



INDEPENDENT CARE HEALTH PLAN

iCare has been securing the wellness of people with complex conditions for over two decades.



2020 SUMMARY OF BENEFITS

iCare Medicare Advantage Plan (HMO)

H2237_IC2205_M 10/6/2019
Updated 11/12/2019

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 customer service representative at 1-800-777-4376 (TTY: 1-800-947-3529), 24 hours a day, 7 days a week. Office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.

Understanding the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.iCareHealthPlan.org or call 1-800-777-4376 (TTY: 1-800-947-3529) to view a copy of the EOC.
- Review the Provider/Pharmacy 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 Provider/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

- In addition to our monthly plan premium, 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 co-payments/co-insurance may change on January 1, 2021.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider/Pharmacy directory).

2020 SUMMARY OF BENEFITS

January 1, 2020 – December 31, 2020

This is a summary of drug and health services covered by iCare Medicare Advantage Plan (HMO) (H2237-011).

Independent Care Health Plan (iCare) insures iCare Medicare Advantage Plan. iCare is an HMO with a Medicare contract. Enrollment in iCare Medicare Advantage plan depends on iCare's contract renewal.

The benefit information provided in this booklet is 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 (EOC)" or you can see it on our website at www.iCareHealthPlan.org.

HOURS OF OPERATION

You can call Customer Service, 24 hours a day, 7 days a week.

Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.

HOW TO CONTACT iCARE MEDICARE ADVANTAGE PLAN

- » If you are a **member** of our plan, call toll-free **1-800-777-4376** (TTY 1-800-947-3529)
 - » If you are **NOT a member** of our plan, call toll-free **1-866-790-3691** or 414-225-4794 (TTY 1-800-947-3529)
 - » Our website: **www.iCareHealthPlan.org**
 - » Email: info@iCareHealthPlan.org
-

WHO CAN JOIN?

To join iCare Medicare Advantage Plan, you:

- » Must have both Medicare Part A and Medicare Part B.
 - » You cannot have End-Stage Renal Disease (exceptions may apply).
 - » You must live in our service area. Our service area includes these counties in Illinois:
 - Boone
 - Winnebago
-

EXTRA HELP

If you meet certain income and resource limits, you may qualify for a program called Extra Help from Medicare to pay the prescription costs, premiums, deductibles, and co-insurance of Medicare prescription drug coverage. Some people pay only a portion of their Medicare drug plan premiums and deductibles based on their income level. The amount of Extra Help you get will determine how much you pay.

Please see page 13 for more information on Extra Help.

The EOC Chapter 2, Section 7 also has information about Extra Help. You can also visit www.socialsecurity.gov/extrahelp, or call Social Security at **1-800-772-1213** (TTY 1-800-325-0778). Social Security representatives are available to help you complete your application. The sooner you apply, the sooner you'll begin receiving benefits.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

The *iCare* Medicare Advantage Plan is a Health Maintenance Organization (HMO) plan. As a member, you must select an in-network doctor to act as your Primary Care Provider (PCP).

Members enrolled in HMO plans must receive their health care from doctors, hospitals and other providers within the *iCare* Medicare Advantage Plan network. If you use providers or facilities that are not in our network, the plan may not pay for these services.

iCare Medicare Advantage Plan also has an extensive network of pharmacies to fill your prescriptions for covered Part D drugs. You must generally use these network pharmacies.

- » You can see our plan's Provider/Pharmacy Directory at our website: www.iCareHealthPlan.org
- » You can use the "Find a Provider" search tool on our website (www.iCareHealthPlan.org) to search for providers or pharmacies in your area.
- » Or, if you would like to receive a copy of the Provider/Pharmacy Directory by mail, call us and we will send you a copy.

WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers — however, we cover even more.

- » **Our plan members get all of the benefits covered by Original Medicare.**
- » **Our plan members also get MORE THAN what is covered by Original Medicare.** Some of the added benefits (or supplemental benefits) are outlined in this booklet — benefits like dental, vision and OTC benefits.

