

We want to help you.  
Call us if you have questions.  
**Medicare Benefits Consultants**  
1-855-839-0918

**Customer Service**  
1-800-777-4376 (TTY: 711)

Our customer service is open  
24 hours a day, 7 days a week.  
Our office hours are Monday –  
Friday, 8:30 a.m. – 5:00 p.m.



## 2022 Summary of Benefits

### iCare Medicare Plan (HMO D-SNP)



**Corporate Office**  
1555 North RiverCenter Drive, Suite 206  
Milwaukee, Wisconsin 53212  
[www.iCareHealthPlan.org](http://www.iCareHealthPlan.org)

iCare is a wholly-owned subsidiary of Humana.

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# 2022 Summary of Benefits

## iCare Medicare Plan (HMO D-SNP) H2237-001

This booklet is a summary of drug and health services covered by iCare Medicare Plan from January 1, 2022, through December 31, 2022. It is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, see our Evidence of Coverage (EOC) at [www.iCareHealthPlan.org](http://www.iCareHealthPlan.org). Or if you would like to receive a one-time copy of the EOC by mail, call us.

### 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 US

- » If you are a member of iCare Medicare Plan, call Customer Service toll-free at 1-800-777-4376 (TTY: 711).
- » If you are NOT a member of iCare Medicare Plan, call toll-free 1-855-839-0918 (TTY: 711).
- » Visit our web site: [www.iCareHealthPlan.org](http://www.iCareHealthPlan.org)
- » Email: [info@iCareHealthPlan.org](mailto:info@iCareHealthPlan.org)

### ABOUT THIS PLAN

Independent Care Health Plan (iCare) insures iCare Medicare Plan. iCare is a Health Maintenance Organization (HMO). An HMO is a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. iCare is also a Dual Eligible Special Needs Plan (D-SNP). D-SNPs enroll individuals who are entitled to both Medicare and medical assistance from a State plan under Medicaid. States cover some Medicare costs depending on the State and the individual's eligibility. How much Medicaid pays depends on your income, assets, and type of care you need. **Because you have Medicare and Medicaid, most of the costs of this plan will be covered for you.**

iCare has a Medicare contract and a contract with the State Medicaid program. Enrollment in iCare Medicare Plan depend on iCare's contract renewal.

### WHO CAN JOIN iCARE MEDICARE PLAN?

- » Must be eligible for Medicare and Medicaid Benefits OR eligible for Medicare and Medicare cost-sharing assistance under Medicaid.
- » Must have both Medicare Part A and Part B to enroll.
- » Must live in the service area for the plan, which includes these counties in Wisconsin:

- |               |              |             |               |
|---------------|--------------|-------------|---------------|
| • Adams       | • Green      | • Marinette | • Sheboygan   |
| • Bayfield    | • Green Lake | • Menominee | • Trempealeau |
| • Brown       | • Iowa       | • Milwaukee | • Vernon      |
| • Calumet     | • Iron       | • Monroe    | • Walworth    |
| • Columbia    | • Jackson    | • Oconto    | • Washburn    |
| • Crawford    | • Jefferson  | • Outagamie | • Washington  |
| • Dane        | • Juneau     | • Ozaukee   | • Waukesha    |
| • Dodge       | • Kenosha    | • Racine    | • Waupaca     |
| • Door        | • Kewaunee   | • Richland  | • Waushara    |
| • Douglas     | • La Crosse  | • Rock      | • Winnebago   |
| • Fond du Lac | • Lafayette  | • Sauk      |               |
| • Grant       | • Manitowoc  | • Shawano   |               |

## 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 are outlined in this booklet like dental, vision and Over-the-Counter (OTC).

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

## WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

The iCare Medicare Plan has a network of doctors, hospitals, pharmacies, and other providers you must use for your health care services. Please contact the plan for more information.

