You qualify for a Special Enrollment Period
You are enrolled in a Medicare Advantage plan. Or, call us and we
Bonus perks like wellness reimbursements,
Q: When can I enroll?
A: To join, you must be enrolled in Medicare Part A and Part B and live in our service area.
Nevada service area: Clark and Nye counties.
Q: Who can join SelectHealth Advantage (HMO)?
A: You may be eligible to enroll in SelectHealth Advantage if:
> You are new to Medicare
> You would like to enroll during the Annual Enrollment Period (AEP), which is every year between October 15 and December 7.
> You are enrolled in a Medicare Advantage plan and want to make a one-time change during the Open Enrollment Period (OEP), which is every year between January 1 and March 31.
> 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

FREQUENTLY ASKED QUESTIONS

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, over-the-counter benefits, transportation, hearing aids, and preventive/comprehensive dental and vision.
> 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: 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: There is no monthly premium on our 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.

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.”

• You move to a new state or county service area
• You lose your employer group health coverage
There may be other special circumstances that would allow you to enroll. If you have questions, call us!

Q: Which doctors, hospitals, and pharmacies can I use?
A: Our plan is on the SelectHealth Advantage 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. Generally, you must use an in-network pharmacy to fill your prescriptions for covered Part D drugs. SelectHealth covers nearly every major retail pharmacy plus many local and independent stores. 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: 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 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: With SelectHealth Advantage, you are required to receive a referral from your Primary Care Provider (PCP) to see most specialists. However, SelectHealth and Intermountain Healthcare® work closely together to ensure you are seen in a timely manner and receive the appropriate referrals. This helps us make sure you see the right doctor at the right time, which also helps keep healthcare costs low.
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.

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

DENTAL COVERAGE

This plan covers preventive and comprehensive dental for no additional cost. See the Summary of Benefits table for more details.

VISION COVERAGE

This plan includes vision services, such as an annual routine eye exam and a vision hardware benefit every other year. See the Summary of Benefits table for more details.

TRANSPORTATION

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

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.

COMPANIONSHIP SERVICES - PAPA PALS

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

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 purchased through a TruHearing provider are covered under one of two benefit tiers. The tier fee includes the cost per hearing aid, hearing exam and evaluation, fitting, and a one-year supply of batteries. Rechargeable battery options are also available at no additional cost.

Your comprehensive hearing aid benefit through TruHearing includes state-of-the-art technology, personalized care, and help along the way. Call TruHearing to learn more and schedule an appointment at 866-201-9695 (TTY: 711).

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

TIER OPTIONS

<table>
<thead>
<tr>
<th>Tier</th>
<th>Benefit Description</th>
<th>Cost Per Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - TruHearing Advanced</td>
<td>$399</td>
<td></td>
</tr>
<tr>
<td>Tier 2 - TruHearing Premium</td>
<td>$699</td>
<td></td>
</tr>
<tr>
<td>BENEFIT</td>
<td>COST</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------</td>
<td></td>
</tr>
<tr>
<td>Premium Amount</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Medical Deductible</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Deductible</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Member Out-of-Pocket Maximum</td>
<td>$1,000</td>
<td></td>
</tr>
</tbody>
</table>

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.

| Inpatient Hospital Coverage*                 | $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*                | $0 copay             |
| Doctor's Office Visits                       | $0 copay             |
| Preventive Care                              | $0 copay             |
| Preventive Dental                            | $0 copay             |
| Vision Services                              | $0 copay             |
| Worldwide Urgently Needed Services           | $10 copay            |
| Worldwide Emergency Care                     | $120 copay           |
| Diagnostic Services, Labs, and Imaging*      | $10 copay            |

Does not include prescription drugs or hearing aid copays. Members are responsible for 20% coinsurance for hearing aids. Copays do not apply to the annual member out-of-pocket maximum. See the Hearing Aid section for more information.

Diagnostic radiology services (e.g., MRIs, CT scans) $75 copay
Nuclear medicine (e.g., PET scans) $200 copay
Diagnostic tests and procedures $0 copay
Lab services $0 copay
Outpatient x-rays $0 copay
Therapeutic radiology services 20% coinsurance

Hearing Services
Routine hearing exam or hearing exam related to a medical condition $0 copay
Hearing aids Copay is for each hearing aid. Copays do not apply to the annual member out-of-pocket maximum. See the Hearing Aid section for more information.

Dental Services*
Limited Medicare-covered dental services related to a medical condition.

Preventive Dental
Two exams, two cleanings, two bitewing x-rays every year, plus one panoramic x-ray every 60 months. Preventive dental is already included in your plan.

Comprehensive Dental
Maximum plan payment of $3,000 and $100 annual deductible, not including preventive dental services.

Basic services 20% coinsurance
Things like fillings, endodontic services, and periodontal maintenance.

Major services 50% coinsurance
Things like dentures and crowns.

