# Texas Independence Health Plan

# 2025 Summary of Benefits

## Texas Independence Community Plan (H5015-002)

Here's a summary of the services we cover from January 1, 2025 through December 31, 2025.

**Keep in mind:** This is just a summary. Need a complete list of what we cover and any limitations? Just visit **texasindependencehealthplan.com** where you'll find the plan's Evidence of Coverage (EOC) or you may call us to request a copy.

## Need Help? We're here to help you.

**Customer Service**
**Call 833-471-8447 (TTY: 833-414-8447)**
8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31;
8:00 A.M. to 8:00 P.M, Monday to Friday from April 1 through September 30.

**Texas Independence Community Plan (HMO I-SNP) is a Health Maintenance Organization (HMO) Special Needs plan (I-SNP) with a Medicare contract. Enrollment in Texas Independence Community Plan (HMO I-SNP) depends on contract renewal.**

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# What is an Institutional Special Needs Plan (I-SNP)

Texas Independence Community Plan (HMO I-SNP) is a Health Maintenance Organization (HMO) Special Needs plan (I-SNP) with a Medicare contract. It includes hospital, medical, and prescription drug benefits in one plan.

## Are you eligible to enroll?

To join Texas Independence Health Plan (HMO I-SNP), you must:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Live in our service area

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. You must live in one of our network nursing homes, or live at home and/or in a contracted assisted living facility and Texas has certified that you need the type of care that is usually provided in a nursing home.

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**Our service area includes the following counties in Texas:** Aransas, Atascosa, Austin, Bandera, Bastrop, Bee, Bexar, Blanco, Brooks, Burleson, Burnet, Caldwell, Calhoun, Cameron, Cass, Chambers, Colorado, Comal, Cooke, Denton, DeWitt, Dimmit, Duval, Fayette, Fort Bend, Franklin, Frio, Galveston, Gillespie, Goliad, Gonzales, Gregg, Grimes, Guadalupe, Hamilton, Hardin, Harris, Harrison, Hays, Hidalgo, Hill, Jack, Jackson, Jefferson, Jim Hogg, Jim Wells, Karnes, Kendall, Kenedy, Kleberg, Lampasas, La Salle, Lavaca, Lee, Liberty, Live Oak, Llano, McMullen, Marion, Mason, Matagorda, Medina, Mills, Montgomery, Morris, Nueces, Palo Pinto, Panola, Real, Refugio, Rusk, San Jacinto, San Saba, Smith, Somervell, Starr, Tarrant, Travis, Upshur, Washington, Webb, Wharton, Willacy, Williamson, Wilson, Wise, Wood, Zapata, Zavala

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# Compare our plan to Medicare

To learn more about the coverage and costs of Original Medicare, look in your “Medicare & You” handbook. View it online at www.medicare.gov or get a copy by calling 1 800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## What you should know

- Prior authorizations: Your provider will work with us to get approval before you receive certain services or drugs. Benefits that may require a prior authorization are listed with an asterisk (*) in the benefits grid.
- Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.
- You can find more details on each benefit listed below in the Evidence of Coverage (EOC)

# Monthly Premium, Deductible and Limits

## PLAN COSTS

| | |
|---|---|
| **Monthly Plan Premium**<br>You must keep paying your Medicare Part B premium | $18.30 |
| **Medical Deductible** | $257 except for insulin furnished through an item of durable medical equipment. |
| **Pharmacy (Part D) deductible** | $590 |
| **Maximum Out-of-Pocket Responsibility**<br>The most you pay for copays, coinsurance and other costs for covered medical services for the year.<br><br>Your premium and prescription drugs do not count toward the maximum out-of-pocket. | $9,350<br><br>Once you have paid $9,350 out of pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. |

# Covered Medical and Hospital Benefits

| | **IN-NETWORK** |
|---|---|
| **INPATIENT HOSPITAL COVERAGE*** | |
| | You pay $1,676 Deductible for each benefit period.<br><br>**Days 1–60:** $0 copay per day for each benefit period.<br><br>**Days 61–90:** $419 copay per day for each benefit period.<br><br>**Days 91 and beyond:** $838 copay per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime).<br><br>Beyond lifetime reserve days:You pay all costs. |
| **OUTPATIENT HOSPITAL COVERAGE** | |
| Outpatient surgery at outpatient hospital | You pay 20% of the total cost for Medicare-covered services. |
| **AMBULATORY SURGICAL CENTER SERVICES** | |
| Ambulatory Surgical Center Services | You pay 20% of the total cost for Medicare-covered services. |

# Covered Medical and Hospital Benefits (cont.)

## DOCTOR OFFICE VISITS

| | |
|---|---|
| Primary care provider (PCP) | You pay 20% of the total cost per visit for Medicare-covered primary care. |
| Specialists | You pay 20% of the total cost per visit for Medicare-covered specialist care. |

## PREVENTIVE CARE

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|---|---|
| **Preventive Care** | You pay nothing.<br><br>Any additional preventive services approved by Medicare during the contract year will be covered. |

