SelectHealth Medicare

Summary of Benefits

Nevada 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 Nevada counties are included in our service areas: Clark and Nye.

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.

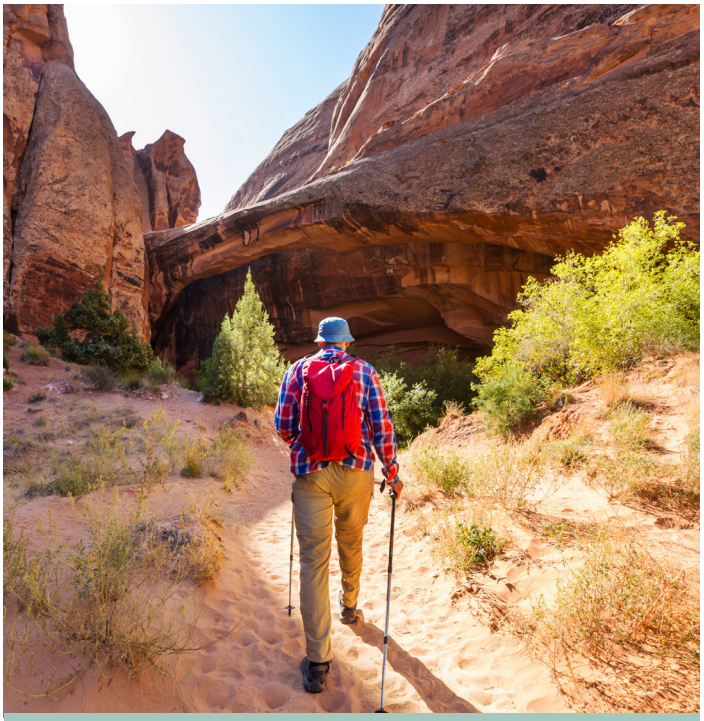
What is an HMO?

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) 012

SelectHealth Medicare Choice (PPO) 019

SelectHealth Medicare No Rx (PPO) 020

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.

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SelectHealth Medicare Essential (HMO) H1994_012

Clark and Nye counties in Nevada.

BENEFIT	COST
Premium Amount	$0
Medical Deductible	$0
Pharmacy Deductible	$0
Member Out-of-Pocket Maximum *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.*	$1,000
Inpatient Hospital Coverage* *Copays start over each time you are admitted to an inpatient hospital facility.*	
All days	$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	$0 copay
Ambulatory surgical center	$0 copay
Diagnostic colonoscopy	$0 copay
Other covered services *Includes: IV infusion therapy, non-nuclear stress tests, and more.*	20% coinsurance
Doctor's Office Visits	
Primary care provider	$0 copay
Specialist *Referrals may be required.*	$0 copay
Preventive Care	
Annual physical/comprehensive wellness visit	$0 copay
Medicare-covered preventive services	$0 copay
Worldwide Emergency Care *Copay is waived if you are admitted to the hospital within 24 hours.*	$125 copay
Worldwide Urgently Needed Services *No extra charges for labs and/or x-rays.* *Copay is waived if you are admitted to the ER or hospital within 24 hours.* *Refer to the Evidence of Coverage for additional details.*	
In-network	$10 copay
Out-of-network	$40 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 radiology services (e.g., MRIs, CT scans)	$60 copay
Nuclear medicine(e.g., PET scans)	$80 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 *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.*	$399 to $699 copay
Dental Services* *Limited Medicare-covered dental services related to a medical condition.*	$0 copay
Preventive Dental *Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 60 months.*	$0 copay
Comprehensive Dental* *Maximum plan payment of $2,500, preventive dental services do not go towards maximum payment. Administered by Delta Dental of California. No deductible.*	
Basic services *Fillings, extractions, endodontic, and periodontal treatment.*	$0 copay
Major services *Things like crowns and dentures.*	50% coinsurance
Vision Services	
Routine and/or preventive eye exam *One per year.*	$0 copay
Non-routine vision exam	$0 copay
Vision test for prescriptions	$0 copay
Eyeglasses or contact lenses after cataract surgery*	$0 copay
Frames or contact lenses *Once per year.*	$300 allowance
Inpatient Mental Health Services*	
Days 1-90	$0 copay
Lifetime reserve days	$0 copay
Outpatient Mental Health Services	
Outpatient individual or group therapy visit in a provider's office	$0 copay
Outpatient individual or group therapy visit in an outpatient facility	$30 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 21-40	$125 copay
Days 41-100	$0 copay
Outpatient Rehabilitation Services*	
Physical, occupational, and speech therapy visit in a provider's office or outpatient facility	$0 copay
Cardiac rehab services	$0 copay
Pulmonary rehab services	$0 copay
Ambulance* *Prior authorization only required for non-emergency transfers.*	$200 copay
Routine Transportation *Services such as getting a ride to and from your doctor, pharmacy, or facility.*	$0 copay, up to 24 one-way trips
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.	$0 copay
Routine foot care *Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits.*	$0 copay
Medical Equipment and Supplies	
Durable medical equipment (e.g., wheelchairs, oxygen, etc.)*	20% coinsurance
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*	$0 copay
Medicare-Covered Acupuncture Services*	
Treatment of lower back pain. *12 initial visits, and additional 8 visits if member is making progress.*	$0 copay

