



2020 Summary of Benefits

SENIORCARE ADVANTAGE • PPO



Scott & White
HEALTH PLAN



Part of
Baylor Scott & White
HEALTH

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

Summary of Benefits

January 1, 2020 - December 31, 2020

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 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](https://www.advantage.swhp.org) by October 15, 2019.

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 <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 PPO

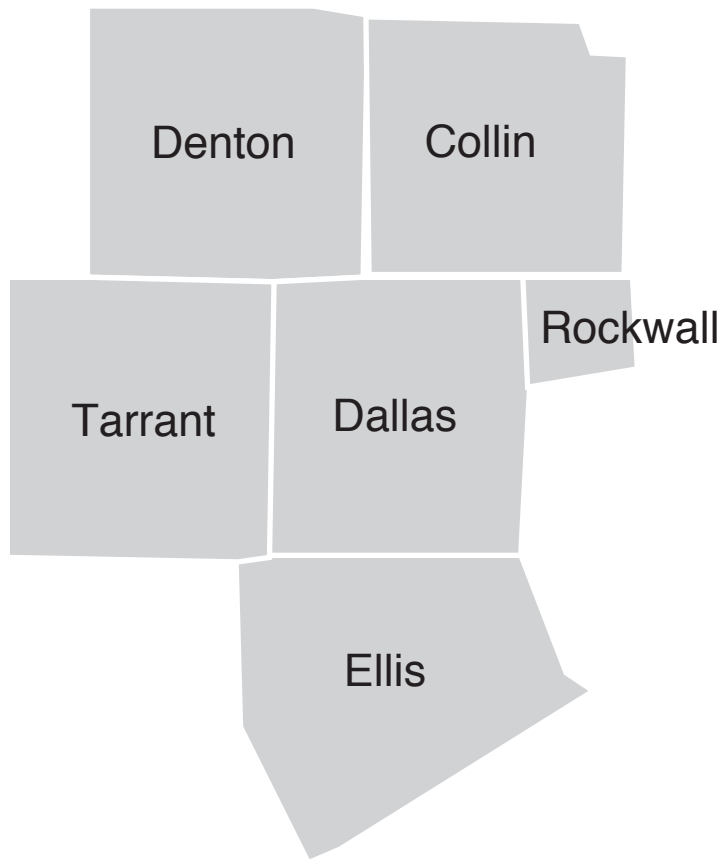
- If you are a member of this plan, you can call us toll free at 1-866-334-3141 or TTY 711, 7 a.m. – 8 p.m., seven days a week (excluding major holidays).
- If you are not a member of this plan, you can call us toll free at 1-800-782-5068 or TTY 711, 8 a.m. – 8 p.m., Monday – Friday.
- Our website: [advantage.swhp.org](https://www.advantage.swhp.org)

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 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 **SeniorCare 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. You may use in- or out-of-network providers.

Out-of-network/non-contracted providers are under no obligation to treat SeniorCare Advantage PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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 |
|--|--|
| Monthly Plan Premium | \$36 per month. You must continue to pay your Medicare Part B premium. |
| Deductible | In-Network You pay \$0. Out-of-Network You pay \$750 for Medicare-covered services. |
| Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i> | In-Network You pay \$6,700 annually. Out-of-Network You pay \$10,000 annually. Maximum out-of-pocket will not exceed \$10,000 for in-network and out-of-network services combined. |
| Inpatient Hospital Coverage | In-Network Days 1 – 5: \$350 copay each day. Days 6 – 90: \$0 copay each day. Out-of-Network Days 1 – 5: You pay 35% coinsurance. Days 60 – 90: You pay 35% coinsurance. |
| Outpatient Hospital Coverage Ambulatory Surgery Center Outpatient Hospital Services | In-Network You pay \$250 copay. Out-of-Network You pay 35% coinsurance. In-Network You pay \$350 copay. Out-of-Network You pay 35% coinsurance. |

