, Cleanings (every six months)	You pay nothing.	You pay nothing.	You pay nothing.
Dental X-rays (every three years)	You pay nothing.	You pay nothing.	You pay nothing.
Extractions and Fillings	You pay 50% of the cost.	You pay 50% of the cost.	You pay 50% of the cost.
Dentures (every five years)	You pay 50% of the cost.	You pay 50% of the cost.	You pay 50% of the cost.
Benefits for dental services are administered and paid by Metropolitan Life Insurance Company. Exclusions and limitations apply. See the *Evidence of Coverage* for full details on the dental benefit.			
Vision Services			
Eyewear	Eyewear covered up to $125 per year.	Eyewear covered up to $125 per year.	Eyewear covered up to $125 per year.
Routine Eye Exam	You pay nothing for one routine eye exam per year.	You pay nothing for one routine eye exam per year.	You pay nothing for one routine eye exam per year.

Premiums and Benefits	Select	Preferred	Premium
Mental Health Services			
Inpatient Visit	Days 1-5: You pay $318 copay per day. Days 6-90: You pay nothing.	You pay $450 copay per stay.	You pay nothing.
Outpatient Individual or Group Therapy Visit	You pay $40 copay.	You pay $15 copay.	You pay nothing.
Skilled Nursing Facility (SNF) Care	Days 1-20: You pay nothing. Days 21-100: You pay $167.50 copay per day.	Days 1-20: You pay nothing. Days 21-100: You pay $35 copay per day.	Days 1-20: You pay nothing. Days 21-100: You pay $15 copay per day.
Physical Therapy			
Occupational therapy visit	You pay $25 copay.	You pay $15 copay.	You pay nothing.
Physical therapy and speech and language therapy visit	You pay $25 copay.	You pay $15 copay.	You pay nothing.
Ambulance Services			
Ground Ambulance	You pay $265 copay.	You pay $75 copay.	You pay $40 copay.
Air Ambulance	You pay $265 copay.	You pay $75 copay.	You pay $40 copay.
Transportation (additional routine)	Not covered.	Not covered.	Not covered.
Medicare Part B Prescription Drugs			
Chemotherapy Drugs	You pay 20% of the cost.	You pay nothing.	You pay nothing.
Other Part B Drugs	You pay 20% of the cost.	You pay nothing.	You pay nothing.

Premiums and Benefits	Select	Preferred	Premium
Wellness Program (e.g. fitness)	Silver and Fit is a fitness program that provides members with a complimentary gym membership at participating gyms in your area. This benefit is at no additional cost to you.	Silver and Fit is a fitness program that provides members with a complimentary gym membership at participating gyms in your area. This benefit is at no additional cost to you.	Silver and Fit is a fitness program that provides members with a complimentary gym membership at participating gyms in your area. This benefit is at no additional cost to you.
Home Health Care	You pay nothing.	You pay nothing.	You pay nothing.
Foot Care (Podiatry Services) Medicare-covered foot exams and treatment.	You pay $45 copay.	You pay $15 copay.	You pay nothing.

Referrals and Authorizations

Referrals from your primary provider for services are not required; however, many services require prior authorization. For complete details, refer to the *Evidence of Coverage*, available on our website at advantage.swhp.org by October 15, 2018.

Outpatient Prescription Drugs						
	Select		**Preferred**		**Premium**	
Deductible	$300 Applies to Tiers 3-5.		$100 Applies to Tiers 3-5.		$50 Applies to Tiers 3-5.	
Initial Coverage (after you pay your deductible, if applicable)	You stay in this stage until your yearly drug costs total $3,820. Total yearly drug costs are the total drug costs paid by both you and your Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.					
	Standard Retail 30-Day Supply	**Mail Order 90-Day Supply**	**Standard Retail 30-Day Supply**	**Mail Order 90-Day Supply**	**Standard Retail 30-Day Supply**	**Mail Order 90-Day Supply**
Tier 1 (Preferred Generic)	You pay $6 copay.	You pay $12 copay.	You pay $3 copay.	You pay $6 copay.	You pay $2 copay.	You pay $4 copay.
Tier 2 (Generic)	You pay $20 copay.	You pay $40 copay.	You pay $15 copay.	You pay $30 copay.	You pay $12 copay.	You pay $24 copay.
Tier 3 (Preferred Brand)	You pay $47 copay.	You pay $94 copay.	You pay $45 copay.	You pay $90 copay.	You pay $45 copay.	You pay $90 copay.
Tier 4 (Non-Preferred)	You pay $100 copay.	You pay $200 copay.	You pay $95 copay.	You pay $190 copay.	You pay $95 copay.	You pay $190 copay.
Tier 5 (Specialty)	You pay 27% of the cost.	Not Available	You pay 31% of the cost.	Not Available	You pay 32% of the cost.	Not Available
Coverage Gap	For the Select and Preferred plans, after your total drug costs (including what our plan has paid and what you have paid) reach $3,820, you will pay no more than 37% coinsurance for generic drugs or 25% coinsurance for brand name drugs. For the Premium plan, after your total drug costs (including what our plan has paid and what you have paid) reach $3,820, you will pay $4 for Tier 1 drugs. For drugs not in Tier 1, you will pay no more than 37% coinsurance for generic drugs or 25% coinsurance for brand name drugs.					
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% coinsurance, or • $3.40 copayment for generic (including brand drugs treated as generic) and a $8.50 copayment for all other drugs.					

Information on Your Prescription Benefit

If you enroll in a plan that includes prescription drug benefits, we encourage you to let us know right away if you have questions, concerns, or problems related to your prescription benefits. For assistance, call our Customer Service Department at 1-866-334-3141, 7 a.m. – 8 p.m., seven days a week.

Cost-sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our *Evidence of Coverage* online.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-866-334-3141 (TTY: 711) from 7 a.m. to 8 p.m. seven days a week.

Understand the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit advantage.swhp.org or call 1-866-334-3141 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understand Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2020.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Scott&White
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PART OF BAYLOR SCOTT & WHITE HEALTH

Language Assistance

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-334-3141 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-334-3141 (TTY: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-334-3141 (TTY: 711).

Chinese:
注意：如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-866-334-3141(TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-334-3141 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-334-3141 (رقم هاتف الصم والبكم: 711

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-866-334-3141 (TTY: 711) کریں۔

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-334-3141 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-334-3141 (ATS : 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-866-334-3141 (TTY: 711) पर कॉल करें।

Persian:
1-866-334-3141 تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711)

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-334-3141 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-334-3141 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-334-3141 (телетайп: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-334-3141 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ ວຍ ເຫ ຼືອ ດ້ ານ ພາສາ, ໂດຍ ບໍ່ ເສ ັ ຽ ຄ່ າ, ແມ ່ ນ ມ ີ ພ ້ ອມ ໃຫ ້ ທ ່ ານ. ໂທ 1-866-334-3141 (TTY: 711).

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Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-334-3141 (TTY: 711).

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

Scott and White Health Plan:

- 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 and accessible electronic 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 Scott and White Health Plan (SWHP) Compliance Officer at 1-254-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org.

If you believe that Scott and White Health Plan 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:

SWHP Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report.aspx?cid=swhp

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the SWHP 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, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.