To search for providers or pharmacies in your area, visit [www.iCareHealthPlan.org](http://www.iCareHealthPlan.org) and click on “Find a Provider”. If you would like to receive a one-time copy of the Provider/Pharmacy Directory by mail, call us. Or use our online order form (go to [www.iCareHealthPlan.org](http://www.iCareHealthPlan.org), scroll down and click on “Make a Request” then fill out and submit the “Hard Copy Request” form) and we will mail you a copy.

## 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. If you receive Extra Help to pay for your prescription drugs, this will also impact how much you pay for your medications.

There are four (4) benefit stages: Deductible, Initial Coverage, Gap Coverage, and Catastrophic Coverage. Refer to page 10 for more information on the four benefit stages, what happens in each stage, and the costs in each stage.

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 the complete plan Formulary (list of Part D prescription drugs) and any restrictions on our web site, [www.iCareHealthPlan.org](http://www.iCareHealthPlan.org). If you would like to receive a one-time copy of the Formulary by mail, call us or use our online order form (go to [www.iCareHealthPlan.org](http://www.iCareHealthPlan.org), scroll down and click on “Make a Request” then fill out and submit the “Hard Copy Request” form) and we will mail you a copy.

## COST-SHARING, BENEFITS AND MEDICAID ELIGIBILITY

Because you get Medicaid assistance from the State, you will pay less for some of your Medicare health care services. Medicaid also provides other benefits to you by covering health care services not usually covered under Medicare. You will also receive “Extra Help” from Medicare to pay for the costs of your Medicare prescription drugs. Refer to page 12 for more information about State Medicaid covered services.

## 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](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 at [www.medicare.gov](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.

# 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: 711), 24 hours a day, 7 days a week. Our 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](http://www.iCareHealthPlan.org) or call 1-800-777-4376 (TTY: 711) 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 medications is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the Comprehensive Formulary to make sure the **medications you take** are covered by the plan. If the drugs you take are not listed, you can ask Customer Service for a list of similar drugs that are covered by the plan. When you receive the list show it to your doctor and ask him or her to prescribe a similar drug that is covered. Or you may be able to ask the plan for an exception to cover your drug.

## UNDERSTANDING IMPORTANT RULES

- You must continue to pay your Medicare Part B premium if you are paying one. The Part B premium is covered (paid for) by the State if you are a full dual member. If you are paying a Part B premium, it is normally taken out of your Social Security check each month.
- If Medicaid is not paying your Medicare premiums, you must continue to pay your Medicare premiums to remain a member of the plan. Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plan's rules for getting your care. Refer to your EOC for more information.
- For most iCare Medicare Plan members, Medicaid pays for your Part A premium (if you don't qualify for it automatically).
- Benefits, premiums, co-payments and/or co-insurance may change on January 1, 2023.
- 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).
- This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a State plan under Medicaid.

## Monthly Premium, Deductible and Limits

<b>Monthly Plan Premium</b>	You pay \$0 or \$42.30. You must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medicaid or a third-party.
<b>Medical Deductible</b>	This plan has deductibles for some hospital and medical services. You pay \$0 or \$233 per year for in-network services, depending on your level of Medicaid eligibility.
<b>Pharmacy (Part D) Deductible</b>	This plan does not have a Part D deductible.
<b>Maximum Out-of-Pocket Responsibility</b> (Does not include prescription drugs)	All Medicare health plans have yearly limits on out-of-pocket costs for medical and hospital care. Your yearly limit in this plan: » \$3,450 for services you receive from in-network providers. In this plan, you may pay nothing for Medicare-covered services depending on your level of Medicaid eligibility. 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 unless you qualify for extra help.

