January 5, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program: Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (CMS-4205-P)

Dear Administrator Brooks-LaSure,

The Academy of Doctors of Audiology (ADA), a leading national association, dedicated to evidence-based audiologic and vestibular care, represents audiologists across the United States who treat millions of Medicare patients each year. The ADA appreciates the opportunity to provide comments to help inform the *Proposed Rule: Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (Proposed Rule)*, put forward by the Centers for Medicare and Medicaid Services (CMS).

Despite the fact that hearing health is essential to overall health, Medicare Part B is statutorily prohibited from covering hearing aids, services related to the fitting and use of a hearing aid, and hearing and balance treatment services such as aural rehabilitation, vestibular rehabilitation, and cerumen removal, when those medically necessary, Medicare-covered treatment services are delivered by licensed, Medicare-qualified audiologists within their state-defined scope of practice.*[1]

By contrast, nearly 98% of Medicare Part C (Medicare Advantage, MA) individual plans offer some type of hearing "benefit," as a supplemental benefit.[2] Medicare Advantage Organizations (MAOs), brokers, agents, and third-party benefit managers, have capitalized on the fragmented and limited hearing health coverage available in traditional Medicare, and have marketed hearing benefits heavily as part of their supplemental benefits packages. More than 90% of television advertising airings, used to market Medicare Advantage plans, promote extra benefits, such as hearing, vision, and dental benefits as a key reason that seniors should select their plans, and more than half of the television advertisements specifically promoted hearing benefits.[3]

[1] *Listed services are reimbursed by Medicare, when delivered by certain other providers.
[2] https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look
[3] https://www.kff.org/report-section/how-health-insurers-and-brokers-are-marketing-medicare-report

According to the Kaiser Family Foundation, 51% of the eligible Medicare population, 30.8 million people, were enrolled in a Medicare Advantage plan in 2023, accounting for $454 billion (54%) of total federal Medicare spending.[4]

With nearly 4,000 different MA plans in the marketplace—and with vast differences in product offerings from state to state, and often county to county, it can be difficult for consumers to compare plan options. Consumers frequently lack accurate and adequate information to make informed decisions about plan networks, pricing-to-benefit ratios, and other standards for coverage. Older adults can be particularly susceptible to predatory marketing and sales tactics employed by Medicare Advantage plan sales agents and brokers.

The ADA supports many of the proposals outlined by CMS in the Proposed Rule that are designed to promote transparency in communications with consumers and beneficiaries—to foster a clear understanding of the nature and availability of supplemental benefits, such as hearing benefits, contained in Medicare Advantage plans, and that are designed to increase benefit utilization by enrolled beneficiaries, appropriately—including:

- The ADA supports CMS' proposal to require MA plans to notify enrollees mid-year of the unused supplemental benefits, including hearing benefits, available to them.
- The ADA supports CMS' proposal to enhance guardrails for agent and broker compensation, and to prohibit contract terms between MA organizations, agents, brokers, and/or third-party marketing organizations that may interfere with the agent's or broker's ability to objectively assess and recommend the plan best suited to address each beneficiary's healthcare needs.
- The ADA supports CMS' proposal to require an annual health equity analysis of utilization management policies and procedures be conducted by the Utilization Management (UM) committee; and
- The ADA agrees with CMS' assertion regarding its authority to collect detailed information from MA organizations under current regulations and its proposal to establish a foundation for new and increased data collection efforts with a focus on transparency, accountability, and clinical outcomes with respect to coverage decisions and benefit access.

While the ADA applauds CMS for proposing these regulatory changes to strengthen the Medicare Advantage program and better protect American healthcare consumers, ADA recommends the agency to take additional actions to address existing regulatory shortcomings and enhance program integrity related to the marketing, delivery, and utilization of hearing benefits within Medicare Part C.

Specifically, the ADA strongly encourages CMS to consider the following additional actions:

I. Enforce compliance with existing regulations that require MAOs to incur a non-zero direct medical cost for supplemental benefits.

Pursuant to 21 CFR 422.100(c)(2)(ii)(B), supplemental benefits in Medicare Advantage require, among other things, that the "MA organization incurs a non-zero direct medical cost, except that in the case of a SSBCI that is not primarily health related that is offered in accordance with § 422.102, the MA

[4] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends

organization may instead incur a non-zero direct non-administrative cost." Further, the Medicare Managed Care Manual Chapter 4 - Benefits and Beneficiary Protections, Section 30.1 – Definition of Supplemental Benefit, states that if the Medicare Advantage plan only incurs an administrative cost, the requirement is not met.[5]

The ADA is concerned that a substantial proportion of hearing benefits, specifically hearing aid benefits, marketed as Medicare Advantage "supplemental benefits" would fail to meet these requirements. In fact, we believe a vast majority of hearing aid benefits in Medicare Advantage are simply hearing aid discounts masquerading as funded benefits. Within these benefit offerings, it is difficult to imagine that the plan sponsor (or third-party benefit administrator) is incurring a "non-zero direct medical cost" when merely offering enrollees discounted hearing aids, which are often presented under a supposed co-payment cost-sharing benefit structure.

As the ADA understands it, Medicare Advantage plans finance supplemental benefits through rebate dollars or through additional premiums charged to enrollees. The ADA is, thus, also concerned that there may be circumstances where beneficiaries have been charged for supplemental hearing benefits that are merely discounts—and that were obtained at no cost by the plan sponsor, and in certain circumstances, even structured to create a financial gain for the plan sponsor and/or the hearing benefit administrator.

II. Prohibit Medicare Advantage Organizations from disguising hearing care discount plans as insurance benefits.

Medicare Advantage hearing health discount program terminology contributes to consumer confusion. Two commonly used terms related to insurance are benefits and copays. These terms are often misappropriated by MAOs, brokers, agents, and even plan sponsors.

Healthcare.gov defines benefits as "the health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents."[6] Hearing aid discount programs do not provide any coverage and it is inaccurate and deceptive to use the term benefit to describe them.

A co-pay (or copayment) is a cost-*sharing* structure in health insurance plans where the insured pays a specified dollar amount, typically a fixed fee, for medical expenses that they have incurred, and the insurer pays the remainder.[7] The term copay should not be used to describe the consumer's payment responsibility under a discount program, since the consumer is responsible for the full payment for all services and products.

We understand that some third-party benefit administrator/manager-administered hearing aid discount programs are even structured to make a profit for plan sponsors by allowing them to benefit from excess revenue from hearing aid sales to participating enrollees and/or by receiving a fee per enrollee. Yet consumers are frequently unable to discern the differences between insurance funded and discount programs based on the program's descriptions alone.

