2024
Summary of Benefits

Medicare Advantage Plans with Part D
Prescription Drug Coverage

Renown Preferred Plan by Senior Care Plus (HMO)

January 1, 2024 – December 31, 2024

Renown®
PREFERRED PLAN
Brought to you by Senior Care Plus

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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 **Renown Preferred Plan by Senior Care Plus (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Renown Preferred Plan by Senior Care Plus (HMO)** 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 **Renown Preferred Plan by Senior Care Plus (HMO).**
- 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 Renown Preferred Plan by Senior Care Plus (HMO)

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 **Renown Preferred Plan by Senior Care Plus (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in Nevada: Carson City, Storey and Washoe.

Which doctors, hospitals, and pharmacies can I use?

Renown Preferred Plan by Senior Care Plus (HMO) 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 six "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

Renown Preferred Plan by Senior Care Plus (HMO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You do not pay a separate monthly plan premium for Renown Preferred Plan by Senior Care Plus (HMO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,125 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	
Inpatient Hospital	**Preferred Facility:** Days 1-4: $300 Copay per day. Days 5-90: $0 Copay per day. **Non-Preferred Facility:** Days 1-5: $440 Copay per day. Days 6-90: $0 Copay per day. May require prior authorization.
Outpatient Hospital	**Preferred Facility:** Outpatient hospital: $300 Copay **Non-Preferred Facility:** Outpatient hospital: $440 Copay
Ambulatory Surgical Center	**Preferred Facility:**

	Ambulatory Surgical Center: $440 Copay. **Non-Preferred Facility:** Ambulatory Surgical Center: $440 Copay. May require prior authorization.
Doctor's Office Visits	Primary care physician visit: $0 Copay. Specialist visit: $35 Copay.
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	$135 Copay per visit. If you are admitted to the hospital within 12 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $135 Copay.
Urgently Needed Services	**Preferred Facility:** $20 Copay per visit. Nationwide Urgent Coverage: $65 Copay. **Non-Preferred Facility:** $65 Copay per visit. Nationwide Urgent Coverage: $65 Copay.
Diagnostic Services / Labs/ Imaging	Diagnostic tests and procedures: $0 - $275 Copay. Lab services: $0 - $120 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $0 - $135 Copay. X-rays: $70 Copay. Therapeutic radiology services (such as radiation treatment for cancer): $50 Copay.
Hearing Services	Exam to diagnose and treat hearing and balance issues: $45 Copay. Routine hearing exam (for up to 1 Every year): Hearing Aid (up to 2 hearing aids every year): $495 - $1,970 Copay.

Dental Services	Medicare Covered: $35 Copay. Preventive dental services: • Oral exam (up to 1 visits every year): $0 Copay. • Cleaning (up to 2 visits every year): $0 Copay. • Dental X-rays (up to 1 visits Other, Describe): $0 Copay. Comprehensive dental services: • Diagnostic Services: $0 Copay. • Restorative Services: $0 Copay. • Endodontics: $0 Copay. • Periodontics: $0 Copay. • Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: $0 Copay. This dental plan will pay up to $1,250 maximum per calendar year.
Vision Services	Routine eye exam (up to 1 visits every year): Our plan pays up to $250 every year for full set of eyeglasses or contact lenses.
Mental Health Care	Outpatient group therapy visit: $35 Copay. Individual therapy visit: $35 Copay. Inpatient Mental Health Service: Days 1-4: $300 Copay per day. Days 5-90: $0 Copay per day.
Skilled Nursing Facility (SNF)	Days 1-20: $20 Copay per day. Days 21-34: $150 Copay per day. Days 35-100: $0 Copay per day. May require prior authorization.
Outpatient Rehabilitation	Occupational therapy visit: $25 Copay. Physical therapy and speech and language therapy visit: $25 Copay. May require prior authorization.

Ambulance	Ground Ambulance: $325 Copay. Air Ambulance: $325 Copay. May require prior authorization.
Transportation	$0 Copay. 24 one way trips to Plan-approved Location May require prior authorization. Max annual allowance $1,250
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 $5,030. 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)	$5 copay	$10 copay	$12.50 copay
Tier 2 (Generic)	$12 copay	$24 copay	$30 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$117.50 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$200 copay	$250 copay
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable	Not Applicable
Tier 6 (Select Care Drugs)	$0 copay	$0 copay	$0 copay

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<tr><th colspan="4">Standard Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th><th>Two-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>Not Applicable</td><td>$10 copay</td><td>$10 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>Not Applicable</td><td>$24 copay</td><td>$24 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>Not Applicable</td><td>$94 copay</td><td>$94 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>Not Applicable</td><td>$200 copay</td><td>$200 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>Not Applicable</td><td>Not Applicable</td><td>Not Applicable</td></tr>
<tr><td>Tier 6 (Select Care Drugs)</td><td>Not Applicable</td><td>$0 copay</td><td>$0 copay</td></tr>
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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 100 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.
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<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 $5,030.
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 $8,000, which is the end of the coverage gap.
Our plan covers Tier 1 Preferred Generics in the coverage gap.
<table>
<tr><th colspan="2">Standard Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 6 (Select Care Drugs)</td><td>$0 copay</td></tr>
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Catastrophic Amount	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

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.

For accommodation of persons with special needs at sales meetings, call **775-982-3158** and 711 for TTY.

Every year, Medicare evaluates plans based on a 5-Star rating system. A salesperson will be present with information and applications. The show contains paid actor portrayals.

The Extensive Duals Plan is a dual-eligible, special-needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

View the notice of privacy practices at **SeniorCarePlus.com**.

Health coverage is offered by Hometown Health Plan, Inc..

All attempts have been made to ensure the accuracy of the information in this document, but errors may occur. Please refer to your Explanation of Coverage for detailed benefit information.

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 **888-775-7003** (TTY 711).

Understanding 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 **SeniorCarePlus.com** or **888-775-7003** (TTY 711) 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 medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding 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/co-insurance may change on January 1, 2025.
- ☐ 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).

Thank You for Reviewing Your 2024 Summary of Benefits

Contact Information: 888-775-7003 (TTY: 711)

Organization name: Senior Care Plus

Organization website: SeniorCarePlus.com

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-775-7003. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-775-7003. Alguien que hable español le podrá ayudar.
Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-775-7003。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-775-7003。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-775-7003. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-775-7003. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-775-7003 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie 1-888-775-7003. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-775-7003 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-775-7003. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-775-7003 سيقوم شخص ما يتحدث العربية . بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-775-7003 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-775-7003. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-775-7003. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-775-7003. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-775-7003. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-775-7003 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。