## Covered Medical and Hospital Benefits

<b>Inpatient Hospital Coverage</b>	<p>This plan covers up to 90 days for an inpatient hospital stay.</p> <p>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.</p> <p>In 2022 the amounts you pay for each benefit period are \$0 or:</p> <ul style="list-style-type: none"> <li>» \$1,556 deductible for each benefit period.</li> <li>» Days 1–60: \$0 co-insurance for each benefit period.</li> <li>» Days 61–90: \$389 co-insurance per day of each benefit period.</li> <li>» Days 91 and beyond: \$778 co-insurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime).</li> <li>» Beyond lifetime reserve days: all costs.</li> </ul> <p><i>Prior Authorization is required. Except in an emergency, you must receive doctor approval before admission.</i></p>
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## Covered Medical and Hospital Benefits

<p><b>Outpatient Hospital Coverage</b></p>	<p><b>Medicare-covered Outpatient Hospital Services</b></p> <p><b>Medicare-covered Observation Services</b></p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance per visit</li> </ul>
<p><b>Ambulatory Surgery Center</b></p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance per visit</li> </ul>
<p><b>Doctor Visits</b></p> <p>Primary Care Provider (PCP)</p> <p>Specialists</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance per visit</li> </ul> <p><i>A referral is not required to see a specialist with the exception of second and all additional opinions.</i></p> <p><i>Prior Authorization is required for Specialist visits.</i></p>
<p><b>Preventive Care</b></p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% co-insurance</li> </ul> <hr/> <p>Our plan covers many preventive services at no cost when you see an in-network provider including the list below:</p> <ul style="list-style-type: none"> <li>» Abdominal aortic aneurysm screening</li> <li>» Alcohol and drug misuse counseling</li> <li>» Annual Wellness Visit</li> <li>» Bone mass measurement</li> <li>» Breast cancer screening (Mammograms)</li> <li>» Cardiovascular disease &amp; screenings</li> <li>» Cervical and vaginal cancer screening</li> <li>» Colorectal cancer screening</li> <li>» Depression screening</li> <li>» Diabetes screening</li> <li>» Medicare diabetes self-management training</li> <li>» Glaucoma screening</li> <li>» Hepatitis C virus screening</li> <li>» HIV screening</li> <li>» Lung cancer screening</li> <li>» Medical nutrition therapy services</li> <li>» Obesity screening and counseling</li> <li>» Prostate cancer screenings (PSA)</li> <li>» Sexually transmitted infections screening and counseling</li> <li>» Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</li> <li>» Vaccines, including flu shots, hepatitis B shots, pneumococcal shots</li> <li>» “Welcome to Medicare” preventive visit (one-time)</li> </ul>

## Covered Medical and Hospital Benefits

<p><b>Emergency Care</b> Emergency Care for Medicare-covered Emergency room visits. <b>Contact the plan after you receive emergency care.</b></p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 or \$120 co-pay per visit for Medicare-covered emergency room visits</li> <li>» \$0 deductible</li> <li>» 0% co-insurance</li> </ul> <p>If you are admitted to the hospital within three (3) days for the same condition that brought you to the emergency room, your co-pay is waived. See the “Inpatient Hospital Care” section of this booklet for other costs or call the plan.</p>
<p><b>Urgent Care</b> Urgent Care for Medicare-covered visits. <b>Contact the plan after you receive urgently needed services.</b></p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance per visit (up to \$65)</li> </ul> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical attention.</p>
<p><b>Diagnostic Procedures/Tests</b> <b>Lab Services</b> <b>Imaging</b></p>	<p><b>Diagnostic Procedures/Tests</b> <i>Prior Authorization is required.</i></p> <p><b>Lab Services</b> <i>Prior Authorization is required.</i></p> <p><b>Diagnostic Radiology Services (ex. MRI)</b></p> <p><b>Therapeutic Radiological Services (ex. radiation oncology)</b></p> <p><b>X-Rays</b></p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul>
<p><b>Hearing Services</b></p>	<p>If ordered by a physician as a diagnostic test, some exams are covered by the plan.</p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul>