[5] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf
[6] https://www.healthcare.gov/glossary/benefits
[7] https://content.naic.org/consumer_glossary.htm

CMS should require Medicare Advantage plans to incorporate consumer protection provisions that will:

- Prohibit plan hearing aid discount programs from leading consumers to believe that the discount plan being offered is an insurance product;
- Require discount plans to provide ongoing, ready access to contact information and provider type for every participating discount plan provider; and
- Require organizations that market discount plans to declare on all advertisements and marketing materials in "bold and prominent type" that the plan is not insurance.

III. Ensure that beneficiaries have access to the diagnostic audiologic services to which they are entitled.

By law, Medicare Advantage plans must cover all medically necessary services that traditional Medicare covers.[8] Under Medicare Part B, beneficiaries are entitled to a diagnostic audiologic assessment when medical necessity is established. The ADA understands that Medicare Advantage bids are, therefore, required to include the diagnostic audiologic assessment.

Medicare Advantage hearing benefits are often managed by third-party benefit administrators, using networks outside of the primary insurers, and that are often affiliated with or wholly owned by a hearing aid manufacturer. Medicare Advantage plan coverage documents typically do not distinguish between a diagnostic audiologic assessment and a routine hearing exam.

The ADA is concerned that many of these plan administrators steer beneficiaries exclusively into their network, and beneficiaries are seldom, if ever, informed that they are eligible to receive a diagnostic audiologic exam under the medical benefit. The beneficiary is instead offered a "free" routine hearing aid exam which is given for the sole purpose of fitting and selling a hearing aid. Many ADA audiologists have consulted beneficiaries who have struggled with the efficacy of hearing aids sold to them under this broken system.

CMS should require plans to notify beneficiaries about the audiology services covered under the medical insurance and provide them with network contacts who can perform a diagnostic audiologic exam, in addition to providing network information only for the "routine hearing exam."

IV. Require greater transparency and integrity regarding network size, scope, and referral methodology.

Many Medicare Advantage plans, brokers, agents, and/or hearing benefit administrators make significant marketing claims regarding the accessibility, size, and scope of their provider networks and the number of hearing aid brands and types in their formulary.

However, upon enrollment in the plan and attempted use of their hearing benefit, many Medicare Advantage enrollees are referred by the benefit administrator/manager to providers who do not offer the full range of hearing aid brands originally advertised within the benefit formulary. In many documented cases, the existence of a financial relationship between the benefits administrator/plan manager, the hearing aid manufacturer, and the clinic/provider results in unsuspecting plan enrollees

[8] https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf

being purposefully steered toward certain network providers who limit their hearing aid brand selection to favor only one hearing aid manufacturer, often one in which the provider and/or the plan administrator has a contractual agreement or ownership relationship that incentivizes the sale of their products. This practice limits consumer choice and competition and creates an unmanageable conflict of interest that may cause financial and clinical harm to the beneficiary/consumer.

CMS should require MAOs, Medicare Advantage plans, brokers, and agents to notify consumers if they are required to go through a third-party administrator (TPA), third-party network (TPN), or third-party manager (Manager), separate from the parent/primary insurer to obtain the promised benefit or coverage approval. CMS should prohibit any benefit structure or procedure that creates financial incentives for plan managers, administrators, device manufacturers, and providers to steer beneficiaries toward specific products.

V. Require disclosure of vertical ownership and/or financial relationships between hearing aid manufacturers, third-party administrators, networks, and retailers.

The five largest global hearing aid manufacturers, which together control more than 90% of the hearing aid market, have long sought vertical integration strategies to ensure their continued market dominance. Four legacy hearing aid manufacturers' vertical channels include hearing benefit plans, third-party benefit administrators, and third-party networks.

Hearing Aid Manufacturer	Owned Plan/Benefit Administrator, Network	Website	Own Hearing Aid Clinics?
Demant	Bird Song and Your Hearing Network	https://birdsonghearing.com https://yourhearingnetwork.com	Yes
GN	Great Hearing Benefits	https://greathearingbenefits.com	Yes
Sonova	None	N/A	Yes
Starkey	Start Hearing (formerly American Hearing Benefits)	https://www.starthearing.com	Yes
WS Audiology	TruHearing and Hearing Care Solutions	https://www.truhearing.com/hearing-aids https://www.hearingcaresolutions.com	Yes

Manufacturers cite revenue generation and market growth as primary reasons for vertical expansion into managed care through their ownership hearing care benefit plans.[9] That growth is built by increasing yield and utilization of their hearing devices by health plans, providers, and consumers.

The benefit plan administrator plays a pivotal role in determining coverage decisions, and in the majority of cases in Medicare Advantage where hearing benefits are offered, the benefit administrator is owned

[9] https://medcitynews.com/2019/10/how-device-makers-are-responding-to-medicare-advantages-quiet-revolution-in-hearing-health

by a hearing aid manufacturer, with a vested interest in generating hearing aid sales, not overall quality of life with audiologic diagnostic and treatment services.[10] As many of the supplemental benefits are not funded, the financial risk is borne largely by the consumer/beneficiary. Yet, the enrollee has no knowledge of the relationship between the manufacturer and the hearing benefit manager, and in some cases also the retail clinic and provider.

CMS should enhance marketing transparency by requiring plan sponsors, brokers, administrators, managers, and providers to disclose manufacturer ownership and/or financial relationships that they have with manufacturers that pose a conflict of interest on all marketing materials, plan details, and audiologic and hearing aid paperwork.

VI. Prohibit manufacturer rebates and other incentives that pay providers to steer beneficiaries to specific devices or technology levels.

The current payment structure in Medicare Advantage for hearing aid benefits incentivizes providers to steer beneficiaries toward purchasing higher cost (premium technology) hearing aids. While a hearing aid exam is typically covered for zero out-of-pocket cost to the beneficiary, the provider is not typically reimbursed for the examination by the plan manager. Rather, the provider is only paid a fitting fee to cover the fitting services provided after the beneficiary purchases hearing aids, secondary to a hearing aid purchase. Typically, hearing benefit administrators pay providers higher fitting fees for fitting and dispensing higher technology hearing aids (and thus more expensive). Yet, fitting these devices often does not require additional time or effort.[11]

Audiologists should be paid fairly for all of the services they deliver, including hearing aid fitting services. Audiologists, as clinical experts in audiologic and vestibular care, should have autonomy in hearing aid device selection for their patients. Additionally, the hearing aid device selection should be based on medical necessity, clinical evidence, and patient needs, rather than the financial interest of the provider, plan manager, and hearing aid manufacturer. The ADA, therefore, recommends that CMS prohibit service fee differentials that incentivize providers to steer beneficiaries toward higher priced products. Additionally, audiologists should be paid for the diagnostic evaluations separately from the hearing aid sales.