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, www.iCareHealthPlan.org. 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 three "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: Yearly Deductible (if applicable), Initial Coverage, Coverage Gap, and Catastrophic Coverage.

You may get drugs from an in-network pharmacy, out-of-network pharmacy, and through the plan's mail order pharmacy at the same cost.

- » You can see our Formulary (list of Part D prescription drugs) at www.iCareHealthPlan.org.
- » Or if you would like to receive a copy of the Formulary by mail, call us and we'll send you a copy.

TIPS FOR COMPARING YOUR MEDICARE CHOICES

- » 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 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 at 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.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS

MONTHLY PLAN PREMIUM

You must keep paying your Medicare Part B premium.

You pay \$26

MEDICAL DEDUCTIBLE

This plan has medical deductibles for some hospital and medical services.

\$198 per year for in-network services.

PHARMACY (PART D) DEDUCTIBLE

Applies to Tiers 2 & 3

\$435.00

MAXIMUM-OUT-OF-POCKET RESPONSIBILITY (does not include prescription drugs)

All Medicare health plans have yearly limits on members' out-of-pocket costs for medical and hospital care. This is the most you pay for co-pays, co-insurance and other costs for medical services for the year.

Your yearly limit(s) in this plan: \$6,700 for in-network Medicare-covered benefits.

COVERED MEDICAL AND HOSPITAL BENEFITS AND SERVICES

INPATIENT HOSPITAL COVERAGE

This 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. The 60 lifetime reserve days can be used only once during a member's lifetime for care provided in either an acute care hospital or a psychiatric hospital. The co-pays for inpatient hospital care are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

You will not be charged additional cost sharing for professional services.

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

In 2020, the amounts you pay for each benefit period are \$0 or:

- » \$1,408 deductible for each benefit period.
- » Days 1–60: \$0 co-insurance for each benefit period.
- » Days 61–90: \$352 co-insurance per day of each benefit period.
- » Days 91 and beyond: \$704 co-insurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).
- » Beyond lifetime reserve days: all costs.

Prior Authorization is required. Except in an emergency, you must receive doctor approval before admission.

COVERED MEDICAL AND HOSPITAL BENEFITS AND SERVICES

OUTPATIENT HOSPITAL COVERAGE

Outpatient Hospital	\$0 co-payment
Medicare-covered Outpatient Hospital Services	\$0 deductible
Medicare-covered Observation Services	You pay 20% co-insurance of the cost per visit

AMBULATORY SURGERY CENTER

Medicare-covered Ambulatory Surgical Center services	\$0 co-payment
	\$0 deductible
	You pay 20% co-insurance of the cost per visit

DOCTOR VISITS

Primary Care	\$0 co-payment
Medicare-covered Primary Care Physician/Practitioner Services	\$0 deductible
	You pay 20% co-insurance of the cost for each visit

Specialists	\$0 co-payment
Medicare-covered Physician Specialist Services.	\$0 deductible
A referral is not required to see a specialist with the exception of second and all additional opinions.	You pay 20% co-insurance of the cost for each visit
<i>May require Prior Authorization from the plan.</i>	

PREVENTIVE CARE

Any additional preventive services approved by Medicare during the contract year will be covered.

Our plan covers many preventive services at no cost (\$0 co-pay, \$0 deductible, 0% co-insurance) when you see an in-network provider including:

- » Abdominal aortic aneurysm screening
- » Alcohol misuse screenings & counseling
- » Bone mass measurement (bone density)
- » Cardiovascular disease screenings
- » Cardiovascular disease (behavioral therapy)
- » Cervical and vaginal cancer screening
- » Colorectal cancer screening:
 - Multi-target stool DNA tests
 - Screening barium enemas
 - Screening colonoscopies
- Screening fecal occult blood tests
- Screening flexible sigmoidoscopies
- » Depression screenings
- » Diabetes screenings
- » Glaucoma tests
- » Hepatitis B Virus (HBV) infection screening
- » Hepatitis C screening test
- » HIV screening
- » Lung cancer screening
- » Mammograms (screening)
- » Medicare diabetes prevention program
- » Nutrition therapy services
- » Obesity screenings and counseling
- » One-time "Welcome to Medicare" preventive visit
- » Prostate cancer screening
- » Sexually transmitted infections screening & counseling
- » Shots:
 - Flu shots
 - Hepatitis B shots
 - Pneumococcal shots
- » Tobacco use cessation counseling
- » Yearly "Wellness" visit

COVERED MEDICAL AND HOSPITAL BENEFITS AND SERVICES

EMERGENCY CARE

Emergency Care for Medicare-covered Emergency room visits.

