Colorado 2024

Select Health Medicare Dual (HMO) H1994_028

Select Health Medicare®

Summary of benefits

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 Dual (HMO-D-SNP)?

To join, you must be fully Medicaid eligible, enrolled in Medicare Part A and Part B, live in our service area, and be 21+ years of age or older.

Our service area includes, Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, and Jefferson counties in Colorado.

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.

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

Select Health Medicare Dual (HMO)

H1994_028

Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, and Jefferson counties in Colorado.
You must qualify for Medicaid to be enrolled on this plan. If you lose Medicaid eligibility and fall into the grace period, you are responsible for the cost-share of your benefits. The most you will have to pay out-of-pocket for plan services in 2024 is $8,850. What you pay for Medicare-covered benefits (deductibles, copays, or coinsurance) counts towards this maximum out-of-pocket amount.

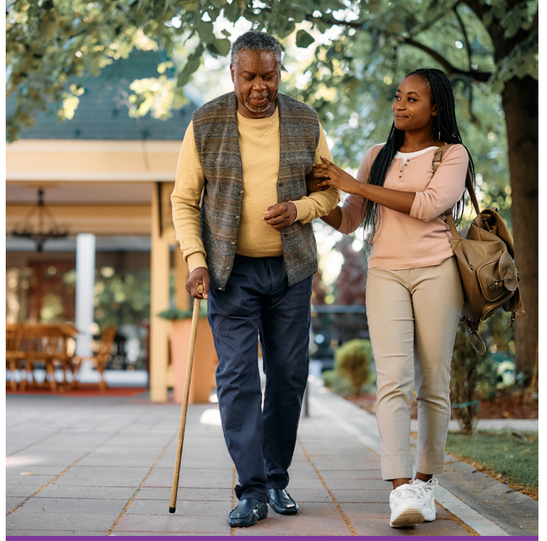
BENEFIT	COST
Premium Amount	$0
Medical Deductible	$0
Member Out-of-Pocket Maximum Does not include prescription drugs, comprehensive dental, and hearing aid copays. If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs.	$8,850
Inpatient Hospital Coverage* Copays start over each time you are admitted as an inpatient.	
All days	$0 copay
Outpatient Facility Coverage*	
Outpatient surgery	$0 copay
Ambulatory surgical center	$0 copay
Doctor's Office Visits	
Primary care provider	$0 copay
Specialist We do not require referrals.	$0 copay
Preventive Care	
Annual physical/comprehensive wellness visit	$0 copay
Medicare-covered preventive services	$0 copay
Emergency Care (Worldwide) Cost-sharing is waived if you are admitted to the hospital within 24 hours.	$0 copay
Urgently Needed Services (Worldwide) No extra charges for labs and/or x-rays. Cost-sharing is waived if you are admitted to the ER or hospital within 24 hours. Refer to the Evidence of Coverage for additional details.	$0 copay
Diagnostic Services, Labs, and Imaging* 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	$0 copay
Advanced Imaging (e.g., MRIs, CT scans)	$0 copay
Lab services	$0 copay
X-Rays	$0 copay
Therapeutic radiology services	$0 copay
Other covered services Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.	$0 copay
Hearing Services	
Hearing exam related to a medical condition	$0 copay
Routine hearing exam One per year.	$0 copay
Hearing aids Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum. See the Hearing Aid section for more information. One per ear per year.	$0 copay
Dental Services* Limited Medicare-covered dental services related to a medical condition.	$0 copay
Maximum plan payment benefit, includes preventive.	$4,000
Preventive Dental Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months.	$0 copay
All covered services	0% coinsurance
Vision Services	
Routine and/or preventive eye exam One per year.	$0 copay
Problem related eye exam	$0 copay
Vision test for prescriptions	$0 copay
Eyeglasses or contact lenses after cataract surgery*	$0 copay
Frames and lenses or contact lenses One purchase per year.	$400 allowance
Inpatient Mental Health Services*	
Days 1-90	$0 copay
Lifetime reserve days	$0 copay
Outpatient Mental Health Services	
Individual and group therapy	$0 copay
Partial hospitalization for mental health*	$0 copay
Substance Abuse* (Outpatient)	
Therapy in a provider's office or outpatient facility setting	$0 copay
Acupuncture	
Treatment of lower back pain 12 initial visits, and additional 8 visits if member is making progress.	$0 copay
Supplemental acupuncture services Up to 20 visits for any condition.	$0 copay
Ambulance* Prior authorization only required for non-emergency transfers.	$0 copay

**Service may require prior authorization.*

BENEFIT	COST
Chiropractic Care*	$0 copay
Foot Care (Podiatry Services)	
Medicare-covered foot exam	$0 copay
Routine foot care Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to twelve visits.	$0 copay
Home Health Care*	$0 copay
Hospice In a Medicare-certified facility.	Covered by Original Medicare
Intermountain Connect Care Visit with a provider via video chat for urgent medical needs. For more information, visit **intermountainconnectcare.org**.	$0 copay
Meals after discharge* After discharge from an inpatient acute hospital or skilled nursing facility.	$0 copay, up to 14 days (3 meals per day)
Medical Equipment and Supplies	
Durable medical equipment (e.g., wheelchairs, oxygen, etc.)*	$0 copay
Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)*	$0 copay
Medicare Part B Drugs* Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs and biologics.	$0 copay
Over-the-Counter Items and Groceries[1] Dollar amounts do not roll over.	$105 allowance per month
Papa Pals (Companionship Services)	$0 copay, up to 120 hours a year
Rehabilitation Services (Outpatient)*	
Physical, occupational, and speech therapy visit.	$0 copay
Cardiac rehab services	$0 copay
Pulmonary rehab services	$0 copay
Renal Dialysis Including services and supplies for home dialysis.	$0 copay
Skilled Nursing Facility (SNF)* Our plan covers up to 100 days in a SNF, no prior hospital stay required.	
Days 1-100	$0 copay
Telehealth Services	$0 copay
Transportation (Routine)* Services such as getting a ride to and from your doctor, pharmacy, or facility.	$0 copay, for unlimited one-way trips
Wellness Your Way	$400 a year

[1] You must have a verified qualifying condition before you can use this benefit to purchase groceries.

