TEXAS INDEPENDENCE HEALTH PLAN

2026 Summary of Benefits

Texas Independence Health Plan (H5015-001)

Here's a summary of the services we cover from January 1, 2026 through December 31, 2026.

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

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

Texas Independence Health 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

This plan is available to anyone with Medicare who meets the Skilled Nursing Facility (SNF) level of care and resides in a contracted nursing home. You must continue to pay your Medicare Part B Premium. Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

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 You must keep paying your Medicare Part B premium	$4.80
Medical Deductible	$257 except for insulin furnished through an item of durable medical equipment. These are 2025 cost-sharing amounts and may change for 2026. Texas Independence Health Plan will provide updated rates as soon as they are released.
Pharmacy (Part D) deductible	$615
Maximum Out-of-Pocket Responsibility The most you pay for copays, coinsurance and other costs for covered medical services for the year. Your premium and prescription drugs do not count toward the maximum out-of-pocket.	$9,250 Once you have paid $9,250 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. **Days 1–60:** $0 copay per day for each benefit period. **Days 61–90:** $419 copay per day for each benefit period. **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). Beyond lifetime reserve days: You pay all costs. These are 2025 cost-sharing amounts and may change for 2026. Texas Independence Health Plan will provide updated rates as soon as they are released.
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	
Preventive Care	You pay nothing. Any additional preventive services approved by Medicare during the contract year will be covered.

EMERGENCY CARE	
Emergency Care Coinsurance is waived if you are admitted to the same hospital within 24 hours for the same condition. 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 Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. Urgent care is covered only within the United States.	You pay 20% of the total cost (up to $40 maximum per vist).

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. Prior Authorization is not required on X-Ray Services.
Advanced radiology services (such as MRI, PET, Nuclear Medicine)*	You pay 20% of the total cost of Medicare-covered services. CT Scans do not require a prior authorization. Authorization is required for complex radiological services, including but not limited to MRA, PET, SPECT scans, as well as radiation oncology and radiation therapy.
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 **Hearing Aids**	$0 copay for routine hearing exams up to 1 per year. $0 copay for evaluation and fitting of hearing aids up to four visits. Our plan pays up to $1,000 every 2 years for hearing aids. The $1,000 amount applies to both ears combined. 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

Medicare-covered dental services	You pay 20% of the total cost for Medicare-covered services.
Routine Dental In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: **Preventive Care** (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	$2,000 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 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*	
Inpatient* 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. **Days 1–60:** $0 copay per day for each benefit period. **Days 61–90:** $419 copay per day for each benefit period. **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). Beyond lifetime reserve days: You pay all costs. These are 2025 cost-sharing amounts and may change for 2026. Texas Independence Health Plan will provide updated rates as soon as they are released.
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. • Days 101 and beyond: You pay all costs. Our plan covers up to 100 days, per benefit period. No prior authorization required for contracted facilities. Plan allows for less than 3 days inpatient hospital stay prior to SNF admission. Hospital days are not required prior to SNF admission.

PHYSICAL THERAPY*	
Rehabilitation Services (Medicare-covered) **Occupational therapy**	You pay $0 cost share for Medicare-covered services.
Physical therapy and speech and language therapy visit*	You pay $0 cost share 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*	
Ambulance (Medicare-covered ground and air transport)	You pay 20% of the total cost for each one-way Medicare-covered ambulance trip. Prior authorization is required for repetitive scheduled non-emergent ambulance transport.

Covered Medical and Hospital Benefits (cont.)

TRANSPORTATION	
Transportation (non-emergent)	You pay $0 copay for up to 14 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. Authorizations are required for billed charges in excess of $1,500. **Part B Rebatable Drug Coinsurance Adjustment:** Beginning April 1, 2023, people with Medicare started to see lower out-of-pocket costs for certain Part B drugs and biologicals with prices that have increased faster than the rate of inflation. For these drugs and biologicals, the beneficiary coinsurance is 20 percent of the inflation-adjusted payment amount, which is less than what the beneficiary would pay in coinsurance otherwise. **Part B Insulin Cost Sharing Cap:** 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, even if you haven't paid your deductible.

STAGES

Stage 1: Deductible | $615

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 $615 for your drugs.

Stage 2: Initial Coverage

You pay copays or coinsurance until your total yearly drug costs reach $2,100.00. 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 $2,100.00)

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) Durable Medical Equipment* (such as wheelchairs, oxygen, etc.)	• You pay 20% of the total cost for Medicare-covered services. • Authorizations are required for billed charges in excess of $500.
Prosthetics* (such as braces, artificial limbs)	• You pay 20% of the total cost for Medicare-covered services. • 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.

This allowance does carry forward to the next quarter if it is unused. 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 Health 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 Health 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.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES (§ 92.11)

English
ATTENTION: If you speak Spanish, Chinese Manadrin, Traditional Chinese, Tagalog, French, Tieng, German, Korean, Russian, Arabic, Hindi, Italian, Portugese, French Creole, Polish, or Japanese, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-833-471-8447 (TTY: 1-833-414-8447) or speak to your provider.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-833-471-8447 (TTY: 1-833-414-8447) o hable con su proveedor.

(Chinese Mandarin) 注意：如果┌┌[中文]，我┌┌免┌┌┌提供┌言┌助服┌。我┌┌免┌提供适┌的┌助工具和服┌，以无障碍格式提供信息。致┌ 1-833-471-8447（文本┌┌：1-833-414-8447）或咨┌┌的服┌提供商。

(Traditional Chinese) 台語 注意：如果┌說[台語]，我們可以┌┌提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-833-471-8447（TTY：1-833-414-8447）或與┌的提供者討論。」

Tagalog (Tagalog)
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-833-471-8447 (TTY: 1-833-414-8447) o makipag-usap sa iyong provider.

Français (French)
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-833-471-8447 (TTY : 1-833-414-8447) ou parlez à votre fournisseur.

Tiếng Việt (Vietnamese)
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-833-471-8447 (Người khuyết tật: 1-833-414-8447) hoặc trao đổi với người cung cấp dịch vụ của bạn.

(German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-833-471-8447 (TTY: 1-833-414-8447) an oder sprechen Sie mit Ihrem Provider.

한국어 (Korean)
주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-833-471-8447 (TTY: 1-833-414-8447)번으로 전화하거나 서비스 제공업체에 문의하십시오.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-833-471-8447 (TTY: 1-833-414-8447) или обратитесь к своему поставщику услуг.

(Arabic) العربية تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-833-471-8447 (1-833-414-8447) أو تحدث إلى مقدم الخدمة".

(Hindi) हिंदी ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-833-471-8447 (TTY: 1-833-414-8447) पर कॉल करें या अपने प्रदाता से बात करें।

(Italian) ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' 1-833-471-8447 (tty: 1-833-414-8447) o parla con il tuo fornitore.

Português (Portugese)
ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-833-471-8447 (TTY: 1-833-414-8447) ou fale com seu provedor.

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-833-471-8447 (TTY: 1-833-414-8447) oswa pale avèk founisè w la.

Polski (Polish)
UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-833-471-8447 (TTY: 1-833-414-8447) lub porozmawiaj ze swoim dostawcą.

(Japanese) 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-833-471-8447（TTY：1-833-414-8447）までお電話ください。または、ご利用の事業者にご相談ください。