# Select Health Medicare®

## Summary of benefits

**Utah 2024**

Select Health Medicare Essential (HMO) 001

Select Health Medicare Enhanced (HMO) 007

Select Health Medicare No Rx (HMO) 016

Select Health Medicare Choice (PPO) 018

Select Health Medicare Essential (HMO) 017

Select Health Medicare Kroger (HMO) 022

Select Health Medicare Classic (HMO) 002

The Summary of Benefits is meant to help you understand what we cover and what you pay. It doesn't list every service we cover or every limitation or exclusion. To get a complete list of services we cover, call and ask for the "Evidence of Coverage."

### Who can join Select Health Medicare (HMO, PPO)?

To join, you must be enrolled in Medicare Part A and Part B and live in one of our service areas.

The following Utah and Idaho counties are included in our service areas: Box Elder, Cache, Davis, Duchesne, Garfield, Grand, Iron, Juab, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne, and Weber counties in Utah, or Franklin county in Idaho.

### What is an HMO?

An HMO Medicare Advantage plan has an established network of doctors, providers, and hospitals where you must get your care, except for emergency care and out-of-area urgent care.

### What is a PPO?

A PPO Medicare Advantage plan has a network of doctors, specialists, hospitals, and other healthcare providers you can use. You also have the flexibility to use out-of-network providers for covered services, usually at a higher cost.

Select Health

### Which doctors, hospitals, and pharmacies can I use?

Our plans are on the Select Health Medicare network. It includes a wide variety of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, and it's not urgent or emergency care, your plan may not pay for these services. You can see our most up-to-date provider and pharmacy directories on our website, **selecthealth.org/medicare**. Or, call us and we will send you a copy of the directories.

### Important message about what you pay for vaccines:

Our plan covers most Part D vaccines at no cost to you.

For coverage and costs of Original Medicare, look in your current *"Medicare & You"* handbook. View it online at **medicare.gov** or get a copy by calling 1-800-MEDICARE (**1-800-633-4227**), 7 days a week, 24 hours a day. TTY users should call **1-877-486-2048**.

### How to contact us

Call us toll-free at **855-442-9940 (TTY: 711)** or visit **selecthealth.org/medicare**.

**Hours of operation:**

**October 1 to March 31** – Monday through Sunday, 8:00 a.m. to 8:00 p.m.

**April 1 to September 30** – Weekdays, 8:00 a.m. to 8:00 p.m., closed weekends.

Outside of these hours of operation, please leave a message and your call will be returned within one business day.

# Select Health Medicare Essential (HMO)

**H1994_001**

Box Elder, Cache, Davis, Franklin (ID), Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, and Weber counties in Utah.

| BENEFIT | COST |
|---|---|
| **Premium Amount** | $0 |
| **Medical Deductible** | $0 |
| **Member Out-of-Pocket Maximum**<br>Does not include prescription drugs, comprehensive dental, and hearing aid copays.<br>If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs. | $5,700 |
| **Inpatient Hospital Coverage***<br>Copays start over each time you are admitted as an inpatient. | |
| Days 1-5 | $410 copay |
| Days 6+ | $0 copay |
| **Outpatient Hospital Coverage*** | |
| Outpatient surgery | $350 copay |
| **Ambulatory surgical center** | $250 copay |
| **Doctor's Office Visits** | |
| Primary care provider | $0 copay |
| Specialist<br>We do not require referrals. | $15 copay |
| **Preventive Care** | |
| Annual physical/comprehensive wellness visit | $0 copay |
| Medicare-covered preventive services | $0 copay |
| **Emergency Care (Worldwide)**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $100 copay |
| **Urgently Needed Services (Worldwide)**<br>No extra charges for labs and/or x-rays.<br>Copay is waived if you are admitted to the ER or hospital within 24 hours.<br>Refer to the Evidence of Coverage for additional details. | $35 copay |
| **Diagnostic Services, Labs, and Imaging***<br>Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay. | |
| Diagnostic tests and procedures | $0 copay |
| Diagnostic colonoscopy | $350 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Advanced Imaging (e.g., MRIs, CT scans) | $200 copay |
| Therapeutic radiology services | 20% coinsurance |
| Other covered services<br>Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more. | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $15 copay |
| Routine hearing exam<br>One per year. | $0 copay |
| Hearing aids<br>Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum. | $299 to $1,799 copay |
| **Dental Services***<br>Limited Medicare-covered dental services related to a medical condition. | $20 copay |
| Maximum plan payment benefit, includes preventive. | $1,500 |
| Preventive dental services<br>Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months | $0 copay |
| Basic dental services | $0 copay |
| Major dental services | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>One per year. | $0 copay |
| Problem-related eye exam | $20 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>One purchase per year. | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-5 | $350 copay |
| Days 6-90 | $0 copay |
| Lifetime reserve days* 1-60 | $0 copay |
| **Outpatient Mental Health Services** | |
| Individual therapy | $25 copay |
| Group therapy | $25 copay |
| Partial hospitalization for mental health* | $55 copay |
| **Substance Abuse* (Outpatient)** | |
| Individual therapy | $25 copay |
| Group therapy | $20 copay |
| **Acupuncture Services*** | |
| Treatment of lower back pain.<br>12 initial visits, and additional 8 visits if member is making progress. | $15 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **Ambulance***<br>Prior authorization only required for non-emergency transfers. | $280 copay |
| **Chiropractic Care*** | $15 copay |
| **Diabetes Specific Benefits** | |
| Primary care provider<br>In-person or through telehealth. | $0 copay |
| Routine eye exam | $0 copay |
| Diabetes monitoring supplies<br>Coverage for test strips and glucose monitors produced by Abbott. | $0 copay |
| Diabetes self-management training | $0 copay |
| Select diabetes drugs in Tier 1 and Tier 2 (non-insulin) | Covered through the gap |
| Continuous Glucose Monitors (CGM)* | $0 copay |
| Part B insulin pumps and supplies | 20% coinsurance up to max<br>$35 copay per month |
| **Insulin** | |
| Tier 3 and Tier 4 insulin<br>30-day supply in all Part D stages. Coverage Gap and deductible do not apply to insulins. | $35 copay |
| Part B pump insulin<br>For use in a pump. | 0-20% coinsurance up to max<br>$35 copay per month |
| **Foot Care (Podiatry Services)**<br>Foot exams and treatment for Medicare-covered services. | $25 copay |
| Routine foot care<br>Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits. | $25 copay |
| **Home Health Care*** | $0 copay |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care**<br>Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Meals after discharge***<br>After discharge from an inpatient acute hospital or skilled nursing facility. | $0 copay, up to 14 days<br>(2 meals per day) |
| **Medical Equipment and Supplies** | |
| Crutches, canes, and walkers | $0 copay |
| All other durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| **Medicare Part B Drugs***<br>Includes chemotherapy drugs, and other Part B drugs and biologics. | 0-20% coinsurance |
| Insulin for use with insulin pumps | 0-20% coinsurance up to max<br>$35 copay per month |
| **Over-the-Counter (OTC) Items**<br>Receive money on your pre-loaded Flex Card for OTC items.<br>Amounts do not roll over. | $95 allowance per quarter |
| **Papa Pals Companionship Services** | $0 copay, up to 30 hours a year |
| **Rehabilitation Services* (Outpatient)** | |
| Physical, occupational, and speech therapy visits. | $20 copay |
| Cardiac rehab services | $0 copay |
| Pulmonary rehab services | $10 copay |
| **Renal Dialysis**<br>Including services and supplies for home dialysis. | 20% coinsurance |
| **Skilled Nursing Facility (SNF)***<br>Our plan covers up to 100 days in a SNF, no prior hospital stay required. | |
| Days 1-20 | $0 copay |
| Days 21-55 | $203 copay |
| Days 56-100 | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $15 copay |
| **Wellness Your Way**<br>Receive money on your pre-loaded Flex Card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $360 per year |

**Service may require prior authorization.*

## YOUR PRESCRIPTION BENEFITS

**Select Health Medicare Essential (HMO) 001**

The below cost-sharing table shows what you will pay for your prescription in the Initial Coverage Stage after you've reached your annual $100 pharmacy deductible **OR** when filling a Tier 1 or Tier 2 drug.
**The $100 pharmacy deductible does not apply to Tier 1 and Tier 2 drugs.**

You stay in the Initial Coverage Stage until your year-to-date total drug costs reaches **$5,030**.
Then you move to the Coverage Gap (Donut Hole) stage.

