Understanding all the details of a plan can be confusing. 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.”

FREQUENTLY ASKED QUESTIONS

Q: Who can join SelectHealth Advantage (HMO)?
A: To join, you must be enrolled in Medicare Part A and Part B and live in one of our service areas:
We have two service areas:
• Magic Valley: Twin Falls county in Idaho.
• South Central Idaho: Cassia, Gooding, Jerome, and Minidoka counties in Idaho.

Q: When can I enroll?
A: You may be eligible to enroll in SelectHealth Advantage if:
> You qualify for a Special Enrollment Period (SEP). Here are a few ways to qualify:
  • You have Medicare and Medicaid
  • You receive Extra Help from the government towards your drug costs
  • You move to a new state or county service area
  • You lose your employer group health coverage
> You qualify for a Medicare Advantage plan if:
  • You lose your employer group health coverage

Q: What’s a prior authorization?
A: A prior authorization is an approval required for some services. Since we seek to improve the healthcare experience, in-network providers are responsible to get a prior authorization for you on required services. So, as long as you see in-network providers, you won’t have to worry about submitting a prior authorization. If you see an out-of-network provider, you may need to work with your provider to get it sent to us.

Q: How much is the monthly premium and is there a limit to how much I’ll have to pay?
A: Your monthly premium depends on which service area you live in. Look at the “Premium Amount” section of the benefits table to find out the premium for your plan. Like most Medicare Advantage health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Take a look at the “Member Out-Of-Pocket Maximum” section of the benefits tables to find out the amount for your plan.

Q: How much is the monthly premium and is there a limit to how much I’ll have to pay?
A: Your monthly premium depends on which service area you live in. Look at the “Premium Amount” section of the benefits table to find out the premium for your plan. 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.

Q: What does SelectHealth Advantage cover?
A: Our plan offers members more benefits than Original Medicare. In addition to our built-in benefits, our plans offer:
> Part D prescription drugs, plus drugs that fall under Part B, like chemotherapy and some medications prescribed by your doctor. Visit our website to view our complete drug formulary.
> Bonus perks like wellness reimbursements, hearing aids, companionship services, and preventive/comprehensive dental and vision options.
> Fixed copays and a yearly out-of-pocket maximum. That means you have predictable costs for visits and services. And unlike Original Medicare, there is a cap for what you’ll have to pay out-of-pocket every year.

Q: How will I determine my drug costs?
A: For plans with prescription drug coverage, our plan categorizes each covered medication into one of five “tiers.” You will need to review our current drug formulary to find out which tier your medications are on and how much they will cost you. Most generics fall into lower-cost Tiers 1 and 2. The amount you pay will depend on the drug’s tier and what stage of the benefit you have reached. Visit the Prescription Drug section of the guide to learn more about the benefit stages.

Q: Are referrals required?
A: Nope! There are no referrals required when you see an in-network provider.

Q: How much is the monthly premium and is there a limit to how much I’ll have to pay?
A: Your monthly premium depends on which service area you live in. Look at the “Premium Amount” section of the benefits table to find out the premium for your plan. Like most Medicare Advantage health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Take a look at the “Member Out-Of-Pocket Maximum” section of the benefits tables to find out the amount for your plan.

HOW TO CONTACT US

Call us toll-free at 855-442-9940 (TTY: 711) or visit our website at 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.
**Magic Valley 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.

---

**Wellness Your Way Reimbursement**

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We’ll reimburse you up to $240 per year for participating in wellness activities.

**What’s a wellness activity?**

- Gym memberships (including classes not included in your membership)
- Approved weight loss programs such as The Weigh to Health®, Weight Watchers, and Jenny Craig
- Nutritional services like dietitian and nutritional counseling services
- Health education classes
- Cooking classes
- Dance lessons
- Race entry fees
- Home safety equipment

You’re free to manage your health—your way. We encourage you to be creative about how you use this benefit. What’s important is that you feel healthy, and a little motivation never hurts.

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**Healthy Living Program**

Our Healthy Living program rewards you for completing activities that keep you healthy—it’s that simple. The program is designed to support you in keeping up with your health by getting preventive care like wellness visits with your Primary Care Provider (PCP) and getting vaccinations.