Vision Services
Routine and/or preventive eye exam $0 copay
Non-routine vision exam $0 copay
Vision test for prescriptions $0 copay
Eyeglasses or contact lenses after cataract surgery* $0 copay
Frames or contact lenses $0 copay
Progressive lenses $0 copay
Single, bifocal, or trifocal lenses $65 copay

Hearing Services
Routine hearing exam or hearing exam related to a medical condition $0 copay
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Non-routine vision exam $0 copay
Vision test for prescriptions $0 copay
Eyeglasses or contact lenses after cataract surgery* $0 copay
Frames or contact lenses $0 copay
Progressive lenses $0 copay
Single, bifocal, or trifocal lenses $65 copay

Diagnostic Services, Labs, and Imaging* Only one copay is collected when multiple tests are performed during the same visit.
**BENEFIT** | **COST**
---|---
Skilled Nursing Facility (SNF)* | Days 1-20: $0 copay, Days 21-35: $125 copay, Days 36-100: $0 copay
Outpatient Rehabilitation Services* | Physical, occupational, and speech therapy visit in a provider’s office or outpatient facility: $0 copay per visit
Cardiac rehab services | $0 copay
Pulmonary rehab services | $0 copay
Ambulance* | Prior authorization only required for non-emergency transfers. $200 copay
Routine Transportation | Services such as getting a ride to and from your doctor, pharmacy, or facility. $0 copay, up to 24 one-way trips per year
Companionship Services | $0 copay, up to 30 hours a year
Medicare Part B Drugs* | Includes chemotherapy drugs, insulin for use with insulin pumps, and other Part B drugs. 20% coinsurance
Foot Care (Podiatry Services) | Medicare-covered foot exam: $0 copay, Routine foot care: $0 copay, Up to four visits.
Medical Equipment and Supplies | Durable medical equipment (e.g., wheelchairs, oxygen, etc.)*: 20% coinsurance, Prosthetic devices and supplies (e.g., braces, artificial limbs, etc.)*: 20% coinsurance, Diabetes monitoring supplies: $0 copay, Coverage for Freestyle and Precision brand glucose monitors and test strips by Abbott Labs: $0 copay, Diabetes self-management training: $0 copay, Therapeutic shoe inserts: 20% coinsurance, Select labs: $0 copay, Tier 1 drugs: Covered through the gap, Continuous Glucose Monitors (CGM)*: $0 copay, Part B insulin pumps and supplies: 20% coinsurance
Wellness Your Way | Your plan reimburses you for approved wellness services. See the Exclusive Plan Benefits section for more information.
Chiropractic Care* | $0 copay
Medicare-Covered Acupuncture Services* | Treatment of lower back pain: $0 copay, 12 initial visits, and additional 8 visits if member is making progress. $0 copay
Home Health Care* | $0 copay
Outpatient Substance Abuse* | Individual or group therapy in a provider’s office: $0 copay, Individual or group therapy in an outpatient facility setting: $30 copay
Over-the-Counter Items | Dollar amounts do not roll over. $50 allowance per quarter
Renal Dialysis | Dialysis center: $0 copay, Outpatient facility: 20% coinsurance, Services and supplies for home dialysis: 20% coinsurance, Hospice: Covered by Original Medicare
Intermountain Connect Care* | Visit with a provider via video chat for urgent medical needs. For more information, visit intermountainconnectcare.org. $0 copay
Telehealth Services | $0 copay

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

<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>Tier 1 drugs</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>30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins. $0 copay</td>
</tr>
<tr>
<td>Tier 3 insulin</td>
<td>30-day supply in all Part D stages. Coverage Gap and deductible do not apply to select insulins. $35 copay</td>
</tr>
<tr>
<td>Part B pump insulin</td>
<td>For use in a pump. 20% coinsurance</td>
</tr>
</tbody>
</table>

*Service may require prior authorization.
Your Prescription Benefits

SelectHealth Advantage

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

You stay in the Initial Coverage Stage until your year-to-date total drug costs reaches **$4,430**. 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.

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.

### PHARMACY DEDUCTIBLE

| Tiers 1, 2, 3, 4, and 5 | $0 |

### COST-SHARING

<table>
<thead>
<tr>
<th>Tier</th>
<th>30-DAY SUPPLY</th>
<th>100-DAY SUPPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
<td>$8</td>
<td>$24</td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$45</td>
<td>$135</td>
</tr>
<tr>
<td>Tier 4 (Nonpreferred Brand)</td>
<td>$95</td>
<td>$285</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>33% coinsurance</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### RETAIL COST-SHARING

<table>
<thead>
<tr>
<th>Tier</th>
<th>30-DAY SUPPLY</th>
<th>100-DAY SUPPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
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<td>$95</td>
<td>$285</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>33% coinsurance</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### MAIL ORDER COST-SHARING

<table>
<thead>
<tr>
<th>Tier</th>
<th>30-DAY SUPPLY</th>
<th>100-DAY SUPPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
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<tr>
<td>Tier 4 (Nonpreferred Brand)</td>
<td>$95</td>
<td>$285</td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>33% coinsurance</td>
<td>N/A</td>
</tr>
</tbody>
</table>

SelectHealth is an HMO plan sponsor with a Medicare contract. Enrollment in SelectHealth Advantage depends on contract renewal. Other providers are available in our network. SelectHealth obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status. This information is available for free in other languages and alternate formats upon request.


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