# SelectHealth Medicare

## Summary of Benefits

## Utah 2023

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 SelectHealth 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, 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 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.

**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.

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

Our plans are on the SelectHealth 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.

**SelectHealth Medicare Essential (HMO) 001**

**SelectHealth Medicare Enhanced (HMO) 007**

**SelectHealth Medicare Choice (PPO) 018**

**SelectHealth Medicare No Rx (HMO) 016**

**SelectHealth Medicare Essential (HMO) 017**

**SelectHealth Medicare Classic (HMO) 002**

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 a.m., closed weekends.

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

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# SelectHealth 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 |
| **Pharmacy Deductible**<br>Does not apply to Tier 1 and Tier 2 drugs. | $100 |
| **Member Out-of-Pocket Maximum**<br>*Does not include prescription drugs or 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 to an inpatient hospital facility.* | |
| Days 1-5 | $410 copay |
| Days 6+ | $0 copay |
| Meals after discharge* | $0 copay, up to 14 days of meals after discharged from an inpatient acute hospital or skilled nursing facility. |
| **Outpatient Facility Coverage*** | |
| Outpatient surgery | $350 copay |
| Ambulatory surgical center | $320 copay |
| Diagnostic colonoscopy | $350 copay |
| Other covered services<br>*Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.* | 20% coinsurance |
| **Doctor's Office Visits** | |
| Primary care provider | $0 copay |
| Specialist<br>*We do not require referrals.* | $20 copay |
| **Preventive Care** | |
| Annual physical/comprehensive wellness visit | $0 copay |
| Medicare-covered preventive services | $0 copay |
| **Worldwide Emergency Care**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $95 copay |
| **Worldwide Urgently Needed Services**<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 radiology services (e.g., MRIs, CT scans) | $300 copay |
| Diagnostic tests and procedures | $0 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Therapeutic radiology services | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $20 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.* | $399 to $1,699 copay |
| **Dental Services***<br>*Limited Medicare-covered dental services related to a medical condition.* | $20 copay |
| **Preventive Dental**<br>*Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months.* | $0 copay |
| **Comprehensive Dental***<br>Basic and Major covered services. No deductible.<br>*Maximum plan payment of $1,500, preventive dental services do not go towards maximum payment.* | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>*One per year.* | $0 copay |
| Non-routine vision exam | $20 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>*One per year.* | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-5 | $350 copay |
| Days 6-90 | $0 copay |
| Lifetime reserve days | $0 copay |
| **Outpatient Mental Health Services** | |
| Outpatient individual or group therapy visit in a provider's office or outpatient facility | $25 copay |
| Partial hospitalization for mental health* | $55 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **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 | $196 copay |
| Days 56-100 | $0 copay |
| **Outpatient Rehabilitation Services*** | |
| Physical, occupational, and speech therapy visit in a provider's office or outpatient facility | $20 copay |
| Cardiac rehab services | $0 copay |
| Pulmonary rehab services | $10 copay |
| **Ambulance*** *Prior authorization only required for non-emergency transfers.* | $280 copay |
| **Routine Transportation** | Not covered |
| **Companionship Services through Papa Pals** | $0 copay, up to 30 hours a year |
| **Medicare Part B Drugs*** *Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs.* | 20% coinsurance |
| **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 |
| **Medical Equipment and Supplies** | |
| Durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Crutches, canes, and walkers | $0 copay |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| **Wellness Your Way** Receive money on your SelectHealth Medicare flexible benefits card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $240 per year |
| **Over-the-Counter Items** Receive money on your SelectHealth Medicare flexible benefits card for OTC items. Amounts do not roll over. | $75 allowance per quarter |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Chiropractic Care*** | $20 copay |
| **Medicare-Covered Acupuncture Services*** | |
| Treatment of lower back pain. *12 initial visits, and additional 8 visits if member is making progress.* | $20 copay |





| | |
|---|---|
| **Home Health Care*** | $0 copay |
| **Outpatient Substance Abuse*** | |
| Individual therapy | $25 copay |
| Group therapy | $20 copay |
| **Renal Dialysis** *Including services and supplies for home dialysis.* | 20% coinsurance |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care** Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $20 copay |

## DIABETES SPECIFIC BENEFITS

If you have a confirmed diabetes diagnosis, some benefits have different copay and coinsurances. See the below table for details.

| **Diabetes Specific Benefits** | |
|---|---|
| Primary care provider *In-person or through telehealth.* | $0 copay |
| Routine and non-routine eye exam | $0 copay |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| 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 1 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $0 copay |
| Tier 3 and Tier 4 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $35 copay |
| Part B pump insulin *For use in a pump.* | 20% coinsurance |

**Service may require prior authorization.*

# Your Prescription Benefits

## SelectHealth 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 **$4,660**. 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 **$7,400** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays most of the cost for your covered drugs. You generally pay **$4.15** for generic drugs and **$10.35** for all other drugs—or 5% of the cost, whichever is greater. You will stay in this stage for the rest of the calendar year through December 31. For more information on how pharmacy coverage stages work, please see the Pharmacy section of the Enrollment Guide.

### PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 (Generics) | $0 | |
| Tiers 3, 4, and 5 (Brands) | $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 Brand) | $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 and have a $0 copay.

Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.



SELECTHEALTH MEDICARE ESSENTIAL (HMO) H1994_001

# 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.**

### $240 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 SelectHealth Medicare flexible benefits card that you can use to participate in wellness activities.

### HEALTHY LIVING INCENTIVE

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

### OVER-THE-COUNTER (OTC) BENEFIT

Receive **$75 per quarter** on your SelectHealth Medicare flexible benefits card for over-the-counter items.

### 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.

### COMPANIONSHIP SERVICES – PAPA PALS

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and even rides to your doctor's office or pharmacy.

### VISION COVERAGE

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

### DENTAL COVERAGE

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

### HEARING AIDS

**Intermountain Healthcare 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 | $399**
- **Tier 2 - Essential | $589**
- **Tier 3 - Standard | $849**
- **Tier 4 - Advanced | $1,199**
- **Tier 5 - Premium | $1,699**

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

# SelectHealth 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 |
| **Pharmacy Deductible**<br>Does not apply to Tier 1 and Tier 2 drugs. | $50 |
| **Member Out-of-Pocket Maximum**<br>*Does not include prescription drugs or 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 to an inpatient hospital facility.* | |
| Days 1-4 | $350 copay |
| Days 5+ | $0 copay |
| Meals after discharge* | $0 copay, up to 14 days of meals after discharged from an inpatient acute hospital or skilled nursing facility. |
| **Outpatient Facility Coverage*** | |
| Outpatient surgery | $300 copay |
| Ambulatory surgical center | $250 copay |
| Diagnostic colonoscopy | $300 copay |
| Other covered services<br>*Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.* | 20% coinsurance |
| **Doctor's Office Visits** | |
| Primary care provider | $0 copay |
| Specialist<br>*We do not require referrals.* | $20 copay |
| **Preventive Care** | |
| Annual physical/comprehensive wellness visit | $0 copay |
| Medicare-covered preventive services | $0 copay |
| **Worldwide Emergency Care**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $95 copay |
| **Worldwide Urgently Needed Services**<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 radiology services (e.g., MRIs, CT scans) | $300 copay |
| Diagnostic tests and procedures | $0 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Therapeutic radiology services | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $20 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.* | $399 to $1,699 copay |
| **Dental Services***<br>*Limited Medicare-covered dental services related to a medical condition.* | $20 copay |
| **Preventive Dental**<br>*Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months.* | $0 copay |
| **Comprehensive Dental***<br>Basic and Major covered services. No deductible.<br>*Maximum plan payment of $2,000, preventive dental services do not go towards maximum payment.* | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>*One per year.* | $0 copay |
| Non-routine vision exam | $20 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>*One per year.* | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-4 | $350 copay |
| Days 5-90 | $0 copay |
| Lifetime reserve days | $0 copay |
| **Outpatient Mental Health Services** | |
| Outpatient individual therapy visit in a provider's office or outpatient facility | $20 copay |
| Outpatient group therapy visit in a provider's office or outpatient facility | $15 copay |
| Partial hospitalization for mental health* | $55 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **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 21-50 | $196 copay |
| Days 51-100 | $0 copay |
| **Outpatient Rehabilitation Services*** | |
| Physical, occupational, and speech therapy visit in a provider's office or outpatient facility | $20 copay |
| Cardiac rehab services | $0 copay |
| Pulmonary rehab services | $10 copay |
| **Ambulance*** *Prior authorization only required for non-emergency transfers.* | $250 copay |
| **Routine Transportation** | $0 copay, up to 24 one-way trips |
| **Companionship Services through Papa Pals** | $0 copay, up to 90 hours a year |
| **Medicare Part B Drugs*** *Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs.* | 20% coinsurance |
| **Foot Care (Podiatry Services)** | |
| Medicare-covered services | $20 copay |
| Routine foot care *Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits.* | $20 copay |
| **Medical Equipment and Supplies** | |
| Durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Crutches, canes, and walkers | $0 copay |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| **Wellness Your Way** Receive money on your SelectHealth Medicare flexible benefits card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $480 per year |
| **Over-the-Counter Items** Receive money on your SelectHealth Medicare flexible benefits card for OTC items. Amounts do not roll over. | $75 allowance per quarter |
| **Intermountai LiVe Well Center Programs** | $0 copay |
| **Chiropractic Care*** | $20 copay |





| | |
|---|---|
| **Medicare-Covered Acupuncture Services*** | |
| Treatment of lower back pain *12 initial visits, and additional 8 visits if member is making progress.* | $20 copay |
| Supplemental Acupuncture Services *Any condition, up to 20 visits.* | $20 copay |
| **Home Health Care*** | $0 copay |
| **Outpatient Substance Abuse** | |
| Individual therapy | $20 copay |
| Group therapy | $15 copay |
| **Renal Dialysis** *Including services and supplies for home dialysis.* | 20% coinsurance |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care** Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $20 copay |

## DIABETES SPECIFIC BENEFITS

If you have a confirmed diabetes diagnosis, some benefits have different copay and coinsurances. See the below table for details.

