
# My Plan Comparison

Central Texas · 2022

Baylor Scott & White Health Plan

BSW SENIORCARE ADVANTAGE

**Rx. Dental. Vision. Hearing. Fitness. Kidney Care.**

Y0058_22CTXMemberPlnPrvw_M

# HMO medical plan benefits

Effective January 1, 2022

| Medical Plan Benefits* | Select | Preferred | Premium |
|---|---|---|---|
| **Monthly Premium**<br>With Part D prescription drugs<br>Without Part D prescription drugs**<br>(See Select Plan Part B premium note below) | <br>$0<br>$0 | <br>$145<br>$83 | <br>$255<br>$199 |
| **Deductible** | $0 | $0 | $0 |
| **Out-of-Pocket Maximum** with Part D<br>**Out-of-Pocket Maximum** without Part D | $6,300<br>$5,900 | $4,900<br>$4,500 | $4,800<br>$4,500 |
| **Annual Physical Exam** | $0 copay | $0 copay | $0 copay |
| **Primary Care Physician** (PCP) **Office Visit** | $0 copay | $0 copay | $0 copay |
| **Specialty Care Physician** (SCP) **Office Visit** | $25 copay | $25 copay | $0 copay |
| **Telehealth Visit** (PCP, SCP, Psychiatry Services) | $0 copay | $0 copay | $0 copay |
| **Diagnostic Tests, X-rays, Lab Services** (separate office visit copay may apply) | $0-$75 copay | $0 copay | $0 copay |
| **Advanced Diagnostic Imaging Services** (MRI, MRA, SPECT, CTA, CT, PET, Nuclear Cardiology) | $300 copay | $15 copay | $0 copay |
| **Physical/Occupational/Speech Therapy** (per visit) | $35 copay | $25 copay | $10 copay |
| **Inpatient Hospital** | Days 1-6: $325/day<br>Days 7-90: $0/day | $700/stay | $100 copay |
| **Inpatient Mental Health** | Days 1-5: $318/day<br>Days 6-90: $0/day | $700/stay | $100 copay |
| **Skilled Nursing Facility** (SNF) | Days 1-20: $0/day<br>Days 21-100: $188/day | Days 1-20: $0/day<br>Days 21-100: $50/day | Days 1-20: $0/day<br>Days 21-100: $15/day |
| **Outpatient Surgery** (facility) | $350 copay | $15 copay | $0 copay |
| **Ambulatory Surgical Center** (facility) | $275 copay | $100 copay | $0 copay |
| **Ambulance** (U.S. only) with Part D<br>**Ambulance** (U.S. only) without Part D | $300 copay<br>$265 copay | $75 copay<br>$75 copay | $40 copay<br>$40 copay |
| **Emergency Care** (U.S. only; copay waived if admitted within 24 hours) | $90 copay | $90 copay | $90 copay |
| **Urgent Care** (U.S. only; copay waived if admitted within 24 hours) | $50 copay | $40 copay | $40 copay |
| **Durable Medical Equipment** (DME) | 20% coinsurance | 20% coinsurance | $0 copay |
| **Podiatry** | $45 copay | $15 copay | $0 copay |
| **Chemotherapy Drugs** | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| **Other Part B Drugs** | 20% coinsurance | 20% coinsurance | 20% coinsurance |

*This is not a complete description of benefits. Please refer to the plan's Evidence of Coverage at BSWHealthPlan.com/Medicare.

** BSW SeniorCare Advantage Select HMO (without Part D) pays $50 toward your Part B premium. This reduction is applied to your Social Security check. Contact Social Security or go to SSA.gov for more information. If you have Part D prescription drug coverage through another carrier, and you purchase a plan with Part D, your drug coverage will end when your new BSW SeniorCare Advantage plan starts. Medicare Advantage plans do not allow members to have medical coverage and prescription drug coverage through two different Medicare Advantage plans. (Stand-alone prescription drug plans (PDPs) are considered Medicare Advantage plans.) If you enroll in a BSW SeniorCare Advantage medical plan without prescription drug coverage, you may owe a late enrollment penalty if you try to sign up for prescription drug coverage later.

