Summary of Benefits

Desert Preferred Choice (HMO)  
H0545, Plan 012

This is a summary of drug and health services covered by Inter Valley Health Plan Desert Preferred Choice (HMO) January 1, 2019 – December 31, 2019.

Inter Valley Health Plan Desert Preferred Choice (HMO) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

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

To join Inter Valley Health Plan Desert Preferred Choice (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes portions of the following county in California: Riverside.

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

Sonja Stump  
Inter Valley Health Plan Member for four years.
<table>
<thead>
<tr>
<th><strong>Premiums &amp; Benefits</strong></th>
<th><strong>Desert Preferred Choice (HMO)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Plan Premium</td>
<td>You pay $0</td>
</tr>
<tr>
<td></td>
<td>You must continue to pay your</td>
</tr>
<tr>
<td></td>
<td>Medicare Part B Premium.</td>
</tr>
<tr>
<td>Deductible</td>
<td>You pay $0</td>
</tr>
<tr>
<td></td>
<td>This Plan does not have a deductible.</td>
</tr>
<tr>
<td>Maximum Out-of Pocket</td>
<td>$3,400 annually</td>
</tr>
<tr>
<td>Responsibility</td>
<td>The most you pay for copays, coinsurance and other costs for Medicare-covered medical services for the year.</td>
</tr>
<tr>
<td></td>
<td>Amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services include hearing aids, routine/Non-Medicare covered dental services and routine/Non-Medicare covered vision services.</td>
</tr>
<tr>
<td>Inpatient Hospital*</td>
<td>You pay $0</td>
</tr>
<tr>
<td></td>
<td>Our Plan covers an unlimited number of days for an inpatient hospital stay.</td>
</tr>
<tr>
<td>Outpatient Hospital*</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Doctor Visits</td>
<td>You pay $0 for primary care visits</td>
</tr>
<tr>
<td></td>
<td>You pay $0 for specialists visits*</td>
</tr>
</tbody>
</table>

*Prior Authorization is required*
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</table>
| Preventive Care (e.g., flu vaccine, diabetic screenings) | You pay $0  

Any additional preventive services approved by Medicare during the contract year are covered. |
| Emergency Care | You pay $100 copay per visit  

$20,000 limit each year for worldwide emergency services.  

This copayment is waived if you are admitted as an inpatient within 24 hours of ER visit for the same condition to the same hospital. |
| Urgently Needed Services | You pay $0 |
| Diagnostic Services/Labs/Imaging* | You pay $0  

- Diagnostic radiology service (e.g., MRI)  
- Lab services  
- Diagnostic tests & procedures  
- Outpatient x-rays |
| Hearing Services* | You pay $0 for hearing exam  

Our plan covers up to $500 towards the purchase of hearing aids every 2 years |

*Prior Authorization is required
# Desert Preferred Choice (HMO)

## Premiums & Benefits

### Dental Services
- Non-Medicare covered (routine)
  - Oral exam: You pay $0
  - Cleaning: You pay $0
  - Dental x-rays: You pay $0

Additional dental services available including diagnostic, preventive and restorative procedures. Copayments for dental services vary based upon the procedure performed by a general dentist. Dental services provided through Dental Health Services (DHS).

### Vision Services
- Non-Medicare covered (routine) eye exam: You pay $0
- Non-Medicare covered (routine) Eyeglasses (frames and lenses):
  - Limit one exam every 2 years from a Vision Service Plan (VSP) provider.
  - We cover up to $100 every 2 years for eyeglasses (frames and lenses).

### Mental Health Services*
- Inpatient visit: You pay $912 per stay
  - Our Plan covers up to 190-lifetime limit in a psychiatric hospital.
- Outpatient group/individual therapy visit: You pay $0

### Skilled Nursing Facility
- You pay $0 for days 1-20
- $75 copay per day for days 21-100
  - Our Plan covers up to 100 days in a skilled nursing facility.
  - No prior hospitalization required

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<th><strong>Desert Preferred Choice (HMO)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy*</td>
<td>You pay $10 per visit</td>
</tr>
<tr>
<td>Ambulance</td>
<td>You pay $150 copay per one-way trip.</td>
</tr>
</tbody>
</table>
| Transportation         | You pay $0 for up to 34 one-way trips per year  
                         | You must use Plan contracted providers for transportation service. |
| Medicare Part B Drugs* | You pay 20% of the cost for chemotherapy and other Part B drugs |
| Medical Equipment/Supplies* |                                       |
| ■ Durable Medical Equipment (DME)  
  (e.g., wheelchairs, oxygen) | You pay 0 – 10% of the cost  
  You pay $0 for DME items with a cost up to $250.  
  For items with a cost over $250, you pay 10% of the cost. |
| ■ Prosthetics  
  (e.g., braces, artificial limbs) | You pay 0 – 20% of the cost  
  You pay $0 for prosthetic items with a cost up to $250.  
  For items with a cost over $250, you pay 20% of the cost. |
| ■ Diabetes supplies   | You pay $0                        |
| Wellness Programs      | You pay $0 for gym/health club membership  
                         | Gym/health club benefits provided by Silver & Fit. |
| (e.g., fitness)        |                                  |

