Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

SENIORCARE Advantage PPO

# 2018 Summary of Benefits

H2032_NTX_SB_Accepted_10_3_2017

NORTH TEXAS

**This is a summary of drug and health services covered in the SeniorCare Advantage (PPO) plan, offered by Scott and White Health Plan through its subsidiary Insurance Company of Scott and White.**

## Summary of Benefits

## January 1, 2018 - December 31, 2018

SeniorCare Advantage (PPO) is offered by Scott and White Health Plan through its subsidiary Insurance Company of Scott and White, 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 doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of the services we cover, call us and ask for the *Evidence of Coverage*.

### Tips for comparing your Medicare choices

This Summary of Benefits gives you a summary of what SeniorCare Advantage (PPO) 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 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.

### Things to know about SeniorCare Advantage (PPO)

- 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 1-800-735-2989.
- If you are not a member of this plan, call toll-free 1-800-782-5068 or TTY 1-800-735-2989.
- Our website: advantage.swhp.org

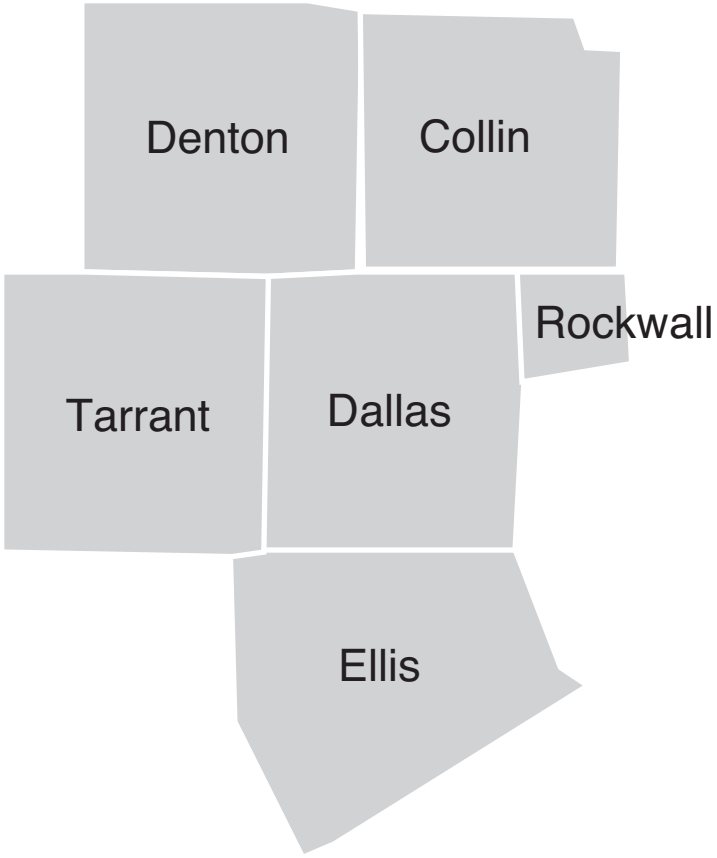
This document is available in other formats such as large print. This document may be available in a non-English language.

### Who can join?

To join SeniorCare Advantage (PPO), you must have Medicare Part A and Medicare Part B, and live in our service area. Our service area includes these counties in Texas: Collin, Dallas, Denton, Ellis, Rockwall, and Tarrant.

What is the service area for North Texas

# Senior*Care* Advantage PPO?




**The counties in the service area are listed below:**

Collin, Dallas, Denton, Ellis, Rockwall, Tarrant

## Which doctors, hospitals, and pharmacies can I use?

SeniorCare Advantage (PPO) has a network directory of doctors, hospitals, pharmacies and other providers that can be found on our website at advantage.swhp.org.