**How does it work?**

1. You complete an activity listed below
2. Once we process the claim, your SelectHealth account is credited the appropriate number of points.
3. Log in (or call us) to redeem your points for a gift card by December 31.

**What are approved activities?**

- Annual Routine Physical - $40
- Breast Cancer Screening - $20
- Colorectal Cancer Screening - $20
- Annual Flu Vaccine - $20
- Diabetes Eye Exam - $20
- Diabetes Kidney Disease Monitoring - $20
- Health Risk Assessment - $20

---

**ST. LUKE’S LIFESTYLE MEDICINE PROGRAMS**

The Intensive Lifestyle Medicine Program hosted by St. Luke’s providers empowers you with the knowledge and skills you need to help achieve better overall health and great quality of life. This program helps prevent, treat, manage, or even reverse many serious health conditions, such as diabetes, prediabetes, obesity, high blood pressure, heart disease, depression, and more.

The St. Luke’s team will work with you to create an individual care plan tailored to your needs. Through a combination of online classes, group or individual visits, and in-person options, you may receive:

- Health coaching
- Nutrition and cooking classes
- Medically supervised group exercise
- Stress resilience and emotional wellness classes
- And more!

For more information, visit [stukesonline.org/health-services/specialties/lifestyle-medicine](http://stukesonline.org/health-services/specialties/lifestyle-medicine)

---

**Dental Coverage - Optional Supplemental Benefit (OSB)**

You can choose to add a Comprehensive Dental Optional Supplemental Benefit (OSB) to your plan. See the OSB table at the end of the Summary of Benefits for more details and pricing.

**Vision Coverage**

This plan includes vision services, such as an annual routine eye exam. See the Summary of Benefit table for more details.

You can add a vision hardware benefit as a Optional Supplemental Benefit (OSB) along with comprehensive dental.

**Meals After Hospital Stay**

This plan covers up to 14 days of meals (2 per day) 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.

---

**HEARING AIDS**

St. Luke’s or Elk’s Audiology

We cover diagnostic hearing and balance evaluations under your plan’s copay, as long as you visit an in-network provider and the evaluation is done in an outpatient setting.

Certain hearing aids purchased through an in-network provider are covered under one of five benefit tiers. The tier fee includes the cost per hearing aid, manufacturer repair and loss and damage warranties, fitting, and follow-up services.

Additional accessories or upgrades beyond the devices described as part of this benefit (such as Bluetooth connectivity) are not covered under the hearing aid benefit but may be available from your provider for an additional fee.

**Note:** Hearing aid copays do not go towards the member Out-of-Pocket Maximum.

**Tier Options**

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<tr>
<th>Tier</th>
<th>Cost Per Aid</th>
</tr>
</thead>
<tbody>
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<td>Tier 1 - Budget</td>
<td>$699</td>
</tr>
<tr>
<td>Tier 2 - Essential</td>
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</tr>
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</tr>
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<td>$1,899</td>
</tr>
<tr>
<td>Tier 5 - Premium</td>
<td>$2,399</td>
</tr>
</tbody>
</table>
**BENEFIT**

**Premium Amount**  
$88

**Medical Deductible**  
$0

**Pharmacy Deductible**  
$150

**Member Out-of-Pocket Maximum**  
$6,700

- **Inpatient Hospital Coverage**  
  - Days 1-6: $295 copay
  - Days 7+: $0 copay

- **Meals after discharge**  
  - $0 copay, up to 14 days of meals (2 per day) after discharged from an inpatient acute hospital or skilled nursing facility.

- **Outpatient Facility Coverage**  
  - Routine and/or preventive eye exam: $50 copay
  - Non-routine vision exam: $50 copay
  - Vision test for prescriptions: $0 copay
  - Eyeglasses or contact lenses after cataract surgery: $0 copay

- **Diagnostic Services, Labs, and Imaging**  
  - Diagnostic radiology services (e.g., MRIs, CT scans): $300 copay
  - Diagnostic tests and procedures: $10 copay
  - Lab services: $10 copay
  - Outpatient x-rays: $20 copay
  - Therapeutic radiology services: 20% coinsurance

- **Hearing Services**  
  - Hearing exam related to a medical condition: $50 copay
  - Routine hearing exam: $50 copay
  - Hearing aids: $699 to $2,399 copay

- **Dental Services**  
  - Limited Medicare-covered dental services related to a medical condition. See the Optional Supplement Benefits section for information on comprehensive dental options.

