2026 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Senior Care Plus Select Plan (HMO)

January 1, 2026 – December 31, 2026

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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 **Senior Care Plus Select Plan (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Senior Care Plus Select Plan (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 **Senior Care Plus Select Plan (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 Senior Care Plus Select Plan (HMO)

Hours of Operation & Contact Information

- From October 1 to March 31, we're open 7 a.m. – 8 p.m., Monday – Friday and 8 a.m. – 8 p.m. Saturday and Sunday.
- From April 1 to September 30, we're open 7 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 **Senior Care Plus Select Plan (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?

Senior Care Plus Select Plan (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: Yearly Deductible, Initial Coverage 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

Senior Care Plus Select Plan (HMO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$180 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $1,450 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 1-2: $145 Copay per day per admission. Days 3-90: $0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. **Non-Preferred Facility:** Days 1-5: $440 Copay per day. Days 6-90: $0 Copay per day. May require prior authorization. May require a referral from your doctor.

Outpatient Hospital	**Preferred Facility:** Outpatient hospital: $145 Copay. Outpatient surgery: $145 Copay. **Non-Preferred Facility:** Outpatient hospital: $440 Copay. Outpatient surgery: $440 Copay. May require prior authorization.
Ambulatory Surgical Center	**Preferred Facility:** Ambulatory Surgical Center: $145 Copay. **Non-Preferred Facility:** Ambulatory Surgical Center: $440 Copay. May require prior authorization. May require a referral from your doctor.
Doctor's Office Visits	**Preferred PCP:** Primary care physician visit: $0 Copay. **Non-Preferred PCP:** Primary care physician visit: $10 Copay. Specialist visit: $5 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	$140 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: $140 Copay Max $10,000 annually.
Urgently Needed Services	**Preferred Facility:** $20 Copay per visit. **Non-Preferred Facility:** $45 Copay per visit. Worldwide Urgent Coverage: $45 Copay.

Diagnostic Services / Labs/ Imaging	Diagnostic tests and procedures: $0 - $250 Copay. Lab services: $0 - $80 Copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $0 - $90 Copay. X-rays: $45 Copay. Therapeutic radiology services (such as radiation treatment for cancer): $80 Copay. May require a referral from your doctor.
Hearing Services	Exam to diagnose and treat hearing and balance issues: $35 Copay. Routine hearing exam (up to 1 visit(s) every year): $0 Copay. Hearing Aid (up to 2 hearing aids every year): Up to $400 allowance.
Dental Services	Medicare Covered: $15 Copay. Preventive dental services: • Oral exam (up to 1 visit(s) every year): $0 Copay. • Cleaning (up to 2 visit(s) every year): $0 Copay. • Dental X-rays (up to 1 visit(s) 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 $1,500 maximum per calendar year.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $5 Copay. Routine eye exam (up to 1 visit(s) every year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: 20% Coinsurance. Our plan pays up to $250 every year for eyewear. Frames or contact lenses: $0 allowance.

<table>
<tr><td>Mental Health Care</td><td>Outpatient group therapy visit: $5 Copay.
Individual therapy visit: $5 Copay.
Inpatient Mental Health Care:
Days 1-2: $145 Copay per day per admission.
Days 3-90: $0 Copay per day.
Our plan covers an unlimited number of days for an inpatient hospital stay.
May require a referral from your doctor.</td></tr>
<tr><td>Skilled Nursing Facility (SNF)</td><td>Days 1-20: $20 Copay per day.
Days 21-34: $200 Copay per day.
Days 35-100: $0 Copay per day.</td></tr>
<tr><td>Outpatient Rehabilitation</td><td>Occupational therapy visit: $15 Copay.
Physical therapy and speech and language therapy visit: $15 Copay.
May require prior authorization.</td></tr>
<tr><td>Ambulance</td><td>Ground Ambulance: $250 Copay.
Air Ambulance: $250 Copay.
May require prior authorization.</td></tr>
<tr><td>Transportation</td><td>24 one-way trips or $1,250 per calendar year.
May require prior authorization.
May require a referral from your doctor.</td></tr>
<tr><td>Medicare Part B Drugs</td><td>For Part B drugs such as chemotherapy drugs: 0% - 20% Coinsurance.
For Part B Insulin: $35
Other Part B drugs: 0% - 20% Coinsurance.
May require prior authorization.</td></tr>
<tr><td colspan="2">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>Deductible</td><td>Prescription Drug Deductible: Not Applicable.</td></tr>
<tr><td>Initial Coverage</td><td>
<table>
<tr><th colspan="4">Standard Retail Cost-Sharing</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>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
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Tier 2 (Generic)	$0 copay	$0 copay	$0 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$117.50 copay
Tier 4 (Non-Preferred Drug)	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable	Not Applicable
Tier 6 (Select Care Drugs)	$0 copay	$0 copay	$0 copay

Standard Mail Order			
Tier	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	Not Applicable	$0 copay	$0 copay
Tier 2 (Generic)	Not Applicable	$0 copay	$0 copay
Tier 3 (Preferred Brand)	Not Applicable	$94 copay	$94 copay
Tier 4 (Non-Preferred Drug)	Not Applicable	50% coinsurance	50% coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable	Not Applicable
Tier 6 (Select Care Drugs)	Not Applicable	$0 copay	$0 copay

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.

Catastrophic Amount	When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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 1-888-775-7003 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-888-775-7003 (TTY: 711).

Senior Care Plus Select Plan is a HMO plan with a Medicare contract. Enrollment in **Senior Care Plus Select Plan** 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, 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.

Health coverage is offered by Hometown Health Plan, Inc.

Understanding the Benefits and Rules

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 1-888-775-7003 (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 http://www.seniorcareplus.com or 1-888-775-7003 (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.
- ☐ Review the formulary to make sure your drugs are covered.

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, 2026.
- ☐ 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).

Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.