You will generally pay 25% on brand-name and generic drugs while in the Coverage Gap. Once you reach **$8,000** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays the full cost for your covered Part D drugs.
**You pay nothing.**

## PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 | $0 | |
| Tiers 3, 4, and 5 | $100 | |
| **COST-SHARING** | **RETAIL COST-SHARING** | **MAIL ORDER COST-SHARING** |
| | 30-DAY SUPPLY \| 100-DAY SUPPLY | 30-DAY SUPPLY \| 100-DAY SUPPLY |
| Tier 1 (Preferred Generic) | $0 \| $0 | $0 \| $0 |
| Tier 2 (Generic) | $6 \| $18 | $0 \| $0 |
| Tier 3 (Preferred Brand) | $47 \| $141 | $47 \| $141 |
| Tier 4 (Nonpreferred Drugs) | $100 \| $300 | $100 \| $300 |
| Tier 5 (Specialty Tier) | 31% coinsurance \| N/A | 31% coinsurance \| N/A |

Please see the Evidence of Coverage (EOC) for information regarding cost-sharing difference depending on pharmacy status, mail-order, Long Term Care (LTC) or home infusion, and 30- or 100-day medication supplies.

### How we help with prescription drug costs.

Select diabetes prescription drugs on Tiers 1 and 2 are covered through the Coverage Gap.
Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.



# Exclusive plan benefits

Our mission is to help you live the healthiest life possible. That's why we give you tools and incentives to help you get healthy and stay healthy.

### Dental Coverage

This plan covers preventive, basic, and major dental services for **no additional cost.**

### Over-The-Counter (OTC) Benefit

Receive **$95** per quarter ($380 annually) on your pre-loaded flex card for over-the-counter items.



### Hearing Aids

**Intermountain Health Hearing, Balance, and Audiology Clinics**

We cover diagnostic hearing and balance evaluations under your plan's copay, as well as certain hearing aids purchased through an in-network Intermountain Audiology provider. Hearing aids are available in five tiers:

Tier 1 - Economy | $299

Tier 2 - Essential | $639

Tier 3 - Standard | $949

Tier 4 - Advanced | $1,299

Tier 5 - Premium | $1,799

**NOTE**: Costs are per hearing aid. Hearing aid copays do not go towards the Member Out-of-Pocket Maximum.

### Vision Coverage

This plan includes vision services, such as an annual routine eye exam and a vision hardware benefit.

### Wellness Your Way

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We'll give you **$360 per year** on a pre-loaded flex card that you can use to participate in wellness activities.

### Healthy Living Incentive

Get up to **$160 a year** loaded onto your flex card for completing activities that keep you healthy, like your annual physical, cancer screenings, and immunizations.

### Papa Pals - Companionship Services

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and help with errands.

### Meals After Hospital Stay

Receive up to **14 days of meals** after you are discharged from an inpatient hospital or skilled nursing facility stay, based on need, at no cost to you. Prior authorization by a Care Manager is required.

# Select Health Medicare Enhanced (HMO)

**H1994_007**

Box Elder, Cache, Davis, Franklin (ID), Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, and Weber counties in Utah.

| BENEFIT | COST |
|---|---|
| **Premium Amount** | $48 |
| **Medical Deductible** | $0 |
| **Member Out-of-Pocket Maximum**<br>Does not include prescription drugs, comprehensive dental, and hearing aid copays.<br>If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs. | $4,700 |
| **Inpatient Hospital Coverage***<br>Copays start over each time you are admitted as an inpatient. | |
| Days 1-4 | $350 copay |
| Days 5+ | $0 copay |
| **Outpatient Hospital Coverage*** | |
| Outpatient surgery | $300 copay |
| **Ambulatory surgical center** | $200 copay |
| **Doctor's Office Visits** | |
| Primary care provider | $0 copay |
| Specialist<br>We do not require referrals. | $10 copay |
| **Preventive Care** | |
| Annual physical/comprehensive wellness visit | $0 copay |
| Medicare-covered preventive services | $0 copay |
| **Emergency Care (Worldwide)**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $100 copay |
| **Urgently Needed Services (Worldwide)**<br>No extra charges for labs and/or x-rays.<br>Copay is waived if you are admitted to the ER or hospital within 24 hours.<br>Refer to the Evidence of Coverage for additional details. | $35 copay |
| **Diagnostic Services, Labs, and Imaging***<br>Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay. | |
| Diagnostic tests and procedures | $0 copay |
| Diagnostic colonoscopy | $300 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Advanced Imaging (e.g., MRIs, CT scans) | $150 copay |
| Therapeutic radiology services | 20% coinsurance |
| Other covered services<br>Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more. | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $10 copay |
| Routine hearing exam<br>One per year. | $0 copay |
| Hearing aids<br>Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum. | $299 to $1,799 copay |
| **Dental Services***<br>Limited Medicare-covered dental services related to a medical condition. | $20 copay |
| Maximum plan payment benefit, includes preventive. | $2,000 |
| Preventive dental services<br>Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months | $0 copay |
| Basic dental services | $0 copay |
| Major dental services | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>One per year. | $0 copay |
| Problem related eye exam | $20 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>One purchase per year. | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-4 | $350 copay |
| Days 5-90 | $0 copay |
| Lifetime reserve days* 1-60 | $0 copay |
| **Outpatient Mental Health Services** | |
| Individual therapy | $20 copay |
| Group therapy | $15 copay |
| Partial hospitalization for mental health* | $55 copay |
| **Substance Abuse* (Outpatient)** | |
| Individual therapy | $20 copay |
| Group therapy | $15 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **Acupuncture Services*** | |
| Treatment of lower back pain.<br>12 initial visits, and additional 8 visits if member is making progress.<br>Up to 20 visits per year. | $10 copay |
| Supplemental Acupuncture Services<br>Up to 20 visits for any condition. | $20 copay |
| **Ambulance***<br>Prior authorization only required for non-emergency transfers. | $250 copay |
| **Chiropractic Care*** | $20 copay |
| **Diabetes Specific Benefits** | |
| Primary care provider<br>In-person or through telehealth. | $0 copay |
| Routine eye exam | $0 copay |
| Diabetes monitoring supplies<br>Coverage for test strips and glucose monitors produced by Abbott. | $0 copay |
| Diabetes self-management training | $0 copay |
| Select diabetes drugs in Tier 1 and Tier 2 (non-insulin) | Covered through the gap |
| Continuous Glucose Monitors (CGM)* | $0 copay |
| Part B insulin pumps and supplies | 20% coinsurance |
| **Insulin** | |
| Tier 3 and Tier 4 insulin<br>30-day supply in all Part D stages. Coverage Gap and deductible do not apply to insulins. | $35 copay |
| Part B pump insulin<br>For use in a pump. | 0-20% coinsurance up to max<br>$35 copay per month |
| **Foot Care (Podiatry Services)**<br>Foot exams and treatment for Medicare-covered services. | $20 copay |
| Routine foot care<br>Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits. | $20 copay |
| **Home Health Care*** | $0 copay |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care**<br>Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Meals after discharge***<br>After discharge from an inpatient acute hospital or skilled nursing facility. | $0 copay, up to 14 days<br>(2 meals per day) |
| **Medical Equipment and Supplies** | |
| Crutches, canes, and walkers | $0 copay |
| All other durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| **Medicare Part B Drugs***<br>Includes chemotherapy drugs, and other Part B drugs and biologics. | 0-20% coinsurance |
| Insulin for use with insulin pumps | 0-20% coinsurance up to max<br>$35 copay per month |
| **Over-the-Counter (OTC) Items**<br>Receive money on your pre-loaded Flex Card for OTC items.<br>Amounts do not roll over. | $95 allowance per quarter |
| **Papa Pals Companionship Services** | $0 copay, up to 90 hours a year |
| **Rehabilitation Services* (Outpatient)** | |
| Physical, occupational, and speech therapy visits. | $20 copay |
| Cardiac rehab services | $0 copay |
| Pulmonary rehab services | $10 copay |
| **Renal Dialysis**<br>Including services and supplies for home dialysis. | 20% coinsurance |
| **Skilled Nursing Facility (SNF)***<br>Our plan covers up to 100 days in a SNF, no prior hospital stay required. | |
| Days 1-20 | $0 copay |
| Days 21-50 | $203 copay |
| Days 51-100 | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $10 copay |
| **Transportation* (Routine)**<br>Prior authorization is required for non-emergent medical transportation. | $0 copay for 24 one-way trips |
| **Wellness Your Way**<br>Receive money on your pre-loaded Flex Card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $500 per year |

**Service may require prior authorization.*

## YOUR PRESCRIPTION BENEFITS

**Select Health Medicare Enhanced (HMO) 007**

The below cost-sharing table shows what you will pay for your prescription in the Initial Coverage Stage after you've reached your annual $50 pharmacy deductible **OR** when filling a Tier 1 or Tier 2 drug.
**The $50 pharmacy deductible does not apply to Tier 1 and Tier 2 drugs.**

You stay in the Initial Coverage Stage until your year-to-date total drug costs reaches **$5,030**.
Then you move to the Coverage Gap (Donut Hole) stage.

