Select Health Medicare Essential (HMO) 001

Select Health Medicare Enhanced (HMO) 007

Select Health Medicare No Rx (HMO) 016

Select Health Medicare Choice (PPO) 018

Select Health Medicare Essential (HMO) 017

Select Health Medicare + Kroger (HMO) 022

Select Health Medicare Classic (HMO) 002

Select Health Medicare®

Utah 2024 Enrollment Guide

Welcome to the Select Health Medicare Enrollment Guide!

This guide will take you through all the important information you need to know before you choose one of our plans.

If you have any questions or would like to talk to someone over the phone or in-person, call our Answer Team at **855-442-9940 (TTY: 711)**. You can also visit us online at **selecthealth.org/medicare**.

Answer Team Hours:

October 1 – March 31:

Weekdays 8:00 a.m. to 8:00 p.m.,
Saturday and Sunday
8:00 a.m. to 8:00 p.m.

April 1 – September 30:

Weekdays 8:00 a.m. to 8:00 p.m.,
closed Saturday and Sunday.

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Meet Select Health

A Quick Hello!

Our members are at the heart of everything we do. Our goal is always to provide you with the best plan to fit your needs, and also help you live the healthiest life possible. It's our mission and it drives everything from our customer service to our business decisions. This is about You.

We Love Locals

Howdy, neighbor! We're a regional company based out of Salt Lake City, Utah, with offices in Colorado, Idaho, and Nevada. When you call us, you're talking to a real person familiar with your community.

It's Simple—Satisfaction

There is a reason over 90% of members stay with us every year—we take satisfaction seriously.* We strive to support you, help you stay healthy, and have the right benefits for your needs.

**Based on member retention reporting.*

Medicare basics

What's a Medicare Advantage plan?

Welcome to Medicare! This stuff can be complicated. That's why we want to make deciding on the best plan for you as easy as possible.

So, here's the scenario: You've enrolled in Original Medicare, but now you need to decide if a Medicare Advantage plan is right for you. Well, first off, what is Original Medicare?

Original Medicare—your government plan—includes Part A and Part B.

Part A covers inpatient hospital or facility stays.

Part B covers certain doctors and preventive services and inpatient/outpatient care. You may pay a premium each month for Part B.

Part C is Medicare Advantage, and that means, we combine Parts A+B. Some plans also include Part D.

Part D provides prescription drug coverage only.

Think of Medicare Advantage (Part C) as All-In-One coverage. You get hospital and medical coverage, plus many plans offer supplemental benefits for vision, dental, hearing, and wellness.

When it comes to Medicare, there isn't a one size fits all option. We can help you figure out the right plan for you.

You've got access

Select Health Medicare offers two types of plans—Health Maintenance Organization **(HMO)** and Preferred Provider Organization **(PPO)**.

HMO Network

If you choose a Select Health Medicare HMO plan, it's important to stay in your network. That means, you can go to any provider that is part of our network.

Because we are part of Intermountain Health®, plus affiliations with a vast number of providers and clinics across our service areas, you have access to the best possible care at the best possible prices.

We also cover emergency and urgent care services across the world.

PPO Network

If you choose a Select Health Medicare PPO plan, you can go to any provider or facility that accepts Medicare patients, in- and out-of-network. However, if you see an out-of-network provider, your copay and coinsurance may be higher for covered services. We also cover emergency and urgent care services across the world.

Finding a Provider or Facility

It's always a good idea to check the in-network status of a healthcare provider before getting care. To verify whether a provider is participating on your plan, visit **selecthealth.org/findadoctor** or call **855-442-9900 (TTY: 711)**. If you see an out-of-network provider, you may be responsible to pay excess charges in addition to higher copay and/or coinsurance.

Picking the right plan for you.

Choosing the right Medicare Advantage plan for your unique situation can seem daunting, but it doesn't have to be. Use this guide to determine which Select Health Medicare plan is right for you, then go straight to the Summary of Benefits section for more details.

Scenario 1 You live in Box Elder, Cache, Davis, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, and Weber counties in Utah, or Franklin county in Idaho and want a plan with **$0 monthly premium**, low copays, comprehensive dental included, and lots of wellness perks.

Go to → Select Health Medicare Essential (HMO) 001 8

Scenario 2 You live in Box Elder, Cache, Davis, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, and Weber counties in Utah, or Franklin county in Idaho and want a plan with **richer benefits** with lower copays, comprehensive dental, and expanded wellness perks.

Go to → Select Health Medicare Enhanced (HMO) 007 14

Scenario 3 You live in Davis, Salt Lake, Utah, or Weber counties and you want a plan with **NO** Part D prescription drug coverage, lower Part B premiums, and comprehensive dental.

Go to → Select Health Medicare No Rx (HMO) 016 20

Scenario 4 You live in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, or Weber counties in Utah, and Franklin county in Idaho and want a plan with a **broader network** of providers, $0 monthly premium, comprehensive dental, and lots of wellness perks.

Go to → Select Health Medicare Choice (PPO) 018 26

Scenario 5 You live in Iron, Sanpete, Sevier, or Washington counties in Utah, and want a plan with a **$0 monthly premium**, low copays, comprehensive dental, and lots of wellness perks.

Go to → Select Health Medicare Essential (HMO) 017 32

Scenario 6 You live in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, or Weber counties and want a plan with **$0 monthly premium** and additional **Smith's grocery store benefits**.

Go to → Select Health Medicare + Kroger (HMO) 022 38

Scenario 7 You live in Duchesne, Garfield, Grand, Iron, Juab, Millard, Piute, Sanpete, Sevier, Uintah, Washington, or Wayne counties in Utah, and want a plan with a low monthly premium, low copays, comprehensive dental, and lots of wellness perks.

Go to → Select Health Medicare Classic (HMO) 002 44

Select Health Medicare®

Summary of benefits

Utah 2024

Select Health Medicare Essential (HMO) 001
Select Health Medicare Enhanced (HMO) 007
Select Health Medicare No Rx (HMO) 016
Select Health Medicare Choice (PPO) 018
Select Health Medicare Essential (HMO) 017
Select Health Medicare Kroger (HMO) 022
Select Health Medicare Classic (HMO) 002

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

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

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

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

What is an HMO?