You pay \$90 co-payment for Medicare-covered emergency room visits.
0% co-insurance.
Contact the Plan after you receive emergency care.
If you are admitted to the hospital within 3 days for the same condition, you do not have to pay your share of the cost for emergency care.
Emergency care is not covered outside the U.S. and its territories.

URGENTLY NEEDED SERVICES

Urgent Care for Medicare-covered urgency care visits.

\$0 co-payment
\$0 deductible
You pay 20% co-insurance of the cost (up to \$65).
Contact the Plan after you receive urgently needed services.
Urgently needed services are immediate care, not emergency care. Urgently needed care/services are not covered outside the U.S. and its territories.

DIAGNOSTIC SERVICES/LABS/IMAGING LAB SERVICES

Diagnostic Tests and Procedures

May require Prior Authorization from the plan.

\$0 co-pay
\$0 deductible
You pay 20% co-insurance of the cost.

Lab Services

May require Prior Authorization from the plan.

\$0 co-pay
\$0 deductible
You pay 20% co-insurance of the cost.

Diagnostic Radiology Services (such as MRIs, CT scans, etc.)

\$0 co-pay
\$0 deductible
You pay 20% co-insurance of the cost.

Outpatient X-Rays

\$0 co-pay
\$0 deductible
You pay 20% co-insurance of the cost.

Therapeutic Radiology Services (such as radiation treatment for cancer)

\$0 co-pay
\$0 deductible
You pay 20% co-insurance of the cost.

HEARING SERVICES

Covers diagnostic hearing and balance exams if your doctor or other health care provider orders them to see if you need medical treatment.

\$0 co-payment
\$0 deductible
You pay 20% co-insurance of the cost for Medicare-covered exam.

COVERED MEDICAL AND HOSPITAL BENEFITS AND SERVICES

DENTAL SERVICES — Medicare-Covered

You must use in-network providers.

\$0 co-pay

\$0 deductible

0% co-insurance

There may be limits on how much the plan will provide.

DENTAL SERVICES — Non-Medicare Covered

We provide a supplemental benefit under Medicare Part C for preventive and comprehensive (combined) dental services up to \$2,500 per calendar year for:

» Oral Exams

» Prophylaxis (Cleaning)

» Dental X-rays

Supplemental Preventive:

» Oral Exams and cleaning: Up to 2 per calendar year.

» Dental X-Rays: Up to 1 per calendar year. X-Rays are limited to either 1 panoramic or 1 full set per calendar year.

Supplemental Comprehensive:

» Diagnostic Services – Up to 2 visits per calendar year.

» Simple Restorative Services – Limited to Amalgams/Resins (No root canals/crowns) – One restoration per tooth per calendar year.

» Extractions – Simple extractions only, no surgical extractions.

» Prosthodontics – Basic Partials and Basic Dentures are covered, no coverage for repair.

» Emergency Office visits: Limited to 2 visits per calendar year.

VISION SERVICES — Medicare Covered

Medicare-covered exams to diagnose and treat certain diseases and conditions of the eye,

including yearly glaucoma screening, diabetic retinopathy screening for people at risk, and age-related macular degeneration.

One pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.

\$0 co-pay

\$0 deductible

You pay 20% co-insurance of the cost

VISION SERVICES — Non-Medicare Covered

This plan provides a supplemental benefit under Medicare Part C for vision services. All enhanced vision benefits are limited to a total of \$450.00 per calendar year towards:

» The purchase of 1 set of eyeglass lenses and frames

» Contact lenses

» Contact fitting

COVERED MEDICAL AND HOSPITAL BENEFITS AND SERVICES

MENTAL HEALTH SERVICES

Mental Health Services

Inpatient Mental Health Care

Prior Authorization is required.