You will generally pay 25% on brand-name and generic drugs while in the Coverage Gap. Once you reach **$8,000** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays the full cost for your covered Part D drugs.
**You pay nothing.**

## PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 | $0 | |
| Tiers 3, 4, and 5 | $50 | |
| **COST-SHARING** | **RETAIL COST-SHARING** | **MAIL ORDER COST-SHARING** |
| | 30-DAY SUPPLY \| 100-DAY SUPPLY | 30-DAY SUPPLY \| 100-DAY SUPPLY |
| Tier 1 (Preferred Generic) | $0 \| $0 | $0 \| $0 |
| Tier 2 (Generic) | $6 \| $18 | $0 \| $0 |
| Tier 3 (Preferred Brand) | $47 \| $141 | $47 \| $141 |
| Tier 4 (Nonpreferred Drugs) | $100 \| $300 | $100 \| $300 |
| Tier 5 (Specialty Tier) | 32% coinsurance \| N/A | 32% coinsurance \| N/A |

Please see the Evidence of Coverage (EOC) for information regarding cost-sharing difference depending on pharmacy status, mail-order, Long Term Care (LTC) or home infusion, and 30- or 100-day medication supplies.

### How we help with prescription drug costs.

All Tier 1 prescription drugs are covered through the Coverage Gap.

Select diabetes prescription drugs on Tier 2 are covered through the Coverage Gap.
Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.





## Exclusive plan benefits

Our mission is to help you live the healthiest life possible. That's why we give you tools and incentives to help you get healthy and stay healthy.

### Dental Coverage

This plan covers preventive and comprehensive dental for **no additional cost**.

### Over-The-Counter (OTC) Benefit

Receive **$95** per quarter ($380 annually) on your pre-loaded flex card for over-the-counter items.

### Hearing Aids

**Intermountain Health Hearing, Balance, and Audiology Clinics**

We cover diagnostic hearing and balance evaluations under your plan's copay, as well as certain hearing aids purchased through an in-network Intermountain Audiology provider. Hearing aids are available in five tiers:

Tier 1 - Economy | $299

Tier 2 - Essential | $639

Tier 3 - Standard | $949

Tier 4 - Advanced | $1,299

Tier 5 - Premium | $1,799

**NOTE**: Costs are per hearing aid. Hearing aid copays do not go towards the Member Out-of-Pocket Maximum.

### Vision Coverage

This plan includes vision services, such as an annual routine eye exam and a vision hardware benefit.

### Wellness Your Way

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We'll give you **$500 per year** on a pre-loaded flex card that you can use to participate in wellness activities.

### Healthy Living Incentive

Get up to **$160 a year** loaded onto your flex card for completing activities that keep you healthy, like your annual physical, cancer screenings, and immunizations.

### Papa Pals - Companionship Services

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and help with errands.

### Meals After Hospital Stay

Receive up to **14 days of meals** after you are discharged from an inpatient hospital or skilled nursing facility stay, based on need, at no cost to you. Prior authorization by a Care Manager is required.

# Select Health Medicare No Rx (HMO)

**H1994_016**

Davis, Salt Lake, Utah, and Weber counties in Utah.
This plan does not include Part D prescription drug coverage.

| BENEFIT | COST |
|---|---|
| **Premium Amount** | $0 |
| **Medical Deductible** | $0 |
| **Member Out-of-Pocket Maximum**<br>Does not include prescription drugs, comprehensive dental, and hearing aid copays.<br>If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs. | $6,700 |
| **Inpatient Hospital Coverage***<br>Copays start over each time you are admitted as an inpatient. | |
| Days 1-5 | $360 copay |
| Days 6+ | $0 copay |
| **Outpatient Hospital Coverage*** | |
| Outpatient surgery | $350 copay |
| **Ambulatory surgical center** | $250 copay |
| **Doctor's Office Visits** | |
| Primary care provider | $0 copay |
| Specialist<br>We do not require referrals. | $40 copay |
| **Preventive Care** | |
| Annual physical/comprehensive wellness visit | $0 copay |
| Medicare-covered preventive services | $0 copay |
| **Emergency Care (Worldwide)**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $100 copay |
| **Urgently Needed Services (Worldwide)**<br>No extra charges for labs and/or x-rays.<br>Copay is waived if you are admitted to the ER or hospital within 24 hours.<br>Refer to the Evidence of Coverage for additional details. | $30 copay |
| **Diagnostic Services, Labs, and Imaging***<br>Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay. | |
| Diagnostic tests and procedures | $0 copay |
| Diagnostic colonoscopy | $350 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Advanced Imaging (e.g., MRIs, CT scans) | $150 copay |
| Therapeutic radiology services | 20% coinsurance |
| Other covered services<br>Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more. | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $40 copay |
| Routine hearing exam<br>One per year. | $0 copay |
| Hearing aids<br>Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum. | $299 to $1,799 copay |
| **Dental Services***<br>Limited Medicare-covered dental services related to a medical condition. | $40 copay |
| Maximum plan payment benefit, includes preventive. | $1,500 |
| Preventive dental services<br>Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months | $0 copay |
| Basic dental services | $0 copay |
| Major dental services | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>One per year. | $0 copay |
| Problem related eye exam | $40 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>One purchase per year. | $200 allowance |
| **Mental Health Services** | |
| Days 1-5 | $360 copay |
| Days 6-90 | $0 copay |
| Lifetime reserve days* 1-60 | $0 copay |
| **Outpatient Mental Health Services** | |
| Individual therapy | $25 copay |
| Group therapy | $15 copay |
| Partial hospitalization for mental health* | $55 copay |
| **Substance Abuse* (Outpatient)** | |
| Individual therapy | $25 copay |
| Group therapy | $15 copay |
| **Acupuncture Services* (Medicare Covered)** | |
| Treatment of lower back pain.<br>12 initial visits, and additional 8 visits if member is making progress. | $20 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **Ambulance*** Prior authorization only required for non-emergency transfers. | $250 copay |
| **Chiropractic Care*** | $15 copay |
| **Diabetes Specific Benefits** | |
| Primary care provider In-person or through telehealth. | $0 copay |
| Routine eye exam | $0 copay |
| Diabetes monitoring supplies Coverage for test strips and glucose monitors produced by Abbott. | $0 copay |
| Diabetes self-management training | $0 copay |
| Continuous Glucose Monitors (CGM)* | $0 copay |
| Part B insulin pumps and supplies | 0-20% coinsurance up to max $35 copay per month |
| **Foot Care (Podiatry Services)** Foot exams and treatment for Medicare-covered services. | $40 copay |
| Routine foot care Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits. | $40 copay |
| **Home Health Care*** | $0 copay |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care** Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Meals after discharge*** After discharge from an inpatient acute hospital or skilled nursing facility. | $0 copay, up to 14 days (2 meals per day) |
| **Medical Equipment and Supplies** | |
| Crutches, canes, and walkers | $0 copay |
| All other durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| **Medicare Part B Drugs*** Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs and biologics. | 0-20% coinsurance |
| Insulin for use with insulin pumps | 0-20% coinsurance up to max $35 copay per month |
| **Over-the-Counter (OTC) Items** Receive money on your pre-loaded Flex Card for OTC items. Amounts do not roll over. | $75 allowance per quarter |
| **Papa Pals Companionship Services** | $0 copay, up to 30 hours a year |
| **Part B Premium Reduction** | Up to $50 reduction |
| **Rehabilitation Services* (Outpatient)** | |
| Physical, occupational, and speech therapy visits. | $20 copay |
| Cardiac rehab services | $0 copay |
| Pulmonary rehab services | $0 copay |
| **Renal Dialysis** Including services and supplies for home dialysis. | 20% coinsurance |
| **Skilled Nursing Facility (SNF)*** Our plan covers up to 100 days in a SNF, no prior hospital stay required. | |
| Days 1-20 | $0 copay |
| Days 21-55 | $203 copay |
| Days 56-100 | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $40 copay |
| **Wellness Your Way** Receive money on your pre-loaded Flex Card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $240 per year |

**Service may require prior authorization.*

# Exclusive plan benefits

Our mission is to help you live the healthiest life possible. That's why we give you tools and incentives to help you get healthy and stay healthy.