SELECTHEALTH MEDICARE ESSENTIAL (HMO) H1994_012

Home Health Care*	$0 copay
Outpatient Substance Abuse*	
Therapy in a provider's office	$0 copay
Therapy in an outpatient facility	$30 copay
Renal Dialysis	
Dialysis center	$0 copay
Outpatient facility	20% coinsurance
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	$0 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
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 Essential (HMO) 012

The below cost-sharing table shows what you will pay for your prescription in the Initial Coverage Stage. **There is no pharmacy deductible on this plan.**

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

Tiers 1, 2, 3, 4, 5	$0	
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)	$0 | $0	$0 | $0
Tier 3 (Preferred Brand)	$47 | $141	$47 | $141
Tier 4 (Nonpreferred Brand)	$100 | $300	$100 | $300
Tier 5 (Specialty Tier)	33% coinsurance | N/A	33% coinsurance | N/A

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

HOW WE HELP WITH PRESCRIPTION DRUG COSTS

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 ESSENTIAL (HMO) H1994_012

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**.

TRANSPORTATION

Our plan includes non-emergent medical transportation at **no additional cost**. This means you can get up to 24 one-way trips to and from your doctor's appointments, facilities, or pharmacy.

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 | $399

Tier 2 | $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_019

Clark and Nye counties in Nevada.

BENEFIT	Cost	Out-of-Network Cost
Premium Amount	$0	$0
Medical Deductible	$0	$0
Pharmacy Deductible	$0	$0
Member Out-of-Pocket Maximum *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	$10,000 combined with in-network
Inpatient Hospital Coverage* *Copays start over each time you are admitted to an inpatient hospital facility.*		
Days 1-5	$295 copay	
Days 6+	$0 copay	
Days 1-20		$500 copay
Days 21+		$0 copay
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	$250 copay	40% coinsurance
Ambulatory surgical center	$175 copay	40% coinsurance
Diagnostic colonoscopy	$250 copay	40% coinsurance
Other covered services *Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.*	20% coinsurance	40% coinsurance
Doctor's Office Visits		
Primary care provider	$0 copay	$20 copay
Specialist *We do not require referrals.*	$35 copay	$75 copay
Preventive Care		
Annual physical/comprehensive wellness visit	$0 copay	$20 copay
Medicare-covered preventive services	$0 copay	40% coinsurance
Worldwide Emergency Care *Copay is waived if you are admitted to the hospital within 24 hours.*	$95 copay	$95 copay
Worldwide Urgently Needed Services *No extra charges for labs and/or x-rays. Copay is waived if you are admitted to the ER or hospital within 24 hours. Refer to the Evidence of Coverage for additional details.*	$10 copay	$40 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 radiology services (e.g., MRIs, CT scans)	$150 copay	40% coinsurance
Nuclear medicine(e.g., PET scans)	$150 copay	40% coinsurance
Diagnostic tests and procedures	20% coinsurance	40% coinsurance
Lab services	$0 copay	$5 copay
Outpatient x-rays	$5 copay	40% coinsurance
Therapeutic radiology services	20% coinsurance	40% coinsurance
Hearing Services		
Hearing exam related to a medical condition	$35 copay	$75 copay
Routine hearing exam *One per year.*	$0 copay	$75 copay
Hearing aids *Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum.*	$399 to $699 copay	Not covered
Dental Services* *Limited Medicare-covered dental services related to a medical condition.*	$35 copay	$75 copay
Preventive Dental *Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 60 months.*	$0 copay	$0 copay
Comprehensive Dental* *Maximum plan payment of $2,500, preventive dental services do not go towards maximum payment. Administered by Delta Dental of California. No deductible.*		
Basic services *Fillings, extractions, endodontic, and periodontal treatment.*	20% coinsurance	20% coinsurance
Major services *Things like crowns and dentures.*	50% coinsurance	50% coinsurance
Vision Services		
Routine and/or preventive eye exam *One per year.*	$0 copay	$35 reimbursement
Non-routine vision exam	$35 copay	$75 copay
Vision test for prescriptions	$0 copay	$35 reimbursement
Eyeglasses or contact lenses after cataract surgery*	$0 copay	$75 copay
Frames or contact lenses *Once per year.*	$300 allowance	$300 reimbursement
Inpatient Mental Health Services*		
Days 1-5	$295 copay	
Days 6-90	$0 copay	
Days 1-20		$500 copay
Days 21-90		$0 copay
Lifetime reserve days	$0 copay	$0 copay

