INTER VALLEY HEALTH PLAN 2021 BENEFITS

Inter Valley Health Plan
Medicare plans for health. Not for profit.

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)	$1,000	$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	$90/$120 outside US $20,000 outside US (ER copay **NOT** waived outside US)	$120 $20,000 outside US (Copay waived with hospital admission)	$90/$120 outside US $20,000 outside US (ER Copay NOT waived)	$0/$120 outside US
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	$5 up to 15 visits per yr **Chiro only** (American Specialty Health 877-335-2746)	$0 up to 20 visits per yr **Chiro only**, prior authorization required	$0 up to 20 visits per yr (Combined w/Acupuncture) (American Specialty Health 877-335-2746)	
GYM MEMBERSHIP	Member reimbursment 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 Optional upgrade $12 per month	Copay varies based upon procedure performed (no upgrade available)	**No basic dental plan** 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	
OTC ITEMS	$50 per quarter	Not Covered	$30 per month	

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RADIATION THERAPY	$15 per visit	10% coinsurance	20%	$0
X-RAY / DIAGNOSTIC X-RAY	$0 – $60 copay	$40 copay	20%	$0
OUTPATIENT HOSP/SURGERY CENTER	$0	$0	20%	$0
TRANSPORTATION	$0 copay, 30 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 Medical supplies $0	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	$0	$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	$4,130	$4,130	$4,130	$4,130
Initial Coverage Limit (30 day retail)			Deductible: $445	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 $3.70
• Tier 2 Generic Drugs	$5 (covered in the coverage gap)	$12 (Covered in Coverage Gap)	Tier 2 – 25%	$0 or $1.30 or $3.70
• Tier 3 Preferred Brand Drugs	$47	$47	Tier 3 – 25%	$0 or $4.00 or $9.20
• Tier 4 Non-preferred Drugs	25%	30%	Tier 4 – 25%	$0 or $1.30 or $3.70 or $4.00 or $9.20
• Tier 5 Specialty Drugs	33%	33%	Tier 5 – 25%	$0 or $1.30 or $3.70 or $4.00 or $9.20
• Tier 6 Select Diabetic Drugs	$11 (covered in the coverage gap)	$11 (Covered in Coverage Gap)	No Tier 6 product	No Tier 6 product
Catastrophic Coverage After yrly out-of-pocket drug costs reach $6,550, the member pays the greater of $3.70 generic and $9.20 brand, or 5%.	Mail order: 2 copays for 90-day (Tiers 1, 2 & 6) 2.5 copays for 90-day (Tiers 3) **Retail: 3 copays for 90-day** **NOT** all drugs are available for 90-day supply. Review formulary for details.	**3 copays for 90-day** **NOT** all drugs are available for 90-day supply. Mail order: 1 month Specialty and Select Care Drugs available.	**NOT** 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) $3.70/$9.20 (2) $1.30/$4.00 (3) $0 (4) 15%