### Dental Coverage

This plan covers preventive and comprehensive dental for **no additional cost**.

### Over-The-Counter (OTC) Benefit

Receive **$75** per quarter ($300 annually) on your pre-loaded flex card for over-the-counter items.

### Hearing Aids

**Intermountain Health Hearing, Balance, and Audiology Clinics**

We cover diagnostic hearing and balance evaluations under your plan's copay, as well as certain hearing aids purchased through an in-network Intermountain Audiology provider. Hearing aids are available in five tiers:

Tier 1 - Economy | $299

Tier 2 - Essential | $639

Tier 3 - Standard | $949

Tier 4 - Advanced | $1,299

Tier 5 - Premium | $1,799

**NOTE**: Costs are per hearing aid. Hearing aid copays do not go towards the Member Out-of-Pocket Maximum.

### Vision Coverage

This plan includes vision services, such as an annual routine eye exam and a vision hardware benefit.

### Wellness Your Way

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We'll give you **$240 per year** on a pre-loaded flex card that you can use to participate in wellness activities.

### Healthy Living Incentive

Get up to **$160 a year** loaded onto your flex card for completing activities that keep you healthy, like your annual physical, cancer screenings, and immunizations.

### Papa Pals - Companionship Services

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and help with errands.

### Meals After Hospital Stay

Receive up to **14 days of meals** after you are discharged from an inpatient hospital or skilled nursing facility stay, based on need, at no cost to you. Prior authorization by a Care Manager is required.

## Notes

# Select Health Medicare Choice (PPO)

**H2246_018**

Box Elder, Cache, Davis, Franklin (ID), Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber counties in Utah.

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Premium Amount** | $0 | |
| **Medical Deductible** | $0 | |
| **Member Out-of-Pocket Maximum**<br>Does not include prescription drugs, comprehensive dental, and hearing aid copays.<br>If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs. | $5,700 | $9,550 combined with In-Network Member Out-of-Pocket Maximum |
| **Inpatient Hospital Coverage***<br>Copays start over each time you are admitted as an inpatient. | | |
| Days 1-5 | $420 copay | 30% coinsurance |
| Days 6+ | $0 copay | 30% coinsurance |
| **Outpatient Hospital Coverage*** | | |
| Outpatient surgery | $360 copay | 30% coinsurance |
| **Ambulatory surgical center** | $260 copay | 30% coinsurance |
| **Doctor's Office Visits** | | |
| Primary care provider | $0 copay | 30% coinsurance |
| Specialist<br>We do not require referrals. | $20 copay | 30% coinsurance |
| **Preventive Care** | | |
| Annual physical/comprehensive wellness visit | $0 copay | $0 copay |
| Medicare-covered preventive services | $0 copay | $0 copay |
| **Emergency Care (Worldwide)**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $100 copay | $100 copay |
| **Urgently Needed Services (Worldwide)**<br>No extra charges for labs and/or x-rays.<br>Copay is waived if you are admitted to the ER or hospital within 24 hours. Refer to the Evidence of Coverage for additional details. | $35 copay | $35 copay |
| **Diagnostic Services, Labs, and Imaging***<br>Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay. | | |
| Diagnostic tests and procedures | $0 copay | 30% coinsurance |
| Diagnostic colonoscopy | $360 copay | 30% coinsurance |
| Lab services | $0 copay | 30% coinsurance |
| Outpatient x-rays | $0 copay | 30% coinsurance |
| Advanced Imaging (e.g., MRIs, CT scans) | $200 copay | 30% coinsurance |
| Therapeutic radiology services | 20% coinsurance | 30% coinsurance |
| Other covered services<br>Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more. | 20% coinsurance | 30% coinsurance |
| **Hearing Services** | | |
| Hearing exam related to a medical condition | $20 copay | 30% coinsurance |
| Routine hearing exam<br>One per year. | $0 copay | 30% coinsurance |
| Hearing aids<br>Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum. | $499 to $799 copay | Not covered |
| **Dental Services***<br>Limited Medicare-covered dental services related to a medical condition. | $25 copay | 30% coinsurance |
| Maximum plan payment benefit, includes preventive. | $1,500 | Combined with in-network |
| Preventive dental services<br>Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months | $0 copay | 10% coinsurance |
| Basic dental services | $0 copay | 10% coinsurance |
| Major dental services | $0 copay | 10% coinsurance |
| **Vision Services** | | |
| Routine and/or preventive eye exam<br>One per year. | $0 copay | $35 Reimbursement for EyeMed |
| Problem related eye exam | $25 copay | 30% coinsurance |
| Vision test for prescriptions | $0 copay | $35 Reimbursement for EyeMed |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay | |
| Frames or contact lenses<br>One purchase per year. | $200 allowance | $200 Reimbursement for EyeMed |
| **Inpatient Mental Health Services*** | | |
| Days 1-5 | $370 copay | 30% coinsurance |
| Days 6-90 | $0 copay | 30% coinsurance |
| Lifetime reserve days* 1-60 | $0 copay | 30% coinsurance |
| **Outpatient Mental Health Services** | | |
| Individual therapy | $25 copay | 30% coinsurance |
| Group therapy | $15 copay | 30% coinsurance |
| Partial hospitalization for mental health* | $55 copay | 30% coinsurance |