## Covered Medical and Hospital Benefits

<p><b>Dental Services – Supplemental Benefit</b> Non-Medicare covered</p> <p>There may be limits on how much the plan will provide.</p> <p><b>\$2,500 maximum benefit coverage amount per year.</b></p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% co-insurance</li> </ul> <p><b>Preventive Care</b></p> <ul style="list-style-type: none"> <li>» Oral Exams: Up to two (2) per calendar year.</li> <li>» Prophylaxis (Cleaning): Up to two (2) per calendar year.</li> <li>» Fluoride Treatment: Up to two (2) per calendar year.</li> <li>» X-Rays are limited to either 1 panoramic, 1 full set, or 1 bitewing set per calendar year.</li> </ul> <p><b>Comprehensive Care</b></p> <ul style="list-style-type: none"> <li>» Diagnostic Services — Up to two (2) visits per calendar year.</li> <li>» Restorative Services — Simple restorations are limited to Amalgams/Resins, one (1) restoration per tooth, per calendar year.</li> <li>» Extractions — Simple extractions only. No surgical extractions.</li> <li>» Prosthodontics/Oral or Maxillofacial Surgery/Other services:             <ul style="list-style-type: none"> <li>• Crowns — Limited to one (1) per tooth per 60 months.</li> <li>• Basic Partials and basic dentures are covered, one (1) every 60 months. No coverage for repair.</li> <li>• No coverage for oral/maxillofacial surgery.</li> </ul> </li> </ul>
<p><b>Vision Services</b> Medicare-covered</p>	<p>Medicare-covered vision services related to the diagnosis and treatment of illness and injury of the eye. Includes limited coverage of eyewear and prosthetic lenses related to cataract surgery. Medicare-covered: diabetic eye exam (diabetic retinopathy); glaucoma test once every 12 months for people at high-risk; age-related macular degeneration (certain diagnosis and treatment).</p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul>
<p><b>Vision Services – Supplemental Benefit</b> Non-Medicare covered</p> <p>There may be limits on how much the plan will provide.</p>	<p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% co-insurance</li> </ul> <p><b>All enhanced vision benefits are limited to a total of \$300.00 per calendar year (combined) towards the purchase of:</b></p> <ul style="list-style-type: none"> <li>» One (1) routine eye exam</li> <li>» One (1) contact fitting</li> <li>» Contact lenses</li> <li>» One (1) set of eyeglasses lenses and/or frames, upgrades combined</li> </ul>

## Covered Medical and Hospital Benefits

<p><b>Mental Health Services</b> Inpatient Hospital – Psychiatric</p>	<p>Our plan covers 90 days for an inpatient hospital stay. 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.</p> <p><i>Prior Authorization is required. A provider referral is required.</i></p> <p>In 2022 the amounts you pay for each benefit period are \$0 or:</p> <ul style="list-style-type: none"> <li>» \$1,556 deductible for each benefit period.</li> <li>» Days 1–60: \$0 co-insurance per day of each benefit period.</li> <li>» Days 61–90: \$389 co-insurance per day of each benefit period.</li> <li>» Days 91 and beyond: \$778 co-insurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime).</li> <li>» Beyond lifetime reserve days: all costs.</li> </ul>
<p><b>Mental Health Services</b> Outpatient Mental Health Care</p>	<p><b>Outpatient Group Therapy Visit</b> <i>Prior Authorization is required.</i></p> <p><b>Outpatient Group Therapy Visit with a Psychiatrist</b> <i>Prior Authorization is required.</i></p> <p><b>Outpatient Individual Therapy Visit</b> <i>Prior Authorization is required.</i></p> <p><b>Outpatient Individual Therapy Visit with a Psychiatrist</b> <i>Prior Authorization is required.</i></p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-payment</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul>
<p><b>Skilled Nursing Facility</b></p>	<p><i>Prior Authorization is required. A provider referral is required.</i></p> <p>Plan covers up to 100 days each benefit period. A three-day prior hospital stay is required.</p> <p>In 2022 the amounts you pay for each benefit period are \$0 or:</p> <ul style="list-style-type: none"> <li>» Days 1–20: \$0 for each benefit period.</li> <li>» Days 21–100: \$194.50 co-insurance per day of each benefit period.</li> <li>» Days 101 and beyond: all costs.</li> </ul> <p>You will not be charged additional cost sharing for professional services.</p>

