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

SENIORCARE (COST)

2017 Summary of Benefits

H4564 CY2017 SB

SENIORCARE (COST)
(a Cost Plan offered by SCOTT AND WHITE HEALTH PLAN with a Medicare contract)

Summary of Benefits

January 1, 2017 - December 31, 2017

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 (Cost) 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 http://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 (Cost)

- You can call us 7 days a week from 7 a.m. to 8 p.m. Central time.
- 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: http://www.seniorcare.swhp.org.

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 1-866-334-3141, Monday - Sunday 7 a.m. to 8 p.m. TTY users should call 1-800-735-2989 or visit us at http://www.seniorcare.swhp.org.

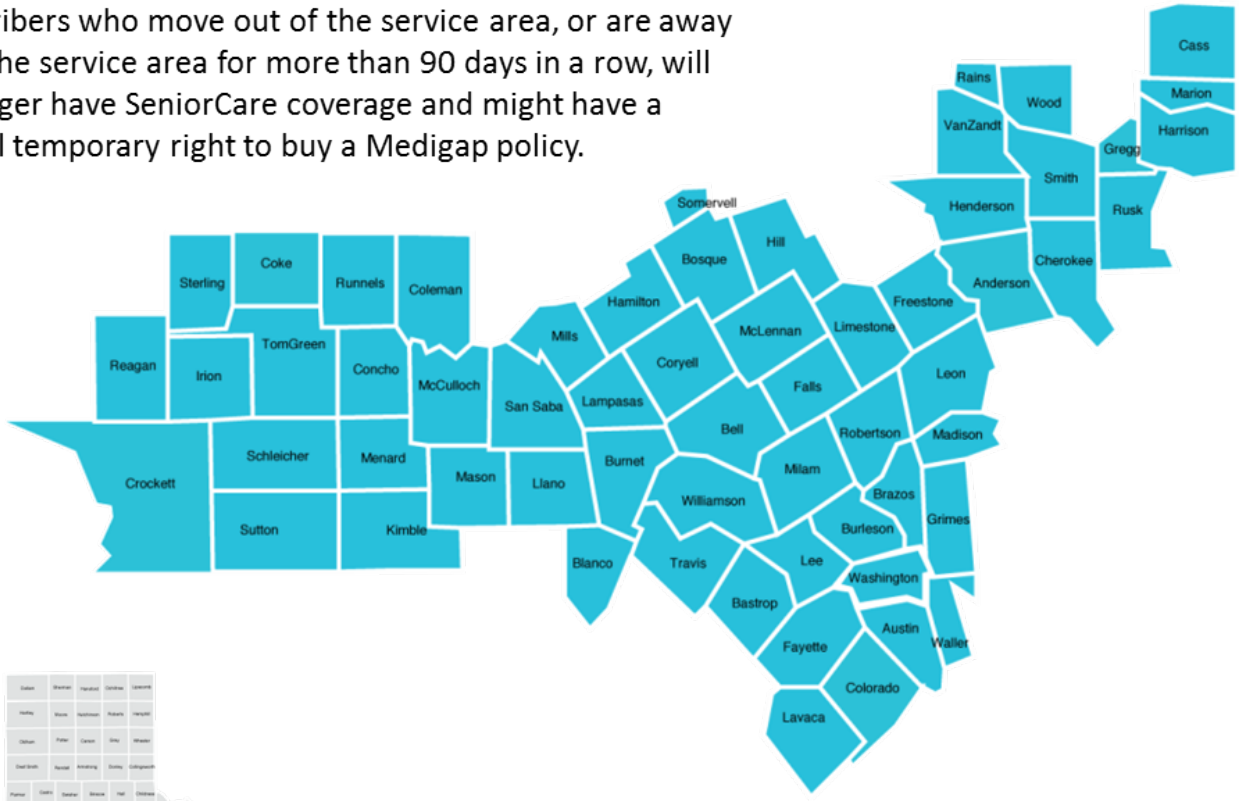
Este documento está disponible en otros formatos, como braille y letras grandes. Este documento puede estar disponible en un idioma que no sea inglés. Para obtener información adicional, llámenos al 1-866-334-3141, lunes a domingo, 7 a.m. a 8 p.m. Usuarios de TTY deben llamar al 1-800-735-2989, o visítenos en http://www.seniorcare.swhp.org.