**Service may require prior authorization.*

| BENEFIT | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Substance Abuse* (Outpatient)** | | |
| Individual therapy | $25 copay | 30% coinsurance |
| Group therapy | $15 copay | 30% coinsurance |
| **Acupuncture Services*** | | |
| Treatment of lower back pain.<br>12 initial visits, and additional 8 visits if member is making progress. | $20 copay | 30% coinsurance<br>Limits are combined for both in-network and out-of-network benefits |
| **Ambulance***<br>Prior authorization only required for non-emergency transfers. | $225 copay | $225 copay |
| **Chiropractic Care*** | $15 copay | 30% coinsurance |
| **Diabetes Specific Benefits** | | |
| Primary care provider<br>In-person or through telehealth. | $0 copay | 30% coinsurance |
| Routine eye exam | $0 copay | $35 Reimbursement for EyeMed |
| Diabetes monitoring supplies<br>Coverage for test strips and glucose monitors by produced by Abbott. | $0 copay | 30% coinsurance |
| Diabetes self-management training | $0 copay | 30% coinsurance |
| Select diabetes drugs in Tier 1 and Tier 2 (non-insulin) | Covered through the gap | N/A |
| Continuous Glucose Monitors (CGM)* | $0 copay | N/A |
| Part B insulin pumps and supplies | 20% coinsurance | 30% coinsurance |
| **Insulin** | | |
| Tier 3 and Tier 4 insulin<br>30-day supply in all Part D stages. Coverage Gap and deductible do not apply to insulins. | $35 copay | N/A |
| Part B pump insulin<br>For use in a pump. | 0-20% coinsurance up to max $35 copay per month | 30% coinsurance |
| **Foot Care (Podiatry Services)**<br>Foot exams and treatment for Medicare-covered services. | $30 copay | 30% coinsurance |
| Routine foot care<br>Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits. | $30 copay | 30% coinsurance<br>Limits are combined for both in-network and out-of-network benefits |
| **Home Health Care*** | $0 copay | 30% coinsurance |
| **Hospice** | Covered by Original Medicare | Not covered |
| **Intermountain Connect Care**<br>Visit with a provider via video chat for urgent medical needs. | $0 copay | N/A |
| **Intermountain LiVe Well Center Programs** | $0 copay | N/A |
| **Meals after discharge***<br>After discharge from an inpatient acute hospital or skilled nursing facility. | $0 copay, up to 14 days (2 meals per day) | N/A |
| **Medical Equipment and Supplies** | | |
| Crutches, canes, and walkers | $0 copay | 30% coinsurance |
| All other durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance | 30% coinsurance |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance | 30% coinsurance |
| **Medicare Part B Drugs***<br>Includes chemotherapy drugs, and other Part B drugs and biologics. | 0-20% coinsurance | 30% coinsurance |
| Insulin for use with insulin pumps | 0-20% coinsurance up to max $35 copay per month | 30% coinsurance |
| **Over-the-Counter (OTC) Items**<br>Receive money on your pre-loaded Flex Card for OTC items. Amounts do not roll over. | $75 allowance per quarter | N/A |
| **Papa Pals Companionship Services** | $0 copay, up to 30 hours a year | N/A |
| **Rehabilitation Services* (Outpatient)** | | |
| Physical, occupational, and speech therapy visits. | $30 copay | 30% coinsurance |
| Cardiac rehab services | $0 copay | 30% coinsurance |
| Pulmonary rehab services | $10 copay | 30% coinsurance |
| **Renal Dialysis**<br>Including services and supplies for home dialysis. | 20% coinsurance | 30% coinsurance |
| **Skilled Nursing Facility (SNF)***<br>Our plan covers up to 100 days in a SNF, no prior hospital stay required. | | |
| Days 1-20 | $0 copay | 30% coinsurance |
| Days 21-55 | $203 copay | 30% coinsurance |
| Days 56-100 | $0 copay | 30% coinsurance |
| **Telehealth Services** | | |
| Telehealth visit with a primary care provider | $0 copay | 30% coinsurance |
| Telehealth visit with a specialist | $20 copay | 30% coinsurance |
| **Wellness Your Way**<br>Receive money on your pre-loaded Flex Card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $260 per year | N/A |

**Service may require prior authorization.*

## YOUR PRESCRIPTION BENEFITS

**Select Health Medicare Choice (PPO) 018**

The below cost-sharing table shows what you will pay for your prescription in the Initial Coverage Stage after you've reached your annual $100 pharmacy deductible **OR** when filling a Tier 1 or Tier 2 drug.
**The $100 pharmacy deductible does not apply to Tier 1 and Tier 2 drugs.**

You stay in the Initial Coverage Stage until your year-to-date total drug costs reaches **$5,030**.
Then you move to the Coverage Gap (Donut Hole) stage.

You will generally pay 25% on brand-name and generic drugs while in the Coverage Gap. Once you reach **$8,000** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays the full cost for your covered Part D drugs.
**You pay nothing.**

## PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 | $0 | |
| Tiers 3, 4, and 5 | $100 | |
| **COST-SHARING** | **RETAIL COST-SHARING** | **MAIL ORDER COST-SHARING** |
| | 30-DAY SUPPLY \| 100-DAY SUPPLY | 30-DAY SUPPLY \| 100-DAY SUPPLY |
| Tier 1 (Preferred Generic) | $0 \| $0 | $0 \| $0 |
| Tier 2 (Generic) | $6 \| $18 | $0 \| $0 |
| Tier 3 (Preferred Brand) | $47 \| $141 | $47 \| $141 |
| Tier 4 (Nonpreferred Drugs) | $100 \| $300 | $100 \| $300 |
| Tier 5 (Specialty Tier) | 31% coinsurance \| N/A | 31% coinsurance \| N/A |

Please see the Evidence of Coverage (EOC) for information regarding cost-sharing difference depending on pharmacy status, mail-order, Long Term Care (LTC) or home infusion, and 30- or 100-day medication supplies.

### How we help with prescription drug costs.

Select diabetes prescription drugs on Tiers 1 and 2 are covered through the Coverage Gap.
Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.





## Exclusive plan benefits

Our mission is to help you live the healthiest life possible. That's why we give you tools and incentives to help you get healthy and stay healthy.

### Dental Coverage

This plan covers preventive and comprehensive dental for **no additional cost**.

### Over-The-Counter (OTC) Benefit

Receive **$75** per quarter ($300 annually) on your pre-loaded flex card for over-the-counter items.

### Hearing Aids

**TruHearing**

We cover diagnostic hearing and balance evaluations under your plan's copay, as long as you visit an in-network provider and the evaluation is done in an outpatient setting. Hearing aids are available in two tiers:

Tier 1 - Advanced | $499

Tier 2 - Premium | $799

**NOTE**: Costs are per hearing aid. Hearing aid copays do not go towards the Member Out-of-Pocket Maximum.

### Vision Coverage

This plan includes vision services, such as an annual routine eye exam and a vision hardware benefit.

### Wellness Your Way

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We'll give you **$260 per year** on a pre-loaded flex card that you can use to participate in wellness activities.

### Healthy Living Incentive

Get up to **$160 a year** loaded onto your flex card for completing activities that keep you healthy, like your annual physical, cancer screenings, and immunizations.

### Papa Pals - Companionship Services

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and help with errands.

### Meals After Hospital Stay

Receive up to **14 days of meals** after you are discharged from an inpatient hospital or skilled nursing facility stay, based on need, at no cost to you. Prior authorization by a Care Manager is required.

# Select Health Medicare Essential (HMO)

**H1994_017**

Iron, Sanpete, Sevier and Washington counties in Utah.

| BENEFIT | COST |
|---|---|
| **Premium Amount** | $0 |
| **Medical Deductible** | $0 |
| **Member Out-of-Pocket Maximum**<br>Does not include prescription drugs, comprehensive dental, and hearing aid copays.<br>If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs. | $5,700 |
| **Inpatient Hospital Coverage***<br>Copays start over each time you are admitted as an inpatient. | |
| Days 1-4 | $475 copay |
| Days 5+ | $0 copay |
| **Outpatient Hospital Coverage*** | |
| Outpatient surgery | $400 copay |
| **Ambulatory surgical center** | $300 copay |
| **Doctor's Office Visits** | |
| Primary care provider | $0 copay |
| Specialist<br>We do not require referrals. | $15 copay |
| **Preventive Care** | |
| Annual physical/comprehensive wellness visit | $0 copay |
| Medicare-covered preventive services | $0 copay |
| **Emergency Care (Worldwide)**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $100 copay |
| **Urgently Needed Services (Worldwide)**<br>No extra charges for labs and/or x-rays.<br>Copay is waived if you are admitted to the ER or hospital within 24 hours.<br>Refer to the Evidence of Coverage for additional details. | $30 copay |
| **Diagnostic Services, Labs, and Imaging***<br>Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay. | |
| Diagnostic tests and procedures | $0 copay |
| Diagnostic colonoscopy | $400 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Advanced Imaging (e.g., MRIs, CT scans) | $200 copay |
| Therapeutic radiology services | 20% coinsurance |
| Other covered services<br>Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more. | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $15 copay |
| Routine hearing exam<br>One per year. | $0 copay |
| Hearing aids<br>Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum. | $499 to $799 copay |
| **Dental Services***<br>Limited Medicare-covered dental services related to a medical condition. | $20 copay |
| Maximum plan payment benefit, includes preventive. | $1,500 |
| Preventive dental services<br>Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months | $0 copay |
| Basic dental services | $0 copay |
| Major dental services | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>One per year. | $0 copay |
| Problem related eye exam | $20 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>One purchase per year. | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-4 | $465 copay |
| Days 5-90 | $0 copay |
| Lifetime reserve days* 1-60 | $0 copay |
| **Outpatient Mental Health Services** | |
| Individual therapy | $20 copay |
| Group therapy | $15 copay |
| Partial hospitalization for mental health* | $55 copay |
| **Substance Abuse* (Outpatient)** | |
| Individual therapy | $20 copay |
| Group therapy | $15 copay |
| **Acupuncture Services*** | |
| Treatment of lower back pain.<br>12 initial visits, and additional 8 visits if member is making progress. | $15 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **Ambulance***<br>Prior authorization only required for non-emergency transfers. | $300 copay |
| **Chiropractic Care*** | $15 copay |
| **Diabetes Specific Benefits** | |
| Primary care provider<br>In-person or through telehealth. | $0 copay |
| Routine eye exam | $0 copay |
| Diabetes monitoring supplies<br>Coverage for test strips and glucose monitors produced by Abbott. | $0 copay |
| Diabetes self-management training | $0 copay |
| Select diabetes drugs in Tier 1 and Tier 2 (non-insulin) | Covered through the gap |
| Continuous Glucose Monitors (CGM)* | $0 copay |
| Part B insulin pumps and supplies | 20% coinsurance |
| **Insulin** | |
| Tier 3 and Tier 4 insulin<br>30-day supply in all Part D stages. Coverage Gap and deductible do not apply to insulins. | $35 copay |
| Part B pump insulin<br>For use in a pump. | 0-20% coinsurance up to max<br>$35 copay per month |
| **Foot Care (Podiatry Services)**<br>Foot exams and treatment for Medicare-covered services. | $20 copay |
| Routine foot care<br>Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits. | $20 copay |
| **Home Health Care*** | $0 copay |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care**<br>Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Meals after discharge***<br>After discharge from an inpatient acute hospital or skilled nursing facility. | $0 copay, up to 14 days<br>(2 meals per day) |
| **Medical Equipment and Supplies** | |
| Crutches, canes, and walkers | $0 copay |
| All other durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| **Medicare Part B Drugs***<br>Includes chemotherapy drugs, and other Part B drugs and biologics. | 0-20% coinsurance |
| Insulin for use with insulin pumps | 0-20% coinsurance up to max<br>$35 copay per month |
| **Over-the-Counter (OTC) Items**<br>Receive money on your pre-loaded Flex Card for OTC items.<br>Amounts do not roll over. | $80 allowance per quarter |
| **Papa Pals Companionship Services** | $0 copay, up to 30 hours a year |
| **Rehabilitation Services* (Outpatient)** | |
| Physical, occupational, and speech therapy visits. | $20 copay |
| Cardiac rehab services | $0 copay |
| Pulmonary rehab services | $10 copay |
| **Renal Dialysis**<br>Including services and supplies for home dialysis. | 20% coinsurance |
| **Skilled Nursing Facility (SNF)***<br>Our plan covers up to 100 days in a SNF, no prior hospital stay required. | |
| Days 1-20 | $0 copay |
| Days 21-55 | $203 copay |
| Days 56-100 | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $15 copay |
| **Wellness Your Way**<br>Receive money on your pre-loaded Flex Card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $260 per year |