## 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 (PPO) 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 | SeniorCare Advantage (PPO) In-Network | SeniorCare Advantage (PPO) Out-of-Network |
|---|---|---|
| **Monthly Plan Premium** | $41 per month.<br>You must continue to pay your Medicare Part B premium. | |
| **Deductible** | You pay nothing. | You pay $750 for non-Medicare-covered services. |
| **Maximum Out-of-Pocket Responsibility (does not include prescription drugs)** | You pay $6,200 annually. | You pay $10,000 annually.<br>Maximum out-of-pocket will not exceed $10,000 for in-network and out-of-network services combined. |
| **Inpatient Hospital Coverage** | Days 1-5: You pay $350 copay per day.<br>Days 6-90: You pay nothing. | Days 1-5: You pay 35% of the cost.<br>Day 6-90: You pay 35% of the cost. |
| **Outpatient Hospital Coverage** | Ambulatory Surgical Center: You pay $250 copay.<br>Outpatient Hospital: You pay $350 copay. | Ambulatory Surgical Center: You pay 35% of the cost.<br>Outpatient Hospital: You pay 35% of the cost. |
| **Doctor Visits** | | |
| Primary Care Provider | You pay nothing per visit. | You pay 35% of the cost per visit. |
| Specialists | You pay $40 copay per visit. | You pay 35% of the cost per visit. |
| **Preventive Care** | You pay nothing. | You pay 35% of the cost per visit. |
| **Emergency Care** | You pay $80 copay per visit.<br>If you are admitted to the hospital within 24 hours, the copay is waived. | You pay $80 copay per visit.<br>If you are admitted to the hospital within 24 hours, the copay is waived. |

| Premiums and Benefits | SeniorCare Advantage (PPO) In-Network | SeniorCare Advantage (PPO) Out-of-Network |
|---|---|---|
| **Urgently Needed Services** | You pay $50 copay per visit.<br><br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. | You pay $50 copay per visit.<br><br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. |
| **Diagnostic Services/ Labs/Imaging** | | |
| Diagnostic radiology service (e.g., MRI) | You pay $300 copay. | You pay 35% of the cost. |
| Lab services | You pay nothing. | You pay 35% of the cost. |
| Diagnostic tests and procedures | You pay $0 - $300 copay. | You pay 35% of the cost. |
| Outpatient X-rays | You pay nothing. | You pay 35% of the cost. |
| Therapeutic Radiology | You pay 20% of the cost. | You pay 35% of the cost. |
| **Hearing Services** | | |
| Routine hearing exam | You pay nothing. | You pay 35% of the cost. |
| Medicare-covered hearing exam | You pay $40 copay. | You pay 35% of the cost. |
| Hearing aid | Hearing aid covered up to $1,000 every three years with unlimited fittings. Supply of batteries and warranty included. | Hearing aid covered up to $1,000 every three years with unlimited fittings. Supply of batteries and warranty included. |
| **Dental Services** | Not covered.<br><br>You may elect dental as an optional, supplemental benefit with an additional monthly premium. | Not covered.<br><br>You may elect dental as an optional, supplemental benefit with an additional monthly premium. |

| Premiums and Benefits | SeniorCare Advantage (PPO) In-Network | SeniorCare Advantage (PPO) Out-of-Network |
|---|---|---|
| **Vision Services** | | |
| Routine eye exam | You pay nothing for one routine eye exam per year. | You pay 35% of the cost for one routine eye exam per year. |
| Eyewear | Eyewear covered up to $125 every year. | Eyewear covered up to $125 every year. |
| **Mental Health Services** | | |
| Inpatient visit | Days 1-5: You pay $318 copay per day.<br>Days 6-90: You pay nothing. | You pay 35% of the cost per stay. |
| Outpatient individual or group therapy visit | You pay $40 copay. | You pay 35% of the cost. |
| Outpatient individual or group therapy visit with a psychiatrist | You pay $40 copay. | You pay 35% of the cost. |
| **Skilled Nursing Facility** | You must use an in-network provider.<br>Days 1-20: You pay nothing.<br>Days 21-100: You pay $167.50 copay per day. | Days 1-20: You pay 35% of the cost.<br>Days 21-100: You pay 35% of the cost. |
| **Physical Therapy** | You must use an in-network provider. | |
| Occupational therapy visit | You pay $25 copay. | You pay 35% of the cost. |
| Physical therapy and speech and language therapy visit | You pay $25 copay. | You pay 35% of the cost. |