Recently, the ADA became aware that some hearing aid manufacturers are paying providers rebates to encourage the use of the manufacturer's devices for managed care patients, including Medicare Advantage patients (examples enclosed). Rebate amounts are based on technology tiers and providers are paid a higher amount for recommending premium hearing aids. Provider participation in these rebate programs is in direct opposition to the ADA's Code of Ethics and could be found to violate the Federal Anti-Kickback Statutes. Manufacturer discount or rebate programs can present a conflict of interest that may compromise professional clinical judgement. Managed care rebate programs that seek to arbitrarily steer a health plan member toward a premium technology product, from a preferred manufacturer, benefits the *manufacturer and the provider*, not the patient. Therefore, the ADA recommends that CMS explicitly prohibit the use of manufacturer rebate programs for manufacturers, plan administrators, and providers participating in Medicare Advantage.

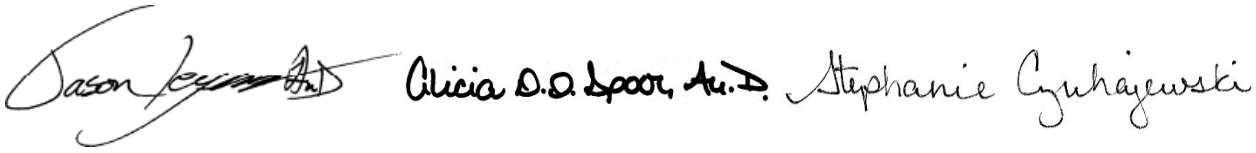
[10] See 9 above.

[11] It should be noted that not all hearing benefit administrators operate this way. However, most currently do.

The ADA further recommends that plan managers be prohibited from interfering with audiologists' prerogative to offer and contract with patients privately for services that are not covered by hearing health supplemental benefits. Many plans do not cover the cost of counseling, aural rehabilitation, cerumen management, and numerous other services, when medically necessary, but also do not allow providers to deliver services to patients for their reasonable and customary fee. The ADA believes that this is a mechanism used by the plan administrator to incentivize "bundled" hearing aid sales, as it forces the provider to rely on the hearing aid fitting fee for revenue, rather than fees for clinical services not associated with the sale of hearing aids. The current model undermines evidence-based practice and consumer protections that are essential to effective care delivery.

The ADA commends CMS for the positive steps that it has taken to enhance transparency and care delivery in Medicare Advantage. In addition to the provisions outlined in the Proposed Rule, the ADA appreciates the opportunity to provide recommendation that would ensure greater transparency in the marketing of hearing aid benefits and the delivery of hearing care for Medicare Advantage beneficiaries. Please contact Ms. Stephanie Czuhajewski at sczuhajewski@audiologist.org for more information, or if further assistance can be provided.

Sincerely,



Jason Leyendecker, Au.D.	Alicia D.D. Spoor, Au.D.	Stephanie Czuhajewski, MPH, CAE
President	Advocacy Chair	Executive Director

Enclosures
(Example: Hearing aid discount plan marketing materials and aligned plan information, Example: Hearing aid manufacturer rebate program marketing information)

Health Plans | TruHearing®

Address your hearing loss for less

Thanks to your IU Health Plans Medicare Advantage plan, you have access to tremendous savings through TruHearing®. Your 2024 hearing benefit covers up to two TruHearing *Standard*, *Advanced* or *Premium* hearing aids per year with low copayments.

2024 Hearing aid coverage

Your plan	Hearing aid	Original Medicare price per aid	Savings per aid	Copay per aid
$0 Preferred (HMO) **Flex Network (HMO-POS)**	TruHearing *Premium*	$3,250	$2,251	**$999**
Select – Medical Only (HMO) **Select Plus (HMO) 001, 002, 003**	TruHearing *Advanced*	$2,720	$2,021	**$699**
Choice (HMO-POS) **Kidney Care (HMO)**	TruHearing *Standard*	$1,719	$1,220	**$499**

Exam: $0 copay *(must be performed by a TruHearing network provider)*

Rechargeable battery option is available on select styles for an additional $50 per hearing aid.

Indiana University Health Plans is an HMO/HMO POS with a Medicare contract. Enrollment in IU Health Plans Medicare depends on the plan's contract renewal with Medicare.

H7220_IUHMA2461_M Accepted 8.14.2023

Call TruHearing to learn more and schedule an appointment | **Hours: 8 am – 8 pm, Monday – Friday**

855.541.6172 (TTY users call 711)

Your hearing aid purchase includes

- Risk-free 60-day trial period
- One year of follow-up visits
- 80 free batteries per non-rechargeable hearing aid
- Full three-year manufacturer warranty

The right hearing aids can change your life.

Research shows that addressing hearing loss can impact your overall health and well-being, including improvements[1] in:

- Mental and emotional health
- Relationship with spouse or partner
- Sense of safety and independence

The best technology for less

- Enhanced speech clarity to understand voices above background noise
- Bluetooth® streaming from your phone for convenient calls, music, movies and more
- Fuss-free rechargeability up to 36 hours with portable charger options[2]

Call TruHearing to verify your benefit and schedule a hearing exam | **Hours: 8 am – 8 pm, Monday – Friday**

855.541.6172 | (TTY users call 711)

[1] MarkeTrak 2022

[2] Available on select models. Thirty-six hours of use on a single charge with five hours streaming.

TruHearing is an independent hearing aid program and network of providers utilized by IU Health Plans Medicare Advantage HMO and HMO POS. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or copayments/coinsurance may change on Jan. 1 of each year.

IU Health does not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, genetic information, veteran status, national origin, gender identity and/or expression, marital status, or any other characteristic protected by federal, state or local law. For language assistance, call 800.455.9776 (TTY/TDD 711).

Retail pricing based on prices for comparable aids. Savings may vary. Follow-up provider visits included for one year following hearing aid purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing Hearing Consultant.

2024 IU Health Plans
Medicare Advantage Plan Guide

Health Plans

Indiana University Health Plans is an HMO/HMO POS with a Medicare contract. Enrollment in IU Health Plans Medicare depends on the plan's contract renewal with Medicare.

H7220_IUHMA24240A_M Accepted 9.27.2023

Health Plans

Your health. *Our plans.*

To choose a plan with the right care for you, it takes two: Indiana University Health Plans and Indiana University Health.