A provider referral is required for Inpatient Psychiatric Hospital Services.

Medicare also covers up to 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. The 60 lifetime reserve days can be used only once during a member’s lifetime for care provided in either an acute care hospital or a psychiatric hospital. Our plan covers 90 days for an inpatient hospital stay.

Prior Authorization is required. A provider referral is required for Inpatient Psychiatric Hospital Services.

In 2020 the amounts you pay for each benefit period are \$0 or:

- » \$1,408 deductible for each benefit period.
- » Days 1–60: \$0 co-insurance per day of each benefit period.
- » Days 61–90: \$352 co-insurance per day of each benefit period.
- » Days 91 and beyond: \$704 co-insurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime).
- » Beyond lifetime reserve days: all costs.

Outpatient Group Therapy Visit

May require Prior Authorization from the plan.

Outpatient Group Therapy Visit with a Psychiatrist

May require Prior Authorization from the plan.

\$0 co-payment

\$0 deductible

You pay 20% co-insurance of the cost.

Outpatient Individual Therapy Visit

May require Prior Authorization from the plan.

Outpatient Individual Therapy Visit with a Psychiatrist

May require Prior Authorization from the plan.

\$0 co-payment

\$0 deductible

You pay 20% co-insurance of the cost.

SKILLED NURSING FACILITY (SNF)

Prior Authorization is required.

A provider referral is required for Skilled Nursing Facility services.

3-day prior hospital stay is required.

You will not be charged additional cost sharing for professional services.

In 2020 the amounts you pay for each benefit period are \$0 or:

- » Days 1–20: \$0 for each benefit period.
- » Days 21–100: \$176 co-insurance per day of each benefit period.
- » Days 101 and beyond: all costs.

PHYSICAL THERAPY

Physical Therapy and Speech-Language Therapy Services

May require Prior Authorization from the plan.

A provider referral is required for Physical Therapy and Speech Therapy Services.

\$0 co-payment

\$0 deductible

You pay 20% co-insurance of the cost.

COVERED MEDICAL AND HOSPITAL BENEFITS AND SERVICES

Occupational Therapy Services

May require Prior Authorization from the plan.

A provider referral is required for Occupational Therapy Services.

\$0 co-payment

\$0 deductible

You pay 20% co-insurance of the cost.

AMBULANCE

Medicare-covered Ground Ambulance Services

Medicare-covered Air Ambulance Services

\$0 co-payment

\$0 deductible

You pay 20% co-insurance of the cost.

TRANSPORTATION

Plan approved health-related location. This plan provides a supplemental benefit under Medicare Part C for Non-Emergency transportation for 64 one-way trips up to 35 miles. Covered only for travel to/from Weight Watchers meetings.

\$0 co-payment

\$0 deductible

0% co-insurance

ADDITIONAL COVERED BENEFITS

OVER-THE-COUNTER (OTC)

A pre-paid benefits card will allow you to spend \$60 per month (\$720/year) for over-the-counter items using an account that is replenished with funds on a monthly basis. Purchase at a retail store, or through a catalog or website. Members refer to your new member kit for more information.

SILVER SNEAKERS® FITNESS

Provides members with free access to participating fitness centers. Members can use the fitness center's equipment, take a fitness class, and more. Members are also able to utilize this benefit in their home with one of four kits.

May require Prior Authorization from the plan.

\$0 co-pay

\$0 deductible

0% co-insurance

WEIGHT WATCHERS®

The plan will supply members with thirteen-weeks' worth of meeting vouchers at a local, on-site Weight Watchers location.

May require Prior Authorization from the plan.

\$0 co-pay

\$0 deductible

0% co-insurance

PRESCRIPTION DRUG BENEFITS

MEDICARE PART B

The Formulary lists drugs that require prior authorization. You can see the complete plan Formulary (list of Part D prescription drugs) and any restrictions on our website at www.iCareHealthPlan.org.

