Summarized Summary of Benefits
SelectHealth Advantage Essential (Wasatch Essential)

Plan Year: 2021

Service Area: Box Elder, Cache, Davis, Franklin (ID), Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, and Weber Counties

Premium	$0
In-Network MOOP	$5,500

Benefit	In-Network	Out-of-Network
Inpatient Services		
Inpatient Hospital Care	No limit to the number of days covered by the plan each hospital stay - Days 1 - 5: $320 copay per day - Days 6+: $0 copay per day Prior authorization required	Not Covered
Skilled Nursing Facility	Plan covers up to 100 days each benefit period No prior hospital stay is required - Days 1 - 20: $0 copay per day - Days 21 - 75: $160 copay per day - Days 76 - 100: $0 copay per day Prior authorization required	Not Covered
Meals After Discharge (Administered by GA Foods)	Plan provides up to 14 days of meals when a member is discharged from an inpatient acute hospital or skilled nursing facility. Meals are provided 7 days at a time. $0 copay for meals after discharge Prior Authorization is required. Care manager will send notification to GA Foods for initial 7 days and will follow up to determine if additional 7 days are needed.	N/A
Professional Services		
Doctor Office Visits	$0 copay PCP $40 copay SCP	Not Covered
TeleHealth Services (remote access technologies, video chat, telephone, etc.)	$0 copay PCP $40 copay SCP or Ancillary Providers	Not Covered
Podiatry Services	$40 copay for Medicare-covered services Routine foot care not covered	Not Covered
Chiropractic Services (Administered by ASH)	$20 copay Prior authorization required	Not Covered
Acupuncture (Administered by ASH)	For Lower Back Pain: $20 copay for 12 initial visits. $20 copay for additional 8 visits if member is making progress. Other Conditions: Not Covered	Not Covered
Preventive Services		
Medicare-Covered Preventive Services	$0 copay	Not Covered
Annual Routine Physical	$0 copay Includes preventive evaluation and management services only. Certain diagnostic procedures and other services may take an additional cost share.	Not Covered
Annual Wellness Visit	$0 copay This is the Original Medicare covered wellness visit that focuses on prevention and health counseling. Diagnostic procedures, labs, etc. take the applicable cost share.	Not Covered
Screening Colonoscopy	$0 copay This includes colonoscopies that start as screening and become diagnostic if polyps are found.	Not Covered

Health and Wellness		
Wellness Your Way	Reimburse up to $240 per calendar year for membership in Health Club/Fitness Classes, Health Education, Nutritional Benefits, In-Home Safety Assessments, and Home/Bathroom Safety Devices. We encourage members to be creative about how they use this benefit: race entry fees, cooking classes, dance lessons, etc. Services not covered under this plan: Golf Greens Fees, Ski Lift Passes, National Parks Pass. The date of service for this benefit is the date you make payment. For example, if you pay on December 15 for a gym membership that starts January 1, December 15 is the date of service.	N/A
Healthy Living	The Healthy Living program allows members to earn rewards for participating in healthy behaviors like going to see their PCP for routine screenings or participating in physical activity.	N/A
Intermountain Move Well Program	Not Covered, but can be reimbursed under the Wellness Your Way Benefit	N/A
Dental Services		
Medicare-Covered	$40 copay Medicare-covered dental benefits Prior authorization required	Not Covered
Preventive Dental	Mandatory Supplemental $0 copay for 2 exams $0 copay for 2 cleanings $0 copay for 2 bitewing x-rays $0 copay for 1 panoramic or full-mouth x-ray every 36 months	Not Covered
Comprehensive Dental	Optional Supplemental ($33 Premium) Maximum Plan Payment $1,500, does not include Preventive Dental services 50% coinsurance for all covered services	Not Covered
Vision Services		
Medicare-Covered	$40 copay for nonroutine (problem oriented) eye exams $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery, up to the Medicare allowed amount. Member is responsible for the remainder of the cost Prior authorization required for medically necessary eyewear	Not Covered
Routine Eye Exam	$40 copay standard benefit $0 copay for members with a confirmed diagnosis of diabetes $0 copay for determination of refraction for all members	Not Covered
Vision Hardware (administered by EyeMed)	Mandatory Supplemental Benefit available every other calendar year $150 allowance for frames or contact lenses $0 copay for single, bifocal, or trifocal lenses $65 copay for progressive lenses $15-$45 copay for upgrades	Not Covered
Hearing Services		
Medicare-Covered	$40 copay	Not Covered
Routine Hearing Exam	Not Covered	Not Covered
Hearing Aids	Selected hearing aids purchased through Intermountain audiology providers are covered under one of four benefit tiers. The fee listed below includes the cost per hearing aid for the device itself, the hearing exam and evaluation, the hearing aid fitting, and a 1-year supply of batteries. Tier 1: Economy - $399 per aid Tier 2: Standard - $849 per aid Tier 3: Advanced - $1,249 per aid Tier 4: Premium - $1,749 per aid *Hearing aid copays ($399 -$1,749) do not apply to the MOOP	Not Covered