*Prior Authorization is required
## OUTPATIENT PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th>Tier</th>
<th>Initial Coverage</th>
<th>30-day supply retail</th>
<th>90-day supply mail order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Preferred Generic Drugs</td>
<td>You pay $0</td>
<td>You pay $0</td>
<td></td>
</tr>
<tr>
<td>Tier 2: Generic Drugs</td>
<td>You pay $9</td>
<td>You pay $27</td>
<td></td>
</tr>
<tr>
<td>Tier 3: Preferred Brand Drugs</td>
<td>You pay $37</td>
<td>You pay $111</td>
<td></td>
</tr>
<tr>
<td>Tier 4: Non-Preferred Drugs</td>
<td>You pay 30%</td>
<td>You pay 30%</td>
<td></td>
</tr>
<tr>
<td>Tier 5: Specialty Drugs</td>
<td>You pay 33%</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 6: Select Care Drugs</td>
<td>You pay $10</td>
<td>You pay $30</td>
<td></td>
</tr>
</tbody>
</table>

### Coverage Gap

Once you and Inter Valley Health Plan have paid $3,820 for drugs:

- You receive a discount on brand name drugs and generally pay no more than 25% of the Plan’s cost.
- You pay no more than 37% of the Plan’s cost for generic drugs.
- You stay in this phase until you have spent $5,100 total (including copays paid in phase 1 and brand name discounts received in phase 2).

### Catastrophic Coverage

After your yearly out-of-pocket drug cost reach $5,100, you pay the greater of:

- 5% of the cost, or
- $3.40 copay for generic drugs and a $8.50 copay for other drugs
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

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

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

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

If you want to know more about the coverage and costs of Original Medicare, look in your current Medicare & You handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. This document is available in other formats such as large print.
Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Sales Representative at 800-500-7018.

**UNDERSTANDING THE BENEFITS**

☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.ivhp.com or call 800-500-7018 to view a copy of the EOC.

☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

**UNDERSTANDING IMPORTANT RULES**

☐ 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.

☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020

☐ 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).
General Notice About Nondiscrimination & Accessibility Requirements

Inter Valley Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of, or because of, race, color, national origin, age, disability, or sex.

Inter Valley Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).

Inter Valley Health Plan provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Inter Valley Health Plan Member Services.

If you believe that Inter Valley Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by phone, mail, or fax, at:

Inter Valley Health Plan
Manager, Grievance and Appeals Department
300 S. Park Avenue, Suite 300, Pomona, CA 91769-6002
800-251-8191 Ext. 469, (TTY/TDD 711)
FAX: 909-620-6413

If you need help filing a grievance, Inter Valley Health Plan Member Services is available to help you.

Or by filling out the “File a Grievance“ form on our website at: www.ivhp.com/AppealsGrievance.

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, D.C. 20201
1-800-368-1019 (TTY: 1-800-537-7697)


Inter Valley Health Plan is a not-for-profit HMO with a Medicare contract. Enrollment in Inter Valley Health Plan depends on contract renewal.
ENGLISH: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-251-8191. (TTY/TDD 711).

SPANISH: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-8191. (TTY/TDD 711).

CHINESE TRADITIONAL: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電1-800-251-8191。（TTY/TDD 711）。

CHINESE SIMPLIFIED: 注意：如果您使用中文，您可以免费获得语言援助服务，请致电1-800-251-8191。（TTY/TDD 711）。

VIETNAMESE: CHỨ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin vui lòng gọi số 1-800-251-8191. (TTY/TDD 711)。

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-8191. (TTY/TDD 711)。

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-8191 번으로 연락해 주십시오. (TTY/TDD 711)。

ARMENIAN: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարե’ք 1-800-251-8191 հեռախոսահամարով: Հեռախոսի համար է՝ (TTY/TDD 711)。

(PERSIAN) Farsi: پناه‌داری یا پایش مردم نگاه کنید. خداحافظی با روایتی دیگری به این موضوع اشاره کنید: 1-800-251-8191 (TTY/TDD 711)。

RUSSIAN: ВНИМАНИЕ! Если вы говорите по-русски, вы можете бесплатно получить услуги переводчика. Звоните по телефону 1-800-251-8191 (TTY/TDD 711)。

JAPANESE: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。お問合せ先 1-800-251-8191（TTY/TDD 711）。

ARABIC: لن توازنت في وغلاف، قاعدملا نامدخ ناف، في برملا، شخبتن انذا: قطوح، يص: ناملا (فلادا) 1-800-251-8191-1 موضر راصلين. (TTY/TDD 711)。

PUNJABI: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ਕੋਲ ਕਰੋ 1-800-251-8191 (TTY/TDD 711)।

MON-KHMER, CAMBODIAN: សូមអរគុណអ្នកមិន ចង្កេស ដើម្បីបញ្ជាក់ ដើម្បីបង្ហាញ ប្រការីមូល និង ស្ថានភ័ព្យីលី ដើម្បីអ៊ីនធឺណិតនិង ការស្វែងយល់ ក្នុងការងារ ប្រការីនិមួយៗ 1-800-251-8191 ’ (TTY/TDD 711)’。

HMONG: LUS CEEV: Yog tias koj hais lus Hmoob (Ntawv Suav - Hmoob), muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-251-8191. (TTY/TDD 711)。

HINDI: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-251-8191 (TTY/TDD 711)।

THAI: โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-251-8191 (TTY/TDD 711)。

Multi-language Interpreter Services
For more information please call the number below or visit us at www.ivhp.com.

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

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

From October 1 to March 31, you can call us 7 days a week from 8 am to 8 pm Pacific Time.

From April 1 to September 30, you can call us Monday through Friday from 8 am to 8 pm Pacific Time.

After hours and holidays, please leave a message and a representative will call on the next business day.

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

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

Inter Valley Health Plan
Medicare plans for health. Not for profit.

800-500-7018 or TTY/TDD 711
8 am to 8 pm, 7 days a week.
300 S. Park Avenue
PO Box 6002, Pomona, CA 91769-6002
www.ivhp.com
www.facebook.com/intervalley