2025

Summary of Benefits

*i*Care Medicare Plan SNP-DE (HMO D-SNP)

This is a Highly Integrated Dual Eligible (HIDE) Special Needs Plan.

Wisconsin

Eastern, South Central and Western Wisconsin

Our service area includes the following county/counties in Wisconsin: Adams, Bayfield, Brown, Buffalo, Calumet, Columbia, Crawford, Dane, Dodge, Door, Douglas, Florence, Fond du Lac, Grant, Green, Green Lake, Iowa, Iron, Jackson, Jefferson, Juneau, Kenosha, Kewaunee, La Crosse, Lafayette, Manitowoc, Marinette, Marquette, Menominee, Milwaukee, Monroe, Oconto, Outagamie, Ozaukee, Pepin, Pierce, Racine, Richland, Rock, Sauk, Shawano, Sheboygan, Trempealeau, Vernon, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago.

H2237_SB_MAPD_HMO_001000_2025_M

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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 **1-800-362-3002 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **icarehealthplan.org** or call **1-800-362-3002 (TTY: 711)** 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.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your 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. The Part A/ Part B premiums may be paid for by Wisconsin Department of Health Services (DHS)(Medicaid).
- ☐ Benefits, premiums and/or copays/coinsurance may change on January 1, 2026.
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.
- ☐ 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. This plan may enroll FBDE, QI, QMB, QMB+, SLMB, SLMB+.

Let's talk about *i*Care Medicare Plan SNP-DE (HMO D-SNP)

Find out more about the *i*Care Medicare Plan SNP-DE (HMO D-SNP) plan – including the health and drug services it covers – in this easy-to-use guide.

*i*Care Medicare Plan SNP-DE (HMO D-SNP) is a Coordinated Care plan HMO with a Medicare contract and a contract with Wisconsin Department of Health Services (DHS)(Medicaid) program. Enrollment in this *i*Care plan depends on contract renewal.

The benefit information provided 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. For a complete list of services we cover, please refer to the plan's Evidence of Coverage on our website, **icarehealthplan.org**.

As a member you must select an in-network doctor within the service area listed in this document to act as your Primary Care Provider (PCP). *i*Care Medicare Plan SNP-DE (HMO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.

You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including acute and chronic-care management, telephonic and in-person health support, assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops, and support for families and caregivers.

To be eligible

If you receive both Medicare and Medicaid benefits, this means you are dual eligible. To enroll in *i*Care Medicare Plan SNP-DE (HMO D-SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from Wisconsin Department of Health Services (DHS)(Medicaid).

*i*Care Medicare Plan SNP-DE (HMO D-SNP) may enroll FBDE, QI, QMB, QMB+, SLMB, SLMB+.

Full Benefit Dual Eligible (FBDE): May help pay Medicare Part A and/or Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

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

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

Qualified Medicare Beneficiary Plus (QMB+): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Plan name

*i*Care Medicare Plan SNP-DE (HMO D-SNP)

More about *i*Care Medicare Plan SNP-DE (HMO D-SNP)

Depending on your level of eligibility for assistance under your state Medicaid program, you may or may not be subject to cost-sharing requirements. The Medicaid Benefit Comparison chart shows specific benefits that Medicaid may cover for some dual eligible members. You will work with your *i*Care care coordinator to understand and access these benefits. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from *i*Care.

Be sure to show the Wisconsin Department of Health Services (DHS)(Medicaid) ID card in addition to your *i*Care membership card to make your provider aware that you also have Medicaid coverage.

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How to reach us

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact *i*Care's Customer Care department or Wisconsin Department of Health Services (DHS)(Medicaid) for further details.

If you're a member of this plan, call toll-free: **1-800-777-4376 (TTY: 711)**.

*i*Care Customer Care is available for phone calls 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m. Calls to these numbers are free.

If you're **not** a member of this plan, call toll free: **1-800-362-3002 (TTY: 711)**.

Or visit our website: **icarehealthplan.org**

Medicaid benefits last validated on 07/01/2024 and are subject to change. For the most current Wisconsin Medicaid coverage information, please visit Wisconsin Department of Health Services (DHS)(Medicaid) website at **http://www.dhs.wisconsin.gov** or call the Medicaid Hotline at 1-800-362-3002 (toll free) 1-800-947-3529 (TTY).

A healthy partnership

Get more from this plan – with extra services and resources provided by *i*Care!

Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** or up to **$43.50** depending on your level of "Extra Help." You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by Wisconsin Department of Health Services (DHS)(Medicaid) Program.
Medical deductible * You pay the same amount as you would with Original Medicare. In 2024, the amounts are as listed. These amounts may change in 2025.	**$0** or **$240*** for in-network Part B services, depending on your level of Medicaid eligibility. The following services listed are excluded from the in-network Part B deductible: • Ambulance Services • Chemotherapy Drugs and Administration • Diabetic Monitoring Supplies • Emergency Room Services • Part A Services (IP, Skilled Nursing and Home Health) • Medicare Covered Preventive Services • Medicare Part B Insulin Drugs • Other Medicare Part B Drugs • Services not covered by Original Medicare • Urgently Needed Services at Urgent Care Centers
Pharmacy (Part D) deductible	**$590** deductible
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year	**$9,350** in-network If you are eligible for Medicare cost-sharing assistance under Wisconsin Department of Health Services (DHS)(Medicaid) you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medical Benefits

	WHAT YOU PAY ON THIS *i*Care PLAN
INPATIENT HOSPITAL COVERAGE	
This plan covers an unlimited number of days for an inpatient stay.	**$0** or **$2,185** copay per admit
OUTPATIENT HOSPITAL COVERAGE	
Diagnostic colonoscopy	**$0** or **20%** of the cost
Diagnostic mammography	**$0** or **20%** of the cost
Surgery services	**$0** or **20%** of the cost
AMBULATORY SURGERY CENTER	
Diagnostic colonoscopy	**$0** or **20%** of the cost

*Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require a referral or preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **icarehealthplan.org**.*

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Medical Benefits (cont.)

	WHAT YOU PAY ON THIS *i*Care PLAN
Surgery services	**$0** or **20%** of the cost
DOCTOR VISITS	
Primary care provider (PCP) • PCP's office	**$0** or **20%** of the cost
Specialist • Specialist's office	**$0** or **20%** of the cost
PREVENTIVE CARE	
This plan covers all Medicare preventive services including: • **Abdominal aortic aneurysm screening** • **Alcohol misuse screening & counseling** • **Annual Wellness Visit (AWV)** • **Bone mass measurement** • **Breast cancer screening (mammogram)** • **Cardiovascular disease risk reduction visit** • **Cardiovascular disease screenings** • **Cervical and vaginal cancer screening** • **Colorectal cancer screening** • **Depression screening** • **Diabetes screening** • **Diabetes self-management training** • **Glaucoma screening** • **HIV screening** • **Immunizations** • **Lung cancer screening** • **Medical nutrition therapy** • **Medicare Diabetes Prevention Program (MDPP)** • **Obesity screening and therapy** • **Prostate cancer screening exams** • **Routine physical Exam** • **Sexually transmitted infections (STIs) screening and counseling** • **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** • **"Welcome to Medicare" preventive visit** Any additional preventive services approved by Medicare during the contract year will be covered.	**$0** copay

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Medical Benefits (cont.)

	WHAT YOU PAY ON THIS *i*Care PLAN
EMERGENCY CARE	
Emergency room If you are admitted to the same hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** or **$110** copay
Physician and professional services at emergency room	**$0** copay
URGENTLY NEEDED SERVICES	
• **Urgent care center** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** or **20%** of the cost
DIAGNOSTIC SERVICES, LABS AND IMAGING	
Advanced imaging services (MRI, MRA, PET and CT scan)	
• Freestanding radiological facility	**$0** or **$300** copay
• Outpatient hospital	**$0** or **$350** copay
• PCP's office	**$0** or **$300** copay
• Specialist's office	**$0** or **$300** copay
Basic radiological services (X-rays)	
• Freestanding radiological facility	**$0** or **$50** copay
• Outpatient hospital	**$0** or **20%** of the cost
• PCP's office	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
• Urgent care center	**$0** or **20%** of the cost
Diagnostic mammography	
• Freestanding radiological facility	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Diagnostic procedures and tests	
• Outpatient hospital	**$0** or **20%** of the cost
• PCP's office	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
• Urgent care center	**$0** or **20%** of the cost

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require a referral or preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit ***icarehealthplan.org****.*

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Medical Benefits (cont.)