| | |
|---|---|
| **Diabetes Specific Benefits** | |
| Primary care provider *In-person or through telehealth.* | $0 copay |
| Routine or non-routine eye exam | $0 copay |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| Tier 1 drugs | Covered through the gap |
| Select diabetes drugs in Tier 2 (non-insulin) | Covered through the gap |
| Continuous Glucose Monitors (CGM)* | $0 copay |
| Part B Insulin pumps and supplies | 20% coinsurance |
| **INSULIN** | |
| Tier 1 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $0 copay |
| Tier 3 and Tier 4 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $35 copay |
| Part B pump insulin *For use in a pump.* | 20% coinsurance |

**Service may require prior authorization.*

# Your Prescription Benefits

## SelectHealth 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 **$4,660**. 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 **$7,400** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays most of the cost for your covered drugs. You generally pay **$4.15** for generic drugs and **$10.35** for all other drugs—or 5% of the cost, whichever is greater. You will stay in this stage for the rest of the calendar year through December 31. For more information on how pharmacy coverage stages work, please see the Pharmacy section of the Enrollment Guide.

### PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 (Generics) | $0 | |
| Tiers 3, 4, and 5 (Brands) | $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 Brand) | $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.



SELECTHEALTH MEDICARE ENHANCED (HMO) H1994_007

# 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.**

### $480 WELLNESS YOUR WAY

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We'll give you **$480 per year** on a SelectHealth Medicare flexible benefits card that you can use to participate in wellness activities.

### HEALTHY LIVING INCENTIVE

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

### OVER-THE-COUNTER (OTC) BENEFIT

Receive **$75 per quarter** on your SelectHealth Medicare flexible benefits card for over-the-counter items.

### 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.

### COMPANIONSHIP SERVICES – PAPA PALS

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and even rides to your doctor's office or pharmacy.

### VISION COVERAGE

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

### DENTAL COVERAGE

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

### HEARING AIDS

**Intermountain Healthcare 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 | $399**
- **Tier 2 - Essential | $589**
- **Tier 3 - Standard | $849**
- **Tier 4 - Advanced | $1,199**
- **Tier 5 - Premium | $1,699**

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

# SelectHealth 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 Cost | Out-of-Network Cost |
|---|---|---|
| **Premium Amount** | $0 | |
| **Medical Deductible** | $0 | |
| **Pharmacy Deductible**<br>*Does not apply to Tier 1 and Tier 2 drugs.* | $100 | |
| **Member Out-of-Pocket Maximum**<br>*Does not include prescription drugs or 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.* | $6,700 | $12,450 combined with in-network |
| **Inpatient Hospital Coverage***<br>*Copays start over each time you are admitted to an inpatient hospital facility.* | | |
| Days 1-5 | $420 copay | 30% coinsurance |
| Days 6+ | $0 copay | 30% coinsurance |
| Meals after discharge* | $0 copay, up to 14 days of meals after discharged from an inpatient acute hospital or skilled nursing facility. | n/a |
| **Outpatient Facility Coverage*** | | |
| Outpatient surgery | $360 copay | 30% coinsurance |
| Ambulatory surgical center | $330 copay | 30% coinsurance |
| Diagnostic colonoscopy | $360 copay | 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 |
| **Doctor's Office Visits** | | |
| Primary care provider | $0 copay | 30% coinsurance |
| Specialist<br>*We do not require referrals.* | $25 copay | 30% coinsurance |
| **Preventive Care** | | |
| Annual physical/comprehensive wellness visit | $0 copay | $0 copay |
| Medicare-covered preventive services | $0 copay | $0 copay |
| **Worldwide Emergency Care**<br>*Copay is waived if you are admitted to the hospital within 24 hours.* | $95 copay | $95 copay |
| **Worldwide Urgently Needed Services**<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 radiology services (e.g., MRIs, CT scans) | $300 copay | 30% coinsurance |
| Diagnostic tests and procedures | $0 copay | 30% coinsurance |
| Lab services | $0 copay | 30% coinsurance |
| Outpatient x-rays | $0 copay | 30% coinsurance |
| Therapeutic radiology services | 20% coinsurance | 30% coinsurance |
| **Hearing Services** | | |
| Hearing exam related to a medical condition | $25 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 |
| **Preventive Dental**<br>*Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months.* | $0 copay | Not covered |
| **Comprehensive Dental***<br>Basic and Major covered services. No deductible.<br>*Maximum plan payment of $1,500, preventive dental services do not go towards maximum payment.* | $0 copay | Not covered |
| **Vision Services** | | |
| Routine and/or preventive eye exam<br>*One per year.* | $0 copay | $35 reimbursement |
| Non-routine vision exam | $25 copay | 30% coinsurance |
| Vision test for prescriptions | $0 copay | $35 reimbursement |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay | 30% coinsurance |
| Frames or contact lenses<br>*Every other year.* | $200 allowance combined in-network and out-of-network | $200 allowance combined in-network and out-of-network |
| **Inpatient Mental Health Services*** | | |
| Days 1-5 | $370 copay | 30% coinsurance |
| Days 6-90 | $0 copay | 30% coinsurance |
| Lifetime reserve days | $0 copay | 30% coinsurance |
| **Outpatient Mental Health Services** | | |
| Outpatient individual therapy visit in a provider's office or outpatient facility | $25 copay | 30% coinsurance |
| Outpatient group therapy visit in a provider's office or outpatient facility | $15 copay | 30% coinsurance |
| Partial hospitalization for mental health* | $55 copay | 30% coinsurance |