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

What is a PPO?

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

Select Health

Which doctors, hospitals, and pharmacies can I use?

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

Important message about what you pay for vaccines:

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

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

How to contact us

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

Hours of operation:

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

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

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

Select Health Medicare Essential (HMO)

H1994_001

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

BENEFIT	COST
Premium Amount	$0
Medical Deductible	$0
Member Out-of-Pocket Maximum Does not include prescription drugs, comprehensive dental, and hearing aid copays. If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs.	$5,700
Inpatient Hospital Coverage* Copays start over each time you are admitted as an inpatient.	
Days 1-5	$410 copay
Days 6+	$0 copay
Outpatient Hospital Coverage*	
Outpatient surgery	$350 copay
Ambulatory surgical center	$250 copay
Doctor's Office Visits	
Primary care provider	$0 copay
Specialist We do not require referrals.	$15 copay
Preventive Care	
Annual physical/comprehensive wellness visit	$0 copay
Medicare-covered preventive services	$0 copay
Emergency Care (Worldwide) Copay is waived if you are admitted to the hospital within 24 hours.	$100 copay
Urgently Needed Services (Worldwide) 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.	$35 copay
Diagnostic Services, Labs, and Imaging* Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay.	
Diagnostic tests and procedures	$0 copay
Diagnostic colonoscopy	$350 copay
Lab services	$0 copay
Outpatient x-rays	$0 copay
Advanced Imaging (e.g., MRIs, CT scans)	$200 copay
Therapeutic radiology services	20% coinsurance
Other covered services Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.	20% coinsurance
Hearing Services	
Hearing exam related to a medical condition	$15 copay
Routine hearing exam 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.	$299 to $1,799 copay
Dental Services* Limited Medicare-covered dental services related to a medical condition.	$20 copay
Maximum plan payment benefit, includes preventive.	$1,500
Preventive dental services Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months	$0 copay
Basic dental services	$0 copay
Major dental services	$0 copay
Vision Services	
Routine and/or preventive eye exam One per year.	$0 copay
Problem-related eye exam	$20 copay
Vision test for prescriptions	$0 copay
Eyeglasses or contact lenses after cataract surgery*	$0 copay
Frames or contact lenses One purchase per year.	$200 allowance
Inpatient Mental Health Services*	
Days 1-5	$350 copay
Days 6-90	$0 copay
Lifetime reserve days* 1-60	$0 copay
Outpatient Mental Health Services	
Individual therapy	$25 copay
Group therapy	$25 copay
Partial hospitalization for mental health*	$55 copay
Substance Abuse* (Outpatient)	
Individual therapy	$25 copay
Group therapy	$20 copay
Acupuncture Services*	
Treatment of lower back pain. 12 initial visits, and additional 8 visits if member is making progress.	$15 copay

**Service may require prior authorization.*

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

**Service may require prior authorization.*

YOUR PRESCRIPTION BENEFITS

Select Health Medicare Essential (HMO) 001

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

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

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

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

PHARMACY DEDUCTIBLE

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

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

How we help with prescription drug costs.

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

Exclusive plan benefits

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

Dental Coverage

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

Over-The-Counter (OTC) Benefit

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

Hearing Aids

Intermountain Health Hearing, Balance, and Audiology Clinics

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

Tier 1 - Economy | $299

Tier 2 - Essential | $639

Tier 3 - Standard | $949

Tier 4 - Advanced | $1,299

Tier 5 - Premium | $1,799

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

Vision Coverage

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

Wellness Your Way

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

Healthy Living Incentive

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

Papa Pals - Companionship Services

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

Meals After Hospital Stay

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

Select Health Medicare Enhanced (HMO)

H1994_007

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

BENEFIT	COST
Premium Amount	$48
Medical Deductible	$0
Member Out-of-Pocket Maximum Does not include prescription drugs, comprehensive dental, and hearing aid copays. If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs.	$4,700
Inpatient Hospital Coverage* Copays start over each time you are admitted as an inpatient.	
Days 1-4	$350 copay
Days 5+	$0 copay
Outpatient Hospital Coverage*	
Outpatient surgery	$300 copay
Ambulatory surgical center	$200 copay
Doctor's Office Visits	
Primary care provider	$0 copay
Specialist We do not require referrals.	$10 copay
Preventive Care	
Annual physical/comprehensive wellness visit	$0 copay
Medicare-covered preventive services	$0 copay
Emergency Care (Worldwide) Copay is waived if you are admitted to the hospital within 24 hours.	$100 copay
Urgently Needed Services (Worldwide) 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.	$35 copay
Diagnostic Services, Labs, and Imaging* Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay.	
Diagnostic tests and procedures	$0 copay
Diagnostic colonoscopy	$300 copay
Lab services	$0 copay
Outpatient x-rays	$0 copay
Advanced Imaging (e.g., MRIs, CT scans)	$150 copay
Therapeutic radiology services	20% coinsurance
Other covered services Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.	20% coinsurance
Hearing Services	
Hearing exam related to a medical condition	$10 copay
Routine hearing exam 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.	$299 to $1,799 copay
Dental Services* Limited Medicare-covered dental services related to a medical condition.	$20 copay
Maximum plan payment benefit, includes preventive.	$2,000
Preventive dental services Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months	$0 copay
Basic dental services	$0 copay
Major dental services	$0 copay
Vision Services	
Routine and/or preventive eye exam One per year.	$0 copay
Problem related eye exam	$20 copay
Vision test for prescriptions	$0 copay
Eyeglasses or contact lenses after cataract surgery*	$0 copay
Frames or contact lenses One purchase per year.	$200 allowance
Inpatient Mental Health Services*	
Days 1-4	$350 copay
Days 5-90	$0 copay
Lifetime reserve days* 1-60	$0 copay
Outpatient Mental Health Services	
Individual therapy	$20 copay
Group therapy	$15 copay
Partial hospitalization for mental health*	$55 copay
Substance Abuse* (Outpatient)	
Individual therapy	$20 copay
Group therapy	$15 copay

**Service may require prior authorization.*

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

**Service may require prior authorization.*

YOUR PRESCRIPTION BENEFITS

Select Health Medicare Enhanced (HMO) 007

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

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

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

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

PHARMACY DEDUCTIBLE

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

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

How we help with prescription drug costs.

