HMO Benefits	Patriot Plan - 009	Essential Plan - 012	Select Plan - 018	Renown Preferred Plan - 023
MONTHLY PLAN PREMIUM	**$0**	**$0**	**$180**	**$0**
PART B REBATE	**$75**	**N/A**	**N/A**	**N/A**
Maximum Out-of-Pocket	$2,500 per year	$3,300 per year	$1,550 per year	$3,225 per year
PHYSICIAN OFFICE VISITS				Renown Preferred Plan is Brought to you by Senior Care Plus
Primary Care Provider (PCP) **Visit**	Preferred: $0 Per visit Non-Preferred: $10 per visit	Preferred: $0 per visit Non-Preferred: $10 per visit	Preferred: $0 per visit Non-Preferred: $10 per visit	$0 per visit (Must use Renown PCP)
Specialist Visit	$40 per visit	$50 per visit	$15 per visit	$45 per visit
Preventive (ACA Covered) **Screenings**	$0 per visit	$0 per visit	$0 per visit	$0 per visit
LAB, IMAGING AND DIAGNOSTICS				
Routine Lab Services	$0 per visit	$0 per visit	$0 per visit	$0 per visit
Diagnostic Tests (X-ray / CT / PET / MRI)	$60 / $95 / $130 / $130	$70 / $100 / $135 / $135	$45 / $65 / $90 / $90	$70 / $100 / $125 / $135
FACILITY / SURGICAL				
Inpatient Hospital Services	Preferred: $250 / 6 days per period Non-Preferred: $440 / 5 days per period	Preferred: $300 / 5 days per period Non-Preferred: $440 / 5 days per period	Preferred: $175 / 3 days per period Non-Preferred: $440 / 5 days per period	Preferred: $300 / 5 days per period Non-Preferred: $440 / 5 days per period
Outpatient Hospital Services	Preferred: $275 per visit Non-Preferred: $440 per visit	Preferred: $300 per visit Non-Preferred: $440 per visit	Preferred: $225 per visit Non-Preferred: $440 per visit	Preferred: $300 per visit Non-Preferred: $440 per visit
Skilled Nursing	$20 days 1–20, $150 days 21–34	$20 days 1–20, $150 days 21–34	$20 days 1–20, $100 days 21–34	$20 days 1–20, $150 days 21–34
EMERGENCY AND URGENT CARE				
Urgent Care Center Services	$30 In-Network / $65 Out-of-Network	$35 In-Network / $65 Out-of-Network	$20 In-Network / $45 Out-of-Network	$35 In-Network / $65 Out-of-Network
Emergency Room Services	$125 per visit	$125 per visit	$125 per visit	$125 per visit
Ambulance Services (ground / air)	$250 per trip	$325 per trip	$250 per trip	$325 per trip
Rx				
Rx – Annual Deductible*	Not covered	N/A	N/A	N/A
Rx – Coverage in the Gap*	Not covered	Preferred $2.50 (Tier 6) Non-preferred $8.50 (Tier 6)	$0 / $0/ $0 (Tiers 1,2,6)	Preferred $2.50 (Tier 6) Non-Preferred $8.50 (Tier 6)
Rx – Preferred Generic (1)*	Not covered	Preferred $5 / Non-Preferred $11	Preferred $0 / Non-Preferred $6	Preferred $5 / Non-Preferred $11
Rx – Non-Preferred Generic (2)*	Not covered	Preferred $12 / Non-Preferred $20	Preferred $0 / Non-Preferred $8	Preferred $12 / Non-Preferred $20
Rx – Preferred Brand (3)*	Not covered	Preferred $41 / Non-Preferred $47 / Senior Savings $35	Preferred $41 / Non-Preferred $47 / Senior Savings $35	Preferred $41 / Non-Preferred $47 / Senior Savings $35
Rx – Non-Preferred Brand (4)*	Not covered	Preferred $94 / Non-Preferred $100	Preferred $94 / Non-Preferred $100	Preferred $94 / Non-Preferred $100
Rx – Specialty (5)*	Not covered	33% Coinsurance	33% Coinsurance	33% Coinsurance
Rx – Select Drugs (6)*	Not covered	Preferred $2.50 / Non-Preferred $8.50	Preferred $0 / Non-Preferred $6	Preferred $2.50 / Non-Preferred $8.50
OTHER				
Teladoc / Dispatch Health	$0 per visit / $30 per visit	$0 per visit / $35 per visit	$0 per visit / $20 per visit	$0 per visit / $35 per visit
Durable Medical Equipment	20% per item / supply	20% per item / supply	10% per item / supply	20% per item
Chiropractic Services	$20 per visit	$25 per visit	$20 per visit	$20 per visit
Vision (Routine Coverage / EyeMed)	$0 per exam, $250 allowance	$0 per exam, $250 allowance	$0 per exam, $250 allowance	$0 per exam, $250 allowance
Hearing Exam / Hearing Aid Coverage	$0 per exam (yearly) / 2 hearing aids per year up to $400	$0 per exam (yearly) / 2 hearing aids per year; $495 – $1,970	$0 per exam (yearly) / 2 hearing aids per year up to $400	$0 per exam (yearly) / 2 hearing aids per year; $495 – $1,970
Fitness Benefit	Included – See list of gyms on website	Included – See list of gyms on website	Included – See list of gyms on website	Included – See list of gyms on website
Dental Coverage (LIBERTY Dental Plan)	$1,500 Comprehensive, first dollar coverage	Preventative Included	$1,500 Comprehensive, first dollar coverage	$1,250 Comprehensive, first dollar coverage
Over-the-Counter Benefit (NationsOTC®)	$25 per quarter	$25 per quarter	$160 per quarter	$50 Quarter
Acupuncture (Low back pain only)	$30 visit / Max 20 visits	$30 visit / Max 20 visits	$30 visit / Max 20 visits	$30 visit / Max 20 visits

Choose Your 2023 Plan! FOR THESE PLANS, BENEFICIARIES MUST RESIDE IN WASHOE COUNTY OR CARSON CITY.

Senior Care Plus
A Medicare Advantage Plan from Hometown Health.

Renown® PREFERRED PLAN
Brought to you by Senior Care Plus

*All copays are for a 30-day supply unless otherwise noted. •Preferred Pharmacies offer savings. • Rx 90-day retail you pay 2.5 times for a 30-day supply. • Rx 90-day mail order you pay 2 times a 30-day supply. This is an advertisement. Senior Care Plus is a Medicare Advantage HMO organization with a Medicare contract. Enrollment in Senior Care Plus depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits and premiums and or copayments/coinsurance may change on January 1 of each year. Other providers are available in our network. A salesperson will be present with information and applications. For accommodation of persons with special needs at sales meetings call 775-982-3158 and 711 for TTY for more information. Material ID: H2960_2023_BenefitsMatrixBrochure_M [CMS Accepted]

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