**Service may require prior authorization.*

| BENEFIT | In-Network Cost | Out-of-Network Cost |
|---|---|---|
| **Skilled Nursing Facility (SNF)*** *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 | $196 copay | 30% coinsurance |
| Days 56-100 | $0 copay | 30% coinsurance |
| **Outpatient Rehabilitation Services*** | | |
| Physical, occupational, and speech therapy visit in a provider's office or outpatient facility | $30 copay | 30% coinsurance |
| Cardiac rehab services | $0 copay | 30% coinsurance |
| Pulmonary rehab services | $10 copay | 30% coinsurance |
| **Ambulance*** *Prior authorization only required for non-emergency transfers.* | $225 copay | $225 copay |
| **Routine Transportation** | Not covered | Not covered |
| **Companionship Services through Papa Pals** | $0 copay, up to 30 hours a year | N/A |
| **Medicare Part B Drugs*** *Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs.* | 20% coinsurance | 30% coinsurance |
| **Foot Care (Podiatry Services)** Foot exams and treatment for Medicare-covered services. | $30 copay | 30% coinsurance |
| Routine foot care *Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits.* | $30 copay | 30% coinsurance |
| **Medical Equipment and Supplies** | | |
| Durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance | 30% coinsurance |
| Crutches, canes, and walkers | $0 copay | 30% coinsurance |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance | 30% coinsurance |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay | 30% coinsurance |
| Diabetes self-management training | $0 copay | 30% coinsurance |
| Therapeutic shoe inserts | 20% coinsurance | 30% coinsurance |
| **Wellness Your Way** Receive money on your SelectHealth Medicare flexible benefits card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $240 a year | N/A |
| **Over-the-Counter Items** Receive money on your SelectHealth Medicare flexible benefits card for OTC items. Amounts do not roll over. | $50 allowance per quarter | N/A |
| **Intermountain LiVe Well Center Programs** | $0 copay | N/A |
| **Chiropractic Care*** | $20 copay | 30% coinsurance |





| | | |
|---|---|---|
| **Medicare-Covered Acupuncture Services*** | | |
| Treatment of lower back pain *12 initial visits, and additional 8 visits if member is making progress.* | $20 copay | 30% coinsurance |
| **Home Health Care*** | $0 copay | 30% coinsurance |
| **Outpatient Substance Abuse** | | |
| Individual therapy | $25 copay | 30% coinsurance |
| Group therapy | $15 copay | 30% coinsurance |
| **Renal Dialysis** *Including services and supplies for home dialysis.* | 20% coinsurance | 30% coinsurance |
| **Hospice** | Covered by Original Medicare | Not covered |
| **Intermountain Connect Care** Visit with a provider via video chat for urgent medical needs. | $0 copay | N/A |
| **Telehealth Services** | | |
| Telehealth visit with a primary care provider | $0 copay | 30% coinsurance |
| Telehealth visit with a specialist | $25 copay | 30% coinsurance |

## DIABETES SPECIFIC BENEFITS

If you have a confirmed diabetes diagnosis, some benefits have different copay and coinsurances. See the below table for details.

| Diabetes Specific Benefits | In-Network Cost | Out-of-Network Cost |
|---|---|---|
| Primary care provider *In-person or through telehealth.* | $0 copay | 30% coinsurance |
| Routine or preventive eye exam | $0 copay | $35 reimbursement |
| Non-routine eye exam | $0 copay | 30% coinsurance |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay | 30% coinsurance |
| Diabetes self-management training | $0 copay | 30% coinsurance |
| Therapeutic shoe inserts | 20% coinsurance | 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 1 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $0 copay | N/A |
| Tier 3 and Tier 4 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $35 copay | N/A |
| Part B pump insulin *For use in a pump.* | 20% coinsurance | 30% coinsurance |

**Service may require prior authorization.*

# Your Prescription Benefits

## SelectHealth 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 **$4,660**. 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 **$7,400** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays most of the cost for your covered drugs. You generally pay **$4.15** for generic drugs and **$10.35** for all other drugs—or 5% of the cost, whichever is greater. You will stay in this stage for the rest of the calendar year through December 31. For more information on how pharmacy coverage stages work, please see the Pharmacy section of the Enrollment Guide.

### PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 (Generics) | $0 | |
| Tiers 3, 4, and 5 (Brands) | $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 Brand) | $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 and have a $0 copay.

Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.



SELECTHEALTH MEDICARE CHOICE (PPO) H2246_018

# 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.**

### $240 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 SelectHealth Medicare flexible benefits card that you can use to participate in wellness activities.

### HEALTHY LIVING INCENTIVE

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

### OVER-THE-COUNTER (OTC) BENEFIT

Receive **$50 per quarter** on your SelectHealth Medicare flexible benefits card for over-the-counter items.