## EMERGENCY CARE

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|---|---|
| **Emergency Care**<br><br>Coinsurance is waived if you are admitted to the same hospital within 24 hours for the same condition.<br><br>Emergency care is covered only within the United States. | You pay 20% of the total cost (up to $100 maximum per visit). |

## URGENTLY NEEDED SERVICES

| | |
|---|---|
| **Urgently Needed Services**<br><br>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.<br><br>Urgent care is covered only within the United States. | You pay 20% of the total cost (up to $45 maximum per visit). |

## DIAGNOSTIC SERVICES, LABS, AND IMAGING*

| | |
|---|---|
| **Diagnostic tests and procedures** | You pay 20% of the total cost of Medicare-covered services. |
| **Lab services*** | You pay 20% of the total cost of Medicare-covered services. |
| **Outpatient diagnostic imaging tests (such as X-rays and ultrasound)*** | You pay 20% of the total cost of Medicare-covered services. |
| **Advanced radiology services (such as MRI, PET, Nuclear Medicine)*** | You pay 20% of the total cost of Medicare-covered services. |
| **Therapeutic radiology (such as radiation treatment for cancer)*** | You pay 20% of the total cost of Medicare-covered services. |

# Covered Medical and Hospital Benefits (cont.)

## HEARING SERVICES

| | |
|---|---|
| **Medicare-covered hearing exams** | You pay 20% of the total cost of Medicare-covered services. |
| **Routine hearing exams**<br><br>**Hearing Aids** | $0 copay for routine hearing exams up to 1 per year.<br><br>$0 copay for evaluation and fitting of hearing aids up to four visits.<br><br>Our plan pays up to $1,000 every 2 years for hearing aids. The $1,000 amount applies to both ears combined.<br><br>You must obtain your hearing aids from a NationsBenefits provider. Please contact NationsBenefits by phone at 1-833-471-8447 (TTY: 1-833-414-8447). |

## DENTAL SERVICES

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|---|---|
| **Medicare-covered dental services** | You pay 20% of the total cost for Medicare-covered services. |
| **Routine Dental**<br><br>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:<br><br>**Preventive Care**<br>(Such as oral exam and cleaning) | You pay a $0 copay for 2 exams and 2 cleanings per year, 2 sets of X-rays per year and 2 fluoride treatments per year. |
| **Supplemental comprehensive dental services** | $1,500 maximum plan coverage amount for preventive and comprehensive dental services combined. |

## VISION SERVICES

| | |
|---|---|
| **Medicare-covered eye exams** | You pay 20% of the total cost for Medicare-covered services. |
| **Medicare-covered eyewear** | You pay 20% of the total cost of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. |
| **Routine vision exam**<br><br>Our plan pays for one routine eye exam every year. | You pay 0% of the total cost. |
| **Supplemental eyewear** | $150 maximum plan coverage amount for routine eye wear every year. |

# Covered Medical and Hospital Benefits (cont.)

## MENTAL HEALTH SERVICES*

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|---|---|
| **Inpatient***<br>Our plan covers up to 190 days in a lifetime for inpatient services in a psychiatric hospital. | You pay: $1,676 deductible for each benefit period.<br>Days 1–60 $0 copay per day for each benefit period.<br>Days 61-90: $419 copay per day for each benefit period.<br>Days 91 and beyond: $838 copay per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime).<br>Beyond lifetime reserve days: You pay all costs. |
| Outpatient group and individual therapy visits | You pay 20% of the total cost for Medicare-covered services. |

## SKILLED NURSING FACILITY*

| | |
|---|---|
| | • You pay: Days 1-100: $0 cost share for each benefit period.<br>• Days 101 and beyond: You pay all costs.<br>Our plan covers up to 100 days, per benefit period. |

## PHYSICAL THERAPY*

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|---|---|
| Rehabilitation Services (Medicare-covered)<br>**Occupational therapy** | You pay 20% of the total cost for Medicare-covered services. |
| **Physical therapy and speech and language therapy visit*** | You pay 20% of the total cost for Medicare-covered services. |
| **Cardiac rehabilitation** | You pay 20% of the total cost for Medicare-covered services. |
| **Pulmonary rehabilitation** | You pay 20% of the total cost for Medicare-covered services. |

## AMBULANCE

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|---|---|
| Ambulance (Medicare-covered ground and air transport) | You pay 20% of the total cost for each one-way Medicare-covered ambulance trip. |

# Covered Medical and Hospital Benefits (cont.)

## TRANSPORTATION

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|---|---|
| Transportation (non-emergent) | You pay $0 copay for up to 12 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. |
| Transportation (non-Medical needs) | You pay a $0 cost share. This benefit offers 4 one-way trips to non-medical related locations within 50 miles of the local service area for non-medical needs to members every year. |