Our 2024 Medicare Advantage benefits include:

$0 **monthly premium***	**$0** **copay*** for IU Health Primary Care visits	**$0** **Rx deductible**

$100 per month Medicare Part B premium reduction*

Plus many more benefits that fit your life as detailed in the following pages

**Only available in select counties*

Contact your broker or call **866.299.9214** (when prompted, press 1) to speak to a Medicare Advantage expert in your county.

Oct. 1 – March 31 | 8 am – 8 pm | Seven days a week
April 1 – Sept. 30 | 8 am – 8 pm | Monday – Friday

IU Health Plans Medicare Advantage – 2024 county list

Plans by county listed below. See pages 3 – 8 to compare benefits by plan.

$0 Preferred (HMO)

Blackford
Brown
Carroll
Delaware
Greene
Jay
Lawrence
Orange
Owen
Tipton
White

Flex Network (HMO-POS)

Allen
Benton
Blackford
Boone
Brown
Carroll
Delaware
Fountain
Greene
Hamilton
Hancock
Hendricks
Henry
Howard
Huntington
Jay
Johnson
Lawrence
Marion
Orange
Owen
Putnam
Randolph
Shelby
Tippecanoe
Tipton
Warren
White
Whitley

Select – Medical Only (HMO)

Allen
Benton
Boone
Brown
Carroll
Cass
Clinton
Delaware
Hamilton
Hancock
Hendricks
Howard
Jay
Johnson
Madison
Marion
Martin*
Monroe
Morgan
Owen
Randolph
Tippecanoe
Tipton
White

New in 2024

Select Plus (HMO) 001

Benton
Brown
Carroll
Cass
Delaware
Fountain
Greene
Howard
Jay
Lawrence
Montgomery
Orange
Owen
Randolph
Tipton
Warren
White

Select Plus (HMO) 002

Boone
Clinton
Hamilton
Hancock
Hendricks
Johnson
Madison
Marion
Martin*
Monroe
Morgan
Tippecanoe

New in 2024

Select Plus (HMO) 003

Allen
Huntington
Whitley

Which Medicare Advantage plan is right for me?

What IU Health Plans members pay

Plan benefit	Flex Network (HMO-POS) *In-network*	*Out-of-network*
	Plan costs	
Monthly plan premium*	$0	
Out-of-pocket cost protection	$3,900 in-network/$8,500 combined in- and out-of-network	
Part B premium reduction	$100	
	Outpatient care/services/supplies	
IU Health Primary Care visits	$0	N/A
All other primary care visits	$0	$15
Specialist	$35	$55
Telehealth virtual visits	$0	N/A
Physical therapy, OT, ST	$20	$55
Outpatient surgery	$350	$375
Ambulance	$295**	
Emergency	$90/$90 worldwide	
Urgent care	$45/$90 worldwide	
Diabetic supplies (test strips, lancets)	$0	40%
Diagnostic tests	20%	40%
Diagnostic labs	$0 – $10	40%
X-rays	$25	$50
Diagnostic and therapeutic radiology	20%	40%
	Inpatient/Home healthcare	
Inpatient – Hospital	$335 per day, days 1-6; $0 per day for days 7 and beyond	$360 per day, days 1-6; $0 per day for days 7-90
Inpatient – Mental health	$335 per day, days 1-6	40%
Skilled nursing (No hospital stay required)	$0 per day, days 1-20; $203 per day, days 21-100	40%
Home health	$0	40%
	Preventive services	
Preventive screenings	$0	$0
Annual physical exam	$0	$0

**You must continue to pay your Medicare Part B premium.*

(continued on next page)

***Out-of-network copay is for Emergency transportation only.*

Which Medicare Advantage plan is right for me?

What IU Health Plans members pay

Plan benefit	$0 Preferred (HMO)
	Plan costs
Monthly plan premium*	$0
Out-of-pocket cost protection	$3,400
Part B premium reduction	$100
	Outpatient care/services/supplies
IU Health Primary Care visits	$0
All other primary care visits	$0
Specialist	$35
Telehealth virtual visits	$0
Physical therapy, OT, ST	$20
Outpatient surgery	$350
Ambulance	$295
Emergency	$90/$90 worldwide
Urgent care	$45/$90 worldwide
Diabetic supplies (test strips, lancets)	$0
Diagnostic tests	20%
Diagnostic labs	$0 – $10
X-rays	$25
Diagnostic and therapeutic radiology	20%
	Inpatient/Home healthcare
Inpatient – Hospital	$345 per day, days 1-6; $0 per day for days 7 and beyond
Inpatient – Mental health	$345 per day, days 1-6
Skilled nursing (No hospital stay required)	$0 per day, days 1-20; $203 per day, days 21-100
Home health	$0
	Preventive services
Preventive screenings	$0
Annual physical exam	$0

**You must continue to pay your Medicare Part B premium.*

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Which Medicare Advantage plan is right for me?

What IU Health Plans members pay

Plan benefit	Select Plus (HMO) 001	Select Plus (HMO) 002
	Plan costs	
Monthly plan premium*	$46	$0
Out-of-pocket cost protection	$5,150	$3,100
Part B premium reduction	N/A	N/A
	Outpatient care/services/supplies	
IU Health Primary Care visits	$0	$0
All other primary care visits	$10	$10
Specialist	$40	$40
Telehealth virtual visits	$0	$0
Physical therapy, OT, ST	$20	$20
Outpatient surgery	$350	$350
Ambulance	$295	$295
Emergency	$90/$90 worldwide	$90/$90 worldwide
Urgent care	$45/$90 worldwide	$45/$90 worldwide
Diabetic supplies (test strips, lancets)	$0	$0
Diagnostic tests	20%	20%
Diagnostic labs	$0 – $10	$0 – $10
X-rays	$25	$30
Diagnostic and therapeutic radiology	20%	20%
	Inpatient/Home healthcare	
Inpatient – Hospital	$300 per day, days 1-6; $0 per day for days 7 and beyond	$340 per day, days 1-6; $0 per day for days 7 and beyond
Inpatient – Mental health	$300 per day, days 1-6	$340 per day, days 1-6
Skilled nursing (No hospital stay required)	$0 per day, days 1-20; $203 per day, days 21-100	$0 per day, days 1-20; $203 per day, days 21-100
Home health	$0	$0
	Preventive services	
Preventive screenings	$0	$0
Annual physical exam	$0	$0

**You must continue to pay your Medicare Part B premium.*

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Which Medicare Advantage plan is right for me?