- **Vision Services**  
  - Routine and/or preventive eye exam: $50 copay
  - Non-routine vision exam: $50 copay
  - Vision test for prescriptions: $0 copay
  - Unscheduled glasses or contact lenses after cataract surgery: $0 copay

- **Inpatient Mental Health Services**  
  - Days 1-6: $260 copay
  - Days 7-90: $0 copay
  - Lifetime reserve days: $0 copay

- **Outpatient Mental Health Services**  
  - Outpatient individual or group therapy visit in a provider’s office or outpatient facility: $40 copay
  - Partial hospitalization for mental health: $55 copay

**Worldwide Emergency Care**  
Copay is waived if you are admitted to the hospital within 24 hours.

**Worldwide Urgently Needed Services**  
No extra charges for labs and/or x-rays.

- **Doctor’s Office Visits**  
  - Primary care provider: $5 copay
  - Specialist: $50 copay

- **Preventive Care**  
  - Annual physical/comprehensive wellness visit: $0 copay
  - Medicare-covered preventive services: $0 copay

- **Skilled Nursing Facility (SNF)**  
  - Our plan covers up to 100 days in a SNF, no prior hospital stay required.
    - Days 1-20: $0 copay
    - Days 21-75: $160 copay
    - Days 76-100: $0 copay

- **Diagnostic Services, Labs, and Imaging**  
  - Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay.

- **Inpatient Hospital Coverage**  
  - Copays start over each time you are admitted to an inpatient hospital facility.

- **Outpatient Facility Coverage**  
  - Routine and/or preventive eye exam: $50 copay
  - Non-routine vision exam: $50 copay
  - Vision test for prescriptions: $0 copay
  - Unscheduled glasses or contact lenses after cataract surgery: $0 copay

- **Inpatient Mental Health Services**  
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    - Days 1-20: $0 copay
    - Days 21-75: $160 copay
    - Days 76-100: $0 copay

*Service may require prior authorization.*
## BENEFIT

### Outpatient Rehabilitation Services*  
Physical, occupational, and speech therapy visit in a provider’s office or outpatient facility  
Cardiac rehab services  
Pulmonary rehab services  

### Ambulance*  
Prior authorization only required for non-emergency transfers.  

### Routine Transportation  
Not covered  

### Companionship Services  
Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs.  

### Foot Care (Podiatry Services)  
Foot exams and treatment for Medicare-covered services.  

### Medical Equipment and Supplies  
Durable medical equipment (e.g., wheelchairs, oxygen, etc.)*  
Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)*  
Diabetes monitoring supplies  
Coverage for Freestyle and Precision brand glucose monitors and test strips by Abbott Labs.  
Diabetes self-management training  
Therapeutic shoe inserts  

### Wellness Your Way  
Our plan reimburses you for approved wellness services.  
See the Healthy You section for more information.  

### St. Luke's Lifestyle Medicine Programs  
$0 copay  

### Chiropractic Care*  
Treatment of lower back pain  

### Medicare-Covered Acupuncture Services*  
12 initial visits, and additional 8 visits if member is making progress.  

### Home Health Care*  
$0 copay  

### Outpatient Substance Abuse  
Individual or group therapy in a provider’s office  
Individual or group therapy in an outpatient facility setting  

### Renal Dialysis  
Including services and supplies for home dialysis.  

### Hospice  
$0 copay  

### Medicare Part B Drugs*  
Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs.  

### Foot Care (Podiatry Services)  
Foot exams and treatment for Medicare-covered services.  

### Medical Equipment and Supplies  
Durable medical equipment (e.g., wheelchairs, oxygen, etc.)*  
Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)*  
Diabetes monitoring supplies  
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### Home Health Care*  
$0 copay  

### Outpatient Substance Abuse  
Individual or group therapy in a provider’s office  
Individual or group therapy in an outpatient facility setting  

### Renal Dialysis  
Including services and supplies for home dialysis.  

### Hospice  
$0 copay  

### Intermountain Connect Care*  
Visit with a provider via video chat for urgent medical needs.  
For more information, visit intermountainconnectcare.org.  

