Summarized Summary of Benefits
SelectHealth Advantage (HCP HMO)

Plan Year: 2021

Service Area: Clark and Nye Counties

Premium	$0
In-Network MOOP	$1,000

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 - All Days: $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 - 35: $125 copay per day - Days 36 - 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 $0 copay SCP	Not Covered
TeleHealth Services (remote access technologies, video chat, telephone, etc.)	$0 copay PCP $0 copay SCP or Ancillary Providers	Not Covered
Podiatry Services	$0 copay for Medicare-covered services $0 copay for routine foot care up to 4 visits	Not Covered
Chiropractic Services	$0 copay Prior authorization required	Not Covered
Acupuncture	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	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: cooking classes, dance lessons, etc. Additional services covered for this SelectHealth Advantage 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	$0 copay Medicare-covered dental benefits Prior authorization required	Not Covered
Preventive Dental (administered by Delta Dental of California)	Mandatory Supplemental $0 copay for 2 exams $0 copay for 2 cleanings $0 copay for 2 sets of bitewing x-rays (4 films) $0 copay for 1 panoramic or full-mouth x-ray every 60 months	Not Covered
Comprehensive Dental (administered by Delta Dental of California)	Mandatory Supplemental Maximum Plan Payment $1,000, does not include Preventive Dental Services Annual Deductible $100, does not apply to Preventive Dental Services 20% coinsurance for basic services (fillings, endodontic services, periodontal maintenance, etc.) 50% coinsurance for major services (implants, dentures, crowns, etc.)	Not Covered
Vision Services		
Medicare-Covered	$0 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	$0 copay $0 copay for determination of refraction	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	$0 copay	Not Covered
Routine Hearing Exam (Administered by TruHearing)	$0 copay for routine hearing exams one per year	Not Covered
Hearing Aids (Administered by TruHearing)	Selected hearing aids purchased through TruHearing providers are covered under one of two 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. Rechargable battery options are also available at no additional cost. Tier 1: $399 per aid Tier 2: $699 per aid *Hearing aid copays ($399 -$699) do not apply to the MOOP	Not Covered
Urgent and Emergent Services		
Ambulance Services	$200 copay Prior authorization is required for non-emergency ambulance transfers	$200 copay Worldwide coverage
Emergency Care	$120 copay Copay waived if admitted inpatient within 24 hours Worldwide coverage	$120 copay $0 if admitted within 24 hours Worldwide coverage
Urgently Needed Care	$10 copay Advanced Imaging still takes a separate copay. UC Copay waived if referred to the ER or admitted inpatient within 24 hours	$40 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	Hospice services not covered under SelectHealth Advantage. Hospice services covered by FFS Medicare.	N/A
Outpatient Services	$0 copay Surgical Services $0 copay Ambulatory Surgical Center $0 copay Outpatient Procedures $0 copay Treatment Room $0 copay Wound Care $0 copay Medical Supplies 20% coinsurance IV Infusion Therapy 20% coinsurance Blood Transfusion Services $0 copay for all other services Prior authorization may be required, check documentation	Not Covered
Diagnostic Colonoscopy	$0 copay	Not Covered
Outpatient Rehabilitation Services	$0 copay physical, occupational, and speech therapy in the office $0 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	$0 copay Cardiac Rehabilitation $0 copay Intensive Cardiac Rehabilitation $0 copay Pulmonary Rehabilitation $0 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 EKG $0 copay Pulmonary Function Test $0 copay in the office or outpatient facility Other diagnostic tests $0 copay These copays apply 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 category per encounter applies. Sleep Studies $50 copay for facility/lab based sleep studies $0 copayment for home-based sleep studies. Cardiac Stress Tests $200 copay for nuclear stress tests 20% coinsurance for non-nuclear stress tests (treadmill, drug, etc.)	Not Covered
Diagnostic and Therapeutic Radiology Services	X-Rays $0 copay Ultrasound $0 copay MRI/CT Scan $55 copay for office or outpatient facility PET Scans $200 copay office or outpatient facility Nuclear Medicine $200 copay office or outpatient facility These copays apply 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 category per encounter applies. 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)	20% coinsurance Prior authorization is required for Durable Medical Equipment	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	$0 copay for renal dialysis in a dialysis center 20% coinsurance renal dialysis in an outpatient facility 20% coinsurance for 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	$0 copay up to 24 one-way trips	Not Covered
Mental Health and Substance Abuse		
Inpatient Mental Health Care	190 days of Inpatient Psychiatric Hospital Care in a Lifetime - Days 1-90: $0 copay per day - Lifetime Reserve Days 1-60: $0 copay Prior authorization required	Not Covered
Outpatient Mental Health Care	Office $0 copay individual therapy $0 copay group therapy Outpatient Hospital $30 copay individual therapy $30 copay group therapy $55 copay partial hospitalization Prior authorization required	Not Covered
Outpatient Substance Abuse Care	Office $0 copay individual $0 copay group Outpatient Hospital $30 copay individual $30 copay group Prior authorization required	Not Covered
Opioid Treatment Program	$0 copay Prior authorization required	Not Covered

Prescription Drugs		
Retail Prescription Drugs Tier 1 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.	$0 deductible 30-Day Supply Tier 1: Preferred Generic - $0 copay Tier 2: Generic - $8 copay Tier 3: Preferred Brand - $45 copay (insulin $35, no deductible) Tier 4: Non-Preferred Brand - $95 copay Tier 5: Specialty - 33% coinsurance 60-Day Supply Tier 1: Preferred Generic - $0 Tier 2: Generic - $16 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 - $24 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 Tier 1 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.	$0 deductible 30-Day Supply Tier 1: Preferred Generic - $0 copay Tier 2: Generic - $0 copay Tier 3: Preferred Brand - $45 copay (insulin $35, no deductible) Tier 4: Non-Preferred Brand - $95 copay Tier 5: Specialty - 33% coinsurance 60-Day Supply Tier 1: Preferred Generic - $0 copay Tier 2: Generic - $0 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 - $0 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