| Premiums and Benefits | SeniorCare Advantage (PPO) In-Network | SeniorCare Advantage (PPO) Out-of-Network |
|---|---|---|
| **Ambulance** | You pay $350 copay. | You pay 35% of the cost. |
| **Transportation** | Not covered. | Not covered. |
| **Foot Care (Podiatry Services)** | You must use an in-network provider. | |
| Medicare-covered foot exams and treatment | You pay $45 copay. | You pay 35% of the cost. |
| **Medical Equipment/Supplies** | You must use an in-network provider. | |
| Durable Medical Equipment (e.g., wheelchairs, oxygen) | You pay 20% of the cost. | You pay 35% of the cost. |
| Prosthetics (e.g., braces, artificial limbs) | You pay 20% of the cost. | You pay 35% of the cost. |
| Diabetes supplies | You pay nothing. | You pay 35% of the cost. |
| **Wellness Programs (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. |
| **Home Health Care** | You pay nothing. | You pay 35% of the cost. |
| **Medicare Part B Drugs** | You pay 20% of the cost for chemotherapy drugs.<br>You pay 20% of the cost for other Part B drugs. | You pay 35% of the cost for chemotherapy drugs.<br>You pay 35% of the cost for other Part B drugs. |

## Referrals and Prior Authorizations

Referrals from your primary provider for services are not required; however, many services require prior authorization. For complete details, please call us and ask for the *Evidence of Coverage*.

| Outpatient Prescription Drugs for SeniorCare Advantage (PPO) | | |
|---|---|---|
| **Prescription Drug Plan<br>$300 deductible applies to tiers 3, 4 and 5.** | | |
| | **Standard Retail Rx<br>30-Day Supply** | **Mail Order<br>90-Day Supply** |
| **Phase 1: Initial Coverage (After you pay your deductible, if applicable)** | | |
| Tier 1: Preferred Generic | You pay $4 copay. | You pay $8 copay. |
| Tier 2: Generic Drugs | You pay $14 copay. | You pay $28 copay. |
| Tier 3: Preferred Brand Drugs | You pay $47 copay. | You pay $94 copay. |
| Tier 4: Non-Preferred Drugs | You pay $99 copay. | You pay $198 copay. |
| Tier 5: Specialty Drugs | You pay 27% of the cost. | A long-term supply is not available for drugs in Tier 5. |

## Additional Details of Your Prescription Drug Coverage

| | |
|---|---|
| **Initial Coverage** | You stay in this stage until your yearly drug costs total $3,750. 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. |
| **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 costs (including what our plan has paid and what you have paid) reach $3,750.<br>After you enter the coverage gap, you pay 35% of the plan's cost for covered brand name drugs and 44% of the plan's cost for covered generic drugs until your costs total $5,000, which is the end for the coverage gap. Not everyone will enter the gap. |
| **Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of:<br>• 5% of the cost, or<br>• $3.35 copay for generic (including brand drugs treated as generic) and an $8.35 copay for all other drugs. |

## Information on Your Prescription Benefit

We encourage you to let us know right away, if after becoming a member 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.

## Information on Your Optional Dental Benefit

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called **"Optional Supplemental Benefits."** If you want these optional supplemental benefits, you must sign up for them, and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

- Optional Supplemental Preventive and Comprehensive Dental Plan – $17 per month.
  - In-network and out-of-network benefits are available.
  - Deductible - $0.
  - Maximum annual benefit - $2,000.

Benefits for dental services are administered and paid by Metropolitan Life Insurance Company. Exclusions and limitations apply, which are outlined in the Explanation of Coverage. Also, see the *Evidence of Coverage* for full details on the dental benefit.

| Benefit | Benefit Amount and Highlights | |
|---|---|---|
| | In-network based on the maximum allowed charge. | Out-of-network based on the maximum allowed charge. |
| Type A Services | You pay nothing. | You pay nothing. |
| Type B Services<br>(no waiting period) | You pay 50% of the cost. | You pay 50% of the cost. |