**Service may require prior authorization.*

## YOUR PRESCRIPTION BENEFITS

**Select Health Medicare Essential (HMO) 017**

The below cost-sharing table shows what you will pay for your prescription in the Initial Coverage Stage after you've reached your annual $200 pharmacy deductible **OR** when filling a Tier 1 or Tier 2 drug.
**The $200 pharmacy deductible does not apply to Tier 1 and Tier 2 drugs.**

You stay in the Initial Coverage Stage until your year-to-date total drug costs reaches **$5,030**.
Then you move to the Coverage Gap (Donut Hole) stage.

You will generally pay 25% on brand-name and generic drugs while in the Coverage Gap. Once you reach **$8,000** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays the full cost for your covered Part D drugs.
**You pay nothing.**

## PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 | $0 | |
| Tiers 3, 4, and 5 | $200 | |
| **COST-SHARING** | **RETAIL COST-SHARING** | **MAIL ORDER COST-SHARING** |
| | 30-DAY SUPPLY \| 100-DAY SUPPLY | 30-DAY SUPPLY \| 100-DAY SUPPLY |
| Tier 1 (Preferred Generic) | $0 \| $0 | $0 \| $0 |
| Tier 2 (Generic) | $15 \| $45 | $0 \| $0 |
| Tier 3 (Preferred Brand) | $47 \| $141 | $47 \| $141 |
| Tier 4 (Nonpreferred Drugs) | $100 \| $300 | $100 \| $300 |
| Tier 5 (Specialty Tier) | 29% coinsurance \| N/A | 29% coinsurance \| N/A |

Please see the Evidence of Coverage (EOC) for information regarding cost-sharing difference depending on pharmacy status, mail-order, Long Term Care (LTC) or home infusion, and 30- or 100-day medication supplies.

### How we help with prescription drug costs.

Select diabetes prescription drugs on Tiers 1 and 2 are covered through the Coverage Gap.
Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.





## Exclusive plan benefits

Our mission is to help you live the healthiest life possible. That's why we give you tools and incentives to help you get healthy and stay healthy.

### Dental Coverage

This plan covers preventive and comprehensive dental for **no additional cost**.

### Over-The-Counter (OTC) Benefit

Receive **$80** per quarter ($320 annually) on your pre-loaded flex card for over-the-counter items.

### Hearing Aids

**TruHearing**

We cover diagnostic hearing and balance evaluations under your plan's copay, as long as you visit an in-network provider and the evaluation is done in an outpatient setting. Hearing aids are available in two tiers:

Tier 1 - Advanced | $499

Tier 2 - Premium | $799

**NOTE**: Costs are per hearing aid. Hearing aid copays do not go towards the Member Out-of-Pocket Maximum.

### Vision Coverage

This plan includes vision services, such as an annual routine eye exam and a vision hardware benefit.

### Wellness Your Way

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We'll give you **$260 per year** on a pre-loaded flex card that you can use to participate in wellness activities.

### Healthy Living Incentive

Get up to **$160 a year** loaded onto your flex card for completing activities that keep you healthy, like your annual physical, cancer screenings, and immunizations.

### Papa Pals - Companionship Services

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and help with errands.

### Meals After Hospital Stay

Receive up to **14 days of meals** after you are discharged from an inpatient hospital or skilled nursing facility stay, based on need, at no cost to you. Prior authorization by a Care Manager is required.

# Select Health Medicare + Kroger (HMO)

**H1994_022**

Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber Counties in Utah. (Must have a qualifying chronic condition to use grocery benefit.)