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

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

Exclusive plan benefits

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

Dental Coverage

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

Over-The-Counter (OTC) Benefit

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

Hearing Aids

Intermountain Health Hearing, Balance, and Audiology Clinics

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

Tier 1 - Economy | $299

Tier 2 - Essential | $639

Tier 3 - Standard | $949

Tier 4 - Advanced | $1,299

Tier 5 - Premium | $1,799

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

Vision Coverage

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

Wellness Your Way

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

Healthy Living Incentive

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

Papa Pals - Companionship Services

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

Meals After Hospital Stay

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

Select Health Medicare No Rx (HMO)

H1994_016

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

BENEFIT	COST
Premium Amount	$0
Medical Deductible	$0
Member Out-of-Pocket Maximum Does not include prescription drugs, comprehensive dental, and hearing aid copays. If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs.	$6,700
Inpatient Hospital Coverage* Copays start over each time you are admitted as an inpatient.	
Days 1-5	$360 copay
Days 6+	$0 copay
Outpatient Hospital Coverage*	
Outpatient surgery	$350 copay
Ambulatory surgical center	$250 copay
Doctor's Office Visits	
Primary care provider	$0 copay
Specialist We do not require referrals.	$40 copay
Preventive Care	
Annual physical/comprehensive wellness visit	$0 copay
Medicare-covered preventive services	$0 copay
Emergency Care (Worldwide) Copay is waived if you are admitted to the hospital within 24 hours.	$100 copay
Urgently Needed Services (Worldwide) 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.	$30 copay
Diagnostic Services, Labs, and Imaging* Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay.	
Diagnostic tests and procedures	$0 copay
Diagnostic colonoscopy	$350 copay
Lab services	$0 copay
Outpatient x-rays	$0 copay
Advanced Imaging (e.g., MRIs, CT scans)	$150 copay
Therapeutic radiology services	20% coinsurance
Other covered services Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.	20% coinsurance
Hearing Services	
Hearing exam related to a medical condition	$40 copay
Routine hearing exam 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.	$299 to $1,799 copay
Dental Services* Limited Medicare-covered dental services related to a medical condition.	$40 copay
Maximum plan payment benefit, includes preventive.	$1,500
Preventive dental services Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months	$0 copay
Basic dental services	$0 copay
Major dental services	$0 copay
Vision Services	
Routine and/or preventive eye exam One per year.	$0 copay
Problem related eye exam	$40 copay
Vision test for prescriptions	$0 copay
Eyeglasses or contact lenses after cataract surgery*	$0 copay
Frames or contact lenses One purchase per year.	$200 allowance
Mental Health Services	
Days 1-5	$360 copay
Days 6-90	$0 copay
Lifetime reserve days* 1-60	$0 copay
Outpatient Mental Health Services	
Individual therapy	$25 copay
Group therapy	$15 copay
Partial hospitalization for mental health*	$55 copay
Substance Abuse* (Outpatient)	
Individual therapy	$25 copay
Group therapy	$15 copay
Acupuncture Services* (Medicare Covered)	
Treatment of lower back pain. 12 initial visits, and additional 8 visits if member is making progress.	$20 copay

**Service may require prior authorization.*

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

**Service may require prior authorization.*

Exclusive plan benefits

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

Dental Coverage

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

Over-The-Counter (OTC) Benefit

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

Hearing Aids

Intermountain Health Hearing, Balance, and Audiology Clinics

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

Tier 1 - Economy | $299

Tier 2 - Essential | $639

Tier 3 - Standard | $949

Tier 4 - Advanced | $1,299

Tier 5 - Premium | $1,799

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

Vision Coverage

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

Wellness Your Way

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

Healthy Living Incentive

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

Papa Pals - Companionship Services

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

Meals After Hospital Stay

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

Notes

Select Health Medicare Choice (PPO)

H2246_018

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

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Premium Amount	$0	
Medical Deductible	$0	
Member Out-of-Pocket Maximum Does not include prescription drugs, comprehensive dental, and hearing aid copays. If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs.	$5,700	$9,550 combined with In-Network Member Out-of-Pocket Maximum
Inpatient Hospital Coverage* Copays start over each time you are admitted as an inpatient.		
Days 1-5	$420 copay	30% coinsurance
Days 6+	$0 copay	30% coinsurance
Outpatient Hospital Coverage*		
Outpatient surgery	$360 copay	30% coinsurance
Ambulatory surgical center	$260 copay	30% coinsurance
Doctor's Office Visits		
Primary care provider	$0 copay	30% coinsurance
Specialist We do not require referrals.	$20 copay	30% coinsurance
Preventive Care		
Annual physical/comprehensive wellness visit	$0 copay	$0 copay
Medicare-covered preventive services	$0 copay	$0 copay
Emergency Care (Worldwide) Copay is waived if you are admitted to the hospital within 24 hours.	$100 copay	$100 copay
Urgently Needed Services (Worldwide) 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.	$35 copay	$35 copay
Diagnostic Services, Labs, and Imaging* Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay.		
Diagnostic tests and procedures	$0 copay	30% coinsurance
Diagnostic colonoscopy	$360 copay	30% coinsurance
Lab services	$0 copay	30% coinsurance
Outpatient x-rays	$0 copay	30% coinsurance
Advanced Imaging (e.g., MRIs, CT scans)	$200 copay	30% coinsurance
Therapeutic radiology services	20% coinsurance	30% coinsurance
Other covered services Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.	20% coinsurance	30% coinsurance
Hearing Services		
Hearing exam related to a medical condition	$20 copay	30% coinsurance
Routine hearing exam One per year.	$0 copay	30% coinsurance
Hearing aids 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* Limited Medicare-covered dental services related to a medical condition.	$25 copay	30% coinsurance
Maximum plan payment benefit, includes preventive.	$1,500	Combined with in-network
Preventive dental services Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months	$0 copay	10% coinsurance
Basic dental services	$0 copay	10% coinsurance
Major dental services	$0 copay	10% coinsurance
Vision Services		
Routine and/or preventive eye exam One per year.	$0 copay	$35 Reimbursement for EyeMed
Problem related eye exam	$25 copay	30% coinsurance
Vision test for prescriptions	$0 copay	$35 Reimbursement for EyeMed
Eyeglasses or contact lenses after cataract surgery*	$0 copay	
Frames or contact lenses One purchase per year.	$200 allowance	$200 Reimbursement for EyeMed
Inpatient Mental Health Services*		
Days 1-5	$370 copay	30% coinsurance
Days 6-90	$0 copay	30% coinsurance
Lifetime reserve days* 1-60	$0 copay	30% coinsurance
Outpatient Mental Health Services		
Individual therapy	$25 copay	30% coinsurance
Group therapy	$15 copay	30% coinsurance
Partial hospitalization for mental health*	$55 copay	30% coinsurance