### Telehealth Services  
Telehealth visit with a primary care provider  
Telehealth visit with a specialist  

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

<table>
<thead>
<tr>
<th>Diabetes-Specific Benefits</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider</td>
<td>$0 copay</td>
</tr>
<tr>
<td>In-person or through telehealth.</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Routine or preventive eye exam</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Diabetes monitoring supplies</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Coverage for Freestyle and Precision brand glucose monitors and test strips by Abbott Labs.</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Diabetes self-management training</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Therapeutic shoe inserts</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Select labs</td>
<td>Covered through the gap</td>
</tr>
<tr>
<td>Select diabetes drugs in Tier 1 and Tier 2 (non-insulin)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Continuous Glucose Monitors (CGM)*</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Part B insulin pumps and supplies</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

### INSULIN  

<table>
<thead>
<tr>
<th>Insulin Type</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 insulin</td>
<td>$3 copay</td>
</tr>
<tr>
<td>30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Tier 3 insulin</td>
<td>$35 copay</td>
</tr>
<tr>
<td>30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins.</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Part B pump insulin</td>
<td>For use in a pump.</td>
</tr>
</tbody>
</table>

*Service may require prior authorization.
Your Prescription Benefits

Magic Valley

The below cost-sharing table shows what you will pay for your prescription in the Initial Coverage Stage after you’ve reached your annual $150 pharmacy deductible OR when filling a Tier 1 or Tier 2 drug. The $150 pharmacy deductible does not apply to Tier 1 and Tier 2 drugs.

You stay in the Initial Coverage Stage until your year-to-date total drug costs reaches $4,430. Then, you move to the Coverage Gap (Donut Hole) stage. You will generally pay 25% on brand-name and generic drugs while in the Coverage Gap. Once you reach $7,050 in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays most of the cost for covered drugs. You generally pay $3.95 for generic drugs and $9.85 for all other drugs—or 5% of the cost, whichever is greater. You will stay in this stage for the rest of the calendar year through December 31. For more information on how pharmacy coverage stages work, please see the Pharmacy section of the Enrollment Guide.

### PHARMACY DEDUCTIBLE

<table>
<thead>
<tr>
<th>Tier 1 and 2 (Generics)</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiers 3, 4, and 5 (Brands)</td>
<td>$150</td>
</tr>
</tbody>
</table>

### COST-SHARING

#### RETAIL COST-SHARING

<table>
<thead>
<tr>
<th>30-DAY SUPPLY</th>
<th>100-DAY SUPPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$3</td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
<td>$15</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$45</td>
</tr>
<tr>
<td>Tier 4 (Nonpreferred Brand)</td>
<td>$95</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

#### MAIL ORDER COST-SHARING

<table>
<thead>
<tr>
<th>30-DAY SUPPLY</th>
<th>100-DAY SUPPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$3</td>
</tr>
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<td>Tier 2 (Generic)</td>
<td>$15</td>
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<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$45</td>
</tr>
<tr>
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<td>$95</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

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

Optional Benefits

You can choose to add the below Comprehensive Dental Optional Supplemental Benefits (OSB) to your plan.

You must continue to pay your Medicare Part B premium; an extra premium will be added each month for these benefits.

### DELTA DENTAL® IDAHO ADVANTAGE

<table>
<thead>
<tr>
<th>Premium Amount</th>
<th>$38</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Deductible</td>
<td>$50</td>
</tr>
<tr>
<td>Annual Maximum Plan Payment</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

**Preventive and Diagnostic**

- Oral examinations: $0 copay, Two per calendar year
- Cleanings: $0 copay, Two per calendar year
- X-rays: $0 copay, Two sets of bitewings per year, and one panoramic every 36 months

**Basic**

- 50% coinsurance, Things like fillings, extractions, endodontic, and periodontal treatment

**Major**

- 60% coinsurance, Things like crowns and dentures

**Orthodontics**

- Not covered

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

### DELTA DENTAL IDAHO ADVANTAGE PLUS EYEWEAR

This optional benefit includes everything in the Comprehensive Dental OSB table, plus an eyewear benefit.