## Description of Type A and Type B Dental Services

| Type A Services | Type B Services |
|---|---|
| Oral exams are limited to once every 6 months less the number of problem-focused examinations received during such months. | Initial installation of full or removable dentures:<br>a) When needed to replace congenitally missing teeth; or<br>b) when needed to replace natural teeth that are lost while the person receiving such benefits was insured for dental insurance under this plan. |
| Screening, including state or federally mandated screening, to determine an individual's need to be seen by a dentist for diagnosis, are limited to once every 6 months. | Replacement of an immediate, temporary full denture with a permanent full denture if the immediate, temporary full denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full denture. |
| Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), are limited to once every 6 months. | Replacement of a non-serviceable full or removable denture if such denture was installed more than 5 calendar years prior to replacement. |
| Problem-focused examinations are limited to once every 6 months less the number of oral exams received during such months. | Adjustments of dentures:<br>a) If at least 6 months have passed since the installation of the existing removable denture; and<br>b) not more than once in any 6-month period. |
| Dental X-rays except as mentioned elsewhere. | Relining and rebasing of existing removable dentures:<br>a) If at least 6 months have passed since the installation of the existing removable denture; and<br>b) not more than once in any 36-month period. |
| Bitewing X-rays, but not more than one set every 36 months. | Tissue Conditioning, but not more than once in a 60-month period. |
| Full mouth or panoramic X-rays once every 36 months. | Initial placement of amalgam fillings. |
| Intraoral-periapical X-rays. | Replacement of an existing amalgam filling, but only if:<br>• At least 24 months have passed since the existing filling was placed; or<br>• a new surface of decay is identified on that tooth. |
| Cleaning of teeth (oral prophylaxis) once every 6 months. | Initial placement of resin fillings.<br>Replacement of an existing resin filling, but only if:<br>a) At least 24 months have passed since the existing filling was placed; or<br>b) a new surface of decay is identified on that tooth. |
| | Simple extractions are limited to one every five years. |
| | Prosthodontics, other oral/maxillofacial surgery, other services are limited to one every five years. |

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# Language Assistance

**English:**
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-334-3141 (TTY: 1-800-735-2989).

**Spanish:**
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-334-3141 (TTY: 1-800-735-2989).

**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: 1-800-735-2989).

**Chinese:**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-334-3141（TTY：1-800-735-2989）。

**Korean:**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-866-334-3141 (TTY: 1-800-735-2989) 번으로 전화해 주십시오.

**Arabic:**
ملحوظة: اذإ كنت تتحدذا ثكر اللغة، فإن خدماا تلمساعدا ةللغوية تتوافر لك بالمجاا .نتصل برقم 1-866-334-3141 (رقم هاتف الصم اولبكم: 1-800-735-2989).

**Urdu:**
خبرا :رادگر ودرا پــآ بولتے ہیں، تو پــآ کو زبان کی مدد کی خدمات مفت میں دستیاب ہا ۔ ہیں
کریں .1-866-334-3141 (TTY: 1-800-735-2989)

**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: 1-800-735-2989).

**French:**
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-334-3141 (ATS : 1-800-735-2989).

**Hindi:**
ध्यान दें: यदि आपको हिंदी बोलने में सहायता संबंधी निःशुल्क सेवाएं उपलब्ध हैं। 1-866-334-3141
(TTY: 1-800-735-2989) पर कॉल करें।

**Persian:**
**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلاز تبانی بصار تـرویگان بارامشد ی
فمهار می باشد. با 1-866-334-3141 (TTY: 1-800-735-2989) تماس بگیرید.

**German:**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-334-3141 (TTY: 1-800-735-2989).

**Gujarati:**
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો
1-866-334-3141 (TTY: 1-800-735-2989).

**Russian:**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-334-3141 (телетайп: 1-800-735-2989).

**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:1-800-735-2989）まで、お電話にてご連絡ください。

**Laotian:**
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ ລິການຊ່ວຍເຫຼືອດ້ານພາສາ,
ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-334-3141 (TTY: 1-800-735-2989).

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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: 1-800-735-2989).

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, 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 Patricia Balz.

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:

Patricia Balz, Vice President of Human Resources
2401 South 31st Street, MS-17-212, Temple, Texas 76508
254-724-8650, 254-724-1631
patricia.balz@bswhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Patricia Balz, Vice President of Human Resources, 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 (TTY)

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

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SENIOR*CARE* Advantage PPO

SeniorCare Advantage PPO is offered by Scott and White Health Plan through its subsidiary Insurance Company of Scott and White, a Medicare Advantage organization with a Medicare contract. Enrollment in SeniorCare Advantage depends on contract renewal.

You must continue to pay your Medicare Part B premium.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/ coinsurance may change on January 1 of each year.

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-866-334-3141 (TTY 1-800-735-2989). **ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-334-3141 (TTY 1-800-735-2989). **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 1-800-735-2989).

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 cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Scott and White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân bi ệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

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