**Service may require prior authorization.*

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Substance Abuse* (Outpatient)		
Individual therapy	$25 copay	30% coinsurance
Group therapy	$15 copay	30% coinsurance
Acupuncture Services*		
Treatment of lower back pain. 12 initial visits, and additional 8 visits if member is making progress.	$20 copay	30% coinsurance Limits are combined for both in-network and out-of-network benefits
Ambulance* Prior authorization only required for non-emergency transfers.	$225 copay	$225 copay
Chiropractic Care*	$15 copay	30% coinsurance
Diabetes Specific Benefits		
Primary care provider In-person or through telehealth.	$0 copay	30% coinsurance
Routine eye exam	$0 copay	$35 Reimbursement for EyeMed
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
Select diabetes drugs in Tier 1 and Tier 2 (non-insulin)	Covered through the gap	N/A
Continuous Glucose Monitors (CGM)*	$0 copay	N/A
Part B insulin pumps and supplies	20% coinsurance	30% coinsurance
Insulin		
Tier 3 and Tier 4 insulin 30-day supply in all Part D stages. Coverage Gap and deductible do not apply to insulins.	$35 copay	N/A
Part B pump insulin For use in a pump.	0-20% coinsurance up to max $35 copay per month	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 Limits are combined for both in-network and out-of-network benefits
Home Health Care*	$0 copay	30% coinsurance
Hospice	Covered by Original Medicare	Not covered
Intermountain Connect Care Visit with a provider via video chat for urgent medical needs.	$0 copay	N/A
Intermountain LiVe Well Center Programs	$0 copay	N/A
Meals after discharge* After discharge from an inpatient acute hospital or skilled nursing facility.	$0 copay, up to 14 days (2 meals per day)	N/A
Medical Equipment and Supplies		
Crutches, canes, and walkers	$0 copay	30% coinsurance
All other durable medical equipment (e.g., wheelchairs, oxygen, etc.)*	20% coinsurance	30% coinsurance
Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)*	20% coinsurance	30% coinsurance
Medicare Part B Drugs* Includes chemotherapy drugs, and other Part B drugs and biologics.	0-20% coinsurance	30% coinsurance
Insulin for use with insulin pumps	0-20% coinsurance up to max $35 copay per month	30% coinsurance
Over-the-Counter (OTC) Items Receive money on your pre-loaded Flex Card for OTC items. Amounts do not roll over.	$75 allowance per quarter	N/A
Papa Pals Companionship Services	$0 copay, up to 30 hours a year	N/A
Rehabilitation Services* (Outpatient)		
Physical, occupational, and speech therapy visits.	$30 copay	30% coinsurance
Cardiac rehab services	$0 copay	30% coinsurance
Pulmonary rehab services	$10 copay	30% coinsurance
Renal Dialysis Including services and supplies for home dialysis.	20% coinsurance	30% 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	30% coinsurance
Days 21-55	$203 copay	30% coinsurance
Days 56-100	$0 copay	30% coinsurance
Telehealth Services		
Telehealth visit with a primary care provider	$0 copay	30% coinsurance
Telehealth visit with a specialist	$20 copay	30% coinsurance
Wellness Your Way Receive money on your pre-loaded Flex Card for approved wellness services such as gym/health club memberships, health education, nutritional benefits, weight management programs, etc.	$260 per year	N/A

**Service may require prior authorization.*

YOUR PRESCRIPTION BENEFITS

Select Health Medicare Choice (PPO) 018

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

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

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

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

PHARMACY DEDUCTIBLE

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

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

How we help with prescription drug costs.

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

Exclusive plan benefits

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

Dental Coverage

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

Over-The-Counter (OTC) Benefit

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

Hearing Aids

TruHearing

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

Tier 1 - Advanced | $499

Tier 2 - Premium | $799

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

Vision Coverage

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

Wellness Your Way

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

Healthy Living Incentive

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

Papa Pals - Companionship Services

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

Meals After Hospital Stay

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

Select Health Medicare Essential (HMO)

H1994_017

Iron, Sanpete, Sevier and Washington counties in Utah.