## MEDICARE PART B DRUGS*

| | |
|---|---|
| **Medicare Part B Drugs*** | You pay 20% of the total cost for Medicare-covered Part B drugs.<br><br>Authorizations are required for billed charges in excess of $1,500.<br><br>**Part B Rebatable Drug Coinsurance Adjustment:**<br>Under the Medicare Part B Rebatable Drug Coinsurance Adjustment provision, beginning April 1, 2023, coinsurance for Part B rebatable drugs will be reduced, if the drug's price has increased at a rate faster than the rate of inflation. The list of Part B rebatable drugs as well as the effective coinsurance for those drugs could change each quarter. Part B rebatable drugs may be in either of the categories "Chemotherapy administration services to include chemotherapy/radiation drugs" or "Other drugs covered under Part B of original Medicare."<br><br>**Part B Insulin Cost Sharing Cap:**<br>Insulin furnished under Part B on or after July 1, 2023, through an item of durable medical equipment (i.e., a medically necessary traditional insulin pump), will be subject to a coinsurance cap for a month's supply of such insulin (that does not exceed $35 and the Medicare Part B deductible will not apply. |

# Prescription Drug Benefits

## PRESCRIPTION DRUGS

**Important Message About What You Pay for Vaccines**
Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

**Important Message About What You Pay for Insulin**
You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

## STAGES

**Stage 1: Deductible |** $590

During this stage, you pay the full cost of your drugs before our plan begins to pay its share of your drugs. You stay in this stage until you have paid $590 for your drugs.

**Stage 2: Initial Coverage**

You pay copays or coinsurance until your total yearly drug costs reach $2,000.00. Total yearly drug costs are the total drug costs paid by both you and the Plan. You may get your drugs at network pharmacies.

| **Tier 1: All Part D Covered Drugs** | | You pay 25% of the total cost of the drug | |
|---|---|---|---|
| | 30-day supply through Retail | 90-day supply through Retail or Mail | 31-day supply through Long-Term care |
| **Tier 1 Drug** | **25%** | **25%** | **25%** |

**Stage 3: Catastrophic Coverage**

(After your year-to-date out-of-pocket costs for prescription drugs reach $2,000.00)

In this stage, the plan pays all of the cost for your covered Part D drugs. You pay nothing. You generally stay in this stage for the rest of the calendar year.

# Additional Benefits

| FOOT CARE (PODIATRY SERVICES) | |
|---|---|
| **Medicare-covered foot care** | • You pay 20% of the total cost for Medicare-covered services. |
| **Routine foot care** | • You pay $0 cost share for up to 6 visits every year. |
| **MEDICAL EQUIPMENT/SUPPLIES** | |
| **Medical Equipment/Supplies (Medicare-covered)**<br>Durable Medical Equipment*<br>(such as wheelchairs, oxygen, etc.) | • You pay 20% of the total cost for Medicare-covered services.<br>• Authorizations are required for billed charges in excess of $500. |
| Prosthetics*<br>(such as braces, artificial limbs) | • You pay 20% of the total cost for Medicare-covered services.<br>• Authorizations are required for billed charges in excess of $500. |
| Diabetes supplies | • You pay 20% of the total cost for Medicare-covered services. |
| **ANNUAL PHYSICAL EXAM** | |
| Annual Physical Exam | You pay 20% of the total cost of the exam. |

***Prior authorization may be required for these benefits. See the EOC for details.**

# More Benefits With **Your Plan**

Enjoy some of these extra benefits included in your 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 **www.txindependencehealthplan.com** to view a copy of the EOC or call 1-833-471-8447.

### Over-the-Counter (OTC)

$60 maximum benefit coverage allowance every quarter for specific over-the-counter drugs and other health-related products, as listed in the OTC catalog.

Any unused benefits will be carried over to the next quarter. Any unused benefit expires at the end of the calendar year and cannot be carried over to the next year.

### Special Supplemental Benefits for the Chronically Ill

• Beauty Visits

You pay $0 cost share for beauty visits up to $100 a year.

This benefit will apply to members with one or more chronic conditions.

For more information, please call us toll-free at 1-833-471-8447, TTY users should call 1-833-414-8447 or visit us at **www.txindependencehealthplan.com**.

Texas Independence Community Plan (HMO I-SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, Texas Independence Community Plan (HMO I-SNP) may not pay for these services.

You can see our plan's provider directory, pharmacy directory, and the complete plan formulary (list of Part D prescription drugs) on our website at www.txindependencehealthplan.com.The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

# MULTI-LANGUAGE INTERPRETER SERVICE

FORM APPROVED
OMB# 0938-1421

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 1-833-471-8447. Someone who speaks English/ Language can help you. This is a free service.

Español (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 1-833-471-8447. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

(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 1-833-471-8447. 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 1-833-471-8447。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 (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 1-833-471-8447. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Français (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 1-833-471-8447. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Tiếng Việt (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 1-833-471-8447. 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 1-833-471-8447. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

한국어 (Korean)
당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-471-8447.번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Русский (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 1-833-471-8447. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

(Arabic) العربية
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 على 1-833-471-8447. هذه خدمة مجانية. سيقوم شخص ما يتحدث العربية بمساعدتك.

(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 1-833-471-8447. 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 1-833-471-8447. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português (Portugese)
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 1-833-471-8447. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

Kreyòl Ayisyen (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 1-833-471-8447. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polski (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 1-833-471-8447. 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 1-833-471-8447.にお電話 ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。



TEXAS INDEPENDENCE HEALTH PLAN