## Covered Medical and Hospital Benefits

<p><b>Rehabilitation Services</b></p> <p>Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.</p>	<p><b>Occupational Therapy Visit</b>  <i>Prior Authorization is required. Provider referral is required.</i></p> <p><b>Physical Therapy and Speech and Language Therapy Visit</b>  <i>Prior Authorization is required. Provider referral is required.</i></p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-payment</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul>
<p><b>Ambulance</b></p>	<p><b>Medicare-covered Air Ambulance Services</b>  Please ask the plan for details.</p> <p><b>Medicare-covered Ground Ambulance Services</b>  Please refer to your EOC for more information.</p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-payment</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul>
<p><b>Transportation</b></p> <p>There may be limits on how much the plan will provide.</p>	<p>The iCare transportation benefit provides members with non-emergency transportation to and from plan approved locations for up to 24 one-way trips annually, up to 25 miles.</p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% co-insurance</li> </ul>

## Prescription Drug Benefits

<p><b>Medicare Part B Drugs</b></p>	<p>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 web site at <a href="http://www.iCareHealthPlan.org">www.iCareHealthPlan.org</a>.</p> <p>Diabetic lancets and test strips are covered up to a 100-day supply at no cost to you (\$0 co-pay, \$0 deductible, and \$0 co-insurance) through Abbott.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>Chemotherapy/Radiation Drugs</b>  <i>Prior authorization is required.</i></p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <p><b>Other Part B Drugs</b>  <i>Prior authorization is required.</i></p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul> </td> </tr> </table>	<p><b>Chemotherapy/Radiation Drugs</b>  <i>Prior authorization is required.</i></p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul>	<p><b>Other Part B Drugs</b>  <i>Prior authorization is required.</i></p> <p>You pay:</p> <ul style="list-style-type: none"> <li>» \$0 co-pay</li> <li>» \$0 deductible</li> <li>» 0% or 20% co-insurance</li> </ul>
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<p><b>Medicare Part D Drugs</b></p>	<p>See chart on page 10 for plan coverage information for prescription drugs.</p>		

## Prescription Drug Savings Benefit

\$0 co-payment for all Medicare-covered prescription drugs for all formularies, on all tiers. Benefit begins in Deductible Stage (when applicable) and continues through the Initial Coverage Stage, only.

iCare Medicare Plan members that are eligible for Medicaid qualify for and are getting “Extra Help” from Medicare to pay for prescription drug plan costs. You do not need to do anything further to get this “Extra Help”. For more information on “Extra Help” or for questions on the Prescription Drug Benefit, please contact Customer Service at 1-800-777-4376 (TTY: 711) or read the Evidence of Coverage (EOC) for this plan at [www.iCareHealthPlan.org](http://www.iCareHealthPlan.org).

## What You Pay as a Member

The Part D prescription drug benefit has four stages of coverage. In each stage, you and the plan pay a different share of your prescription drug costs. The cost-sharing may change when entering another stage of the Part D prescription drug coverage benefit.

**STAGE 1: Deductible** — This plan does not have a deductible.

**STAGE 2: Initial Coverage Stage** — After a member pays the deductible, if applicable, up to the initial coverage limit of \$4,430.

**In 2022, while in the Initial Coverage Stage, members will have a \$0 co-pay for all Medicare-covered drugs on all tiers.**

**STAGE 3: Gap Coverage Stage** — Members will have co-pays during the Coverage Gap Stage. Co-payments start after the total drug costs paid by you and the plan reach \$4,430, up to the out-of-pocket threshold of \$7,050.

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. The amount you pay each time you fill your drug (listed in the table below) depends on the drug’s tier, your level of extra help, and institutional status.