| Premiums and Benefits | SeniorCare Advantage |
|--|---|
| <p>Doctor Visits</p> <p>Primary Care Providers</p> <p>Specialists</p> | <p>In-Network You pay \$0 copay per visit.</p> <p>Out-of-Network You pay 35% coinsurance per visit.</p> <p>In-Network You pay \$40 copay per visit.</p> <p>Out-of-Network You pay 35% coinsurance per visit.</p> |
| <p>Preventive Care</p> | <p>In-Network You pay \$0 copay.</p> <p>Out-of-Network You pay 35% coinsurance per visit.</p> |
| <p>Emergency Care</p> | <p>In-Network You pay \$90 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.</p> <p>Out-of-Network You pay \$90 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.</p> |
| <p>Urgently Needed Services</p> | <p>In-Network You pay \$50 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.</p> <p>Out-of-Network You pay \$50 copay per visit. If you are admitted to the hospital within 24 hours, for the same condition, the copay is waived.</p> |

| Premiums and Benefits | SeniorCare Advantage |
|---|--|
| Diagnostic Services/Labs/Imaging Diagnostic Tests and Procedures Lab Services Diagnostic Radiology Services (e.g. MRI, CAT Scan) Outpatient X-rays | <p>In-Network You pay \$0 copay.</p> <p>Out-of-Network You pay 35% coinsurance.</p> <p>In-Network You pay \$0 copay.</p> <p>Out-of-Network You pay 35% coinsurance.</p> <p>In-Network You pay \$75 – \$300 copay.</p> <p>Out-of-Network You pay 35% coinsurance.</p> <p>In-Network You pay \$0 copay.</p> <p>Out-of-Network You pay 35% coinsurance.</p> |
| Hearing Services Medicare-covered Hearing Exam Routine Hearing Exam Hearing Aids | <p>In-Network You pay \$40 copay for Medicare-covered hearing exam.</p> <p>Out-of-Network You pay 35% coinsurance.</p> <p>In-Network You pay \$0 copay. Limited to 1 visit every year.</p> <p>Out-of-Network You pay 35% coinsurance.</p> <p>Not covered.</p> |

| Premiums and Benefits | SeniorCare Advantage |
|--|---|
| Dental Services | Covered with additional premium. See “Dental – Optional Supplemental Benefit” below. |
| Vision Services | |
| Eyewear | In-Network and Out-of-Network Combined \$125 allowance toward the purchase of eyewear every year. |
| Routine Eye Exam | In-Network You pay \$0 copay for one routine eye exam per year. Out-of-Network You pay 35% coinsurance. |
| Mental Health Services | |
| Inpatient Visit | In-Network Days 1 – 5: \$318 copay each day. Days 6 – 90: \$0 copay each day. Out-of-Network You pay 35% coinsurance per stay. |
| Outpatient Individual or Group Therapy Visit | In-Network You pay \$40 copay. Out-of-Network You pay 35% coinsurance. |
| Skilled Nursing Facility (SNF) Care | In-Network Days 1 – 20: \$0 copay each day. Days 21 – 100: \$167.50 copay each day. Out-of-Network Days 1 – 20: You pay 35% coinsurance per day. Days 21 – 100: You pay 35% coinsurance per day. |

| Premiums and Benefits | SeniorCare Advantage |
|---|--|
| Physical Therapy Occupational therapy visit Physical therapy and speech and language therapy visit | In-Network You Pay \$25 copay. Out-of-Network You pay 35% coinsurance. In-Network You Pay \$25 copay. Out-of-Network You pay 35% coinsurance. |
| Ambulance Services Ground Ambulance Air Ambulance | In-Network You pay \$350 copay. Out-of-Network You pay 35% coinsurance. In-Network You pay \$350 copay. Out-of-Network You pay 35% coinsurance. |
| Transportation (additional routine) | In-Network Not covered. Out-of-Network Not covered. |
| Medicare Part B Prescription Drugs Chemotherapy Drugs | In-Network You pay 20% coinsurance. Out-of-Network You pay 35% coinsurance. |