	WHAT YOU PAY ON THIS *i*Care PLAN
Lab services	
• Freestanding laboratory	**$0** or **$30** copay
• Outpatient hospital	**$0** or **20%** of the cost
• PCP's office	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
• Urgent care center	**$0** or **20%** of the cost
Nuclear medicine and services	
• Freestanding radiological facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
Sleep study	
• Member's home	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Therapeutic radiology (Radiation therapy)	
• Freestanding radiological facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
HEARING SERVICES	
Medicare-covered hearing	**$0** or **20%** of the cost
Mandatory supplemental hearing benefit	**HER945** • **$0** copay for routine hearing exams up to 1 per year. • **$0** copay for each Advanced level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models • Rechargeable style options available for Premium and Advanced aids for an additional $50 per aid **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (TTY: 711).**
DENTAL SERVICES	
Medicare-covered dental	**$0** or **20%** of the cost

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Medical Benefits (cont.)

	WHAT YOU PAY ON THIS *i*Care PLAN
Mandatory supplemental dental benefit	**DEN999** • **$0** copay for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. • **$0** copay for comprehensive oral evaluation or periodontal exam, occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. • **$0** copay for bridge recementation, bridges, complete dentures, crown recementation, panoramic film or diagnostic x-rays, partial dentures up to 1 every 5 years. • **$0** copay for crown, root canal, root canal retreatment up to 1 per tooth per lifetime. • **$0** copay for bitewing x-rays, intraoral x-rays up to 1 set(s) per year. • **$0** copay for adjustments to dentures, denture rebase, denture reline, denture repair, emergency diagnostic exam, tissue conditioning up to 1 per year. • **$0** copay for emergency treatment for pain, fluoride treatment, oral surgery, periodic oral exam, prophylaxis (cleaning) up to 2 per year. • **$0** copay for periodontal maintenance up to 4 per year. • **$0** copay for amalgam and/or composite filling, necessary anesthesia with covered service, simple or surgical extraction up to unlimited per year. • **$4,000** maximum benefit coverage amount per year for all diagnostic/preventive and comprehensive benefits.
VISION SERVICES	
Eyewear (post cataract surgery)	**$0** or **20%** of the cost
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered vision services	**$0** or **20%** of the cost
Mandatory supplemental vision benefit	**VIS036** • **$400** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames 1 pair(s) per year, fitting for eyeglasses-lenses and frames 1 per year.

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Medical Benefits (cont.)

	WHAT YOU PAY ON THIS *i*Care PLAN
	• **$50** maximum benefit coverage amount per year for routine exam 1 per year. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.
MENTAL HEALTH SERVICES	
Inpatient This plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** or **$2,036** copay per admit
Mental health therapy visits	
• Outpatient hospital	**$0** or **20%** of the cost
• Partial hospitalization	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Outpatient substance abuse services	
• Outpatient hospital	**$0** or **20%** of the cost
• Partial hospitalization	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
SKILLED NURSING FACILITY	
This plan covers up to 100 days in a SNF	**$0** copay per day for days 1-20 **$0** or **$214** copay per day for days 21-100
AMBULANCE	
• **Air**	**$0** or **20%** of the cost
• **Ground**	**$0** or **$315** copay per date of service
TRANSPORTATION	
The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.	**$0** copay for plan approved location up to 60 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip.

Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require a referral or preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit ***icarehealthplan.org****.*

Medical Benefits (cont.)

	WHAT YOU PAY ON THIS *i*Care PLAN
MEDICARE PART B DRUGS Some rebatable Part B drugs may be subject to a lower coinsurance.	
Allergy shots and serum	
• PCP's office	**$0** copay
• Specialist's office	**$0** copay
Chemotherapy drugs	
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Other Part B drugs	
• Outpatient hospital	**$0** or **20%** of the cost
• PCP's office	**$0** or **20%** of the cost
• Pharmacy	**$0** copay
• Specialist's office	**$0** or **20%** of the cost
Part B Insulin	
• Outpatient hospital	**$0** or **20%** of the cost
• PCP's office	**$0** or **20%** of the cost
• Pharmacy	**$0** copay
• Specialist's office	**$0** or **20%** of the cost
You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.	

*Your primary care provider (PCP) will work with you to coordinate the care you need with specialists or certain other providers in the network. This is called a "referral." Certain procedures, services and drugs may need advance approval from this plan. This is called "preauthorization." To learn more about services that require a referral or preauthorization from the plan, contact your PCP, refer to the Evidence of Coverage (EOC) for this plan, or visit **icarehealthplan.org**.*

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Prescription Drug Benefits

PLAN HIGHLIGHTS

"Extra Help"	Most of our members qualify for and are getting "Extra Help" from Medicare to pay for their prescription drug plan costs. If you are in the "Extra Help" program, please refer to the "Extra Help" section below to view your deductible and initial coverage stage cost shares.
Insulin costs	You won't pay more than **$35** for a one-month (up to 30-day) supply of each insulin product covered by this plan.
$0 vaccines	**$0** copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

DEDUCTIBLE

This plan has a **$590** deductible. You pay the full cost of your drugs until you reach **$590**. Then, you only pay your cost-share.