### 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.

### COMPANIONSHIP SERVICES – PAPA PALS

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and even rides to your doctor's office or pharmacy.

### VISION COVERAGE

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

### DENTAL COVERAGE

This plan covers preventive and comprehensive dental 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 | $499**

**Tier 2 | $799**

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

# SelectHealth 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 |
| **Part B Premium Reduction** | Up to $50 reduction |
| **Medical Deductible** | $0 |
| **Member Out-of-Pocket Maximum**<br>*Does not include 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.* | $6,700 |
| **Inpatient Hospital Coverage***<br>*Copays start over each time you are admitted to an inpatient hospital facility.* | |
| Days 1-5 | $360 copay |
| Days 6+ | $0 copay |
| Meals after discharge* | $0 copay, up to 14 days of meals after discharged from an inpatient acute hospital or skilled nursing facility. |
| **Outpatient Facility Coverage*** | |
| Outpatient surgery | $350 copay |
| Ambulatory surgical center | $325 copay |
| Diagnostic colonoscopy | $350 copay |
| Other covered services<br>*Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.* | 20% coinsurance |
| **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 |
| **Worldwide Emergency Care**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $95 copay |
| **Worldwide Urgently Needed Services**<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 radiology services (e.g., MRIs, CT scans) | $150 copay |
| Diagnostic tests and procedures | $0 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Therapeutic radiology services | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $0 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.* | $399 to $1,699 copay |
| **Dental Services***<br>*Limited Medicare-covered dental services related to a medical condition.* | $40 copay |
| **Preventive Dental**<br>*Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months.* | $0 copay |
| **Comprehensive Dental***<br>Basic and Major covered services. No deductible.<br>*Maximum plan payment of $1,500, including preventive dental services.* | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>*One per year.* | $0 copay |
| Non-routine vision exam | $40 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>*One per year.* | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-5 | $360 copay |
| Days 6-90 | $0 copay |
| Lifetime reserve days | $0 copay |
| **Outpatient Mental Health Services** | |
| Outpatient individual therapy visit in a provider's office or outpatient facility | $25 copay |
| Outpatient group therapy visit in a provider's office or outpatient facility | $15 copay |
| Partial hospitalization for mental health* | $55 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **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 | $196 copay |
| Days 56-100 | $0 copay |
| **Outpatient Rehabilitation Services*** | |
| Physical, occupational, and speech therapy visit in a provider's office or outpatient facility | $20 copay |
| Cardiac rehab services | $0 copay |
| Pulmonary rehab services | $0 copay |
| **Ambulance*** *Prior authorization only required for non-emergency transfers.* | $250 copay |
| **Routine Transportation** | Not covered |
| **Companionship Services through Papa Pals** | $0 copay, up to 30 hours a year |
| **Medicare Part B Drugs*** *Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs.* | 20% coinsurance |
| **Foot Care (Podiatry Services)** | |
| Medicare-covered foot exam | $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 |
| **Medical Equipment and Supplies** | |
| Durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Crutches, canes, and walkers | $0 copay |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| **Wellness Your Way** Receive money on your SelectHealth Medicare flexible benefits card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $240 a year |
| **Over-the-Counter Items** Receive money on your SelectHealth Medicare flexible benefits card for OTC items. Amounts do not roll over. | $75 allowance per quarter |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Chiropractic Care*** | $20 copay |





| | |
|---|---|
| **Medicare-Covered Acupuncture Services*** | |
| Treatment of lower back pain *12 initial visits, and additional 8 visits if member is making progress.* | $20 copay |
| **Home Health Care*** | $0 copay |
| **Outpatient Substance Abuse*** | |
| Individual therapy | $25 copay |
| Group therapy | $15 copay |
| **Renal Dialysis** *Including services and supplies for home dialysis.* | 20% coinsurance |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care** Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $40 copay |

## DIABETES SPECIFIC BENEFITS

If you have a confirmed diabetes diagnosis, some benefits have different copay and coinsurances. See the below table for details.

| **Diabetes Specific Benefits** | |
|---|---|
| Primary care provider *In-person or through telehealth.* | $0 copay |
| Routine and non-routine eye exam | $0 copay |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| Continuous Glucose Monitors (CGM)* | $0 copay |
| Part B Insulin pumps and supplies | 20% coinsurance |

**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.**

### $240 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 SelectHealth Medicare flexible benefits card that you can use to participate in wellness activities.

### HEALTHY LIVING INCENTIVE

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

### OVER-THE-COUNTER (OTC) BENEFIT

Receive **$75 per quarter** on your SelectHealth Medicare flexible benefits card for over-the-counter items.

### 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.

### COMPANIONSHIP SERVICES – PAPA PALS

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and even rides to your doctor's office or pharmacy.