What IU Health Plans members pay

Plan benefit	Select Plus (HMO) 003	Select – Medical Only (HMO)
	Plan costs	
Monthly plan premium*	$0	$0
Out-of-pocket cost protection	$3,100	$5,000
Part B premium reduction	N/A	$21
	Outpatient care/services/supplies	
IU Health Primary Care visits	$0	$0
All other primary care visits	$0	$0
Specialist	$40	$40
Telehealth virtual visits	$0	$0
Physical therapy, OT, ST	$20	$40
Outpatient surgery	$350	$350
Ambulance	$295	$295
Emergency	$90/$90 worldwide	$90
Urgent care	$45/$90 worldwide	$60
Diabetic supplies (test strips, lancets)	$0	$0
Diagnostic tests	20%	20%
Diagnostic labs	$0 – $10	$0 – $10
X-rays	$25	$25
Diagnostic and therapeutic radiology	20%	20%
	Inpatient/Home healthcare	
Inpatient – Hospital	$300 per day, days 1-6; $0 per day for days 7 and beyond	$335 per day, days 1-6; $0 per day for days 7 and beyond
Inpatient – Mental health	$300 per day, days 1-6	$335 per day, days 1-6
Skilled nursing (No hospital stay required)	$0 per day, days 1-20; $203 per day, days 21-100	$0 per day, days 1-20; $203 per day, days 21-100
Home health	$0	$0
	Preventive services	
Preventive screenings	$0	$0
Annual physical exam	$0	$0

**You must continue to pay your Medicare Part B premium.*

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Which Medicare Advantage plan is right for me?

What IU Health Plans members pay

Plan benefit	$0 Preferred (HMO)	Flex Network (HMO-POS) *In-network*	Flex Network (HMO-POS) *Out-of-network*
	Additional benefits and wellness programs		
Fitness membership	$0	$0	N/A
Preventive and basic dental services	$0 preventive; 50% basic; up to $1,000 coverage/year	$0 preventive; 50% basic; up to $1,000 coverage/year	N/A
Routine vision exam	$0	$0	Limited coverage
Frames/lenses or contacts	$250 allowance	$250 allowance	Limited coverage
Hearing aids	$499/$699/$999	$499/$699/$999	N/A
Travel benefit	For members traveling out of state for more than 30 days and up to 9 consecutive months	For members traveling out of state for more than 30 days and up to 9 consecutive months	N/A
Over-the-counter (OTC) items	$80 per quarter – no rollover	$80 per quarter – no rollover	N/A
Meals	42 meals	42 meals	N/A
Transportation	24 one-way rides	24 one-way rides	N/A

(continued on next page)

Which Medicare Advantage plan is right for me?

What IU Health Plans members pay

Plan benefit	Select Plus (HMO) 001	Select Plus (HMO) 002	Select Plus (HMO) 003	Select – Medical Only (HMO)
	Additional benefits and wellness programs			
Fitness membership	$0	$0	$0	$0
Preventive and basic dental services	$0 preventive; 50% basic; up to $1,000 coverage/year	$0 preventive; 50% basic; up to $1,000 coverage/year	$0 preventive; 50% basic; up to $1,000 coverage/year	$0 preventive; 50% basic; up to $1,000 coverage/year
Routine vision exam	$0	$0	$0	$0
Frames/lenses or contacts	$250 allowance	$250 allowance	$250 allowance	$250 allowance
Hearing aids	$499/$699/ $999	$499/$699/ $999	$499/$699/ $999	$499/$699/ $999
Travel benefit	For members traveling out of state for more than 30 days and up to 9 consecutive months	For members traveling out of state for more than 30 days and up to 9 consecutive months	For members traveling out of state for more than 30 days and up to 9 consecutive months	N/A
Over-the-counter (OTC) items	$80 per quarter – no rollover	$80 per quarter – no rollover	$80 per quarter – no rollover	$80 per quarter – no rollover
Meals	42 meals	42 meals	42 meals	42 meals
Transportation	24 one-way rides	24 one-way rides	24 one-way rides	24 one-way rides

Prescription drug information

Drug costs – $0 Preferred (HMO), Flex Network (HMO-POS) and Select Plus (HMO) plans			
Tier	Preferred retail pharmacy* (30-day supply)	Standard retail pharmacy (30-day supply)	CVS Caremark mail-order service (90- to 100-day supply)
	$0 Rx deductible		
Tier 1 – Preferred Generic	$0	$3	$0
Tier 2 – Generic	$12	$12	$0
Tier 3 – Preferred Brand	$37 (insulins $35**)	$47 (insulins $35**)	$141 (insulins $105**)
Tier 4 – Non-Preferred Brand	$100	$100	$300
Tier 5 – Specialty	33%	33%	Not available
Tier 6 – Select Care	$0	$0	$0

**IU Health Plans preferred pharmacies include Costco, CVS, Kroger, Target, Walmart, IU Health retail pharmacies and more.*

***Insulin copay not subject to coverage gap.*

Additional dental benefits

Optional supplemental dental benefits available for **all plans*****		
Plan	Additional monthly premium	Benefits
Dental Enhanced 1000	$23	Up to $1,000 per plan year for basic restorative care and major restorative care
Dental Enhanced 1500	$28	Up to $1,500 per plan year for basic restorative care and major restorative care

****You must still continue to pay your dental premium in addition to your Medicare Part B premium and monthly plan premium.*

The benefits information provided is a brief summary, not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or copayments/coinsurance may change on Jan. 1 of each year.

Additional benefits

We are pleased to offer you these extra benefits with your IU Health Plans Medicare Advantage plan.

Dental, vision, hearing and fitness membership benefits
Learn more about your dental, vision, hearing and fitness benefits at **iuhealthplans.org > Medicare Advantage Plans > Tools & Resources > Extra Benefit Plan Information**.

Healthy rewards program
Earn a $50 Walmart Healthy Living Gift Card for completing an Annual Wellness Visit.

Pharmacy benefits
Select Plus (HMO), Flex Network (HMO-POS), $0 Preferred (HMO)
- $0 Rx deductible
- Preferred retail pharmacy network and mail-order options

Telehealth virtual visits
Access to on-demand virtual visits conveniently from your smartphone, tablet or computer for diagnosis and treatment of certain non-emergency medical issues. You pay $0 copay.

Over-the-counter (OTC) mail-order items
$80 quarterly allowance for the purchase of over-the-counter products from the OTC Health Solutions mail-order catalog. One order per quarter. You will lose the unused balance.

Meals
Provides 42 healthy, refrigerated, home-delivered meals following an inpatient hospital discharge.

Health coaches
Health coaching through our Healthy Results® program provides personalized resources to help you support new habits and address your health goals.

Transportation
Access to 24 one-way rides to plan-approved, health-related locations.