May require Prior Authorization from the plan.

Chemotherapy drugs	\$0 co-pay \$0 deductible You pay 20% co-insurance of the cost.
Other Part B drugs	\$0 co-pay \$0 deductible You pay 20% co-insurance of the cost.

MEDICARE PART D

Our plan groups each medication into one of three “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. Cost-sharing may change when entering another phase of the Part D benefit or if you qualify for “Extra Help.” To find out if you qualify for “Extra Help,” please contact the Social Security Office at 1-800-772-1213 Monday —Friday, 7 a.m. —7 p.m. TTY users should call 1-800-325-0778.

For any questions, call Customer Service at 1-800-777-4376 (TTY 1-800-947-3529) or access the Evidence of Coverage (EOC) online.

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

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

You may get drugs from an in-network pharmacy, out-of-network pharmacy, and through the plan’s mail order pharmacy at the same cost.

Days’ Supply Available

Unless otherwise specified, you can get your Part D Drug (s) in the following days’ supply amounts:

» One-month supply (up to 30 days)*

» Two-month supply (31-60 days)

» Three-month supply (61-90 days)

*Long term care pharmacy (one-month supply =31 days)

The Part D Prescription Drug benefit has four stages of coverage as shown below. In each stage, you and the plan pay a different share of your prescription drug costs. After you complete Stage 1 you automatically move to Stage 2; once you complete Stage 2, you move to Stage 3; and so on.

The cost-sharing may change when entering another stage of the Part D prescription drug coverage benefit. For more information, you may contact Customer Service at 1-800-777-4376 (TTY 1-800-947-3529), 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.

What YOU PAY as a Member of This Plan



STAGE 1: Yearly Deductible

This plan has a \$435 deductible for Tier 2 and Tier 3 drugs. You pay the full cost of these drugs until you reach \$435. Then you only pay your cost-share.

STAGE 2: Initial Coverage Stage

After you pay your deductible, if applicable, you pay the following until your total yearly drug costs reach \$4,020.

Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

Tier	Standard Retail		Standard Mail Order
	1 Month	3 Month	3 Month
Tier 1 (Generic)	\$15.00 co-pay	\$45.00 co-pay	\$45.00 co-pay
Tier 2 (Brand)	\$48.00 co-pay	\$144.00 co-pay	\$144.00 co-pay
Tier 3 (Specialty)	25% co-insurance		NA

STAGE 3: Gap Coverage Stage

After you enter the coverage gap (you enter the coverage gap after the total drugs costs paid by you and the plan reach \$4,020):

- » **GENERIC:** You pay 25% of the plan's cost for covered drugs
- » **OTHER DRUGS:** You pay 25% of the plan's cost for covered drugs

Until your costs total \$6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap.

STAGE 4: Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350 the Catastrophic Stage begins. Member's will now pay the following co-insurance or co-pay amounts for the remainder of the year.

You pay the greater of 5% co-insurance OR:

GENERIC: \$3.60 co-pay for covered drugs

OTHER DRUGS: \$8.95 co-pay for covered drugs

Anyone who has Medicare can get Medicare prescription drug coverage. Some people with limited resources and income may also be able to get Extra Help to pay for the costs — monthly premiums, annual deductibles, and prescription co-payments — related to a Medicare prescription drug plan. Many people qualify for these important savings and don't even know it.

Some people automatically qualify for help with prescription costs. You automatically qualify for lower prescription costs through Extra Help if you have Medicare and meet any of these conditions:

- » Have full Medicaid coverage.
- » Get help from your state Medicaid program paying your Part B premiums (from a Medicare Savings Program).
- » Get Supplemental Security Income (SSI) benefits.

Even if you automatically qualify this year, you may not qualify for Extra Help next year. Changes in your income or resources may cause you to no longer qualify for lower prescription drug costs through one of the programs listed above. You'll get a notice by the end of September if you no longer automatically qualify. Even if you get this notice, you may still qualify for help with prescription costs, but you need to apply to find out.