### VISION COVERAGE

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

### DENTAL COVERAGE

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

### HEARING AIDS

**Intermountain Healthcare 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 | $399**
- **Tier 2 - Essential | $589**
- **Tier 3 - Standard | $849**
- **Tier 4 - Advanced | $1,199**
- **Tier 5 - Premium | $1,699**

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



SELECTHEALTH MEDICARE NO RX (HMO) H1994_016

## Notes

# SelectHealth Medicare Essential (HMO) H1994_017

**Iron and Washington counties in Utah.**

| BENEFIT | COST |
|---|---|
| **Premium Amount** | $0 |
| **Medical Deductible** | $0 |
| **Pharmacy Deductible**<br>*Does not apply to Tier 1 and Tier 2 drugs.* | $200 |
| **Member Out-of-Pocket Maximum**<br>*Does not include prescription drugs or 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 to an inpatient hospital facility.* | |
| Days 1-4 | $475 copay |
| Days 5+ | $0 copay |
| Meals after discharge* | $0 copay, up to 14 days of meals after discharged from an inpatient acute hospital or skilled nursing facility. |
| **Outpatient Facility Coverage*** | |
| Outpatient surgery | $400 copay |
| Ambulatory surgical center | $350 copay |
| Diagnostic colonoscopy | $300 copay |
| Other covered services<br>*Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.* | 20% coinsurance |
| **Doctor's Office Visits** | |
| Primary care provider | $0 copay |
| Specialist<br>*We do not require referrals.* | $17 copay |
| **Preventive Care** | |
| Annual physical/comprehensive wellness visit | $0 copay |
| Medicare-covered preventive services | $0 copay |
| **Worldwide Emergency Care**<br>Copay is waived if you are admitted to the hospital within 24 hours. | $95 copay |
| **Worldwide Urgently Needed Services**<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 radiology services (e.g., MRIs, CT scans) | $250 copay |
| Diagnostic tests and procedures | $0 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Therapeutic radiology services | 20% coinsurance |
| **Hearing Services** | |
| Hearing exam related to a medical condition | $17 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.* | $17 copay |
| **Preventive Dental**<br>*Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months.* | $0 copay |
| **Comprehensive Dental***<br>Basic and Major covered services. No deductible.<br>*Maximum plan payment of $1,500, preventive dental services do not go towards maximum payment.* | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>*One per year.* | $0 copay |
| Non-routine vision exam | $17 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>*One per year.* | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-4 | $465 copay |
| Days 5-90 | $0 copay |
| Lifetime reserve days | $0 copay |
| **Outpatient Mental Health Services** | |
| Outpatient individual therapy visit in a provider's office or outpatient facility | $20 copay |
| Outpatient group therapy visit in a provider's office or outpatient facility | $15 copay |
| Partial hospitalization for mental health* | $55 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **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 | $196 copay |
| Days 56-100 | $0 copay |
| **Outpatient Rehabilitation Services*** | |
| Physical, occupational, and speech therapy visit in a provider's office or outpatient facility | $20 copay |
| Cardiac rehab services | $0 copay |
| Pulmonary rehab services | $10 copay |
| **Ambulance*** *Prior authorization only required for non-emergency transfers.* | $300 copay |
| **Routine Transportation** | Not covered |
| **Companionship Services through Papa Pals** | $0 copay, up to 30 hours a year |
| **Medicare Part B Drugs*** *Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs.* | 20% coinsurance |
| **Foot Care (Podiatry Services)** Foot exams and treatment for Medicare-covered services. | $20 copay |
| Routine Foot Care *Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits.* | $20 copay |
| **Medical Equipment and Supplies** | |
| Durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Crutches, canes, and walkers | $0 copay |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| **Wellness Your Way** Receive money on your SelectHealth Medicare flexible benefits card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $240 a year |
| **Over-the-Counter Items** Receive money on your SelectHealth Medicare flexible benefits card for OTC items. Amounts do not roll over. | $50 allowance per quarter |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Chiropractic Care*** | $20 copay |
| **Medicare-Covered Acupuncture Services*** | |
| Treatment of lower back pain *12 initial visits, and additional 8 visits if member is making progress.* | $20 copay |



SELECTHEALTH MEDICARE ESSENTIAL (HMO) H1994_017

| | |
|---|---|
| **Home Health Care*** | $0 copay |
| **Outpatient Substance Abuse*** | |
| Individual therapy | $20 copay |
| Group therapy | $15 copay |
| **Renal Dialysis** *Including services and supplies for home dialysis.* | 20% coinsurance |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care** Visit with a provider via video chat for urgent medical needs. | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $17 copay |

## DIABETES SPECIFIC BENEFITS

If you have a confirmed diabetes diagnosis, some benefits have different copay and coinsurances. See the below table for details.

| **Diabetes Specific Benefits** | |
|---|---|
| Primary care provider *In-person or through telehealth.* | $0 copay |
| Routine and non-routine eye exam | $0 copay |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| 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 1 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $0 copay |
| Tier 3 and Tier 4 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $35 copay |
| Part B pump insulin *For use in a pump.* | 20% coinsurance |

**Service may require prior authorization.*

# Your Prescription Benefits

## SelectHealth 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 **$4,660**. 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 **$7,400** in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays most of the cost for your covered drugs. You generally pay **$4.15** for generic drugs and **$10.35** for all other drugs—or 5% of the cost, whichever is greater. You will stay in this stage for the rest of the calendar year through December 31. For more information on how pharmacy coverage stages work, please see the Pharmacy section of the Enrollment Guide.

### PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 (Generics) | $0 | |
| Tiers 3, 4, and 5 (Brands) | $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 Brand) | $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 and have a $0 copay.

Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.



SELECTHEALTH MEDICARE ESSENTIAL (HMO) H1994_017

# 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.**

### $240 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 SelectHealth Medicare flexible benefits card that you can use to participate in wellness activities.

### HEALTHY LIVING INCENTIVE

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

### OVER-THE-COUNTER (OTC) BENEFIT

Receive **$50 per quarter** on your SelectHealth Medicare flexible benefits card for over-the-counter items.

### 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.

### COMPANIONSHIP SERVICES – PAPA PALS

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and even rides to your doctor's office or pharmacy.

### VISION COVERAGE

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

### DENTAL COVERAGE

This plan covers preventive and comprehensive dental 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 | $499**

**Tier 2 | $799**

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

# SelectHealth Medicare Classic (HMO) H1994_002

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

| BENEFIT | COST |
|---|---|
| **Premium Amount** | $38 |
| **Medical Deductible** | $0 |
| **Pharmacy Deductible**<br>*Does not apply to Tier 1 and Tier 2 drugs.* | $200 |
| **Member Out-of-Pocket Maximum**<br>*Does not include prescription drugs or 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 to an inpatient hospital facility.* | |
| Days 1-5 | $410 copay |
| Days 6+ | $0 copay |
| Meals after discharge* | $0 copay, up to 14 days of meals after discharged from an inpatient acute hospital or skilled nursing facility. |
| **Outpatient Facility Coverage*** | |
| Outpatient surgery | $380 copay |
| Ambulatory surgical center | $330 copay |
| Diagnostic colonoscopy | $380 copay |
| Other covered services<br>*Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.* | 20% coinsurance |
| **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 |
| **Worldwide Emergency Care**<br>*Copay is waived if you are admitted to the hospital within 24 hours.* | $95 copay |
| **Worldwide Urgently Needed Services**<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 radiology services (e.g., MRIs, CT scans) | $320 copay |
| Diagnostic tests and procedures | $0 copay |
| Lab services | $0 copay |
| Outpatient x-rays | $0 copay |
| Therapeutic radiology services | 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 |
| **Preventive Dental**<br>*Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months.* | $0 copay |
| **Comprehensive Dental***<br>Basic and Major covered services. No deductible.<br>*Maximum plan payment of $1,000, preventive dental services do not go towards maximum payment.* | $0 copay |
| **Vision Services** | |
| Routine and/or preventive eye exam<br>*One per year.* | $0 copay |
| Non-routine vision exam | $40 copay |
| Vision test for prescriptions | $0 copay |
| Eyeglasses or contact lenses after cataract surgery* | $0 copay |
| Frames or contact lenses<br>*One per year.* | $200 allowance |
| **Inpatient Mental Health Services*** | |
| Days 1-4 | $395 copay |
| Days 5-90 | $0 copay |
| Lifetime reserve days | $0 copay |
| **Outpatient Mental Health Services** | |
| Outpatient individual or group therapy visit in a provider's office or outpatient facility | $40 copay |
| Partial hospitalization for mental health* | $55 copay |

**Service may require prior authorization.*

| BENEFIT | COST |
|---|---|
| **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 | $196 copay |
| Days 56-100 | $0 copay |
| **Outpatient Rehabilitation Services*** | |
| Physical, occupational, and speech therapy visit in a provider's office or outpatient facility | $20 copay |
| Cardiac rehab services | $10 copay |
| Pulmonary rehab services | $20 copay |
| **Ambulance*** *Prior authorization only required for non-emergency transfers.* | $275 copay |
| **Routine Transportation** | Not covered |
| **Companionship Services through Papa Pals** | $0 copay, up to 30 hours a year |
| **Medicare Part B Drugs*** *Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs.* | 20% coinsurance |
| **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 |
| **Medical Equipment and Supplies** | |
| Durable medical equipment (e.g., wheelchairs, oxygen, etc.)* | 20% coinsurance |
| Crutches, canes, and walkers | $0 copay |
| Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)* | 20% coinsurance |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| **Wellness Your Way** Receive money on your SelectHealth Medicare flexible benefits card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc. | $240 per year |
| **Over-the-Counter Items** Receive money on your SelectHealth Medicare flexible benefits card for OTC items. Amounts do not roll over. | $50 allowance per quarter |
| **Intermountain LiVe Well Center Programs** | $0 copay |
| **Chiropractic Care*** | $20 copay |
| **Medicare-Covered Acupuncture Services*** | |
| Treatment of lower back pain *12 initial visits, and additional 8 visits if member is making progress.* | $20 copay |



SELECTHEALTH MEDICARE CLASSIC (HMO) H1994_002

| | |
|---|---|
| **Home Health Care*** | $0 copay |
| **Outpatient Substance Abuse*** | |
| Therapy in a provider's office | $40 copay |
| Therapy in an outpatient facility setting | $50 copay |
| **Renal Dialysis** *Including services and supplies for home dialysis.* | 20% coinsurance |
| **Hospice** | Covered by Original Medicare |
| **Intermountain Connect Care** *Visit with a provider via video chat for urgent medical needs.* | $0 copay |
| **Telehealth Services** | |
| Telehealth visit with a primary care provider | $0 copay |
| Telehealth visit with a specialist | $40 copay |