**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, basic, and major dental services for **no additional cost**.

Over-The-Counter (OTC) Benefit and Groceries

Receive **$105 per month** on your pre-loaded flex card for over-the-counter items and groceries. You must have a verified qualifying condition before you can use this benefit to purchase groceries.

Hearing Aids

NationsHearing

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.

Certain hearing aids purchased through an in-network NationsHearing provider are covered. Selected hearing aids purchased through Nations audiology providers are covered under one benefit tier.

This includes the hearing aid, the hearing aid fitting, three follow-up visits within 12 months after the initial fitting, a 1-year supply of batteries, and a one-time replacement device for loss or damage.

Additional accessories or upgrades beyond the tier one device described as part of the benefit are not covered under the hearing aid benefit.

Hearing Aid Option	Your Cost
Tier 1 - Economy	$0

Wellness Your Way

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We'll give you **$400 per year** on a pre-loaded flex card that you can use to participate in wellness activities.

Vision Coverage

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

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.

Transportation

Our plan includes non-emergent medical transportation at **no additional cost**. This means you can get unlimited one-way trips to and from your doctor's appointments, facilities, or pharmacy.

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.

Prescription benefits

YOUR PRESCRIPTION BENEFITS

Select Health Medicare Dual (HMO) 028

The below cost-sharing table shows what you will pay for your prescriptions in the Initial Coverage Stage.

You stay in this stage until your year-to-date total drug costs reaches **$8,000**. Then, you skip directly to the Catastrophic Coverage Stage.

During the Catastrophic Coverage Stage, the plan pays the cost for your covered drugs. You will stay in this stage for the rest of the calendar year through December 31.

PHARMACY COST SHARING

Annual Pharmacy Deductible	$0
Generic	Per prescription, you'll pay either $0, $1.55, or $4.50. Copays depend on LIS level.
Brand-name	Per prescription, you'll pay either $0, $4.60, or $11.20. Copays depend on LIS level.
Catastrophic	$0

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.

Benefit Comparison Tool

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, have full Medicaid eligibility, be at least 21 years old, and live in our service area.

Generally, services you receive by providers or pharmacies is paid first by Medicare and then by Medicaid. This means Medicare is the primary payer, and Medicaid secondary.

The below benefits show what is covered by Medicaid and Select Health Medicare Dual. If a benefit is exhausted or not covered by your Medicare plan, then your Medicaid coverage may provide additional coverage. This will depend on your level of Medicaid eligibility.

If Medicare doesn't cover a service, there is a cost-share (copay or coinsurance), or a benefit has been exhausted, your Medicaid coverage may help. However, it's important to remember that you may have to pay a cost-share. Please see your Medicaid Member Handbook for details on cost-sharing and coverage.

This table does not include every benefit and service that we cover or every limitation or exclusion. To get a complete list of services, please refer to the Evidence of Coverage (EOC). You can get a copy of the EOC by visiting **SelectHealth.org/medicare** or by calling us at **855-442-9940 (TTY: 711)**.

If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Health First Colorado (Colorado's Medicaid Program), **800-221-3943 (TTY: 711)**.

BENEFIT	MEDICAID	SELECT HEALTH MEDICARE DUAL
Inpatient hospital	Covered	Covered, $0 copay
Outpatient hospital	Covered	Covered, $0 copay
Doctor's office visits	Covered	Covered, $0 copay
Preventive care	Covered	Covered, $0 copay
Emergency care	Covered	Covered, $0 copay
Urgent care	Covered	Covered, $0 copay
Diagnostic services, labs, and imaging	Covered	Covered, $0 copay
Hearing services	Not covered unless 20 years of age or younger	Covered, $0 copay
Dental services	Covered	Covered, $0 copay
Vision services	Eye exams covered, glasses and contact lenses only after surgery	Covered, $0 copay
Inpatient mental health services	Covered	Covered, $0 copay
Outpatient mental health services	Covered	Covered, $0 copay
Outpatient rehabilitation services	Covered OT/PT/ST	Covered, $0 copay
Substance abuse (Outpatient)	Covered	Covered, $0 copay
Ambulance	Covered	Covered, $0 copay
Chiropractic care	Covered only after spinal cord injury	Covered, $0 copay
Foot care (podiatry services)	Covered	Covered, $0 copay
Groceries	Not covered	Covered, $0 copay
Gym membership	Not covered	Covered, $0 copay
Home health care	Covered	Covered, $0 copay
Hospice	Covered	Covered, $0 copay
Papa Pals (Companionship services)	Not covered	Covered, $0 copay
Medical equipment	Covered	Covered, $0 copay
Medicare Part B drugs	Covered	Covered, $0 copay
Medicare-covered acupuncture services	Not covered	Covered, $0 copay
Over-the-counter items	Limited coverage	Covered, $0 copay
Renal dialysis	Covered	Covered, $0 copay
Skilled nursing facility	Covered	Covered, $0 copay
Telehealth services	Covered	Covered, $0 copay
Transportation (Routine Non-Emergent)	Covered	Covered, $0 copay

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。

OMB Approval No. 0938-1421 (Expires 12/31/2025)
Y0165_2400363_C

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.

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.

Select Health Medicare **1-855-442-9900 (TTY: 711)** / Select Health: **1-800-538-8038**

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.