**Service may require prior authorization.*

BENEFIT	Cost	Out-of-Network Cost
Outpatient Mental Health Services		
Individual therapy visit in a provider's office or outpatient facility	$25 copay	$65 copay
Group therapy visit in an provider's office or outpatient facility	$20 copay	$45 copay
Partial hospitalization for mental health*	$55 copay	$65 copay
Skilled Nursing Facility (SNF)* *Our plan covers up to 100 days in a SNF, no prior hospital stay required.*		
Days 1-20	$0 copay	40% coinsurance
Days 21-35	$196 copay	40% coinsurance
Days 36-100	$0 copay	40% coinsurance
Outpatient Rehabilitation Services*		
Physical, occupational, and speech therapy visit in a provider's office or outpatient facility	$20 copay	$75 copay
Cardiac rehab services	$0 copay	40% coinsurance
Pulmonary rehab services	$20 copay	40% coinsurance
Ambulance* *Prior authorization only required for non-emergency transfers.*	$270 copay	$270 copay
Routine Transportation *Services such as getting a ride to and from your doctor, pharmacy, or facility.*	$0 copay, up to 24 one-way trips	N/A
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	40% coinsurance
Foot Care (Podiatry Services) Foot exams and treatment for Medicare-covered services.	$35 copay	$75 copay
Routine foot care *Treatment that is considered preventive (i.e. cutting or removal of corns, warts, calluses, or nails), up to six visits.*	$35 copay	$75 copay
Medical Equipment and Supplies		
Durable medical equipment (e.g., wheelchairs, oxygen, etc.)*	20% coinsurance	40% coinsurance
Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)*	20% coinsurance	50% coinsurance
Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.*	$0 copay	40% coinsurance
Diabetes self-management training	$0 copay	40% coinsurance
Therapeutic shoe inserts	20% coinsurance	40% 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	N/A
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	N/A

Intermountain LiVe Well Center Programs	$0 copay	N/A
Chiropractic Care*	$20 copay	$75 copay
Medicare-Covered Acupuncture Services*		
Treatment of lower back pain. *12 initial visits, and additional 8 visits if member is making progress.*	$35 copay	$75 copay
Home Health Care*	$0 copay	50% coinsurance
Outpatient Substance Abuse*		
Individual therapy	$25 copay	$65 copay
Group therapy	$20 copay	$45 copay
Renal Dialysis		
Dialysis center	$0 copay	20% coinsurance
Outpatient facility	20% coinsurance	20% coinsurance
Services and supplies for home dialysis	20% coinsurance	20% coinsurance
Hospice	Covered by Original Medicare	N/A
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	Not covered
Telehealth visit with a specialist	$35 copay	Not covered

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
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
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 Choice (PPO) 019

The below cost-sharing table shows what you will pay for your prescription in the Initial Coverage Stage. **There is no pharmacy deductible on this plan.**

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

Tiers 1, 2, 3, 4, 5	$0	
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)	$8 | $24	$8 | $16
Tier 3 (Preferred Brand)	$47 | $141	$47 | $141
Tier 4 (Nonpreferred Brand)	$100 | $300	$100 | $300
Tier 5 (Specialty Tier)	33% coinsurance | N/A	33% coinsurance | N/A

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

HOW WE HELP WITH PRESCRIPTION DRUG COSTS

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 CHOICE (PPO) H2246_019

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

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 | $399

Tier 2 | $699

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

SelectHealth Medicare No Rx (PPO) H2246_020

Clark and Nye counties in Nevada.