BENEFIT	COST
Premium Amount	$0
Medical Deductible	$0
Member Out-of-Pocket Maximum Does not include prescription drugs, comprehensive dental, and hearing aid copays. If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs.	$5,700
Inpatient Hospital Coverage* Copays start over each time you are admitted as an inpatient.	
Days 1-4	$475 copay
Days 5+	$0 copay
Outpatient Hospital Coverage*	
Outpatient surgery	$400 copay
Ambulatory surgical center	$300 copay
Doctor's Office Visits	
Primary care provider	$0 copay
Specialist We do not require referrals.	$15 copay
Preventive Care	
Annual physical/comprehensive wellness visit	$0 copay
Medicare-covered preventive services	$0 copay
Emergency Care (Worldwide) Copay is waived if you are admitted to the hospital within 24 hours.	$100 copay
Urgently Needed Services (Worldwide) 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.	$30 copay
Diagnostic Services, Labs, and Imaging* Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay.	
Diagnostic tests and procedures	$0 copay
Diagnostic colonoscopy	$400 copay
Lab services	$0 copay
Outpatient x-rays	$0 copay
Advanced Imaging (e.g., MRIs, CT scans)	$200 copay
Therapeutic radiology services	20% coinsurance
Other covered services Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.	20% coinsurance
Hearing Services	
Hearing exam related to a medical condition	$15 copay
Routine hearing exam 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.	$499 to $799 copay
Dental Services* Limited Medicare-covered dental services related to a medical condition.	$20 copay
Maximum plan payment benefit, includes preventive.	$1,500
Preventive dental services Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months	$0 copay
Basic dental services	$0 copay
Major dental services	$0 copay
Vision Services	
Routine and/or preventive eye exam One per year.	$0 copay
Problem related eye exam	$20 copay
Vision test for prescriptions	$0 copay
Eyeglasses or contact lenses after cataract surgery*	$0 copay
Frames or contact lenses One purchase per year.	$200 allowance
Inpatient Mental Health Services*	
Days 1-4	$465 copay
Days 5-90	$0 copay
Lifetime reserve days* 1-60	$0 copay
Outpatient Mental Health Services	
Individual therapy	$20 copay
Group therapy	$15 copay
Partial hospitalization for mental health*	$55 copay
Substance Abuse* (Outpatient)	
Individual therapy	$20 copay
Group therapy	$15 copay
Acupuncture Services*	
Treatment of lower back pain. 12 initial visits, and additional 8 visits if member is making progress.	$15 copay

**Service may require prior authorization.*

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

**Service may require prior authorization.*

YOUR PRESCRIPTION BENEFITS

Select Health Medicare Essential (HMO) 017

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

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

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

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

PHARMACY DEDUCTIBLE

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

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

How we help with prescription drug costs.

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

Exclusive plan benefits

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

Dental Coverage

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

Over-The-Counter (OTC) Benefit

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

Hearing Aids

TruHearing

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

Tier 1 - Advanced | $499

Tier 2 - Premium | $799

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

Vision Coverage

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

Wellness Your Way

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

Healthy Living Incentive

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

Papa Pals - Companionship Services

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

Meals After Hospital Stay

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

Select Health Medicare + Kroger (HMO)

H1994_022

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

BENEFIT	COST
Premium Amount	$0
Medical Deductible	$0
Member Out-of-Pocket Maximum Does not include prescription drugs, comprehensive dental, and hearing aid copays. If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs.	$5,700
Inpatient Hospital Coverage* Copays start over each time you are admitted as an inpatient.	
Days 1-5	$410 copay
Days 6+	$0 copay
Outpatient Hospital Coverage*	
Outpatient surgery	$350 copay
Ambulatory surgical center	$250 copay
Doctor's Office Visits	
Primary care provider	$0 copay
Specialist We do not require referrals.	$15 copay
Preventive Care	
Annual physical/comprehensive wellness visit	$0 copay
Medicare-covered preventive services	$0 copay
Emergency Care (Worldwide) Copay is waived if you are admitted to the hospital within 24 hours.	$100 copay
Urgently Needed Services (Worldwide) 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.	$35 copay
Diagnostic Services, Labs, and Imaging* Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay.	
Diagnostic tests and procedures	$0 copay
Diagnostic colonoscopy	$350 copay
Lab services	$0 copay
Outpatient x-rays	$0 copay
Advanced Imaging (e.g., MRIs, CT scans)	$200 copay
Therapeutic radiology services	20% coinsurance
Other covered services Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.	20% coinsurance
Hearing Services	
Hearing exam related to a medical condition	$15 copay
Routine hearing exam 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.	$499 to $799 copay
Dental Services* Limited Medicare-covered dental services related to a medical condition.	$20 copay
Maximum plan payment benefit, includes preventive.	$1,500
Preventive dental services Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months	$0 copay
Basic dental services	$0 copay
Major dental services	$0 copay
Vision Services	
Routine and/or preventive eye exam One per year.	$0 copay
Problem related eye exam	$20 copay
Vision test for prescriptions	$0 copay
Eyeglasses or contact lenses after cataract surgery*	$0 copay
Frames or contact lenses One purchase per year.	$200 allowance
Inpatient Mental Health Services*	
Days 1-5	$350 copay
Days 6-90	$0 copay
Lifetime reserve days* 1-60	$0 copay
Outpatient Mental Health Services	
Individual and group therapy	$25 copay
Partial hospitalization for mental health*	$55 copay
Substance Abuse* (Outpatient)	
Individual therapy	$25 copay
Group therapy	$20 copay
Acupuncture Services*	
Treatment of lower back pain. 12 initial visits, and additional 8 visits if member is making progress.	$15 copay

**Service may require prior authorization.*

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

**Service may require prior authorization.*

YOUR PRESCRIPTION BENEFITS

Select Health Medicare + Kroger (HMO) 022

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

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

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

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

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

PHARMACY DEDUCTIBLE

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

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

How we help with prescription drug costs.