INITIAL COVERAGE

You pay the following until your total out-of-pocket costs reach **$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

Pharmacy Cost-Sharing

	Retail Cost-Sharing Includes all in-network retail pharmacies		**Mail-Order Cost-Sharing**	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***
All Plan-Covered Part D Drugs	25%	25%	25%	25%

To find which pharmacies are available in our network, go to **https://www.icarehealthplan.org/Find-a-Provider.htm** .
*Some drugs are limited to a 30-day supply.

You won't pay more than **$35** for a one-month (up to 30-day) supply of each plan-covered insulin product regardless of cost-sharing tier, even if you haven't paid your deductible.

Insulin Cost-Sharing				
	Retail Cost-Sharing Includes all in-network retail pharmacies		**Mail-Order Cost-Sharing**	
Day supply	**30-day**	**90-day***	**30-day**	**90-day***
All Plan-Covered Part D Insulins	$35	$105	$35	$105

To find which pharmacies are available in our network, go to **https://www.icarehealthplan.org/Find-a-Provider.htm** .

*Some drugs are limited to a 30-day supply.

CATASTROPHIC COVERAGE

After your total out-of-pocket costs reach **$2,000** you pay **$0** for plan-covered Part D drugs.

EXTRA HELP

If you receive "Extra Help" for your drugs you will have a **$0** deductible.

Prior to reaching your annual **$2,000** out-of-pocket limit you will pay one of the following depending on your level of "Extra Help:"

- **$4.90** for generic/preferred multi-source drug or biosimilar; **$12.15** for any other drug; OR
- **$1.60** for generic/preferred multi-source drug or biosimilar; **$4.80** for any other drug; OR
- **$0** for all drugs

After reaching your annual **$2,000** out-of-pocket limit, you will pay **$0** for the remainder of the calendar year, regardless of the level of "Extra Help" you receive. Additional information will be available on your LIS rider.

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and 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 (TTY: 1-800-325-0778), Monday – Friday, 7 a.m. – 7 p.m. For more information on your prescription drug benefit, please call us or access your Evidence of Coverage online.

If you reside at an in-network long-term care facility, you pay the same as you would at an in-network retail pharmacy. Under certain situations you may be able to get drugs from an out-of-network pharmacy but may pay more than you would pay at an in-network pharmacy.

Additional benefits

	WHAT YOU PAY ON THIS *i*Care PLAN
Acupuncture services (Medicare-covered)	**$0** copay for acupuncture for chronic low back pain visits up to 20 visit(s) per year.
Chiropractic services (Medicare-covered)	**$0** or **20%** of the cost
Podiatry services (Medicare-covered)	**$0** or **20%** of the cost
MEDICAL EQUIPMENT/SUPPLIES	
Diabetic monitoring supplies	
• Diabetic supplier	**$0** copay
• Network retail pharmacy	**$0** copay
Durable medical equipment (DME)	**$0** or **20%** of the cost
Medical supplies at medical supplier	**$0** or **20%** of the cost
Prosthetic devices and related supplies	**$0** or **20%** of the cost
REHABILITATION SERVICES	
Cardiac rehabilitation services	
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Occupational therapy	
• Comprehensive outpatient rehab facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Physical therapy	
• Comprehensive outpatient rehab facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Pulmonary rehabilitation services	
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Speech therapy	
• Comprehensive outpatient rehab facility	**$0** or **20%** of the cost
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost
Supervised Exercise Therapy (SET) for Peripheral Artery Disease (PAD)	
• Outpatient hospital	**$0** or **20%** of the cost
• Specialist's office	**$0** or **20%** of the cost

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by *i*Care Medicare Plan SNP-DE (HMO D-SNP). For each benefit listed below, you can see what Wisconsin Department of Health Services (DHS)(Medicaid) covers and what this plan covers.

All Medicaid benefits are subject to Wisconsin Department of Health Services (DHS)(Medicaid) eligibility guidelines and requirements and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact Wisconsin Department of Health Services (DHS)(Medicaid) at 1-800-362-3002 (toll free) 1-800-947-3529 (TTY).