# PPO medical plan benefits

Effective January 1, 2022

| Medical Plan Benefits* | Basic[1] | Platinum[2] |
|---|---|---|
| Monthly Premium | $37 | $140 |
| Deductible | $0 | $0 |
| Out-of-Pocket Maximum | $7,000 | $4,700 |
| Primary Care Physician (PCP) Office Visit | $0 copay | $0 copay |
| Annual Physical Exam | $0 copay | $0 copay |
| Specialty Care Physician (SCP) Office Visit | $40 copay | $20 copay |
| Telehealth Visit (PCP, SCP, Psychiatry) | $0 copay | $0 copay |
| Diagnostic Tests, X-rays, Lab Services (separate office visit copay may apply) | $0-$75 copay | $0-$20 copay |
| Advanced Diagnostic Imaging Services (MRI, MRA, SPECT, CTA, CT, PET, Nuclear Cardiology) | $300 copay | $200 copay |
| Physical/Occupational/Speech Therapy (per visit) | $35 copay | $25 copay |
| Inpatient Hospital | Days 1-6: $325/day<br>Days 7-90: $0/day | Days 1-5: $250/day<br>Days 6-90: $0/day |
| Inpatient Mental Health | Days 1-5: $318/day<br>Days 6-90:$0/day | Days 1-5: $250/day<br>Days 6-90: $0/day |
| Skilled Nursing Facility (SNF) | Days 1-20: $0/day<br>Days 21-100: $188/day | Days 1-20: $0/day<br>Days 21-100: $50/day |
| Outpatient Surgery (facility) | $350 copay | $100 copay |
| Ambulatory Surgical Center (facility) | $275 copay | $75 copay |
| Ambulance (U.S. only) | $325 copay | $75 copay |
| Emergency Care (U.S. only; copay waived if admitted within 24 hours) | $90 copay | $90 copay |
| Urgent Care (U.S. only; copay waived if admitted within 24 hours) | $50 copay | $50 copay |
| Durable Medical Equipment (DME) | 20% coinsurance | 20% coinsurance |
| Podiatry | $45 copay | $45 copay |
| Chemotherapy Drugs | 20% coinsurance | 20% coinsurance |
| Other Part B Drugs | 20% coinsurance | 20% coinsurance |

*This is not a complete description of benefits. Please refer to the plan's Evidence of Coverage at BSWHealthPlan.com/Medicare. [1]To help maximize BSW SeniorCare Advantage PPO benefits, use in-network providers for care; out-of-network cost-sharing for the Basic PPO is 35%. There is a $750 deductible and $10,000 out-of-pocket maximum for services received out-of-network. [2]To help maximize BSW SeniorCare Advantage PPO benefits, use in-network providers for care; out-of-network cost-sharing for the Platinum PPO is 30%. There is no deductible and $10,000 out-of-pocket maximum for services received out-of-network.

# HMO Rx and dental benefits

| Prescription Drug Benefits | Select Rx | Preferred Rx | Premium Rx |
|---|---|---|---|
| Initial Coverage Amount | $4,430 | $4,430 | $4,430 |
| Deductible | $300 | $100 | $0 |
| Deductible Applies to: | Tiers 4-5 | Tiers 4-5 | Tiers 1-5 |
| Retail Copays During Initial Coverage Period | | | |
| Tier 1 - Preferred Generic Drugs | $6 copay | $3 copay | $2 copay |
| Tier 2 - Generic Drugs | $20 copay | $15 copay | $12 copay |
| Tier 3 - Preferred Brand Drugs | $47 copay | $45 copay | $45 copay |
| Tier 4 - Non-Preferred Drugs | $100 copay | $95 copay | $95 copay |
| Tier 5 - Specialty Drugs | 27% coinsurance | 31% coinsurance | 33% coinsurance |
| Mail-Order Copays | **Tiers 1 - 2** are $0 copay;<br>**Tiers 3 - 4** are 2 copays for a 90-day supply | | |
| After Initial Coverage Amount - You Pay | | | |
| Preferred Generic Drugs | 25% coinsurance | 25% coinsurance | 25% coinsurance |
| Other Generic Drugs | 25% coinsurance | 25% coinsurance | 25% coinsurance |
| Brand-Name Drugs | 25% coinsurance | 25% coinsurance | 25% coinsurance |
| Total Out-of-Pocket You Pay Before Catastrophic Coverage | $7,050 | $7,050 | $7,050 |
| Catastrophic Coverage Amounts - You Pay | **The greater of 5% or $3.95 for generic drugs** (including brand drugs treated as generic) **or $9.85 for all other drugs** | | |