For a complete list of benefits, see the Evidence of Coverage (EOC) and other plan information at **iuhealthplans.org > Medicare Advantage Plans > Tools & Resources**.

Indiana University Health Plans is an HMO/HMO POS with a Medicare contract. Enrollment in IU Health Plans Medicare depends on the plan's contract renewal with Medicare.

If you have questions, we're here to help. Please call IU Health Plans Member Advocates toll free at **800.455.9776 (TTY/TDD 711)**. Language assistance available.

IU Health does not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, genetic information, veteran status, national origin, gender identity and/or expression, marital status, or any other characteristic protected by federal, state or local law.

Health Plans

950 N. Meridian St., Suite 400
Indianapolis, IN 46204-1202

iuhealthplans.org

If you have questions, we're here to help. Please call our IU Health Plans Member Advocates toll free at **800.455.9776 (TTY/TDD 711)**. Language assistance available.

IU Health Plans Member Advocates hours:
Oct. 1 to March 31 – 8 am to 8 pm, seven days a week
April 1 to Sept. 30 – 8 am to 8 pm, Monday – Friday
You may receive assistance through alternate technology after hours, on weekends and holidays; or visit **iuhealthplans.org**.

IU Health does not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, genetic information, veteran status, national origin, gender identity and/or expression, marital status, or any other characteristic protected by federal, state or local law.

OTICON
Managed Care Programs

Oticon Managed Care Rebate Program

The Oticon Managed Care Rebate Program provides you with a quarterly rebate in recognition of your participation in select managed care networks when fitting Oticon products. We value your role in serving those patients seeking hearing healthcare through their preferred program. You'll receive your rebate at the end of each quarter from the net sales of eligible units sold.

Review your current practice goals and growth potential – we can help

Enroll in the program – it's easy

Begin accepting referrals from designated partner networks

Get started

Contact your Oticon Account Manager at **800-526-3921** to discuss the program terms and conditions for enrollment. They can also connect you to the appropriate Hearing Benefits Manager (HBM) partner if you're not already enrolled with any HBMs.

Upon completion of the Oticon Managed Care Rebate Enrollment Agreement, return it via email to partnersetup@oticon.com.

After this form is processed, you may begin earning the rebate. Each quarter's net Managed Care purchases will calculate your rebate at the end of your quarterly accrual period. It's that easy!

*Accounts must be in current financial standing in order to receive a rebate in the form of a check.

Track your progress

Your Oticon Inside Sales Representative will remind you of your rebates earned. Rebates are paid quarterly in the form of a check or statement credit to the practice.*

OTICON
Managed Care Programs

MANAGED CARE REBATE ENROLLMENT AGREEMENT FORM

Provider Name: _____

Business Name: _____

Account Number: _____

Provider Address: _____

Contact Person: _____

Earning a Rebate:	Provider shall earn a rebate from qualifying Net unit orders made during their Quarterly Period.
Measurement Period:	Per quarterly term
Rebate Value:	For Net Orders made during the Quarterly Period, the Provider shall receive the aggregate rebate value earned. See Exhibit B, the Oticon Managed Care Rebate Schedule for rates.
Rebate Payout:	The rebates earned during a Quarterly Period shall be paid to the Provider within 1 month following the end of the Quarterly Period in the form of a check. Accounts must be in current financial standing in order to receive a rebate in the form of a check. Past due accounts will receive a statement credit.
Effective Date:	The start of the program will occur the first of the month in which the agreement is signed.

By signing below, the Provider agrees to and accepts all of the Terms and Conditions of the Oticon Managed Care Rebate Agreement (the **"Agreement"**). The Agreement consists of this Rebate Form (the **"Rebate Form"**), the attached Rebate Agreement Terms and Conditions (the **"Terms and Conditions"**), and such additional agreements and exhibits, if any, as are attached hereto.

Oticon Inc.:

Signature/Date: _____

Name: _____

Title: _____

[PROVIDER]:

Signature/Date: _____

Name: _____

Title: _____

Upon completion of this form, return it to partnersetup@oticon.com

oticon
life-changing **technology**

Rebate Agreement Terms and Conditions

WHEREAS, the Hearing Benefit Managers (defined below) are leading hearing benefits administrators that provide or arrange for the provision of hearing care items and services to members of government-sponsored, commercial, and employer-sponsored health plans ("**Members**"), some of which are EMCOs (defined below);

WHEREAS, the Hearing Benefit Managers contract with hearing care professionals, like Provider, to furnish professional hearing care services, including testing, fitting, and dispensing of hearing aids, to Members;

WHEREAS, the Hearing Benefit Managers also contract with Oticon to supply hearing aids (and related accessories and supplies) to the Hearing Benefit Managers' network of hearing care professionals that shall be dispensed to Members, as appropriate;

WHEREAS, Oticon, in its capacity as a Downstream Contractor (defined below) of the Hearing Benefit Managers, desire to offer price reductions to Provider, in its capacity as another Downstream Contractor of the Hearing Benefit Managers;

NOW, THEREFORE, in consideration of the foregoing Recitals and the mutual covenants and promises contained herein, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

Terms and Conditions

1. Incorporation By Reference. The Rebate Form, introductory paragraph and Recitals set forth above are hereby made a part of this Agreement and incorporated herein by reference

2. Definitions.

2.1 "**Anti-Kickback Statute**" means the federal health care program anti-kickback statute, set forth at 42 U.S.C. § 1320a-7b(b).

2.2 "**Downstream Contractor**" has the meaning given to that term under 42 C.F.R. § 1001.952(t)(2)(i).

2.3 "**Eligible Managed Care Organization**" (or "**EMCO**") has the meaning given to that term under 42 C.F.R. § 1001.952(t)(2)(ii).

2.4 "**Eligible Order**" means the order of a Product for dispensing to a Member.

2.5 "**Federal Health Care Program**" has the meaning set forth at 42 U.S.C. § 1320a-7b(f) and includes Medicare, Medicaid, TRICARE, and certain other government-funded health care programs and plans.

2.6 "**Hearing Benefit Managers**" are the hearing benefits administrators listed on Exhibit A, which is attached hereto and incorporated herein by reference.

2.7 "**HMO**" means a health maintenance organization.

2.8 "**Net Orders**" means the aggregate dollar amount of Eligible Orders, net of returns, made by, or on behalf of, Provider.

2.9 "**Products**" include those Oticon-branded hearing aids listed on Exhibit B, which is attached hereto and incorporated herein by reference.