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Ambulance	Covered	Covered
Ambulatory surgical center	Covered	Covered
Dentures	Covered	Covered
Diagnostic services, labs, and imaging	Covered	Covered
Doctor visits	Covered	Covered
Emergency care	Covered	Covered
Eyeglasses	Covered	Covered
Hearing aids	Covered	Covered
Home and community based waiver service programs	Covered	Not Covered
Inpatient hospital	Covered	Covered
Inpatient mental health services, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Covered	Covered with limitations
Inpatient mental health services, under age 21	Covered	Covered with limitations
Intermediate care facilities for individuals with intellectual disabilities (ICFs-IID)	Covered	Not Covered
Medicare Part B drugs	Covered	Covered
Mental health services	Covered	Covered

BENEFIT	MEDICAID BENEFIT	THIS PLAN BENEFIT
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations
Outpatient hospital coverage	Covered	Covered
Physical, occupational, speech therapy	Covered	Covered
Preventive care	Covered	Covered
Skilled nursing facility	Covered	Covered
Transportation	Covered	Covered
Urgently needed services	Covered	Covered

More benefits with **this plan**

Enjoy some of these extra benefits included in this plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **icarehealthplan.org** to view a copy of the EOC or call **1-800-362-3002**.

***i*Care Meal Program**
Receive two (2) meals per day for 7 days (up to 14 meals) delivered to member's home after an inpatient stay in a hospital or nursing facility. Meal delivery must be scheduled within 30 days of discharge event. Limited to four (4) times per year.

Prior authorization is required.

Notes

Notes

Notice of Non-Discrimination

Independent Care Health Plan (*i*Care), a wholly-owned subsidiary of Humana, complies with applicable Federal civil rights laws and does not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Independent Care Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **1-800-777-4376 (TTY: 1-800-947-3529)**, available 24 hours a day, 7 days a week (Standard office hours: Monday – Friday, 8:30 a.m. – 5:00 p.m. Central time). If you believe that Independent Care Health Plan has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail, fax, or email with Independent Care Health Plan's Grievance and Appeal Coordinator at 1555 North RiverCenter Drive, Suite 206, Milwaukee, Wisconsin 53212, **1-800-777-4376 x1076 (TTY: 1-800-947-3529)**, Fax: 1-414-918-7589, or **advocate@icarehealthplan.org**. If you need help filing a grievance, Independent Care Health Plan's Grievance and Appeal Coordinator can help you.

You can also file a 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, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

This notice is available at **icarehealthplan.org**.

WIHMEBBEN

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-777-4376. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-777-4376. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Hmong: Peb muaj kev pab txhais lus dawb los teb cov lus nug uas koj muaj txog peb txoj kev npaj khomob lossis tshuaj. Yog xav tau ib tug neeg txhais lus, hu rau peb ntawm 1-800-777-4376. Ib tug neeg uas hais lus Askiv / thiab lwm yam lus tuaj yeem pab koj. Qhov no yog ib qho kev pab dawb.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-777-4376。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-777-4376。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-777-4376. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-777-4376. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-777-4376 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-777-4376. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-777-4376 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-777-4376. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على1-800-777-4376. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-777-4376 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-777-4376. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-777-4376. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-777-4376. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-777-4376. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、[1-800-777-4376 にお電話くださぃ。日本語を話す人 者 が支援ぃたします。これは無料のサー ビスです。

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Find out **more**

Need help finding a doctor or pharmacy? You can see this plan's **Provider and Pharmacy Directory** at our website at **https://www.icarehealthplan.org/Find-a-Provider.htm** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see this plan's **Drug Guide** at our website at **https://www.icarehealthplan.org/Find-a-Provider.htm** or call us at the number listed at the beginning of this booklet and we will send you one.

To find out more about the coverage and costs of Original Medicare, look in the 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, seven days a week. TTY users should call 1-877-486-2048.

*i*Care Medicare Plan SNP-DE (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2026 based on a review of *i*Care Medicare Plan SNP-DE (HMO D-SNP) Model of Care.

If you get Medicare cost-share assistance, *i*Care Medicare Plan SNP-DE (HMO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are billed or asked to pay an in-network provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made payment you have the right to a refund. If your provider will not stop billing, you can call us at 1-800-777-4376 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). *i*Care or Medicare can ask your provider to stop billing you and refund any payment you have made.

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

iCare
INDEPENDENT CARE HEALTH PLAN
*i*Care is a wholly-owned subsidiary of Humana

*i*Care Medicare Plan SNP-DE (HMO D-SNP)
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