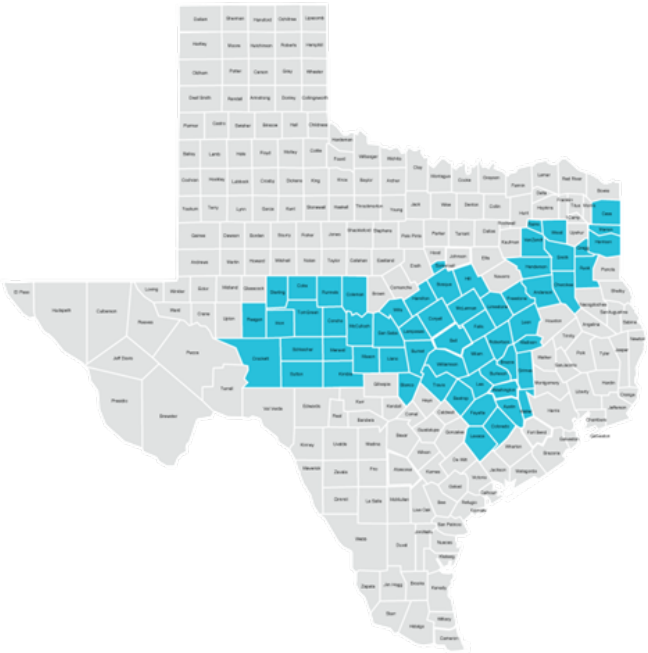
Who can join?
To join SeniorCare (Cost), you must be enrolled in Medicare Part B (or have both Medicare Part A and Medicare Part B), and live in our service area. Our service area includes the following counties in Texas:

Anderson, Austin, Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Cass, Cherokee, Coke, Coleman, Colorado, Concho, Coryell, Crockett, Falls, Fayette, Freestone, Gregg, Grimes, Hamilton, Harrison, Henderson, Hill, Irion, Kimble, Lampasas, Lavaca, Lee, Leon, Limestone, Llano, Madison, Marion, Mason, McCulloch, McLennan, Menard, Milam, Mills, Rains, Reagan, Robertson, Runnels, Rusk, San Saba, Schleicher, Smith, Somervell, Sterling, Sutton, Tom Green, Travis, Van Zandt, Waller, Washington, Williamson, and Wood.

SeniorCare (Cost) Service Area

Subscribers who move out of the service area, or are away from the service area for more than 90 days in a row, will no longer have SeniorCare coverage and might have a special temporary right to buy a Medigap policy.





SeniorCare Service Area

The following counties are in the SeniorCare service area:

- Anderson
- Austin
- Bastrop
- Bell
- Blanco
- Bosque
- Brazos
- Burleson
- Burnet
- Cass
- Cherokee
- Coke
- Coleman
- Colorado
- Concho
- Coryell
- Crockett
- Falls
- Fayette
- Freestone
- Gregg
- Grimes
- Hamilton
- Harrison
- Henderson
- Hill
- Irion
- Kimble
- Lampasas
- Lavaca
- Lee
- Leon
- Limestone
- Llano
- Madison
- Marion
- Mason
- McCulloch
- McLennan
- Menard
- Milam
- Mills
- Rains
- Reagan
- Robertson
- Runnels
- Rusk
- San Saba
- Schleicher
- Smith
- Somervell
- Sterling
- Sutton
- Tom Green
- Travis
- Van Zandt
- Waller
- Washington
- Williamson
- Wood

Which doctors, hospitals, and pharmacies can I use?
SeniorCare (Cost) has a network of doctors, hospitals, pharmacies and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You can see our plan's provider directory at our website at http://www.seniorcare.swhp.org.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
You can see our plan's provider directory at our website (http://www.seniorcare.swhp.org). You can see our plan's pharmacy directory at our website (http://www.seniorcare.swhp.org). 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.
- 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 (Cost) does cover Medicare Part B prescription drugs. Part D drug coverage is optional and SeniorCare (Cost) provides Part D coverage when the member selects the Part D drug coverage and pays the Part D premium.
- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.seniorcare.swhp.org.
- Or, call us and we will send you a copy of the formulary.
- You can see our plan's pharmacy directory at our website at http://www.seniorcare.swhp.org.