If your co-payment amounts change next year, you'll get a notice in the mail in early October with the new amounts. If you don't get a notice from Medicare, you'll get the same level of Extra Help that you got for this year.

The EOC Chapter 2, Section 7 also has information about Extra Help. You can also visit www.socialsecurity.gov/extrahelp, or call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). Social Security representatives are available to help you complete your application. The sooner you apply, the sooner you'll begin receiving benefits.

You can also call and speak to the *i*Care Member Retention Specialists at 1-414-272-5621 (toll-free call Customer Service at 1-800-777-4376 / TTY 1-800-947-3529 and ask to speak to a Member Retention Specialist). Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.

EXTRA HELP

This table shows what your co-pay would be per prescription if you get Extra Help. It also shows you what your monthly plan premium would be if you get Extra Help.

Low Income Subsidy (LIS) Level	Your cost sharing amount for generic/brand drugs treated like generics.	Your cost-sharing amount for all other drugs.	Monthly Premium for <i>i</i> Care Medicare Advantage Plan	
LIS 1	\$3.60 for each prescription	\$8.95 for each prescription	LIS 1, 2 & 3 100%	\$0
LIS 2	\$1.30 for each prescription	\$3.90 for each prescription	LIS 4 75%	\$6.50
LIS 3	\$0 for each prescription	\$0 for each prescription	LIS 4 50%	\$13.00
LIS 4	15% for each prescription	15% for each prescription	LIS 4 25%	\$19.50

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-777-4376 (TTY: 1-800-947-3529).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-777-4376 (TTY: 1-800-947-3529).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-777-4376 (TTY: 1-800-947-3529).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電。1-800-777-4376 (TTY: 1-800-947-3529).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-777-4376 (TTY: 1-800-947-3529).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-777-4376 (رقم هاتف الصم والبكم: 1-800-947-3529).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-777-4376 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-777-4376 (TTY: 1-800-947-3529) 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-777-4376 (TTY: 1-800-947-3529).

Pennsylvania Dutch: Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-777-4376 (TTY: 1-800-947-3529).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-777-4376 (TTY: 1-800-947-3529).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-777-4376 (ATS: 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-777-4376 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-777-4376 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-777-4376 (TTY: 1-800-947-3529).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-777-4376 (TTY: 1-800-947-3529).

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, or sex.

Independent Care Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, or sex.

Independent Care Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - » Qualified sign language interpreters
 - » Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - » Qualified interpreters
 - » Information written in other languages

If you need these services, contact Customer Service at 1-800-777-4376 (TTY: 1-800-947-3529), 24 hours a day, 7 days a week (Office hours: Monday – Friday, 8:30 a.m. – 5:00 p.m.).

If you believe that Independent Care Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, or sex, you can file a grievance with: QAPI Nurse Jeanne Weiss, 1555 North RiverCenter Drive, Suite 206, Milwaukee, Wisconsin 53212, 1-800-777-4376 (TTY 1-800-947-3529), P: 414-963-5343, F: 414-918-7592; or jweiss@icarehealthplan.org. You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance the QAPI Nurse Jeanne Weiss is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Last update: 8/9/2019

IMPORTANT INFORMATION

Independent Care Health Plan (*iCare*) insures *iCare* Medicare Advantage Plan. *iCare* is an HMO with a Medicare contract. Enrollment in *iCare* Medicare Advantage plan depends on *iCare*'s contract renewal.

This document may be available in other formats such as Braille, large print or audio. This document may be available in a non-English language. For additional information call Customer Service at 1-800-777-4376 (TTY 1-800-947-3529). Customer service has free language interpreter services available for non-English speakers.



1555 North RiverCenter Drive, Suite 206
Milwaukee, WI 53212

Phone: 1-800-777-4376, 24 hours a day, 7 days a week

TTY: 1-800-947-3529

Our office hours are Monday – Friday,
8:30 a.m. – 5:00 p.m.

www.iCareHealthPlan.org