2015 Summary of Benefits

Desert Preferred Choice (HMO)

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Se Habla Español.

Inter Valley Health Plan

For health. Not for profit.

It's Personal.

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Summary Of Benefits January 1, 2015 - December 31, 2015

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage".

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Inter Valley Health Plan Desert Preferred Choice (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Inter Valley Health Plan Desert Preferred Choice (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Inter Valley Health Plan Desert Preferred Choice (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at (800) 500-7018. TTY/TDD (800) 505-7150.

Esta información está disponible gratis en otros idiomas. Por favor llame a nuestro número de servicio al cliente al 800-251-8191 y 800-505-7150, de 7:30 am a 8 pm, los 7 días de la semana.

Summary Of Benefits January 1, 2015 - December 31, 2015

Things to Know About Inter Valley Health Plan Desert Preferred Choice (HMO)

Hours of Operation

You can call us 7 days a week from 7:30 a.m. to 8:00 p.m. Pacific time.

Inter Valley Health Plan Desert Preferred Choice (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free (800) 251-8191. TTY/TDD (800) 505-7150.
- If you are not a member of this plan, call toll-free (800) 500-7018. TTY/TDD (800) 505-7150.
- Our website: http://www.ivhp.com

Who can join?

To join **Inter Valley Health Plan Desert Preferred Choice (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following county in California: Riverside*.

* denotes partial county

Riverside County:

91752; 92028; 92201; 92202; 92203; 92210; 92211; 92220; 92223; 92230; 92234; 92235; 92236; 92240; 92241; 92247; 92248; 92253; 92255; 92258; 92260; 92261; 92262; 92263; 92264; 92270; 92276; 92282; 92292; 92320; 92324; 92373; 92399; 92501; 92502; 92503; 92504; 92505; 92506; 92507; 92508; 92509; 92513; 92514; 92515; 92516; 92517; 92518; 92519; 92521; 92522; 92530; 92531; 92532; 92536; 92539; 92543; 92544; 92545; 92546; 92548; 92549; 92551; 92552; 92553; 92554; 92555; 92556; 92557; 92561; 92562; 92563; 92564; 92567; 92570; 92571; 92572; 92581; 92582; 92583; 92584; 92585; 92586; 92587; 92589; 92590; 92591; 92592; 92593; 92595; 92596; 92599; 92860; 92877; 92878; 92879; 92880; 92881; 92882; 92883;

Which doctors, hospitals, and pharmacies can I use?

Inter Valley Health Plan Desert Preferred Choice (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.ivhp.com).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what* is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, http://www.ivhp.com.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium?	$0 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply. Inter Valley Health Plan is a not-for-proft HMO with a Medicare contract. Enrollment in Inter Valley Health Plan depends on contract renewal.

COVERED MEDICAL AND HOSPITAL BENEFITS

Note:

- **Services with a [1] may require prior authorization.**
- **Services with a [2] may require a referral from your doctor.**

OUTPATIENT CARE AND SERVICES

Acupuncture and Other Alternative Therapies[1,2]	For up to 4 visit(s) every year; there is a limit to how much our plan will pay: You pay nothing
Ambulance[1]	$100 copay If you are admitted to the hospital, you do not have to pay for the ambulance services.
Chiropractic Care[1,2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing Routine chiropractic visit (for up to 6 every year): You pay nothing
Dental Services[1,2]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing Preventive dental services: • Cleaning (for up to 2 every year): You pay nothing • Dental x-ray(s) (for up to 2 every year): You pay nothing • Fluoride treatment (for up to 2 every year): You pay nothing • Oral exam (for up to 2 every year): You pay nothing
Diabetes Supplies and Services[1,2]	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing

Diagnostic Tests, Lab and Radiology Services, and X-Rays[1,2]	Diagnostic radiology services (such as MRIs, CT scans): You pay nothing Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): 10% of the cost
Doctor's Office Visits[1,2]	Primary care physician visit: You pay nothing Specialist visit: You pay nothing
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	0-10% of the cost, depending on the equipment
Emergency Care	$50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. $20,000 plan coverage limit for emergency services outside the US and its territories every year.
Foot Care *(podiatry services)*[1,2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing Routine foot care (for up to 2 visit(s) every three months; there is a limit to how much our plan will pay): You pay nothing
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: You pay nothing Routine hearing exam (for up to 1 every year): You pay nothing Hearing aid fitting/evaluation (for up to 1 every year): You pay nothing Hearing aid: You pay nothing Our plan pays up to $1,000 every two years for hearing aids.
Home Health Care[1,2]	You pay nothing Includes medically necessary, Medicare-covered, intermittent skilled nursing care, home health aide services and rehabilitation services.

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

Mental Health Care[1,2]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $912 copay per stay Outpatient group therapy visit: You pay nothing Outpatient individual therapy visit: You pay nothing
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing Occupational therapy visit: You pay nothing Physical therapy and speech and language therapy visit: You pay nothing
Outpatient Substance Abuse[1,2]	Group therapy visit: You pay nothing Individual therapy visit: You pay nothing
Outpatient Surgery[1,2]	Ambulatory surgical center: You pay nothing Outpatient hospital: You pay nothing
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: 0-20% of the cost, depending on the device Related medical supplies: 0-20% of the cost, depending on the supply
Renal Dialysis[1,2]	You pay nothing
Transportation[1,2]	You pay nothing Our plan covers up to 34 one-way trips per year to plan-approved locations.

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

Urgent Care	You pay nothing If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Routine eye exam (for up to 1 every two years): You pay nothing Contact lenses (for up to 1 every two years): You pay nothing Eyeglasses (frames and lenses) (for up to 1 every two years): You pay nothing Eyeglasses or contact lenses after cataract surgery: You pay nothing Our plan pays up to $100 every two years for contact lenses and eyeglasses (frames and lenses).

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

Preventive Care[1,2]	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings • Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

• Services with a [1] may require prior authorization.
• Services with a [2] may require a referral from your doctor.

INPATIENT CARE	
Inpatient Hospital Care[1,2]	Our plan covers an unlimited number of days for an inpatient hospital stay. You pay nothing
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1,2]	Our plan covers up to 100 days in a SNF. • $0 copay per day for days 1 through 20 • $25 copay per day for days 21 through 100
PRESCRIPTION DRUG BENEFITS	
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost
Initial Coverage	You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. **Standard Retail Cost-Sharing**

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Non-Preferred Generic)	$3 copay	$9 copay
Tier 3 (Preferred Brand)	$40 copay	$120 copay
Tier 4 (Non-Preferred Brand)	$80 copay	$240 copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

- Services with a [1] may require prior authorization.
- Services with a [2] may require a referral from your doctor.

Initial Coverage
(Continued)

Standard Mail Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	Not Offered	$0
Tier 2 (Non-Preferred Generic)	Not Offered	$9 copay
Tier 3 (Preferred Brand)	Not Offered	$120 copay
Tier 4 (Non-Preferred Brand)	Not Offered	$240 copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Coverage Gap
(Continued)

Standard Retail Cost-Sharing

Tier	Drugs Covered	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$0	$0
Tier 2 (Non-Preferred Generic)	All	$3 copay	$9 copay

Standard Mail Order Cost-Sharing

Tier	Drugs Covered	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	Not Offered	$0
Tier 2 (Non-Preferred Generic)	All	Not Offered	$9 copay

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:

- 5% of the cost, or
- $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.

Additional Information About Inter Valley Health Plan Desert Preferred Choice (HMO)

Health club membership – You pay $0 for health club membership at participating fitness clubs. Membership includes standard fitness facility services. Any services that typically require an additional fee are not included.

800-500-7018

TTY/TDD 800-505-7150

7:30 am to 8 pm, 7 days a week.

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