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, http://www.seniorcare.swhp.org.

Premiums and Benefits	SeniorCare (Cost) **Select HMO**	SeniorCare (Cost) **Preferred HMO**
Monthly Plan Premium	$0 per month In addition, you must keep paying your Medicare Part B premium.	$90 per month In addition, you must keep paying your Medicare Part B premium.
Deductible	The plan does not have a medical deductible.	The plan does not have a medical deductible.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$6,700 annually	$3,400 annually
Inpatient Hospital Coverage	$375 copay per day for days 1 through 5. You pay nothing per day for days 6 through 90. You pay nothing per day for days 91 and beyond.	$450 copay per stay
Doctor Visits	You must use an in-network provider.	You must use an in-network provider.
Primary	You pay $20 copay per visit.	You pay $15 copay per visit.
Specialists	You pay $50 copay per visit.	You pay $15 copay per visit.
Preventive Care	You pay nothing.	You pay nothing.
Emergency Care	You pay $200 copay per visit. If you are admitted to the hospital within 24 hours then the copay is waived.	You pay $200 copay per visit. If you are admitted to the hospital within 24 hours then the copay is waived.
Urgently Needed Services	You pay $40 copay per visit.	You pay $40 copay per visit.
Diagnostic Services/ Labs/Imaging	You must use an in-network provider.	You must use an in-network provider.
Diagnostic radiology service *(e.g., MRI)*	You pay 20% of the cost.	You pay $0 - $15 copay per visit.
Lab services	You pay 20% of the cost.	You pay $15 copay per visit.
Diagnostic tests and procedures	You pay 20% of the cost.	You pay $15 copay per visit.
Outpatient X-rays	You pay 20% of the cost.	You pay $15 copay per visit.
Therapeutic Radiology	You pay 20% of the cost.	You pay $15 copay per visit.

SeniorCare (Cost) **VIP HMO**	SeniorCare (Cost) **Premium HMO**
$130 per month In addition, you must keep paying your Medicare Part B premium.	$183 per month In addition, you must keep paying your Medicare Part B premium.
The plan does not have a medical deductible.	The plan does not have a medical deductible.
$3,400 annually	$3,400 annually
$200 copay per day for days 1 through 5. You pay nothing per day for days 6 through 90. You pay nothing per day for days 91 and beyond.	You pay nothing
You must use an in-network provider. You pay $10 copay per visit. You pay $10 copay per visit.	You must use an in-network provider. You pay nothing. You pay nothing.
You pay nothing.	You pay nothing.
You pay $125 copay per visit. If you are admitted to the hospital within 24 hours then the copay is waived.	You pay $75 copay per visit. If you are admitted to the hospital within 24 hours then the copay is waived.
You pay $40 copay per visit.	You pay $40 copay per visit.
You must use an in-network provider. You pay $10 copay per visit. You pay $10 copay per visit. You pay $10 copay per visit. You pay $10 copay per visit.	You must use an in-network provider. You pay nothing. You pay nothing. You pay nothing. You pay nothing.