BENEFIT	Cost	Out-of-Network Cost
Premium Amount	$0	$0
Part B Premium Reduction	$100 reduction	N/A
Medical Deductible	$0	$0
Member Out-of-Pocket Maximum *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	$10,000 combined with in-network
Inpatient Hospital Coverage* *Copays start over each time you are admitted to an inpatient hospital facility.*		
Days 1-3	$395 copay	40% coinsurance
Days 4+	$0 copay	40% 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	$375 copay	40% coinsurance
Ambulatory surgical center	$325 copay	40% coinsurance
Diagnostic colonoscopy	$375 copay	40% coinsurance
Other covered services *Includes: IV infusion therapy, non-nuclear stress tests, and more.*	20% coinsurance	40% coinsurance
Doctor's Office Visits		
Primary care provider	$0 copay	40% coinsurance
Specialist *We do not require referrals.*	$40 copay	40% coinsurance
Preventive Care		
Annual physical/comprehensive wellness visit	$0 copay	40% coinsurance
Medicare-covered preventive services	$0 copay	40% coinsurance
Worldwide Emergency Care *Copay is waived if you are admitted to the hospital within 24 hours.*	$95 copay	$95 copay
Worldwide Urgently Needed Services *No extra charges for labs and/or x-rays.* *Copay is waived if you are admitted to the ER or hospital within 24 hours. Refer to the Evidence of Coverage for additional details.*	$20 copay	$40 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 radiology services (e.g., MRIs, CT scans)	$75 copay	40% coinsurance
Nuclear medicine(e.g., PET scans)	$150 copay	40% coinsurance
Diagnostic tests and procedures	$0 copay	40% coinsurance
Lab services	$0 copay	40% coinsurance
Outpatient x-rays	$0 copay	40% coinsurance
Therapeutic radiology services	20% coinsurance	40% coinsurance
Hearing Services		
Hearing exam related to a medical condition	$0 copay	40% coinsurance
Routine hearing exam *One per year.*	$0 copay	40% coinsurance
Hearing aids *Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum.*	$399 to $699 copay	Not covered
Dental Services* *Limited Medicare-covered dental services related to a medical condition.*	$40 copay	40% coinsurance
Preventive Dental *Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 60 months.*	$0 copay	$0 copay
Comprehensive Dental* *Maximum plan payment of $2,500, preventive dental services do not go towards maximum payment. Administered by Delta Dental of California. No deductible.*		
Basic services *Fillings, extractions, endodontic, and periodontal treatment.*	20% coinsurance	20% coinsurance
Major services *Things like crowns and dentures.*	50% coinsurance	50% coinsurance
Vision Services		
Routine and/or preventive eye exam *One per year.*	$0 copay	$35 reimbursement
Non-routine vision exam	$0 copay	40% coinsurance
Vision test for prescriptions	$0 copay	$35 reimbursement
Eyeglasses or contact lenses after cataract surgery*	$0 copay	40% coinsurance
Frames or contact lenses *Once per year.*	$300 allowance	$300 reimbursement

