



Inter Valley Health Plan

Medicare plans for health. Not for profit.

2021 Summary of Benefits

Service To Seniors (HMO) H0545, Plan 001

This is a summary of drug and health services covered by **Inter Valley Health Plan Service To Seniors (HMO)** January 1, 2021 – December 31, 2021.

Inter Valley Health Plan Service To Seniors (HMO) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

This information is not a complete description of benefits. Call our Sales Department at 800-500-7018 or TTY 711 for more information.

To join **Inter Valley Health Plan Service To Seniors (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 portions of the following counties in California: Los Angeles, Orange, Riverside and San Bernardino.

Inter Valley Health Plan Service To Seniors (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.



Premiums & Benefits	Service To Seniors (HMO)
Monthly Plan Premium	<p>You pay \$0</p> <p>You must continue to pay your Medicare Part B Premium.</p>
Deductible	<p>You pay \$0</p> <p>This Plan does not have a deductible.</p>
<p>Maximum Out-of Pocket Responsibility (Does not include prescription drugs)</p>	<p>\$1,000 annually</p> <p>The most you pay for copays and coinsurance for Medicare-covered medical services for the year.</p> <p>Amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services include health club/gym/fitness studio membership fees, hearing aids, routine/Non-Medicare covered dental services and routine/Non-Medicare covered vision services.</p>
Inpatient Hospital Services*	<p>You pay \$0 for each Medicare-covered hospital stay.</p> <p>Our Plan covers an unlimited number of days for an inpatient hospital stay.</p>
Outpatient Hospital Services*	<ul style="list-style-type: none"> ■ You pay \$0 for Outpatient Hospital ■ You pay \$0 for Ambulatory Surgical Center
Doctor Visits	<p>You pay \$0 for primary care visits</p> <p>You pay \$0 for specialists visits*</p>
<p>Preventive Care (example: flu vaccine, annual wellness visit, diabetic screenings, breast cancer screenings (mammograms) and colorectal cancer screenings.)</p>	<p>You pay \$0</p> <p>Any additional preventive services approved by Medicare during the contract year are covered.</p>

*Prior Authorization is required

Premiums & Benefits	Service To Seniors (HMO)
Emergency Care	<p>You pay \$90 copay per visit within the U.S. and its territories</p> <p>You pay \$120 copay worldwide</p> <p>The emergency room copay will be waived if you are admitted as an inpatient within 24 hours of the ER visit for the same condition (within the US & its territories).</p> <p>You are covered for worldwide emergency services.</p>
Urgently Needed Services	You pay \$0
<p>Diagnostic Services/Labs/Imaging*</p> <ul style="list-style-type: none"> ■ Lab services ■ Diagnostic tests & procedures ■ Outpatient x-rays ■ Therapeutic radiology ■ Diagnostic radiology service (example, MRI) 	<p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$0</p> <p>You pay \$15 per visit</p> <p>You pay \$60 copay</p>
<p>Hearing Services</p> <ul style="list-style-type: none"> ■ Non-Medicare covered (routine) hearing exam ■ Non-Medicare covered (routine) hearing aids 	<p>You pay \$0 for up to 1 visit per year</p> <p>You pay \$699 copay per aid for Tru Hearing Advanced or \$999 copay per aid for Tru Hearing Premium.</p> <p>You are covered for up to 2 hearing aids every year. You must go to a Tru Hearing contracted provider to obtain a routine hearing exam and hearing aids.</p>
<p>Dental Services</p> <p>Non-Medicare covered (routine)</p> <ul style="list-style-type: none"> ■ Oral exam ■ Cleaning ■ Dental x-rays 	<p>You pay \$4 copay</p> <p>You pay \$10 copay</p> <p>You pay \$0 to \$10</p> <p>Additional dental services available including diagnostic, preventive and restorative procedures. Copayments for dental services vary based upon the procedure performed by a general dentist. Dental services provided through Dental Health Services (DHS).</p>

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Premiums & Benefits	Service To Seniors (HMO)
<p>Vision Services Eye Exam</p> <ul style="list-style-type: none"> ■ Non-Medicare covered (routine) ■ Non-Medicare covered (routine) Eyeglasses (frames and lenses) 	<p>You pay \$0</p> <p>You pay \$0</p> <p>Limit one exam per year from a Vision Service Plan (VSP) provider.</p> <p>We cover up to \$175 every two years for eyeglasses (frames and lenses).</p>
<p>Mental Health Services*</p> <ul style="list-style-type: none"> ■ Outpatient group/individual therapy visit ■ Inpatient visit 	<p>You pay \$0</p> <p>\$75 copay for days 1 – 6</p> <p>You pay \$0 for days 7 – 90</p> <p>Our Plan covers up to 190-lifetime limit in a psychiatric hospital.</p>
<p>Skilled Nursing Facility*</p>	<p>You pay \$0 for days 1-20</p> <p>\$50 copay per day for days 21-100</p> <p>Our Plan covers up to 100 days in a skilled nursing facility. No prior hospitalization required.</p>
<p>Physical Therapy*</p>	<ul style="list-style-type: none"> ■ You pay \$0 for Physical Therapy visits ■ You pay \$0 for outpatient rehabilitation visits (example, occupational and speech therapy).
<p>Ambulance</p>	<p>You pay \$195 copay per one-way trip.</p>
<p>Transportation</p>	<p>You pay \$0 for up to 30 one-way trips per year.</p> <p>You must use Inter Valley Health Plan contracted providers to obtain routine transportation services.</p>
<p>Medicare Part B Drugs*</p>	<p>You pay 15% of the cost for chemotherapy and other Part B drugs.</p>

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OUTPATIENT PRESCRIPTION DRUGS