Premiums and Benefits	SeniorCare (Cost) **Select HMO**	SeniorCare (Cost) **Preferred HMO**
Hearing Services Routine hearing exam Hearing aid	 You pay $50 copay per visit. You must use a HearUSA network provider. Hearing aid is not covered.	 You pay $15 copay per visit. You must use a HearUSA network provider. Hearing aid is not covered.
Dental Services	Not covered. You may elect dental as an optional, supplemental benefit with an additional monthly premium.	Not covered. You may elect dental as an optional, supplemental benefit with an additional monthly premium.
Vision Services	Not covered.	$125 annual allowance toward the purchase of 1 pair of glasses or 1 pair of hard contact lenses or frames or 1 pair of lenses for glasses. Must use participating Baylor Scott & White Health provider.
Mental Health Services Inpatient visit Outpatient group therapy visit Outpatient individual therapy visit	You must use an in-network provider. You pay $375 per stay. You pay nothing per stay for days 91 and beyond. You pay 20% coinsurance for outpatient group therapy visit. You pay 20% coinsurance for outpatient individual therapy visit.	You must use an in-network provider. You pay $450 per stay. You pay nothing per stay for days 91 and beyond. You pay $15 copay for outpatient group therapy visit. You pay $15 copay for outpatient group therapy visit.
Skilled Nursing Facility	You must use an in-network provider. You pay nothing per day for days 1 through 20. $125 copay per day for days 21 through 100.	You must use an in-network provider. You pay nothing per day for days 1 through 20. $35 copay per day for days 21 through 100.

SeniorCare (Cost) **VIP HMO**	SeniorCare (Cost) **Premium HMO**
You pay $10 copay per visit. You must use a HearUSA network provider. Hearing aid is not covered.	You pay nothing for hearing exam. You must use a HearUSA network provider. Hearing aid covered up to $1,000 every 3 years with unlimited fittings. Supply of batteries and warranty included.
Not covered. You may elect dental as an optional, supplemental benefit with an additional monthly premium.	Not covered. You may elect dental as an optional, supplemental benefit with an additional monthly premium.
$125 annual allowance toward the purchase of 1 pair of glasses or 1 pair of hard contact lenses or frames or 1 pair of lenses for glasses. Must use participating Baylor Scott & White Health provider.	$125 annual allowance toward the purchase of 1 pair of glasses or 1 pair of hard contact lenses or frames or 1 pair of lenses for glasses. Must use participating Baylor Scott & White Health provider.
You must use an in-network provider. You pay $200 per stay. You pay nothing per stay for days 91 and beyond. You pay $5 copay for outpatient group therapy visit. You pay $5 copay for outpatient group therapy visit.	You must use an in-network provider. You pay nothing per stay. You pay nothing for outpatient group therapy visit. You pay nothing for outpatient group therapy visit.
You must use an in-network provider. You pay nothing per day for days 1 through 20. $30 copay per day for days 21 through 100.	You must use an in-network provider. You pay nothing per day for days 1 through 20. $15 copay per day for days 21 through 100.

Premiums and Benefits	SeniorCare (Cost) **Select HMO**	SeniorCare (Cost) **Preferred HMO**
Rehabilitation Services	You must use an in-network provider.	You must use an in-network provider.
Occupational therapy visit	You pay 20% coinsurance.	You pay $15 copay.
Physical therapy and speech and language therapy visit	You pay 20% coinsurance.	You pay $15 copay.
Ambulance	You pay $100 copay. If you are admitted to hospital within 24 hours then the copay is waived.	You pay $75 copay. If you are admitted to hospital within 24 hours then the copay is waived.
Transportation	Not covered	Not covered
Foot Care (podiatry services)	You must use an in-network provider.	You must use an in-network provider.
Foot exams and treatment	You pay 20% coinsurance.	You pay $15 copay.
Routine foot care	Not covered.	Not covered.
Medical Equipment/Supplies	You must use an in-network provider.	You must use an in-network provider.
Durable Medical Equipment (e.g., wheelchairs, oxygen)	You pay 20% coinsurance.	You pay 20% coinsurance.
Prosthetics (e.g., braces, artificial limbs)	You pay 20% coinsurance.	You pay 20% coinsurance.
Diabetes supplies	You pay 20% coinsurance.	You pay 20% coinsurance.
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.
Medicare Part B Drugs	You pay 20% of the cost for chemotherapy drugs. You pay 20% of the cost for other Part B drugs.	You pay nothing for chemotherapy drugs. You pay nothing for other Part B drugs.