<table>
<thead>
<tr>
<th>Premium Amount</th>
<th>$43</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyewear Benefit</td>
<td>$200 allowance every year</td>
</tr>
</tbody>
</table>

Includes preventive and comprehensive dental care. Suitable towards contacts, frames, lenses, and lens options.

HOW WE HELP WITH PRESCRIPTION DRUG COSTS

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

**WELLNESS YOUR WAY REIMBURSEMENT**

Our flexible wellness benefit allows you to choose how you want to get and stay healthy. We’ll reimburse you up to $240 per year for participating in wellness activities.

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- Health coaching
- Nutrition and cooking classes
- Medically supervised group exercise
- Stress resilience and emotional wellness classes
- And more!

For more information, visit stlukesonline.org/health-services/specialties/lifestyle-medicine

**DENTAL COVERAGE - OPTIONAL SUPPLEMENTAL BENEFIT (OSB)**

You can choose to add a Comprehensive Dental Optional Supplemental Benefit (OSB) to your plan. See the OSB table at the end of the Summary of Benefits for more details and pricing.

**VISION COVERAGE**

This plan includes vision services, such as an annual routine eye exam. See the Summary of Benefit table for more details.

You can add a vision hardware benefit as a Optional Supplemental Benefit (OSB) along with comprehensive dental.

**MEALS AFTER HOSPITAL STAY**

This plan covers up to 14 days of meals (2 per day) 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.

**HEARING AIDS**

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**TIER OPTIONS**

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<td>Tier 4 - Advanced</td>
<td>$1,899</td>
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<td>Tier 5 - Premium</td>
<td>$2,399</td>
</tr>
</tbody>
</table>

**COMPANIONSHIP SERVICES - PAPA PATS**

We connect our members with Papa Pals to lend companionship services and help with daily living activities such as:

- Technology lessons
- House tasks like laundry, light cleaning, organizing, and meal preparations
- Virtual and in-person companionship
- Help running errands

**SOUTH CENTRAL IDAHO (HMO)**
## BENEFIT

<table>
<thead>
<tr>
<th>Premium Amount</th>
<th>Medical Deductible</th>
<th>Pharmacy Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>$107</td>
<td>$0</td>
<td>$200</td>
</tr>
</tbody>
</table>

### Member Out-of-Pocket Maximum
- $6,700

### Inpatient Hospital Coverage*
- Copays start over each time you are admitted to an inpatient hospital facility.
  - Days 1-6: $295 copay
  - Days 7+: $0 copay

### Meals after discharge*
- $0 copay, up to 14 days of meals (2 per day) after discharged from an inpatient acute hospital or skilled nursing facility.

### Outpatient Facility Coverage*
- Outpatient surgery and ambulatory surgical center: $315 copay
- Diagnostic colonoscopy: $315 copay
- Other covered services (includes: IV infusion therapy, non-nuclear stress tests, facility or lab-based sleep studies, and more.): 20% coinsurance

### Doctor’s Office Visits
- Primary care provider: $5 copay
- Specialist: $50 copay

### Preventive Care
- Annual physical/comprehensive wellness visit: $0 copay
- Medicare-covered preventive services: $0 copay

### Worldwide Emergency Care
- Copay is waived if you are admitted to the hospital within 24 hours.

### Worldwide Urgently Needed Services
- No extra charges for labs and/or x-rays.
- Copay is waived if you are admitted to the ER or hospital within 24 hours. Refer to the Evidence of Coverage for additional details.

### Diagnostic Services, Labs, and Imaging*
- Only one copay is collected when multiple tests are performed during the same visit. Copays are in addition to any applicable primary care or specialist copay.
- Diagnostic radiology services (e.g., MRIs, CT scans): $300 copay
- Diagnostic tests and procedures: $10 copay
- Lab services: $10 copay
- Outpatient x-rays: $20 copay
- Therapeutic radiology services: 20% coinsurance

### Hearing Services
- Hearing exam related to a medical condition: $50 copay
- Routine hearing exam: $50 copay
- Hearing aids: $699 to $2,399 copay

### Dental Services*
- Limited Medicare-covered dental services related to a medical condition. See the Optional Supplemental Benefits section for information on comprehensive dental options.