Initial Coverage	30-day supply retail	90-day supply mail order (90-day supply available on some drugs)
■ Tier 1: Preferred Generic Drugs	You pay \$0	You pay \$0
■ Tier 2: Generic Drugs	You pay \$5	You pay \$10
■ Tier 3: Preferred Brand Drugs	You pay \$47	You pay \$117.50
■ Tier 4: Non-Preferred Drugs	You pay 25%	You pay 25%
■ Tier 5: Specialty Drugs	You pay 33%	Not covered
■ Tier 6: Select Diabetic Drugs	You pay \$11	You pay \$22

<p>Coverage for select Insulins</p> <p>NEW</p>	<p>You pay \$20 per prescription for a 30-day supply of select insulins in Tier 3: Preferred Band Drugs filled at a network pharmacy.</p> <p>You pay \$35 per prescription for a 30-day supply of select insulins in Tier 4: Non-Preferred Drugs filled at a network pharmacy.</p> <p>Inter Valley Health Plan Service To Seniors (HMO) offers additional gap coverage for Select Insulins.</p>
<p>Coverage Gap</p> <p>(Coverage Gap applies only to Tiers 1, 2 and 6)</p>	<p>Once you and Inter Valley Health Plan have paid \$4,130 for drugs:</p> <ul style="list-style-type: none"> ■ You pay the same copay as in the Initial Coverage Stage for Tier 1 and Tier 2, or 25% of the cost for generic drugs whichever is lower. ■ For drugs in Tier 6, you pay the same copay as the initial Coverage Stage or you pay 25% of the negotiated price (and a portion of the dispensing fee) for brand name drugs, whichever is lower. ■ For drugs in other tiers, you pay 25% of the negotiated price (and a portion of the dispensing fee) for brand name drugs and 25% of the cost for generic drugs. ■ You stay in this phase until you have spent \$6,550 total (including copays paid in phase 1 and brand name discounts received in phase 2).
<p>Catastrophic Coverage</p>	<p>After your yearly out-of-pocket drug cost reach \$6,550, you pay the greater of:</p> <ul style="list-style-type: none"> ■ 5% of the cost, or ■ \$3.70 copay for generic drugs and a \$9.20 copay for other drugs

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

Cost sharing may change depending on the pharmacy you choose (example, retail, mail order, long-term care, etc), whether you receive a 30 or 90-day supply, and when you enter another phase of the Part D benefit.

For more information, please call the Sales Department at the number provided or access our Evidence of Coverage online.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits

Premiums & Benefits	Service To Seniors (HMO)
<p>Medical Equipment/Supplies*</p> <ul style="list-style-type: none"> ■ Durable Medical Equipment (DME) (example, wheelchairs, oxygen) ■ Prosthetics (example, braces, artificial limbs) ■ Diabetes supplies 	<p>You pay 10% of the cost</p> <p>You pay 10% of the cost</p> <p>You pay \$0</p>
<p>Chiropractic Services NEW</p>	<p>15 visits per year..... \$5 copay per visit</p> <p>You can self-refer to a provider contracted with American Specialty Health (ASH) for an initial chiropractic visit. Any subsequent visits will require prior authorization through ASH.</p>
<p>Over-the-counter Items</p>	<p>Coverage up to \$50 each quarter (every 3 months) towards over-the-counter items.</p> <p>Contact the Plan for a list of available items and detailed instructions on ordering items.</p>
<p>Wellness Programs (example, fitness)</p>	<p>You may be reimbursed up to \$25 per month toward gym/health club/fitness studio membership dues.</p>
<p>Nurse Hotline</p>	<p>You pay \$0 to speak with a registered nurse 24 hours a day, 7 days a week, 888-463-9220.</p>
<p>Personal Emergency Response System* NEW</p>	<p>You pay \$0</p>
HELP WITH CHRONIC CONDITIONS	
<p>After an Inpatient Stay due to one of the following diagnosis:*</p> <ul style="list-style-type: none"> ■ Chronic Obstructive Pulmonary Disease (COPD) ■ Chronic Heart Failure ■ Stroke with Paralysis 	<p>You pay \$0 for:</p> <ul style="list-style-type: none"> ■ In-Home Support Services — up to 20 hours ■ Home-Delivered Meals — up to 10 meals <p>Criteria and limitations apply</p>

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Premiums & Benefits

Service To Seniors (HMO)

OPTIONAL SUPPLEMENTAL BENEFITS

Enhanced Dental Services

- Monthly premium

You pay \$12 per month

Benefits include preventive, diagnostic and restorative dental services. Copayments for dental services vary based upon the procedure performed.

Enhanced Dental Services provided through Dental Health Services (DHS).

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

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Sales Representative at 800-500-7018.

UNDERSTANDING THE BENEFITS

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.ivhp.com or call 800-500-7018 to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

UNDERSTANDING IMPORTANT RULES

- You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).



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For more information please call the number below or visit us at ivhp.com.

Current Members call toll free: 1-800-251-8191, TTY users should call 711.

Prospective Members call toll free: 1-800-500-7018, TTY users should call 711.

Contact our Member Care Team or Pharmacy Care Team

October 1 to March 31: 8 am to 8 pm, 7 days a week.

We are closed on Thanksgiving Day and Christmas Day.

Contact us April 1 to September 30: 8 am to 8 pm, Monday through Friday.

We are closed on federal holidays.

NOTE: When we are closed you have the option to leave a message. Messages received will be returned within one (1) business day.

You can see our plan's provider/pharmacy directory on our website at ivhp.com.

You can see the complete Plan formulary (list of Part D prescription drugs) and restrictions on our website at ivhp.com

800-500-7018 or TTY 711
8 am to 8 pm, 7 days a week.
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