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

Exclusive plan benefits

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

Over-The-Counter (OTC) and Grocery Benefit

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

Dental Coverage

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

Hearing Aids

TruHearing

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

Tier 1 - Advanced | $499

Tier 2 - Premium | $799

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

Vision Coverage

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

Wellness Your Way

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

Healthy Living Incentive

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

Meals After Hospital Stay

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

Papa Pals - Companionship Services

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

Select Health Medicare Classic (HMO)

H1994_002

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

BENEFIT	COST
Premium Amount	$29
Medical Deductible	$0
Member Out-of-Pocket Maximum Does not include prescription drugs, comprehensive dental, and hearing aid copays. If you reach the limit on out-of-pocket costs, you're covered 100% for the rest of the year. You will still need to pay monthly premiums and cost-sharing for your Part D drugs.	$6,700
Inpatient Hospital Coverage* Copays start over each time you are admitted as an inpatient.	
Days 1-5	$410 copay
Days 6+	$0 copay
Outpatient Hospital Coverage*	
Outpatient surgery	$380 copay
Ambulatory surgical center	$280 copay
Doctor's Office Visits	
Primary care provider	$0 copay
Specialist We do not require referrals.	$40 copay
Preventive Care	
Annual physical/comprehensive wellness visit	$0 copay
Medicare-covered preventive services	$0 copay
Emergency Care (Worldwide) Copay is waived if you are admitted to the hospital within 24 hours.	$100 copay
Urgently Needed Services (Worldwide) 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.	$25 copay
Diagnostic Services, Labs, and Imaging* Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay.	
Diagnostic tests and procedures	$0 copay
Diagnostic colonoscopy	$380 copay
Lab services	$0 copay
Outpatient x-rays	$0 copay
Advanced Imaging (e.g., MRIs, CT scans)	$320 copay
Therapeutic radiology services	20% coinsurance
Other covered services Includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.	20% coinsurance
Hearing Services	
Hearing exam related to a medical condition	$40 copay
Routine hearing exam 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.	$499 to $799 copay
Dental Services* Limited Medicare-covered dental services related to a medical condition.	$40 copay
Maximum plan payment benefit, includes preventive.	$2,000
Preventive dental services Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 36 months	$0 copay
Basic dental services	$0 copay
Major dental services	$0 copay
Vision Services	
Routine and/or preventive eye exam One per year.	$0 copay
Problem related eye exam	$40 copay
Vision test for prescriptions	$0 copay
Eyeglasses or contact lenses after cataract surgery*	$0 copay
Frames or contact lenses One purchase per year.	$200 allowance
Inpatient Mental Health Services*	
Days 1-4	$395 copay
Days 5-90	$0 copay
Lifetime reserve days* 1-60	$0 copay
Outpatient Mental Health Services	
Individual	$40 copay
Group therapy	$40 copay
Partial hospitalization for mental health*	$55 copay
Substance Abuse* (Outpatient)	
Individual therapy	$50 copay
Group therapy	$40 copay
Acupuncture Services*	
Treatment of lower back pain. 12 initial visits, and additional 8 visits if member is making progress.	$20 copay

**Service may require prior authorization.*

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

**Service may require prior authorization.*

YOUR PRESCRIPTION BENEFITS

Select Health Medicare Classic (HMO) 002

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

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

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

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

PHARMACY DEDUCTIBLE

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

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

How we help with prescription drug costs.

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

Exclusive plan benefits

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

Dental Coverage

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

Over-The-Counter (OTC) Benefit

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

Hearing Aids

TruHearing

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

Tier 1 - Advanced | $499

Tier 2 - Premium | $799

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

Vision Coverage

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

Wellness Your Way

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

Healthy Living Incentive

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

Papa Pals - Companionship Services

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

Meals After Hospital Stay

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

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

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

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

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-855-442-9900**。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，爲此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-855-442-9900**。我們講中文的人員將樂意爲您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-855-442- 9900**. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-855-442-9900.** Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-855-442-9900** sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-855-442-9900**. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-855-442-9900** 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-855-442-9900**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية لإلجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-855-442-9900.** سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-855-442-9900** पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-855-442-9900**. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-855-442-9900**. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-855-442-9900**. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-855-442-9900**. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-855-442-9900** にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

Form CMS-10802

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

Select Health

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

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats.

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

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Select Health Medicare flexible benefits card

We have partnered with NationsBenefits® to combine our wellness benefits and incentives into a single program. Your Select Health Medicare Flexible Benefits card is a prepaid and re-loadable MasterCard®, but it's not a credit card.

You can use this card to pay for eligible items and services. Plus, we can add funds to your card when you complete certain activities.

Healthy Living

You can earn rewards for keeping up with wellness activities like annual routine physicals and flu shots. Visit **selecthealth.org** for a list of potential activities and the amounts you can earn.

- Once you complete activities, you don't have to do a thing. We will automatically add your reward to your account balance. Rewards are applied when Select Health receives confirmation reporting usually within 4-6 weeks of activity completion.
- These funds are the most flexible of all, and offer many unique ways in which you can spend, like buying healthy groceries, that fancy smart watch you've been eyeing, or even your utilities or cell phone bill.
- You can earn Healthy Living rewards all year long. This balance will expire at the end of the year, so remember to use it by **December 31, 2024**.

How to use your benefits

Wellness Your Way

With Wellness Your Way, you're free to manage your health your way. Choose and pay for wellness activities that help you live a healthier life.

- You can pay for expenses like gym memberships, approved weight loss programs, nutritional services, health education classes, and home or bathroom safety devices. Plus, enjoy unique activities like golf green fees, ski lift passes, and national parks passes.
- We will load your Wellness Your Way balance onto your card at the beginning of the year. This balance will expire at the end of the year, so remember to use it by **December 31, 2024**.

Over-The-Counter (OTC) benefit

You have access to a variety of brand-name and generic health and wellness products with your OTC benefit through NationsOTC®.

- The OTC benefit covers many everyday health items like pain relievers, vitamins and minerals (e.g., fish oil, calcium, multivitamins), bandages, antibiotic ointment, toothbrushes, toothpaste, dental floss, cough drops, cotton swabs, antacids, lotion, eye drops, first aid supplies, and more! Visit **selecthealthmedicare.org** for a list of covered items.
- You can use your card to make purchases at local retailers, or you can submit OTC orders online, by phone, or by mail.
- Depending on your plan, your OTC balance will be loaded monthly or quarterly. On some plans the OTC allowance is combined with other benefits to maximize flexibility. Please check the summary of benefits for details.