3. Eligibility. For each [quarter] during the Term ("**Measurement Period**"), Provider shall earn a Rebate for Provider's Net Orders during the Measurement Period. Notwithstanding the foregoing, Provider shall not be eligible for any Rebate if the representations and warranties set forth in Section 6.1 are not true and accurate during the entirety of the applicable Measurement Period. To the extent that a Provider recommends any Oticon Products, they shall do so in an honest, accurate, complete, and non-coercive manner that respects each patient's freedom of choice and is designed to serve the patient's best clinical interests.

4. Rebate.

4.1 If Provider meets the requirements set forth in Section 3 during the Measurement Period, the Provider shall earn according to the schedule rate published on Exhibit B ("**Rebate**").

4.2 The Rebate shall be paid to the Provider in accordance with the method outlined above. If the Provider has an overdue balance, then the Rebate shall be applied towards the overdue balance.

4.3 The Rebate shall be calculated for the Measurement Period and paid in one lump sum payment to Provider within ninety (90) days following the end of the Measurement Period.

5. Audit; Overpayments & Underpayments.

5.1 Unless otherwise required by law, Oticon, and its authorized agents or a third party if required by law, may audit Provider's books and records to verify compliance with the requirements of this Agreement.

5.2 If either party becomes aware that all or any part of any payment (including, but not necessarily limited to, the Rebate payment) made to Provider by Oticon is greater than or less than the amount Oticon is obligated to pay under this Agreement (the "**Over or Under Payment Amount**"), such party shall use commercially reasonable efforts to notify the other party in writing within ten (10) business days. In the

event that the Over or Under Payment Amount is disputed, the parties shall resolve the discrepancy in good faith; however, if the parties cannot agree, Oticon's determination of the Over or Under Payment Amount shall prevail. In the event that all or any part of the Over or Under Payment Amount is not disputed, the undisputed amount, if any, shall be paid by Provider or Oticon, as the case may be, by adding to or withholding from the amount due on the next payment.

6. Exclusion.

6.1 Provider represents and warrants that Provider is not (i) excluded, debarred, or suspended from participation in any Federal Health Care Program; (ii) declared ineligible, or voluntarily excluded by any federal department or agency; or (iii) convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7a(a). Provider shall provide Oticon immediate written notice if this representation and warranty ceases to be true and accurate during the Term.

6.2 Oticon represents and warrants that Oticon is not (i) excluded, debarred, or suspended from participation in any Federal Health Care Program; (ii) declared ineligible, or voluntarily excluded by any federal department or agency; or (iii) convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7a(a).

7. Payment for Arranging for Items or Services. The parties represent and warrant that:

7.1 To the best of the parties' knowledge and belief, the Hearing Benefit Managers contract (directly or indirectly) with one or more EMCOs to arrange for the provision of hearing care items and services to the EMCO's members.

7.2 Both Oticon and Provider are Downstream Contractors of the Hearing Benefit Managers.

7.3 Oticon's payment of the Rebates to Provider are intended to serve as payment to Provider for arranging for Oticon's hearing care items and/or services to be provided to Members, some of whom are enrolled in an EMCO plan, as contemplated by 42 U.S.C. § 1320a-7b(b)(3)(F) and 42 C.F.R. § 1001.952(t).

7.4 Neither party shall seek or claim separate payment in any form from a Federal Health Care Program for any hearing care items and services provided to Members under or pursuant to this Agreement, some of whom are enrolled in an EMCO plan, as contemplated by 42 U.S.C. § 1320a-7b(b)(3)(F) and 42 C.F.R. § 1001.952(t).

7.5 The exchange of remuneration under this Agreement between Oticon and Provider (including Oticon's payment of Rebates to Provider) is not in return for or to induce the provision or acceptance of business (other than business covered by this Agreement) for which payment may be made in whole or in part by a Federal Health Care Program on a fee-for-service or cost basis.

7.6 Neither party will shift the financial burden of this Agreement by seeking or claiming increased payments from a Federal Health Care Program.

7.7 To the best of the parties' knowledge and belief, the arrangement between the EMCO and the Hearing Benefit Managers covering the hearing care items and/or services that are covered by this Agreement do not involve (i) a federally qualified health center receiving supplemental payments, (ii) a HMO or a competitive medical plan with a cost-based contract under section 1876 of the Social Security Act, or (iii) a federally qualified HMO, unless the items or services are covered by a risk based contract under sections 1854 or 1876 of the Social Security Act.

7.8 The parties agree to be transparent (by providing documents and other information and responding to questions, as may be requested) with third party payors, including Federal Health Care Programs, with respect to the Rebates and other remuneration exchanged under this Agreement.

8. Other Representations and Warranties.

8.1 Each party represents and warrants that it has full power and authority to execute and perform this Agreement. Without limiting the foregoing, each party represents and warrants that neither the execution nor the performance of this Agreement will conflict with any agreement, arrangement, or understanding to which that party or any of its affiliates is a party or is subject.

8.2 Each party represents that it is in compliance with and shall continue to comply with all applicable federal and state laws, rules, and regulations related to this Agreement, including but not limited to the Anti-Kickback Statute and its state law counterparts.

9. Term and Termination.

9.1 The Term of this Agreement shall commence on _____ (**"Effective Date"**), and shall continue for a period of one (1) year, unless earlier terminated in accordance with this Agreement ("**Initial Term**"). The Agreement shall automatically renew for additional terms of one (1) year (each a "**Renewal Term**") unless either party gives written notice to the other party sixty (60) days prior to the expiration of the then-current Term. The Initial Term and the Renewal Terms are collective referred to herein as the "**Term**."

9.2 Oticon may terminate this Agreement with or without cause upon sixty (60) calendar days' written notice to Provider.

9.3 This Agreement may not be amended during the Initial Term. The Agreement may not be amended more than once per Renewal Term.

9.4 If any Party terminates this Agreement prior to the end of the first twelve (12) months following the Effective Date, the Parties agree that they shall not enter into another agreement for the same or similar arrangement until after such twelve (12) month period.

9.5 Notwithstanding anything to the contrary in this Agreement, Oticon may terminate this Agreement immediately if the representation and warranty made by Provider in Section 6.1 above ceases to be true and accurate.

10. Confidentiality and Privacy.

10.1 Subject to any disclosure and reporting obligations provided by state or federal law, the parties shall each maintain the confidentiality of any confidential and/or proprietary information of the other party, including, but not limited to, any pricing or cost information; marketing or product information; information on invoices and reports; the pricing details of this Agreement; and any other information or data designated as confidential or proprietary by the disclosing party ("**Confidential Information**").

