

# INTER VALLEY HEALTH PLAN 2020 BENEFITS



BENEFIT	SERVICE TO SENIORS	DESERT PREFERRED CHOICE (Coachella Valley)	VITALITY PLUS (Copays listed coordinated with Medi-Cal & LIS)	
			Plan Benefit	Coordinated w/Med-Cal
ANNUAL OUT-OF-POCKET MAX (Parts A & B)	\$2,000	\$1,500	\$5,900	
PCP/SPECIALIST VISIT	\$0	\$0	\$0	\$0
MENTAL HEALTH SPECIALIST VISIT	\$0	\$0	20%	\$0
OUT-PATIENT SUBSTANCE ABUSE VISIT	\$0	\$0	20%	\$0
URGENT CARE	\$0	\$0	\$0	\$0
EMERGENCY CARE • Copay Per Visit • Annual Maximum	\$120 \$20,000 outside US (ER copay <b>NOT</b> waived outside US)	\$120 \$20,000 outside US (Copay waived with hospital admission)	ER/UR \$120 outside US	\$0/\$120 outside US \$20,000 outside US (ER Copay <b>NOT</b> waived)
AMBULANCE	\$195 per trip	\$200 per trip (Copay waived with hospital admission)	20%	\$0
ACUTE INPATIENT HOSPITAL	\$0	\$0	Medicare FFS Cost	\$0
MENTAL HEALTH INPATIENT	\$75/Day, Days 1-6 \$450 maximum copay/stay	\$912 copay for each Medicare-covered stay	Medicare FFS Cost	\$0
SKILLED NURSING FACILITY	\$0 Per Day/Days 1 – 20 \$50 Per Day/Days 21 – 100	\$0 Per Day/Days 1 – 20 \$100 Per Day/Days 21 – 35 \$0 Per Day/Days 36 – 100	Medicare FFS Cost	\$0
CHIROPRACTIC CARE (Routine Care) ACUPUNCTURE	Not Covered	\$0 up to 20 visits per yr <b>Chiro only</b> , prior authorization required	\$0 up to 20 visits per yr (Combined w/Acupuncture) (American Specialty Health 877-335-2746)	
GYM MEMBERSHIP	Member reimbursement up to \$25 each month for gym/health club dues	\$0 Silver & Fit (877) 427-4788	\$0 (Silver & Fit 877-427-4788)	
ROUTINE DENTAL: Dental Health Services (DHS) 888-645-1261	Copay varies based upon procedure performed	Copay varies based upon procedure performed (no upgrade available)	<b>No basic dental plan</b> Optional upgrade – \$12 per month	
ROUTINE VISION: Vision Service Plan (VSP) 800-877-7195 • Eye Exams • Eyewear	\$0 copay (every 12 months) \$0 copay (\$175 material allowance every 24 months)	\$0 copay (every 24 months) \$0 copay (\$100 material allowance every 24 months)	\$0 copay (every 12 months) \$0 copay (\$175 material allowance every 24 months)	
ROUTINE PODIATRY	Not Covered	Not Covered	\$0 (up to 4 visits per year)	
NURSING HOTLINE	888-463-9220	888-463-9220	888-463-9220	
RADIATION THERAPY	\$15 per visit	10% coinsurance	20%	\$0
OTC ITEMS	\$30 per quarter	Not Covered	\$30 per month	

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X-RAY / DIAGNOSTIC X-RAY	\$0 – \$60 copay	\$40 copay	20%	\$0
OUTPATIENT HOSP/SURGERY CENTER	\$0	\$0	20%	\$0
TRANSPORTATION	\$0 copay, 12 one-way trips (American Logistics 844-813-5845)	\$0 copay, 24 one-way trips Transportation line 760-969-6555 (Prior Authorization required)	\$0 copay, 60 one-way trips (American Logistics 844-813-5845)	
DME AND PROSTHETICS	10% coinsurance	0 – 10% coinsurance (DME) 0 – 20% coinsurance (Prosthetics)	20%	\$0
DIABETIC SUPPLIES	\$0	\$0	20%	\$0
DIABETIC THERAPUTIC SHOES/INSERTS	10% coinsurance	\$0	20%	\$0
PHYSICAL/SPEECH/OCCUPATIONAL THERAPY	\$10	\$10	20%	\$0
MEDICARE PART B DRUGS	15% coinsurance	20% coinsurance	20%	\$0
ROUTINE HEARING EXAM AND HEARING AIDS STS/VP only: Tru Hearing 866-201-9936	\$0 copay for up to: • 1 routine hearing test per yr • \$699 copay per aid for Tru Hearing Advanced or \$999 copay per aid for Tru Hearing Premium.	\$0 copay for up to: • 1 routine hearing test per yr • 1 fitting/eval for hearing aids per yr • \$500 coverage limit for hearing aids every 2 yrs (Prior Authorization required)	\$0 copay for up to: • 1 routine hearing test per yr • \$699 copay per aid for TruHearing Advanced or \$999 copay per aid for Tru Hearing Premium.	
PART D DRUGS	\$4,020	\$4,020	\$4,020	\$4,020
Initial Coverage Limit (30 day retail)			Deductible: \$435	Deductible: \$0
• Tier 1 Preferred Generic Drugs	\$0 (covered in the coverage gap)	\$0 (Covered in Coverage Gap)	Tier 1 – \$0	\$0 or \$1.30 or \$3.60
• Tier 2 Generic Drugs	\$5 (covered in the coverage gap)	\$12 (Covered in Coverage Gap)	Tier 2 – 25%	\$0 or \$1.30 or \$3.60
• Tier 3 Preferred Brand Drugs	\$47	\$47	Tier 3 – 25%	\$0 or \$3.90 or \$8.95
• Tier 4 Non-preferred Drugs	25%	30%	Tier 4 – 25%	\$0 or \$1.30 or \$3.60 or \$3.90 or \$8.95
• Tier 5 Specialty Drugs	33%	33%	Tier 5 – 25%	\$0 or \$1.30 or \$3.60 or \$3.90 or \$8.95
• Tier 6 Select Diabetic Drugs (STS) / Select Care Drugs (DPC)	\$11 (covered in the coverage gap)	\$11 (Covered in Coverage Gap)	No Tier 6 for product	No Tier 6 for product
Catastrophic Coverage After yrly out-of-pocket drug costs reach \$6,350, the member pays the greater of \$3.60 generic and \$8.95 brand, or 5%.	Mail order: 2 copays for 90-day (Tiers 1, 2 & 6) 2.5 copays for 90-day (Tiers 3) <b>Retail: 3 copays for 90-day</b> <b>NOT</b> all drugs are available for 90-day supply. Review formulary for details.	<b>3 copays for 90-day</b> <b>NOT</b> all drugs are available for 90-day supply. Mail order: 1 month Specialty and Select Care Drugs available.	<b>NOT</b> all drugs are available for 90-day supply.	

**COVERAGE GAP DISCOUNT** – Member pays no more than 25% of cost of Brand drugs and 25% of the cost for generic drugs.

**LIS COPAYS** (1) \$3.60/\$8.95 (2) \$1.30/\$3.90 (3) \$0 (4) 15%