SeniorCare (Cost) **VIP HMO**	SeniorCare (Cost) **Premium HMO**
You must use an in-network provider. You pay $5 copay. You pay $5 copay.	You must use an in-network provider. You pay nothing. You pay nothing.
You pay $60 copay. If you are admitted to hospital within 24 hours then the copay is waived.	You pay $40 copay. If you are admitted to hospital within 24 hours then the copay is waived.
Not covered	Not covered
You must use an in-network provider. You pay $10 copay. Not covered.	You must use an in-network provider. You pay nothing. Not covered.
You must use an in-network provider. You pay 10% coinsurance. You pay 10% coinsurance. You pay 10% coinsurance.	You must use an in-network provider. You pay nothing. You pay nothing. You pay nothing.
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.
You pay nothing for chemotherapy drugs. You pay nothing for other Part B drugs.	You pay nothing for chemotherapy drugs. You pay nothing for other Part B drugs.

Outpatient Prescription Drugs		
	Standard Retail Rx 30-Day Supply	**Mail Order 90-Day Supply**
Value RX Plan $71.20 monthly premium $250 deductible applies to all tiers (Tiers 1-5).		
Phase 1: Initial Coverage (After you pay your deductible, if applicable)		
Tier 1: Preferred Generic	You pay $10.	You pay $20.
Tier 2: Generic Drugs	You pay $20.	You pay $40.
Tier 3: Preferred Brand Drugs	You pay $45.	You pay $90.
Tier 4: Non-Preferred Drugs	You pay $90.	You pay $180.
Tier 5: Specialty Drugs	You pay 28%.	A long-term supply is not available for drugs in Tier 5.
Basic RX Plan $76.40 monthly premium $100 deductible applies to Tiers 3, 4 and 5.		
Phase 1: Initial Coverage (After you pay your deductible, if applicable)		
Tier 1: Preferred Generic	You pay $4.	You pay $8.
Tier 2: Generic Drugs	You pay $20.	You pay $40.
Tier 3: Preferred Brand Drugs	You pay $47.	You pay $94.
Tier 4: Non-Preferred Drugs	You pay $100.	You pay $200.
Tier 5: Specialty Drugs	You pay 31%.	A long-term supply is not available for drugs in Tier 5.

Outpatient Prescription Drugs (Continued)		
	Standard Retail Rx 30-Day Supply	**Mail Order 90-Day Supply**
Enhanced RX Plan $125.60 monthly premium $50 deductible applies to Tiers 3, 4 and 5.		
Phase 1: Initial Coverage (After you pay your deductible, if applicable)		
Tier 1: Preferred Generic	You pay $2.	You pay $4.
Tier 2: Generic Drugs	You pay $12.	You pay $24.
Tier 3: Preferred Brand Drugs	You pay $47.	You pay $94.
Tier 4: Non-Preferred Drugs	You pay $95.	You pay $190.
Tier 5: Specialty Drugs	You pay 32%.	A long-term supply is not available for drugs in Tier 5.

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 1-866-334-3141. 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 1-866-334-3141. 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 1-866-334-3141.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 1-866-334-3141.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 1-866-334-3141. 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 1-866-334-3141. 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 1-866-334-3141. 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 unter 1-866-334-3141. 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 1-866-334-3141 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 1-866-334-3141. 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 1-866-334-3141. 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 1-866-334-3141 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 1-866-334-3141. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-866-334-3141. 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 1-866-334-3141. 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 1-866-334-3141. 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、1-866-334-3141. 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。

Information on Your Optional Prescription Benefit

Scott and White Health Plan encourages 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, Monday – Sunday, 7 a.m. to 8 p.m.

For complete details on the prescription drug plans, please call Scott and White Health Plan and ask for the Evidence of Coverage.

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.

For New Prescriptions:

- Take your prescription to a participating network pharmacy of your choice.

Transfer Prescriptions:

- Call the pharmacy and give the prescription label information to the staff or take your label to a participating network pharmacy of your choice. They will complete the transfer for you. Please allow 24 hours for transfer prescriptions.

Refills:

Refills may be picked up at your local participating network pharmacy.