Urgent and Emergent Services		
Ambulance Services	$225 copay Prior authorization is required for non-emergency ambulance transfers	$225 copay Worldwide coverage
Emergency Care	$90 copay Copay waived if admitted inpatient within 24 hours Worldwide coverage	$90 copay $0 if admitted within 24 hours Worldwide coverage
Urgently Needed Care	$25 copay Labs, X-rays, and Dx Tests are included in this copay. Advanced Imaging still takes a separate copay. Copay waived if referred to the ER or admitted inpatient within 24 hours	$25 copay $0 if referred to ER or admitted inpatient within 24 hours Worldwide coverage
Intermountain Connect Care Urgent Care	$0 copay	N/A
Outpatient Services		
Home Health Care	$0 copay Prior authorization required	Not Covered
Hospice Care	$0 copay for routine home hospice services. $0 copay for respite hospice services up to 7 days at a time. $0 copay for general inpatient hospice services. $0 copay for hospice-related drugs. Additional supplemental benefits available from in-network hospice providers at no additional cost: - Enteral and parenteral nutrition	$0 copay for routine home hospice services. 5% coinsurance for respite hospice services up to 5 days at a time. $0 copay for general inpatient hospice services. Up to $5 copay for hospice-related drugs. Additional supplemental benefits not available from out-of-network hospice providers.
Outpatient Services	$320 copay Surgical Services $320 copay Ambulatory Surgical Center $320 copay Outpatient Procedures $40 copay Treatment Room $40 copay Wound Care 20% coinsurance Medical Supplies 20% coinsurance IV Infusion Therapy 20% coinsurance Blood Transfusion Services 20% for all other services Prior authorization may be required, check documentation	Not Covered
Diagnostic Colonoscopy	$320 copay	Not Covered
Outpatient Rehabilitation Services	$40 copay physical, occupational, and speech therapy in the office $40 copay physical, occupational, and speech therapy in the outpatient hospital Prior authorization is required for PT after 20 visits Prior authorization is required for OT after 10 visits Prior authorization is required for ST after 10 visits	Not Covered
Cardiac and Pulmonary Rehabilitation Services	$10 copay Cardiac Rehabilitation $10 copay Intensive Cardiac Rehabilitation $30 copay Pulmonary Rehabilitation $30 copay Supervised Exercise Therapy for Peripheral Artery Disease	Not Covered

Diagnostic Procedures and Tests		
Diagnostic Procedures and Tests and Lab Services	Lab Services - $0 copay This copay applies for all places of service, in addition to applicable cost sharing for office visits, outpatient services, or other separately identifiable services. Only one copay per visit for labs and diagnostic tests combined. Diagnostic Procedures and Tests - $0 copay This copay applies for all places of service, in addition to applicable cost sharing for office visits, outpatient services, or other separately identifiable services. Only one copay per visit for labs and diagnostic tests combined. Sleep Studies 20% coinsurance for facility/lab based sleep studies PCP/SCP copayment for home-based sleep studies. Cardiac Stress Tests $300 copay for nuclear stress tests 20% coinsurance for non-nuclear stress tests (treadmill, drug, etc.) Prior Authorization is required for Sleep Studies and genetic testing	Not Covered
Diagnostic and Therapeutic Radiology Services	X-Rays - $20 copay This copay applies for all places of service, in addition to applicable cost sharing for office visits, outpatient services, or other separately identifiable services. Only one copay per visit for x-rays. Advanced Imaging/Diagnostic Radiological Services $300 copay office or outpatient facility This copay applies for all places of service, in addition to applicable cost sharing for office visits, outpatient services, or other separately identifiable services. Nuclear Medicine $300 copay office or outpatient facility This copay applies for all places of service, in addition to applicable cost sharing for office visits, outpatient services, or other separately identifiable services. Therapeutic Radiology 20% coinsurance office or outpatient facility Prior Authorization required for Advanced Imaging and Nuclear Medicine	Not Covered