| Premiums and Benefits | SeniorCare Advantage |
|--|--|
| Medicare Part B Prescription Drugs (continued) Other Part B Drugs | In-Network You pay 20% coinsurance. Out-of-Network You pay 35% coinsurance. |
| Home Health Care | In-Network You pay \$0 copay. Out-of-Network You pay 35% coinsurance. |
| Foot Care (Podiatry Services) Medicare-covered foot exams and treatment. | In-Network You pay \$45 copay. Out-of-Network You pay 35% coinsurance. |
| Telehealth Services – Primary Care Visit | In-Network You pay \$0 copay. Out-of-Network You pay 35% coinsurance |
| Opioid Treatment Service | In-Network You pay \$45 copay. Out-of-Network You pay 35% coinsurance. |

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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, 2019.

| Outpatient Prescription Drugs | | |
|---|---|---------------------------------|
| Deductible | \$300 Applies to Tiers 3 – 5. | |
| Initial Coverage (after you pay your deductible, if applicable) | <p>You stay in this stage until your yearly drug costs total \$4,020. 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.</p> <p>Costs may differ based on pharmacy type or status (e.g., mail order, long-term care (LTC) or home infusion, and 30 or 90 day supply).</p> | |
| | Standard Retail 30-Day Supply | Mail Order 90-Day Supply |
| Tier 1 (Preferred Generic) | You pay \$4 | You pay \$8 |
| Tier 2 (Generic) | You pay \$14 | You pay \$28 |
| Tier 3 (Preferred Brand) | You pay \$47 | You pay \$94 |
| Tier 4 (Non-Preferred) | You pay \$99 | You pay \$198 |
| Tier 5 (Specialty) | You pay 27% of the cost. | Not Available |
| Coverage Gap | <p>After your total drug costs (including what our plan has paid and what you have paid) reach \$4,020, you will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap.</p> | |
| Catastrophic Coverage | <p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay the greater of:</p> <ul style="list-style-type: none"> • 5% coinsurance, or • \$3.60 copayment for generic (including brand drugs treated as generic) and a \$8.95 copayment 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.

Dental - Optional Supplemental Benefit

Dental coverage is an optional supplemental benefit for the SeniorCare Advantage PPO plan, available for an additional \$20 per month.

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.

| Dental Services | SeniorCare Advantage PPO |
|--|--------------------------|
| Monthly Premium | \$20 per month |
| Yearly Benefit Maximum | \$2,000 |
| Deductible | You pay nothing. |
| Oral Exams, Cleanings (every six months) | You pay nothing. |
| Dental X-rays (every three years) | You pay nothing. |
| Extractions and Fillings | You pay 50% of the cost. |
| Dentures (every five years) | You pay 50% of the cost. |

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 for which 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).
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.

**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:

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

Urdu:

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

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 हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-334-3141 (TTY: 711) पर कॉल करें।

Persian:

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

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 નિઃશુલ્ક 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 ງ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການບໍລິການ ອຸປະຕິບັດ ອັດຕະໂນມັດ ພາສາ, ໂດຍບໍ່ ເສັ້ນຄ່າ, ແມ່ນ ມີ ພ້ອມ ທີ່ ທ່ານ. ໂທ 1-866-334-3141 (TTY: 711).



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:
 - 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 1-214-820-8888 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>.



2020 Star Ratings

Scott and White Health Plan - H2032

2020 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2020, Scott and White Health Plan received the following Overall Star Rating from Medicare.



3.5 Stars

We received the following Summary Star Rating for Scott and White Health Plan's health/drug plan services:



Health Plan Services:

4.5 Stars



Drug Plan Services:

3 Stars

The number of stars shows how well our plan performs.



5 stars - excellent



4 stars - above average



3 stars - average



2 stars - below average



1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 7:00 a.m. to 8:00 p.m. Central time at 866-334-3141 (toll-free) or 711 (TTY).

Current members please call 866-334-3141 (toll-free) or 711 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

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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 biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

2020 Summary of Benefits

SeniorCare Advantage PPO

Medicare Advantage Prescription Drug Plan (MAPD)

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.

Other pharmacies, physicians and providers are available in our network.

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