| BENEFIT | COST |
|---|---|
| **Premium Amount** | $0 |
| **Medical Deductible** | $0 |
| **Member Out-of-Pocket Maximum**<br>Does not include prescription drugs, comprehensive dental, and hearing aid copays.<br>If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs. | $5,700 |
| **Inpatient Hospital Coverage***<br>Copays start over each time you are admitted as an inpatient. | |
| Days 1-5 | $410 copay |
| Days 6+ | $0 copay |
| **Outpatient Hospital Coverage*** | |
| Outpatient surgery | $350 copay |
| **Ambulatory surgical center** | $250 copay |
| **Doctor's Office Visits** | |
| Primary care provider | $0 copay |
| Specialist<br>We do not require referrals. | $15 copay |
| **Preventive Care** | |
| Annual physical/comprehensive wellness visit | $0 copay |
| Medicare-covered preventive services | $0 copay |
| **Emergency Care (Worldwide)**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $100 copay |
| **Urgently Needed Services (Worldwide)**<br>No extra charges for labs and/or x-rays.<br>Copay is waived if you are admitted to the ER or hospital within 24 hours.<br>Refer to the Evidence of Coverage for additional details. | $35 copay |
| **Diagnostic Services, Labs, and Imaging***<br>Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay. | |
| Diagnostic tests and procedures | $0 copay |
| Diagnostic colonoscopy | $350 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Advanced Imaging (e.g., MRIs, CT scans) | $200 copay |
| Therapeutic radiology services | 20% coinsurance |
| Other covered services<br>Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more. | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $15 copay |
| Routine hearing exam<br>One per year. | $0 copay |
| Hearing aids<br>Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum. | $499 to $799 copay |
| **Dental Services***<br>Limited Medicare-covered dental services related to a medical condition. | $20 copay |
| Maximum plan payment benefit, includes preventive. | $1,500 |
| Preventive dental services<br>Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months | $0 copay |
| Basic dental services | $0 copay |
| Major dental services | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>One per year. | $0 copay |
| Problem related eye exam | $20 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>One purchase per year. | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-5 | $350 copay |
| Days 6-90 | $0 copay |
| Lifetime reserve days* 1-60 | $0 copay |
| **Outpatient Mental Health Services** | |
| Individual and group therapy | $25 copay |
| Partial hospitalization for mental health* | $55 copay |
| **Substance Abuse* (Outpatient)** | |
| Individual therapy | $25 copay |
| Group therapy | $20 copay |
| **Acupuncture Services*** | |
| Treatment of lower back pain.<br>12 initial visits, and additional 8 visits if member is making progress. | $15 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **Ambulance*** Prior authorization only required for non-emergency transfers. | $280 copay |
| **Chiropractic Care*** | $15 copay |
| **Diabetes Specific Benefits** | |
| Primary care provider In-person or through telehealth. | $0 copay |
| Routine eye exam | $0 copay |
| Diabetes monitoring supplies Coverage for test strips and glucose monitors produced by Abbott. | $0 copay |
| Diabetes self-management training | $0 copay |
| Select diabetes drugs in Tier 1 and Tier 2 (non-insulin) | Covered through the gap |
| Continuous Glucose Monitors (CGM)* | $0 copay |
| Part B insulin pumps and supplies | 20% coinsurance |
| **Insulin** | |
| Tier 3 and Tier 4 insulin 30-day supply in all Part D stages. Coverage Gap and deductible do not apply to insulins. | $35 copay |
| Part B pump insulin For use in a pump. | 0-20% coinsurance up to max $35 copay per month |
| **Foot Care (Podiatry Services)** Foot exams and treatment for Medicare-covered services. | $25 copay |
| Routine foot care Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits. | $25 copay |
| **Grocery Benefit** Members with qualifying conditions can use their over-the-counter benefit to buy groceries at Smith's grocery stores. | $55 combined allowance per month |
| **Home Health Care*** | $0 copay |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care** Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Meals after discharge*** After discharge from an inpatient acute hospital or skilled nursing facility. | $0 copay, up to 14 days (2 meals per day) |
| **Medical Equipment and Supplies** | |
| Crutches, canes, and walkers | $0 copay |
| All other durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| **Medicare Part B Drugs*** Includes chemotherapy drugs, and other Part B drugs and biologics. | 0-20% coinsurance |
| Insulin for use with insulin pumps | 0-20% coinsurance up to max $35 copay per month |
| **Over-the-Counter (OTC)** Receive money on your pre-loaded Flex Card for OTC item, combined with grocery benefit. Amounts do not roll over. | $55 combined allowance per month |
| **Papa Pals Companionship Services** | $0 copay, up to 30 hours a year |
| **Rehabilitation Services* (Outpatient)** | |
| Physical, occupational, and speech therapy visits. | $20 copay |
| Cardiac rehab services | $0 copay |
| Pulmonary rehab services | $10 copay |
| **Renal Dialysis** Including services and supplies for home dialysis. | 20% coinsurance |
| **Skilled Nursing Facility (SNF)*** Our plan covers up to 100 days in a SNF, no prior hospital stay required. | |
| Days 1-20 | $0 copay |
| Days 21-55 | $203 copay |
| Days 56-100 | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $15 copay |
| **Wellness Your Way** Receive money on your pre-loaded Flex Card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $360 per year |

**Service may require prior authorization.*

## YOUR PRESCRIPTION BENEFITS

**Select Health Medicare + Kroger (HMO) 022**

The below cost-sharing table shows what you will pay for your prescription in the Initial Coverage Stage after you've reached your annual $200 pharmacy deductible OR when filling a Tier 1 or Tier 2 drug.

**The $200 pharmacy deductible does not apply to Tier 1 and Tier 2 drugs.**

You stay in the Initial Coverage Stage until your year-to-date total drug costs reaches **$5,030**. Then you move to the Coverage Gap (Donut Hole) stage.

You will generally pay 25% on brand-name and generic drugs while in the Coverage Gap. Once you reach **$8,000** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays the full cost for your covered Part D drugs. **You pay nothing.**

## PHARMACY DEDUCTIBLE

| | | | | | | |
|---|---|---|---|---|---|---|
| Tier 1 and 2 | $0 | | | | | |
| Tiers 3, 4, and 5 | $200 | | | | | |
| **COST-SHARING** | **PREFERRED RETAIL** | | **STANDARD RETAIL** | | **MAIL ORDER** | |
| | 30-DAY SUPPLY | 100-DAY SUPPLY | 30-DAY SUPPLY | 100-DAY SUPPLY | 30-DAY SUPPLY | 100-DAY SUPPLY |
| Tier 1 (Preferred Generic) | $0 \| $0 | | $0 \| $0 | | $0 \| $0 | |
| Tier 2 (Generic) | $5 \| $15 | | $10 \| $30 | | $0 \| $0 | |
| Tier 3 (Preferred Brand) | $40 \| $120 | | $47 \| $141 | | $40 \| $120 | |
| Tier 4 (Nonpreferred Drugs) | $90 \| $270 | | $100 \| $300 | | $90 \| $270 | |
| Tier 5 (Specialty Tier) | 33% coinsurance \| N/A | | 33% coinsurance \| N/A | | 33% coinsurance \| N/A | |

Please see the Evidence of Coverage (EOC) for information regarding cost-sharing difference depending on pharmacy status, mail-order, Long Term Care (LTC) or home infusion, and 30- or 100-day medication supplies.

### How we help with prescription drug costs.

Select diabetes prescription drugs on Tiers 1 and 2 are covered through the Coverage Gap.
Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.



# Exclusive plan benefits

Our mission is to help you live the healthiest life possible. That's why we give you tools and incentives to help you get healthy and stay healthy.

### Over-The-Counter (OTC) and Grocery Benefit

Receive **$55** per month on your pre-loaded flex card for either over-the-counter items or groceries at Smith's grocery stores. Your OTC benefit can also be used online.

### Dental Coverage

This plan covers preventive, basic, and major dental services for **no additional cost**.



### Hearing Aids

**TruHearing**

We cover diagnostic hearing and balance evaluations under your plan's copay, as long as you visit an in-network provider and the evaluation is done in an outpatient setting. Hearing aids are available in two tiers:

Tier 1 - Advanced | $499

Tier 2 - Premium | $799

**NOTE:** Costs are per hearing aid. Hearing aid copays do not go towards the Member Out-of-Pocket Maximum.

### Vision Coverage

This plan includes vision services, such as an annual routine eye exam and a vision hardware benefit.

### Wellness Your Way

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We'll give you **$360 per year** on a pre-loaded flex card that you can use to participate in wellness activities.

### Healthy Living Incentive

Get up to **$160 a year** loaded onto your flex card for completing activities that keep you healthy, like your annual physical, cancer screenings, and immunizations.

### Meals After Hospital Stay

Receive up to **14 days of meals** after you are discharged from an inpatient hospital or skilled nursing facility stay, based on need, at no cost to you. Prior authorization by a Care Manager is required.

### Papa Pals - Companionship Services

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and help with errands.

# Select Health Medicare Classic (HMO)

**H1994_002**

Duchesne, Garfield, Grand, Iron, Juab, Millard, Piute, Sanpete, Sevier, Uintah, Washington, and Wayne counties in Utah.