Tier	Standard Retail & Mail Order Pharmacies		
	1 Month (30 days) Each Prescription	2 Month (60 days) Each Prescription	3 Month (90 days) Each Prescription
<b>Tier 1</b> (Preferred Generic)	\$0/\$1.35/\$3.95 co-pay	\$0/\$1.35/\$3.95 co-pay	\$0/\$1.35/\$3.95 co-pay
<b>Tier 2</b> (Generic)	\$0/\$1.35/\$3.95 co-pay	\$0/\$1.35/\$3.95 co-pay	\$0/\$1.35/\$3.95 co-pay
<b>Tier 3</b> (Preferred Brand)	\$0/\$1.35/\$3.95/\$4.00/\$9.85 co-pay	\$0/\$1.35/\$3.95/\$4.00/\$9.85 co-pay	\$0/\$1.35/\$3.95/\$4.00/\$9.85 co-pay
<b>Tier 4</b> (Non-Preferred Drug)	\$0/\$1.35/\$3.95/\$4.00/\$9.85 co-pay	\$0/\$1.35/\$3.95/\$4.00/\$9.85 co-pay	\$0/\$1.35/\$3.95/\$4.00/\$9.85 co-pay
<b>Tier 5</b> (Specialty Tier)	\$0/\$1.35/\$3.95/\$4.00/\$9.85 co-pay	Not available	Not available

If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy. Only a one month or 31-day supply is allowed. You may get drugs from an in-network pharmacy, out-of-network pharmacy (one month fill/supply only), and through the plan’s mail order pharmacy at the same costs listed in the table above.

**STAGE 4: Catastrophic Coverage Stage** — After your annual out-of-pocket drug costs (including drugs purchased through a retail pharmacy and through mail order) exceed \$7,050, members pay nothing (\$0 co-pay) for all drugs.

## Supplemental Covered Benefits — You Pay \$0

<b>Personal Emergency Response System (PERS)</b>	<p>The personal emergency response system provides help in emergency situations. The medical alert service comes with an installed in-home communication device and a wearable button. <i>Prior Authorization may be required.</i></p>
<b>SilverSneakers® Fitness</b>	<p>SilverSneakers can help you live a healthier, more active life through fitness and social connections. You are covered for a fitness benefit through SilverSneakers at participating locations and have access to instructors who lead specially designed group exercise classes. At participating locations nationwide, you can take classes plus use exercise equipment and use other amenities. <i>Prior Authorization may be required.</i></p>
<b>Weight Watchers®</b>	<p>iCare will supply members with local Weight Watchers meeting voucher packs. These packs will contain thirteen-weeks' worth of meeting vouchers at a local, on-site Weight Watchers location. Members can request new voucher packs near the end of each thirteen-week period if they continue to use Weight Watchers. This benefit is only for Weight Watchers meeting participation and does not include meals. <i>Prior Authorization may be required.</i></p>
<b>Meals</b>	<p>If you are transitioning from an inpatient hospital or skilled nursing facility, you are eligible for a maximum of 28 meals per year (14 days total — 2 meals per day).</p>
<b>Over-the-Counter (OTC) Program</b>	<p>\$100 every month for approved over-the-counter items at participating retailers, online or through a catalog purchase using a pre-paid benefits card. Balance re-sets quarterly.</p>

## More Benefits with Your Plan — No Cost to Participate

<b>Flexible Care Assistance</b> Special Supplemental Benefits for the Chronically Ill (SSBCI) Flexible Care Assistance	<p>Flexible Care Assistance is available to chronically ill members who are participating with care management services and meet program criteria. Eligible members may receive medical expenses assistance, primarily health related, and non-primarily health related additional benefits to address specific needs based on the individual's unique situations. Benefits are limited up to \$500 per year and must be coordinated and authorized by a Care Coordinator. There is no cost to participate.</p>
<b>Healthy Foods Card</b>	<p>\$50 automatically loaded every month to spend at participating retailers toward the purchase of approved healthy foods.</p>

# Medicaid Covered Services

The benefits described on pages 4-11 are covered by Medicare. Now, we will explain to you what is covered by Medicaid.