There is no deductible for BSW SeniorCare Advantage for select insulins. Your out-of-pocket costs for select insulins will be $35 for a 30-day supply during the deductible and initial coverage phase. BSW SeniorCare Advantage also offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will also be $35 for a 30-day supply.

| Dental Benefits (for all HMO plans) | |
|---|---|
| Monthly Premium | Included |
| Yearly Benefit Maximum | $2,000 |
| Deductible | $0 |
| **Oral Exams, Cleanings** (every 6 months) | $0 |
| **Dental X-rays** (every 3 years) | $0 |
| **Extractions and Fillings** | 50% |
| **Dentures** (every 5 years) | 50% |
| **Restorative Services** (every 2 years) | 50% |

For plan changes or annual enrollment assistance, please call 1.877.845.3901 (TTY: 711) or email HPCustomerEngagement@BSWHealth.org for more information.

# PPO Rx and dental benefits

| Prescription Drug Benefits | Basic | Platinum |
|---|---|---|
| Initial Coverage Amount | $4,430 | $4,430 |
| Deductible | $250 | $50 |
| Deductible Applies to: | Tiers 3-5 | Tiers 3-5 |
| Retail Copays During Initial Coverage Period | | |
| Tier 1 – Preferred Generic Drugs | $3 copay | $2 copay |
| Tier 2 – Generic Drugs | $14 copay | $12 copay |
| Tier 3 – Preferred Brand Drugs | $47 copay | $45 copay |
| Tier 4 – Non-Preferred Drugs | $99 copay | $95 copay |
| Tier 5 – Specialty Drugs | 28% coinsurance | 32% coinsurance |
| Mail-Order Copays | Tiers 1 - 2 are $0 copay; Tiers 3 - 4 are 2 copays for a 90-day supply | |
| After Initial Coverage Amount - You Pay | | |
| Preferred Generic Drugs | 25% coinsurance | 25% coinsurance |
| Other Generic Drugs | 25% coinsurance | 25% coinsurance |
| Brand-Name Drugs | 25% coinsurance | 25% coinsurance |
| Total Out-of-Pocket You Pay Before Catastrophic Coverage | $7,050 | $7,050 |
| Catastrophic Coverage Amounts - You Pay | The greater of 5% or $3.95 for generic drugs (including brand drugs treated as generic) or $9.85 for all other drugs | |

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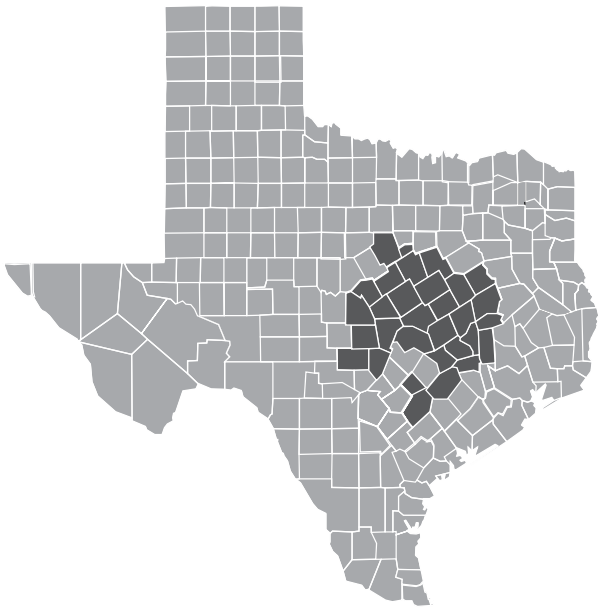
| Dental Benefits | Basic | Platinum |
|---|---|---|
| Monthly Premium | $20 | Included |
| Yearly Benefit Maximum | $2,000 | $2,000 |
| Deductible | $0 | $0 |
| Oral Exams, Cleanings (every 6 months) | $0 | $0 |
| Dental X-rays (every 3 years) | $0 | $0 |
| Extractions and Fillings | 50% | 50% |
| Dentures (every 5 years) | 50% | 50% |
| Restorative Services (every 2 years) | 50% | 50% |