MyBenefits portal

Managing your flexible benefits

Managing your flexible benefits can be easily done through **selecthealth.nationsbenefits.com** or by downloading the MyBenefits app.

Through the portal, you can view your benefit-specific information and easily:

- Activate and manage your Select Health Flexible Benefits card
- Review your account balance
- Check for eligible products and services
- Order health and wellness products
- Search for retail locations that accept your card
- Track order and transaction history
- Request reimbursement

Flexible Benefits Card support

NationsBenefits Member Experience Advisors are ready to serve you 24/7/365.

You can call **833-878-0232 (TTY: 711)** or visit **selecthealth.nationsbenefits.com**.

Healthy Living rewards can be earned all year long, but this balance will expire at the end of the year, so it must be used by **December 31, 2024**.

Prescription Drug coverage on HMO and PPO plans

Understanding Part D

This section applies to Select Health Medicare HMO and PPO plans: Classic, Essential, Enhanced, Kroger, and Choice. Part D benefits are automatically included in these plans at no additional cost.

Choosing the Select Health Medicare No Rx plan? Remember:

If you choose the Select Health Medicare No Rx (HMO) plan, it does not include Part D prescription drug coverage.

What Are Tiers?

Prescription drugs are grouped into tiers on formularies that show you which drugs are covered on your plan. The tier for any medication you take determines the cost of that drug.

$ **Tier 1** – Preferred Generic Drugs

$$ **Tier 2** – Generic Drugs

$$$ **Tier 3** – Preferred Brand Drugs

$$$$ **Tier 4** – Non-Preferred Drugs

$$$$$ **Tier 5** – Specialty Drugs

Not sure which tier your medication is on or how much it will cost?

Let us help check your prescriptions and see how much you can save on a Select Health Medicare plan. Call us at **855-442-9940 (TTY: 711)** for a no-cost, no-obligation prescription check!

You can also view our formulary and use our Drug Look Up tool online at **selecthealth.org/medicare**.

Need help with prescription costs?

Medicare may be able to help you pay for your medications. If your yearly income and resources are below certain financial limits, you may qualify for Extra Help.

To see if you qualify, call:

- 800-MEDICARE **(800-633-2048)**, 24 hours a day, 7 days a week. TTY users, please call **877-486-2048**. You can also visit **medicare.gov** or "Programs for People with Limited Income and Resources" in your *Medicare and You* handbook.
- Your local Social Security office
- Your local state Medicaid office
- Select Health has additional resources to help you with prescription drug costs. For help, call us at **855-442-9940 (TTY: 711)**.

There are four coverage stages:

Stage 1 – Deductible

This is the amount you must pay for your brand-name and generic drugs *before* your plan starts paying. You will pay the full amount for your drugs until the deductible is reached.

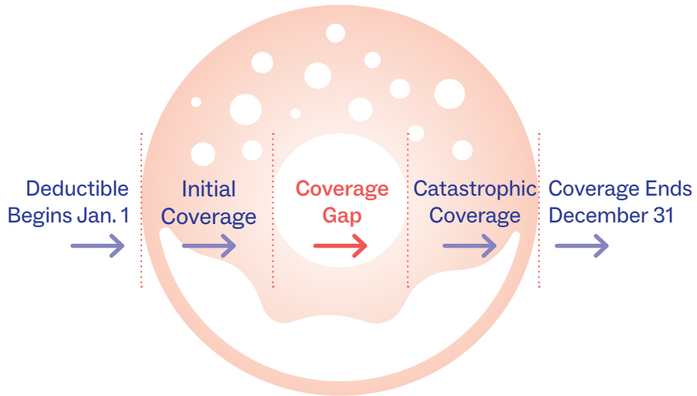
Remember: Select Health Medicare plans **do not have a deductible for Tier 1 and 2 drugs**. Coverage for these drugs starts in Stage 2. That means you will only have to pay your deductible for Tier 3, 4, and 5 drugs.

Stage 2 – Initial Coverage

During this stage, you pay your copay and we pay the rest. You stay in this stage until the amount of your year-to-date **total drug costs reach the yearly amount set by Medicare**. For 2024, this is **$5,030**. The total drug costs include what you pay AND what we pay for prescriptions.

Stage 3 – Coverage Gap (Donut Hole)

You stay in this stage until the amount you pay for prescriptions reaches the threshold Medicare has established. For 2024, this is **$8,000**.



Remember: Our plans feature additional coverage while you're in this stage. See the Summary of Benefits section for more details.

Stage 4 – Catastrophic Coverage

During this stage, the plan pays the full cost for your covered drugs. You stay in this stage for the rest of the calendar year through December 31. **You pay nothing.**

Intermountain Home Delivery Pharmacy

Select Health offers contactless mail-order prescriptions with **Intermountain Home Delivery Pharmacy**. They will deliver straight to your door within five days of receiving your prescription, with no additional cost to you. They will also work with your provider and current pharmacy to make transferring your prescriptions easy. Call **855-779-3960 (TTY: 711)** for help getting started.

Select Health Medicare Advantage resources

To get the answers you need, here is a list of our partner organizations and resources.

Benefit	Partner	Contact
Vision exams, glasses, and contacts	EyeMed (Access Network)	**844-872-8868** **eyemed.com**
Dental benefits	Select Health Dental	**855-442-9900**
Hearing testing and hearing aids	Intermountain Health Audiology TruHearing	**855-442-9900** **866-201-9695**
24/7 online care healthcare	Intermountain Connect Care	**intermountainconnectcare.org**
Friendship, transportation, technology assistance, and home tasks	Papa Pals	**888-452-4553** **papa.com**
Over-the-Counter (OTC) medications Wellness Your Way Healthy Living Transportation	NationsBenefits (Flex Card)	**833-878-0232** **selecthealth.nationsbenefits.com**
Prescription drug home delivery	Intermountain Home Delivery Pharmacy	**855-779-3960** **homedeliveryrx@imail.org** **intermountainhealthcare.org/services/pharmacy/home-delivery/**
Reduced prescription costs	Rx Savings Solutions	**selecthealth.org/rxsavings**
Find a doctor and make appointments	Select Health Member Advocates	**800-515-2220**

Select Health Medicare Benefits

855-442-9900 (TTY: 711)

selecthealth.org/medicare

Medicare

medicare.gov

1-800-MEDICARE **(800-633-4227)**

TTY – **877-486-2048**

What's next?