## YOUR STATE MEDICAID PROGRAM

Your State Medicaid program can be reached through the office of the Wisconsin Department of Health Services: Division of Medicaid Services ([www.dhs.wisconsin.gov/dms/index.htm](http://www.dhs.wisconsin.gov/dms/index.htm)).

A person who is entitled to both Medicare and medical assistance from a State Medicaid plan is considered dual eligible. As a dual eligible beneficiary your services are paid first by Medicare and then by Medicaid. Your Medicaid coverage varies depending on your income, resources, and other factors. Benefits may include full Medicaid benefits and/or payment of some or all your Medicare cost-share (premiums, deductibles, co-insurance, or co-pays). Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for Medicare-covered services.

## WHAT YOU PAY FOR COVERED SERVICES MAY DEPEND ON YOUR LEVEL OF MEDICAID ELIGIBILITY

Below is a list of dual eligible coverage categories for beneficiaries:

**Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, co-insurance, and co-pays). Most people with QMB are also eligible for full Medicaid benefits.

If you are a QMB Beneficiary:

- » You have a 0% cost-share, except for Part D prescription drug co-pays, as long as you remain a QMB member.
- » Preventive services and supplemental benefits provided by *iCare* are also at a \$0 cost-share.

**Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits.

**Qualifying Individual (QI):** Helps pay Part B premiums.

**Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

**If you are a SLMB or SLMB+:**

- » You may be eligible for full Medicaid benefits and as such your cost-share is 0% or 20%. Typically, your cost-share is 0% when the service is covered by both Medicare and Medicaid if you are found to be eligible for full Medicaid.
- » Preventive services and supplemental benefits provided by *iCare* are also at a \$0 cost-share. In some instances, you will pay 20% when a service or benefit is not covered by Medicaid.

**If you are a QI or QDWI Beneficiary:**

- » Because Medicaid does not pay your cost-share, and you do not have full Medicaid benefits, your cost-share is typically 20%. There are a few exceptions such as preventive wellness exams and supplemental benefits provided by *iCare* where you will have a \$0 cost-share.

## ELIGIBILITY CHANGES

It is important to read and respond to all mail that comes from Social Security and the State Medicaid office and to maintain your Medicaid eligibility status. Periodically, as required by CMS, we will check the status of your Medicaid eligibility as well as your dual eligible category. If your eligibility status changes, your cost-share may also change from 0% to 20% or from 20% to 0%. If you lose Medicaid coverage entirely, you will be given a grace period so that you can reapply for Medicaid and become reinstated if you still qualify.

If you no longer qualify for Medicaid, you may be involuntarily disenrolled from your plan. Your State

Medicaid agency will send you notification of your loss of Medicaid or change in Medicaid category. We may also contact you to remind you to reapply for Medicaid. For this reason, it is important to let us know whenever your mailing address and/or phone number changes.

If you are currently entitled to receive full or partial Medicaid benefits, please see your Medicaid member handbook or other State Medicaid documents for full details on your Medicaid benefits, limitations, restrictions, and exclusions. The Medicaid program can be reached through the office of the Wisconsin Department of Health Services: Division of Medicaid Services ([www.dhs.wisconsin.gov/dms/index.htm](http://www.dhs.wisconsin.gov/dms/index.htm)).

## HOW TO READ THE MEDICAID BENEFITS CHART

The chart below and on page 14 shows the services/benefits covered by Medicaid. The charts apply only if you are entitled to benefits under your Medicaid program. Your cost-share varies based on your Medicaid category. **Please refer to your Medicaid-Only Handbook or your Medicaid Enrollment and Benefits Booklet for more information about your benefits, your cost share (co-pays, if applicable), limitations and exclusions (what is covered and what is not covered).**

### Medicaid Covered Benefits

**AMBULATORY SURGICAL CENTERS:** Coverage of certain surgical procedures and related lab services.

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**BEHAVIORAL TREATMENT:** Full coverage of comprehensive and focused behavioral treatment services (with prior authorization).