# HMO supplemental benefits and additional care programs

| Supplemental Benefits (for all HMO plans except as noted) | |
|---|---|
| **Routine Eye Exam** (one per year; must use a network provider) | $0 copay |
| **Eyewear** (annual allowance; must use a network provider) | $125 allowance toward purchase |
| **Routine Hearing Exam** (one per year) | $0 copay |
| **Hearing Aids** (every three years) | $1,000 allowance toward purchase |
| **Fitness** (at participating Silver&Fit locations) | $0 cost |
| **Over-the-Counter (OTC) Allowance** (must use OTC Network card at participating retailers; no rollover) | $50 allowance per quarter in Select Rx plan; $30 per quarter in all other plans |
| **In-Home Meals** (14 meals per hospital discharge to home; limit 3 discharges per year) | $0 cost |
| **Routine Transportation** (up to 24 one-way trips per year, or 12 round trips up to 50 miles each way) | $0 cost |
| **In-Home Support Services** (assistance in performing activities of daily living) | $0 cost |

| Additional Care Programs (for all HMO plans) | |
|---|---|
| **In-Home Acute Care** for eligible members with complex health issues | $0 cost |
| **Kidney Health Program** for eligible members diagnosed with kidney disease | $0 cost |

# HMO – coverage area



Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Colorado, Coryell, Erath, Falls, Fayette, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington and Williamson counties

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| **Routine Eye Exam** (one per year; must use a network provider) | **$0 copay** |
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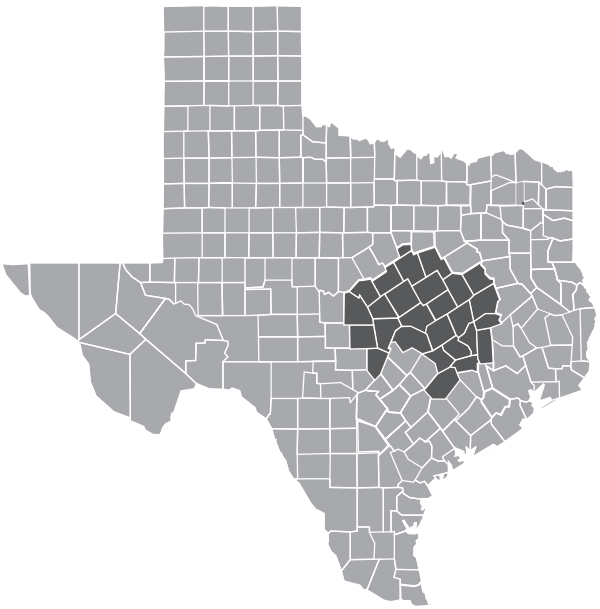
# PPO – coverage area



Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Coryell, Falls, Fayette, Freestone, Gillespie, Grimes, Hamilton, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington and Williamson counties

Scott and White Health Plan, doing business as Baylor Scott & White Health Plan, and its subsidiary Baylor Scott & White Insurance Company are Medicare Advantage organizations with Medicare contracts. Baylor Scott & White Health Plan offers HMO plans. Baylor Scott & White Insurance Company offers PPO plans. Enrollment in Baylor Scott & White Health Plan or Baylor Scott & White Insurance Company depends on contract renewal.

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

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