## DIABETES SPECIFIC BENEFITS

If you have a confirmed diabetes diagnosis, some benefits have different copay and coinsurances. See the below table for details.

| | |
|---|---|
| **Diabetes Specific Benefits** | |
| Primary care provider *In-person or through telehealth.* | $0 copay |
| Routine and non-routine eye exam | $0 copay |
| Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.* | $0 copay |
| Diabetes self-management training | $0 copay |
| Therapeutic shoe inserts | 20% coinsurance |
| 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 1 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $0 copay |
| Tier 3 and Tier 4 insulin *30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.* | $35 copay |
| Part B pump insulin *For use in a pump.* | 20% coinsurance |

**Service may require prior authorization.*

# Your Prescription Benefits

## SelectHealth 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.
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You will generally pay 25% on brand-name and generic drugs while in the Coverage Gap. Once you reach **$7,400** in annual total drug costs, you move to the Catastrophic Coverage stage.

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### PHARMACY DEDUCTIBLE

| | | |
|---|---|---|
| Tier 1 and 2 (Generics) | $0 | |
| Tiers 3, 4, and 5 (Brands) | $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 Brand) | $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 and have a $0 copay.

Tier 3 and Tier 4 insulin copays are capped at a $35 copay for a 30-day supply, during all Part D stages.



SELECTHEALTH MEDICARE CLASSIC (HMO) H1994_002

# Exclusive Plan Benefits

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### $240 WELLNESS YOUR WAY

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### HEALTHY LIVING INCENTIVE

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

### OVER-THE-COUNTER (OTC) BENEFIT

Receive **$50 per quarter** on your SelectHealth Medicare flexible benefits card for over-the-counter items.

### 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.

### COMPANIONSHIP SERVICES – PAPA PALS

Get connected with a *Papa Pal* to lend companionship services and help with daily living activities such as technology lessons, light house tasks, and even rides to your doctor's office or pharmacy.

### VISION COVERAGE

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

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This plan covers preventive and comprehensive dental 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 | $499**

**Tier 2 | $799**

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

# Multi-Language Insert

selecthealth

## Multi-Language Interpreter Services

SelectHealth: **1-855-442-9900** (TTY:711)

SelectHealth provides free services to help you communicate with us such as letters in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Member Services team at **1-855-442-9900** for additional information (TTY users, please call 711). Hours are 24 hours a day, 7 days a week.

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-855-442-9900** (TTY: 711). Someone who speaks English can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-855-442-9900**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese:** 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。

**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.

**Navajo:** Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę́'', t'áá jiik'eh, éí ná hóló', kojį' hódíílnih SelectHealth.

**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 للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على ١-٨٥٥-٤٤٢-٩٩٠٠. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.



# Multi-Language Insert

selecthealth

**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。

**Amharic:** ስለ ጤና ወይም የመድኃኒት ዕቅዳችን ማንኛውንም ጥያቄ ለመመለስ ነፃ የአስተርጓሚ አገልግሎት አለን። አስተርጓሚ ለማግኘት በ **1-855-442-9900** ይደውሉልን። አማርኛ የሚናገር ሰው ሊረዳህ ይችላል። ይህ ነፃ አገልግሎት ነው።

**Serbian:** Имамо бесплатне услуге преводиоца за одговоре на сва ваша питања о нашем здравственом плану или плану за лекове. Да бисте добили преводиоца, само нас позовите на **1-855-442-9900**. Неко ко говори српски може вам помоћи. Ово је бесплатна услуга.

**Persian:** ما خدمات مترجم رایگان داریم تا به هر سؤالی که ممکن است در مورد طرح سلامت یا داروی خود داشته باشید پاسخ دهیم. برای دریافت مترجم، فقط با شماره **1-855-442-9900** تماس بگیرید. کسی که فارسی صحبت می کند می تواند به شما کمک کند. این یک سرویس رایگان است.

**Thai:** เรามีบริการล่ามฟรีเพื่อตอบคำถามที่คุณอาจมีเกี่ยวกับสุขภาพหรือแผนยาของเรา หากต้องการล่าม เพียงโทรหาเราที่ **1-855-442-9900** คนที่พูดภาษาไทยสามารถช่วยคุณได้ นี่เป็นบริการฟรี

**Nepali:** हाम्रो स्वास्थ्य वा औषधि योजनाको बारेमा तपाईलाई हुन सक्ने कुनै पनि प्रश्नको जवाफ दिन हामीसँग निःशुल्क दोभाषे सेवाहरू छन्। एक दोभासे प्राप्त गर्न, हामीलाई **1-855-442-9900** मा कल गर्नुहोस्। नेपाली बोल्ने कोहीले तपाईंलाई मद्दत गर्न सक्छ। यो निःशुल्क सेवा हो।

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ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth Medicare: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**. 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 SelectHealth Medicare: **1-855-442-9900** (TTY: 711) / SelectHealth: **1-800-538-5038**.

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