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**CHIROPRACTIC SERVICES:** Full coverage.

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**DENTAL SERVICES:** Full coverage.

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**DISPOSABLE MEDICAL SUPPLIES:** Full coverage.

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**DRUGS — PRESCRIPTION:** Coverage for generic drugs, brand name drugs, and some Over-the-Counter (OTC drugs). Limit of five opioid prescription refills per month.

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**DURABLE MEDICAL EQUIPMENT:** Full coverage.

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**END STAGE RENAL DISEASE (ESRD):** Full coverage.

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**HEALTHCHECK SCREENINGS FOR CHILDREN:** Full coverage of HealthCheck screenings and other services for individuals under 21 years of age.

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**HEARING SERVICES:** Full coverage.

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**HOME CARE SERVICES (HOME HEALTH, PRIVATE DUTY NURSING, AND PERSONAL CARE):** Full coverage of private duty nursing, home health services, and personal care.

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**HOSPICE:** Full coverage.

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**HOSPITAL SERVICES — INPATIENT:** Full coverage.

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**HOSPITAL SERVICES — OUTPATIENT:** Full coverage.

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**HOSPITAL SERVICES — OUTPATIENT EMERGENCY ROOM:** Full coverage.

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**MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT:** Full coverage (not including room and board).

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**NURSING HOME SERVICES:** Full coverage.

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**PHYSICIAN SERVICES:** Full coverage, including laboratory and radiology.

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**PODIATRY SERVICES:** Full coverage.

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**PRENATAL/MATERNITY CARE:** Full coverage, including prenatal care coordination and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. This includes services provided by nurse midwives and licensed midwives.

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**REPRODUCTIVE HEALTH SERVICES — FAMILY PLANNING SERVICES:** Full coverage, with the exceptions listed below. Does not cover:

- » Reversal of voluntary sterilization
  - » Infertility treatments
  - » Surrogate parenting and related services, including, but not limited to:
    - Artificial insemination
    - Obstetrical care
    - Labor or delivery
    - Prescription or over-the-counter drugs
- 

**ROUTINE VISION:** Full coverage, including eyeglasses. No co-pay for eyeglasses selected from the Medicaid collection.

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**THERAPY — PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), AND SPEECH AND LANGUAGE PATHOLOGY (SLP):** Full coverage.

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**TRANSPORTATION — AMBULANCE, SPECIALIZED MEDICAL VEHICLE (SMV), COMMON CARRIER:** Full coverage for Medicaid-covered emergency transportation services and non-emergency transportation to and from a Medicaid certified provider.

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# 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 the Grievance and Appeal Coordinator, 1555 North RiverCenter Drive, Suite 206, Milwaukee, Wisconsin 53212, 1-800-777-4376 x1076 (TTY: 1-800-947-3529), F: 414-918-7589, or [advocate@icarehealthplan.org](mailto:advocate@icarehealthplan.org). You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance, the Grievance and Appeal Coordinator 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, 1-800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Last update: 08/24/2020

## 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 انكر 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, ໂດຍບໍ່ເສັຽຄ່າ, 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).



## Not a member yet?

If you are **NOT a member of the iCare Medicare Plan**, contact our Licensed Medicare Benefits Consultants. Call toll-free 1-855-839-0918 (TTY: 711). Or contact your broker.

## Existing Members call Customer Service

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

TTY: 711

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



### Corporate Office

1555 North RiverCenter Drive, Suite 206  
Milwaukee, Wisconsin 53212

[www.iCareHealthPlan.org](http://www.iCareHealthPlan.org)

**iCare is a wholly-owned subsidiary of Humana.**