| BENEFIT | COST |
|---|---|
| **Premium Amount** | $29 |
| **Medical Deductible** | $0 |
| **Member Out-of-Pocket Maximum**<br>Does not include prescription drugs, comprehensive dental, and hearing aid copays.<br>If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs. | $6,700 |
| **Inpatient Hospital Coverage***<br>Copays start over each time you are admitted as an inpatient. | |
| Days 1-5 | $410 copay |
| Days 6+ | $0 copay |
| **Outpatient Hospital Coverage*** | |
| Outpatient surgery | $380 copay |
| **Ambulatory surgical center** | $280 copay |
| **Doctor's Office Visits** | |
| Primary care provider | $0 copay |
| Specialist<br>We do not require referrals. | $40 copay |
| **Preventive Care** | |
| Annual physical/comprehensive wellness visit | $0 copay |
| Medicare-covered preventive services | $0 copay |
| **Emergency Care (Worldwide)**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $100 copay |
| **Urgently Needed Services (Worldwide)**<br>No extra charges for labs and/or x-rays.<br>Copay is waived if you are admitted to the ER or hospital within 24 hours.<br>Refer to the Evidence of Coverage for additional details. | $25 copay |
| **Diagnostic Services, Labs, and Imaging***<br>Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay. | |
| Diagnostic tests and procedures | $0 copay |
| Diagnostic colonoscopy | $380 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Advanced Imaging (e.g., MRIs, CT scans) | $320 copay |
| Therapeutic radiology services | 20% coinsurance |
| Other covered services<br>Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more. | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $40 copay |
| Routine hearing exam<br>One per year. | $0 copay |
| Hearing aids<br>Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum. | $499 to $799 copay |
| **Dental Services***<br>Limited Medicare-covered dental services related to a medical condition. | $40 copay |
| Maximum plan payment benefit, includes preventive. | $2,000 |
| Preventive dental services<br>Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months | $0 copay |
| Basic dental services | $0 copay |
| Major dental services | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>One per year. | $0 copay |
| Problem related eye exam | $40 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>One purchase per year. | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-4 | $395 copay |
| Days 5-90 | $0 copay |
| Lifetime reserve days* 1-60 | $0 copay |
| **Outpatient Mental Health Services** | |
| Individual | $40 copay |
| Group therapy | $40 copay |
| Partial hospitalization for mental health* | $55 copay |
| **Substance Abuse* (Outpatient)** | |
| Individual therapy | $50 copay |
| Group therapy | $40 copay |
| **Acupuncture Services*** | |
| Treatment of lower back pain.<br>12 initial visits, and additional 8 visits if member is making progress. | $20 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **Ambulance*** Prior authorization only required for non-emergency transfers. | $275 copay |
| **Chiropractic Care*** | $15 copay |
| **Diabetes Specific Benefits** | |
| Primary care provider In-person or through telehealth. | $0 copay |
| Routine eye exam | $0 copay |
| Diabetes monitoring supplies Coverage for test strips and glucose monitors produced by Abbott. | $0 copay |
| Diabetes self-management training | $0 copay |
| Select diabetes drugs in Tier 1 and Tier 2 (non-insulin) | Covered through the gap |
| Continuous Glucose Monitors (CGM)* | $0 copay |
| Part B insulin pumps and supplies | 20% coinsurance |
| **Insulin** | |
| Tier 3 and Tier 4 insulin 30-day supply in all Part D stages. Coverage Gap and deductible do not apply to insulins. | $35 copay |
| Part B pump insulin For use in a pump. | 0-20% coinsurance up to max $35 copay per month |
| **Foot Care (Podiatry Services)** Foot exams and treatment for Medicare-covered services. | $40 copay |
| Routine foot care Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits. | $40 copay |
| **Home Health Care*** | $0 copay |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care** Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Meals after discharge*** After discharge from an inpatient acute hospital or skilled nursing facility. | $0 copay, up to 14 days (2 meals per day) |
| **Medical Equipment and Supplies** | |
| Crutches, canes, and walkers | $0 copay |
| All other durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| **Medicare Part B Drugs*** Includes chemotherapy drugs, and other Part B drugs and biologics. | 0-20% coinsurance |
| Insulin for use with insulin pumps | 0-20% coinsurance up to max $35 copay per month |
| **Over-the-Counter (OTC) Items** Receive money on your pre-loaded Flex Card for OTC items. Amounts do not roll over. | $75 allowance per quarter |
| **Papa Pals Companionship Services** | $0 copay, up to 30 hours a year |
| **Rehabilitation Services* (Outpatient)** | |
| Physical, occupational, and speech therapy visit. | $20 copay |
| Cardiac rehab services | $10 copay |
| Pulmonary rehab services | $15 copay |
| **Renal Dialysis** Including services and supplies for home dialysis. | 20% coinsurance |
| **Skilled Nursing Facility (SNF)*** Our plan covers up to 100 days in a SNF, no prior hospital stay required. | |
| Days 1-20 | $0 copay |
| Days 21-55 | $203 copay |
| Days 56-100 | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $40 copay |
| **Wellness Your Way** Receive money on your pre-loaded Flex Card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $300 per year |

**Service may require prior authorization.*

## YOUR PRESCRIPTION BENEFITS

**Select Health Medicare Classic (HMO) 002**

The below cost-sharing table shows what you will pay for your prescription in the Initial Coverage Stage after you've reached your annual $200 pharmacy deductible **OR** when filling a Tier 1 or Tier 2 drug.
**The $200 pharmacy deductible does not apply to Tier 1 and Tier 2 drugs.**

You stay in the Initial Coverage Stage until your year-to-date total drug costs reaches **$3,050**.
Then you move to the Coverage Gap (Donut Hole) stage.

You will generally pay 25% on brand-name and generic drugs while in the Coverage Gap. Once you reach **$8,000** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays the full cost for your covered Part D drugs.
**You pay nothing.**

## PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 | $0 | |
| Tiers 3, 4, and 5 | $200 | |
| **COST-SHARING** | **RETAIL COST-SHARING** | **MAIL ORDER COST-SHARING** |
| | 30-DAY SUPPLY \| 100-DAY SUPPLY | 30-DAY SUPPLY \| 100-DAY SUPPLY |
| Tier 1 (Preferred Generic) | $0 \| $0 | $0 \| $0 |
| Tier 2 (Generic) | $10 \| $30 | $0 \| $0 |
| Tier 3 (Preferred Brand) | $47 \| $141 | $47 \| $141 |
| Tier 4 (Nonpreferred Drugs) | $100 \| $300 | $100 \| $300 |
| Tier 5 (Specialty Tier) | 29% coinsurance \| N/A | 29% coinsurance \| N/A |

Please see the Evidence of Coverage (EOC) for information regarding cost-sharing difference depending on pharmacy status, mail-order, Long Term Care (LTC) or home infusion, and 30- or 100-day medication supplies.

### How we help with prescription drug costs.

Select diabetes prescription drugs on Tiers 1 and 2 are covered through the Coverage Gap.
Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.



# Exclusive plan benefits

Our mission is to help you live the healthiest life possible. That's why we give you tools and incentives to help you get healthy and stay healthy.

### Dental Coverage

This plan covers preventive and comprehensive dental for **no additional cost**.

### Over-The-Counter (OTC) Benefit

Receive **$75** per quarter ($300 annually) on your pre-loaded flex card for over-the-counter items.



### Hearing Aids

**TruHearing**

We cover diagnostic hearing and balance evaluations under your plan's copay, as long as you visit an in-network provider and the evaluation is done in an outpatient setting. Hearing aids are available in two tiers:

Tier 1 - Advanced | $499

Tier 2 - Premium | $799

**NOTE**: Costs are per hearing aid. Hearing aid copays do not go towards the Member Out-of-Pocket Maximum.

### Vision Coverage

This plan includes vision services, such as an annual routine eye exam and a vision hardware benefit.

### Wellness Your Way

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We'll give you **$300 per year** on a pre-loaded flex card that you can use to participate in wellness activities.

### Healthy Living Incentive

Get up to **$160 a year** loaded onto your flex card for completing activities that keep you healthy, like your annual physical, cancer screenings, and immunizations.

### Papa Pals - Companionship Services

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and help with errands.

### Meals After Hospital Stay

Receive up to **14 days of meals** after you are discharged from an inpatient hospital or skilled nursing facility stay, based on need, at no cost to you. Prior authorization by a Care Manager is required.

## Multi-Language Interpreter Services 1-855-442-9900 (TTY:711)

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats by contacting Select Health Medicare at **855-442-9900 (TTY: 711)**

**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 **1-855-442- 9900**. 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 **1-855-442-9900**。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，爲此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-855-442-9900**。我們講中文的人員將樂意爲您提供幫助。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 **1-855-442- 9900**. 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 **1-855-442-9900.** 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 **1-855-442-9900** 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 **1-855-442-9900**. 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 **1-855-442-9900** 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 **1-855-442-9900**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية لإلجابة عن أي أسئلة تتعلق بالصحة أو جدول االدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى االتصال بنا على **1-855-442-9900.** 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 **1-855-442-9900** 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 **1-855-442-9900**. 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 **1-855-442-9900**. 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 **1-855-442-9900**. 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 **1-855-442-9900**. 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、**1-855-442-9900** 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。

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Notes

Select Health

Select Health is an HMO, PPO, SNP plan sponsor with a Medicare contract. Enrollment in Select Health Medicare depends on contract renewal.

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ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電.