- Call the Scott and White Health Plan network pharmacy where you would like to pick up your prescription.
- Give the prescription number and name of the pharmacy where you placed the original order.

Mail Order:

- To establish mail order service, please see the pharmacy directory or contact Customer Service.

After Hours/Weekends:

- For prescriptions received during evening or weekend hours that must be started immediately, please call the appropriate network pharmacy for emergency number instructions.

Out-of-Network Pharmacy Benefits:

Prescription drugs are available at out-of-network pharmacies in special circumstances including: 1) illness while traveling outside of the plan's service area where there is no network pharmacy; 2) traveling outside plan's service area and running out or losing drug with no access to network pharmacy; 3) no access to network pharmacy; 4) drug not stocked at network or mail order pharmacy; or 5) vaccine administered in physician's office; or 6) drug dispensed in out-of-network pharmacy while in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.

You pay 100% of the out-of-network pharmacy usual and customary charge. You then submit the claim to Scott and White Health Plan for reimbursement. In addition to paying the copayments/ coinsurance, you will be required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescriptions.

Scott and White Health Plan Exceptions, Grievances and Appeals Notice
Scott and White Health Plan encourages you to let us know right away, if after becoming a member you have questions, concerns, or problems related to your covered services or the care you receive. For assistance, you will call our Customer Service Department at 1-866-334-3141, Monday – Sunday, 7 a.m. to 8 p.m.
For complete details of our exceptions, appeals and grievances procedures, please call Scott and White Health Plan and ask for the Evidence of Coverage.

Exclusions & Limitations
To learn more about the Exclusions & Limitations that apply to SeniorCare (Cost), the prescription drug benefit or the optional dental services benefit, please call Scott and White Health Plan and ask for the Evidence of Coverage.

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 Scott and White Health Plan and ask for the Evidence of Coverage.

"Medicare & You"
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.

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 – $13 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 Explanation of Coverage for full details on the dental benefit.

Benefit	Benefit Amount and Highlights	
Covered Percentage for:	In-network based on the maximum allowed charge	Out-of-network based on the maximum allowed charge
Type A Services	100%	100%
Type B Services (no waiting period)	50%	50%
Deductibles for Yearly Individual Deductible Covered	$0 for the following covered services: Type B	$0 for the following covered services: Type B
Maximum Benefit Yearly Individual Maximum	$2,000 for the following covered services: Type A & Type B	$2,000 for the following covered services: Type A & Type B

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: a) When needed to replace congenitally missing teeth; or 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: a) If at least 6 months have passed since the installation of the existing removable denture; b) not more than once in any 6-month period.
Dental X-rays except as mentioned elsewhere.	Relining and rebasing of existing removable dentures: a) if at least 6 months have passed since the installation of the existing removable denture; and 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: a) At least 24 months have passed since the existing filling was placed; or b) A new surface of decay is identified on that tooth.
Cleaning of teeth (oral prophylaxis) once every 6 months.	Initial placement of resin fillings. Replacement of an existing resin filling, but only if: a) At least 24 months have passed since the existing filling was placed; or b) A new surface of decay is identified on that tooth.
	Simple extractions.
	Surgical extractions.
	Oral surgery except as mentioned elsewhere.

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

SENIOR*CARE* (COST)

SeniorCare (Cost) is an HMO plan with a Medicare contract. Enrollment in SeniorCare depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or copayments may change on January 1 of each year. You must continue to pay your Medicare Part B premium. Medicare beneficiaries may also enroll in SeniorCare through the CMS Medicare Online Enrollment Center located at http://www.medicare.gov.

This information is available for free in other languages. Please contact our customer service number at: 1-866-334-3141 (TTY 1-800-735-2989) 7 a.m. - 8 p.m. CST Monday - Sunday.

Esta información está disponible de forma gratuita en otros idiomas. Por favor póngase en contacto con nuestro número de servicio al cliente en: 1-866-334-3141 (TTY 1-800-735-2989) 7 a.m. - 8 p.m. tiempo central, de lunes a domingo.

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