**Service may require prior authorization.*

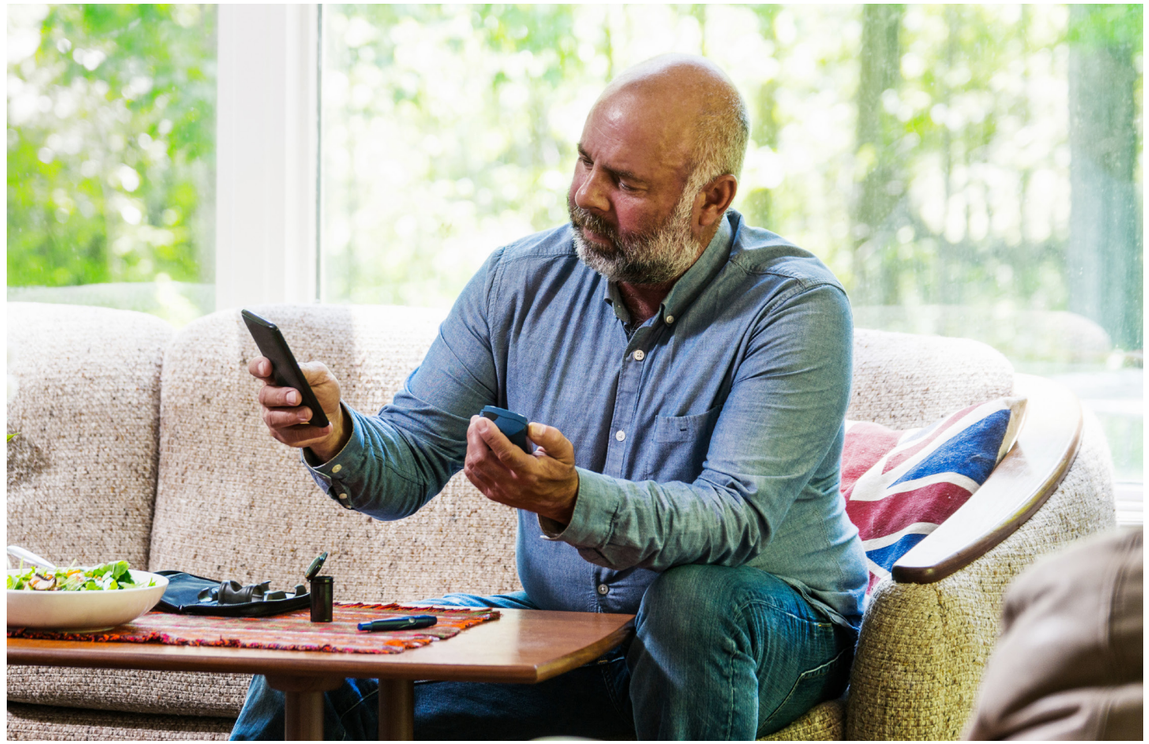
BENEFIT	Cost	Out-of-Network Cost
Inpatient Mental Health Services*		
Days 1-3	$395 copay	40% coinsurance
Days 4-90	$0 copay	40% coinsurance
Lifetime reserve days	$0 copay	40% coinsurance
Outpatient Mental Health Services		
Individual therapy visit in a provider's office or outpatient facility	$25 copay	40% coinsurance
Group therapy visit in an provider's office or outpatient facility	$20 copay	40% coinsurance
Partial hospitalization for mental health*	$55 copay	40% coinsurance
Skilled Nursing Facility (SNF)* *Our plan covers up to 100 days in a SNF, no prior hospital stay required.*		
Days 1-20	$0 copay	40% coinsurance
Days 21-100	$196 copay	40% coinsurance
Outpatient Rehabilitation Services*		
Physical, occupational, and speech therapy visit in a provider's office or outpatient facility	$20 copay	40% coinsurance
Cardiac rehab services	$0 copay	40% coinsurance
Pulmonary rehab services	$20 copay	40% coinsurance
Ambulance* *Prior authorization only required for non-emergency transfers.*	$250 copay	$250 copay
Routine Transportation *Services such as getting a ride to and from your doctor, pharmacy, or facility.*	$0 copay, up to 24 one-way trips	N/A
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	40% coinsurance
Foot Care (Podiatry Services) Foot exams and treatment for Medicare-covered services.	$40 copay	40% coinsurance
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	40% coinsurance
Medical Equipment and Supplies		
Durable medical equipment (e.g., wheelchairs, oxygen, etc.)*	20% coinsurance	40% coinsurance
Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)*	20% coinsurance	40% coinsurance
Diabetes monitoring supplies *Coverage for test strips and glucose monitors by produced by Abbott.*	$0 copay	40% coinsurance
Diabetes self-management training	$0 copay	40% coinsurance
Therapeutic shoe inserts	20% coinsurance	40% 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	N/A
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	N/A
Intermountain LiVe Well Center Programs	$0 copay	N/A
Chiropractic Care*	$10 copay	40% coinsurance
Medicare-Covered Acupuncture Services*		
Treatment of lower back pain. *12 initial visits, and additional 8 visits if member is making progress.*	$40 copay	40% coinsurance
Home Health Care*	$0 copay	40% coinsurance
Outpatient Substance Abuse*		
Individual therapy	$40 copay	40% coinsurance
Group therapy	$25 copay	40% coinsurance
Renal Dialysis		
Dialysis center	$0 copay	20% coinsurance
Outpatient facility	20% coinsurance	20% coinsurance
Services and supplies for home dialysis	20% coinsurance	20% coinsurance
Hospice	Covered by Original Medicare	N/A
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	Not covered
Telehealth visit with a specialist	$40 copay	Not covered

Service may require prior authorization.

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
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



SELECTHEALTH MEDICARE NO RX (PPO) H2246_020

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 includes 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 | $399

Tier 2 | $699

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

Multi-Language Insert

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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

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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।

SelectHealth is an HMO, PPO, D-SNP plan sponsor with a Medicare contract. Enrollment in SelectHealth Medicare depends on contract renewal. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. SelectHealth 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 upon request.

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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