Now that you've picked a plan, what happens next? If you've decided to enroll in a Select Health Medicare plan, let's get to know each other! We would like to chat with you to make sure you understand everything about your soon-to-be plan and benefits.

How to enroll

Call Us. Enroll over the phone by calling toll-free at **855-442-9940 (TTY: 711)**.

Contact Your Agent. A Select Health-appointed agent can help you enroll. If you do not have an agent, call us for help getting connected with an agent.

Go Online. Visit us at **selecthealth.org/medicare** and click on "ENROLL NOW" to complete the online application.

After enrolling

After you enroll, you'll receive a confirmation email and letter informing you that your enrollment application was processed. Once your plan is active, we'll send you a welcome kit containing all the information you need to use your benefits.

Remember, if you're enrolling during the Annual Enrollment Period (AEP), your plan won't be effective until January 1. If you are enrolling during the Open Enrollment Period (OEP) or a Special Enrollment Period (SEP), your plan will become effective the first day of the next month.

Following your enrollment your agent may help you complete your health risk assessment, helping you earn healthy living dollars. You may also complete this directly with Select Health within the first 60 days of your enrollment.

We're always just a call away

At any time, if you need help with your plan, benefits, finding a doctor, or scheduling an appointment, call our Member Services team at **855-442-9900 (TTY: 711)** and we'll be happy to assist you!

Pre-Enrollment checklist

Before making an enrollment decision, it's important that you fully understand our benefits and rules. If you have any questions, you can call and speak to an Answer Team member at **855-442-9940 (TTY: 711)**.

Understanding the benefits:

- Review the full list of benefits found in the Evidence of Coverage, especially for those services for which you routinely see a doctor. Visit **selecthealth.org/medicare** or call **855-442-9940 (TTY: 711)** to view a copy of the EOC.
- Review the provider directory.
  - HMO: Review the provider directory (or ask your doctors) to make sure the doctors you see are in the network. If they are not listed, you will likely have to select new doctors.
  - PPO: Review the provider directory (or ask your doctors) to make sure the doctors you see are in the network. If they are not listed, you will likely have to select new doctors to receive the preferred benefit. Out-of-network doctors are not obligated to treat plan members, except in emergencies. 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.
- Review the plan formulary. The formulary is a list of generic and brand-name prescription drugs covered by the health plan. The formulary also reviews the different tiers of the drug plan, the drugs that fall within each tier, and your cost.

Understanding Important Rules:

- In addition to your monthly plan premium (if you have one), you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums, and/or copayments/ co-insurance may change on January 1, 2024.
- Emergency Situations.
  - HMO: Except in emergency or urgent situations, we do not cover services performed by out-of-network providers (doctors who are not listed in the provider directory)
  - PPO: Except in an emergency, out-of-network providers are not obligated to treat a plan member. 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.

Understanding the Effect on Current Coverage

- If you are currently enrolled in an MA plan, your current MA healthcare coverage will end once your new MA coverage starts.
- If you are currently enrolled in Original Medicare, your MA coverage will begin the first day of the month designated by your enrollment. All medical claims and payments will be processed by your MA plan.
- If you have Tricare, your coverage may be affected once your new MA coverage starts. Please contact your sales agent or Tricare for more information.
- If you have a Medigap plan, once your MA coverage starts, you may want to drop your Medigap plan because you will be paying for coverage you cannot use.
- If you have Employer Group coverage, your coverage may be affected once your new MA coverage starts. Please contact your employer or your sales agent for more information.

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or their authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.

(Refer to page 2 for product descriptions)

☐ Stand-alone Medicare Prescription Drug Plans (Part D)
☐ Hospital Indemnity Products
☐ Medicare Advantage Plans (Part C)
☐ Medicare Supplement (Medigap)
☐ Dental/Vision/Hearing Products

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They **do not** work directly for the Federal Government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE AND SIGNATURE DATE:	
Signature	Signature Date
IF YOU ARE THE AUTHORIZED REPRESENTATIVE, PLEASE SIGN ABOVE AND PRINT BELOW.	
Representative's Name	Your Relationship to the Beneficiary

TO BE COMPLETED BY AGENT:	
Agent Name	Agent Phone
Beneficiary Name	Beneficiary Phone (Optional)
Beneficiary Address (Optional)	
Initial Method of Contact (Indicate here if the beneficiary was a walk-in)	
Agent's Signature	
Plan(s) the Agent Represented During This Meeting	Date Appointment Completed
CMS requires that there is at least a 48-hour period between the initiation of a SOA and the meeting with the agent. There are two exceptions to the 48-hour rule which are: A) When the request for an appointment is within four days of the end of a valid election period. B) When a beneficiary initiates an unscheduled in-person meeting.	

Scope of Appointment documentation is subject to CMS record retention requirements.

STAND-ALONE MEDICARE PRESCRIPTION DRUG PLANS (PART D)
Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-For-Service Plans, and Medicare Medical Savings Account Plans.
MEDICARE ADVANTAGE PLANS (PART C) AND COST PLANS
Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).
Medicare HMO Point-of-Service (HMO-POS) Plans — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copayment or coinsurance.
Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.
Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital, and provider that accepts the plan's payment, terms and conditions, and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.
Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.
Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.
Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.
OTHER RELATED PRODUCTS
Dental/Vision/Hearing Products — Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans are not affiliated or connected to Medicare.
Hospital Indemnity Products — Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans are not affiliated or connected to Medicare.
Medicare Supplement (Medigap) Products — Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and coinsurance amounts for Medicare-approved services.

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Select Health

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