### Vision Services
- Routine and/or preventive eye exam: $50 copay
- Non-routine vision exam: $50 copay
- Vision test for prescriptions: $0 copay
- Eyeglasses or contact lenses after cataract surgery*: $0 copay

### Inpatient Mental Health Services*
- Days 1-6: $260 copay
- Days 7-90: $0 copay
- Lifetime reserve days: $0 copay

### Outpatient Mental Health Services
- Outpatient individual or group therapy visit in a provider’s office or outpatient facility: $40 copay
- Partial hospitalization for mental health*: $55 copay

### 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 21-75: $160 copay
  - Days 76-100: $0 copay

*Service may require prior authorization.
DIABETES-SPECIFIC BENEFITS

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes self-management training</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Therapeutic shoe inserts</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Select labs</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Select diabetes drugs in Tier 1 and Tier 2 (non-insulin)</td>
<td>Covered through the gap</td>
</tr>
<tr>
<td>Continuous Glucose Monitors (CGM)*</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Part B insulin pumps and supplies</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

INSULIN

<table>
<thead>
<tr>
<th>Tier</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 insulin</td>
<td>$3 copay</td>
</tr>
<tr>
<td>Tier 3 insulin</td>
<td>$35 copay</td>
</tr>
</tbody>
</table>

*Service may require prior authorization.*
Your Prescription Benefits

South Central Idaho

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

You stay in the Initial Coverage Stage until your year-to-date total drug costs reaches $4,430. Then, you move to the Coverage Gap (Donut Hole) stage.

You will generally pay 25% on brand-name and generic drugs while in the Coverage Gap. Once you reach $7,050 in annual total drug costs, you move to the Catastrophic Coverage stage.

During the Catastrophic Coverage stage, the plan pays most of the cost for covered drugs. You generally pay $3.95 for generic drugs and $9.85 for all other drugs—or 5% of the cost, whichever is greater. You will stay in this stage for the rest of the calendar year through December 31. For more information on how pharmacy coverage stages work, please see the Pharmacy section of the Enrollment Guide.

### PHARMACY DEDUCTIBLE

| Tier 1 and 2 (Generics) | $0 |
| Tiers 3, 4, and 5 (Brands) | $200 |

### COST-SHARING

<table>
<thead>
<tr>
<th>Tier</th>
<th>Tier 1 (Preferred Generic)</th>
<th>Tier 2 (Generic)</th>
<th>Tier 3 (Preferred Brand)</th>
<th>Tier 4 (Nonpreferred Brand)</th>
<th>Tier 5 (Specialty Tier)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-DAY SUPPLY</td>
<td>100-DAY SUPPLY</td>
<td>30-DAY SUPPLY</td>
<td>100-DAY SUPPLY</td>
<td>30-DAY SUPPLY</td>
<td>100-DAY SUPPLY</td>
</tr>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$3</td>
<td>$9</td>
<td>$3</td>
<td>$6</td>
<td></td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
<td>$15</td>
<td>$45</td>
<td>$15</td>
<td>$30</td>
<td></td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$45</td>
<td>$135</td>
<td>$45</td>
<td>$135</td>
<td></td>
</tr>
<tr>
<td>Tier 4 (Nonpreferred Brand)</td>
<td>$95</td>
<td>$285</td>
<td>$95</td>
<td>$285</td>
<td></td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>29% coinsurance</td>
<td>N/A</td>
<td>29% coinsurance</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

### HOW WE HELP WITH PRESCRIPTION DRUG COSTS

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

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

### DELTA DENTAL® IDAHO ADVANTAGE

**Premium Amount** | $38
---|---
**Dental Deductible** | $50
**Annual Maximum Plan Payment** | $1,000

**Preventive and Diagnostic**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral examinations</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Cleanings</td>
<td>$0 copay</td>
</tr>
<tr>
<td>X-rays</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

**Basic**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% coinsurance</td>
<td>Things like fillings, extractions, endodontic, and periodontal treatment</td>
</tr>
</tbody>
</table>

**Major**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>60% coinsurance</td>
<td>Things like crowns and dentures</td>
</tr>
</tbody>
</table>

**Orthodontics**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

This information is available for free in other languages and alternate formats upon request.