Other Services		
Durable Medical Equipment (DME)	$0 copay for crutches, canes, and walkers 20% coinsurance all other DME Prior authorization is required for DME	Not Covered
Prosthetic Devices	20% coinsurance Prior authorization is required for Prosthetic Devices	Not Covered
Diabetes Programs and Supplies	$0 copay for Diabetes self-management training $0 copay for Diabetes monitoring supplies Only Freestyle and Precision brand monitors and test strips produced by Abbott Labs are covered. 20% coinsurance for Therapeutic shoes or inserts	Not Covered
Kidney Disease and Conditions	20% coinsurance Renal Dialysis, including Services and Supplies for Home Dialysis $0 copay for kidney disease education	Not Covered
Over the Counter (administered by Convey)	$50 per quarter, does not roll over	Not Covered
Part B Drugs	20% coinsurance Prior authorization is required for certain Part B drugs	Not Covered
Non-Emergent Medical Transportation	Not Covered	Not Covered
Mental Health and Substance Abuse		
Inpatient Mental Health Care	190 days of Inpatient Psychiatric Hospital Care in a Lifetime - Days 1 - 5: $285 copay per day - Days 6 - 90: $0 copay per day - Lifetime Reserve days 1 - 60: $0 copay per day Prior authorization required	Not Covered
Outpatient Mental Health Care	Office $40 copay individual therapy $40 copay group therapy Outpatient Hospital $40 copay individual therapy $40 copay group therapy $55 copay partial hospitalization Prior authorization is required for partial hospitalization	Not Covered
Outpatient Substance Abuse Care	$40 copay SCP office $50 copay Outpatient Hospital	Not Covered
Opioid Treatment Program	10% coinsurance	Not Covered

Prescription Drugs		
Retail Prescription Drugs Diabetes Generics (non-insulin): T1 and T2 Diabetes medications (excluding insulin) covered through the coverage gap. Insulins: Insulin is covered through the coverage gap. T1 insulins have the stated copay for their tier. T3 Insulins have a $35 copay per one month supply in all Part D stages.	$200 deductible - applies to Tier 3, Tier 4, and Tier 5 30-Day Supply Tier 1: Preferred Generic - $0 copay Tier 2: Generic - $10 copay Tier 3: Preferred Brand - $45 copay (insulin $35, no deductible) Tier 4: Non-Preferred Brand - $95 copay Tier 5: Specialty - 29% coinsurance 60-Day Supply Tier 1: Preferred Generic - $0 Tier 2: Generic - $20 Tier 3: Preferred Brand - $90 (insulin $70, no deductible) Tier 4: Non-Preferred Generic - $190 Tier 5: Specialty - N/A 100-Day Supply Tier 1: Preferred Generic - $0 Tier 2: Generic - $30 Tier 3: Preferred Brand - $135 (insulin $105, no deductible) Tier 4: Non-Preferred Generic - $285 Tier 5: Specialty - N/A	N/A
Mail Order Prescription Drugs Diabetes Generics (non-insulin): T1 and T2 Diabetes medications (excluding insulin) covered through the coverage gap. Insulins: Insulin is covered through the coverage gap. T1 insulins have the stated copay for their tier. T3 Insulins have a $35 copay per one month supply in all Part D stages.	$200 deductible - applies to Tier 3, Tier 4, and Tier 5 30-Day Supply Tier 1: Preferred Generic - $0 copay Tier 2: Generic - $10 copay Tier 3: Preferred Brand - $45 copay (insulin $35, no deductible) Tier 4: Non-Preferred Brand - $95 copay Tier 5: Specialty - 29% coinsurance 60-Day Supply Tier 1: Preferred Generic - $0 copay Tier 2: Generic - $20 copay Tier 3: Preferred Brand - $90 copay (insulin $70, no deductible) Tier 4: Non-Preferred Brand - $190 copay Tier 5: Specialty - N/A 100-Day Supply Tier 1: Preferred Generic - $0 copay Tier 2: Generic - $20 copay Tier 3: Preferred Brand - $135 copay (insulin $105, no deductible) Tier 4: Non-Preferred Brand - $285 copay Tier 5: Specialty - N/A	N/A