10.2 Confidential Information shall not include such information which: (a) becomes public knowledge through no fault of the recipient; (b) is lawfully received from a third party with no obligation of confidentiality to the disclosing party; (c) as shown by written records was known to or already in the possession of recipient prior to the receipt from the disclosing party; (d) is developed by recipient independently of any disclosure; or (e) is required by law to be disclosed, so long as the procedures set forth immediately hereafter are followed.

11. Indemnification. Oticon shall not be liable to Provider or its affiliates or any of their respective officers, directors, employees, subcontractors, delegates, or other agents for, and Provider shall indemnify, defend, and hold harmless Oticon and its affiliates and any of their respective directors, officers, employees and other agents (collectively, the "**Oticon Indemnitees**") from and against, any and all third-party liabilities, losses, suits, claims, costs, expenses (including reasonable attorney's fees and disbursements), interest, penalties, fines, judgments and actual or direct damages of any kind whatsoever (collectively, "**Losses"**) to the extent and proportion that such Losses relate to or arise from (a) negligent acts or omissions or willful misconduct of Provider or any Provider employee, or (b) a material breach of this Agreement by Provider.

12. Record Keeping. Each party shall, at all times, keep and maintain accurate books, records, files and information with respect to orders of Products pursuant to this Agreement for seven (7) years from the date of orders, or such longer time as may be required by law.

13. Miscellaneous.

13.1 Sales Policies. Sales of Products to Provider are subject to Oticon's standard terms and conditions in effect from time to time, provided that in the event of a conflict between this Agreement and such terms and conditions, this Agreement shall prevail. Provider accepts and agrees to be bound by the terms and conditions as well as any other Oticon policy then in effect in connection with the price, supply and sale of Products. Oticon's obligations hereunder are subject to Provider's compliance with those terms and conditions. Oticon's price list and all other Oticon policies in connection with the price, supply and sale of Products are subject to change by Oticon from time to time without notice.

13.2 Independent Contractors. The parties hereto are independent contractors engaged in the operation of their own respective businesses. Nothing therein shall be deemed or construed to create any other relationship between the parties.

13.3 Governing Law. This Agreement will be construed under and in accordance with the applicable laws of the State of New Jersey without regard to its conflict of laws provisions. Any legal action, suit, or other proceeding arising out of or in any way connected with, this Agreement may be brought in the courts of the State of New Jersey, or in the United States courts for the District of New Jersey. With respect to any such proceeding in any such court: (a) each party generally and unconditionally submits itself and its property to the nonexclusive jurisdiction of such court; and (b) each party waives, to the fullest extent permitted by law, any objection it has or hereafter may have to the venue of such proceeding, as well as any claim it has or may have that such proceeding is in an inconvenient forum.

13.4 Legal Construction. In case any one or more of the provisions contained in this Agreement will for any reason be held invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability will not affect any other provision of this Agreement and this Agreement will be construed as if the invalid, illegal, or unenforceable provision had never been contained in it.

13.5 Amendment. Except as otherwise specified herein, this Agreement may be modified only by a written instrument signed by Oticon and Provider.

13.6 Entire Agreement. This Agreement, including all exhibits attached hereto, constitute the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes any and all prior negotiations, correspondence, agreements, understandings, duties or obligations between the parties with respect to the subject matter hereof.

13.7 Third Parties. Except as otherwise provided herein, nothing in this Agreement shall confer any benefits or rights on any person or entity other than the parties to this Agreement.

13.8 Headings. The headings of various articles and sections in this Agreement are for convenience of reference only and shall not define, limit or otherwise affect any of the terms or sections or provisions hereof.

13.9 Notices. All notices required or permitted under this Agreement shall be in writing and shall be deemed duly given when given in person or mailed by first class, certified mail to the following address, or to such other address or to such other person as may be designated by written notice given from time to time during the Term of this Agreement by one party to the other:

TO OTICON:

Oticon, Inc.
580 Howard Avenue
Somerset, New Jersey 08873
Attn. Legal Department

TO PROVIDER:

The address listed on the Rebate Form

13.10 Survival. Any provision of this Agreement that contemplates performance, observance, or enforcement subsequent to the termination or expiration of this Agreement, including requirements pertaining to record-keeping, shall survive and remain in full force and effect between the parties.

13.11 Jury Trial Waiver. IN ANY LITIGATION RELATING TO THIS AGREEMENT OR ANY OTHER DOCUMENT OR INSTRUMENT DELIVERED IN CONNECTION WITH THIS AGREEMENT OR ANY OBLIGATION, OTICON AND PROVIDER EACH HEREBY WAIVE THE RIGHT TO TRIAL BY JURY. PROVIDER ACKNOWLEDGES THAT IT HAS HAD THE OPPORTUNITY TO CONSULT WITH COUNSEL ON THE RAMIFICATIONS OF WAIVING THE RIGHT TO REQUEST TRIAL BY JURY.

13.12 Counterparts. The parties may execute this Agreement in one or more counterpart copies, each of which shall be deemed an original.

Exhibit A

List of Hearing Benefit Managers

- United HealthCare Hearing (EPIC)
- Great Lakes Provider Network, LLC
- Hearing Care Solutions, Inc (HCS)
- Audiology Distribution, LLC DBA HearUSA
- Your Hearing Network, LLC
- TruHearing, Inc
- Amplifon Hearing Healthcare, Corp (AHHC)
- AudioNet America, Inc.
- Simpli Hearing, LLC
- Advanced Hearing Providers, LLC (AHP)
- Unified Hearing Solutions
- One Call (OCCM)
- Nations Benefits, LLC
- Advocate Aurora Health

Exhibit B

OTICON
Managed Care Rebate Program

OTICON MANAGED CARE REBATE SCHEDULE

$50 per unit	**$25** per unit	**$10** per unit
More 1	More 2	CROS Devices
Opn Play 1	Opn Play 2	More 3
Opn S 1	Opn S 2	Opn S 3
Own 1 Custom Product	Own 2 Custom Product	Own 3 Custom Product
Opn 1 Custom Product	Opn 2 Custom Product	Own 4 Custom Product
Play PX 1	Play PX 2	Own 5 Custom Product
Xceed 1	Xceed 2	Opn 3 Custom Product
Xceed Play 1		Ruby 1
		Ruby 2
		Zircon 1
		Zircon 2
		Siya 1 Custom Product
		Siya 2 Custom Product
		Xceed 3
		Xceed Play 2

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oticon
life-changing **technology**

WIDEX

SOUND LIKE NO OTHER

MANAGED CARE REBATE ENROLLMENT AGREEMENT FORM

Provider Name: _____

Business Name: _____

Account Number: _____

Provider Address: _____

Contact Person: _____

Earning a Rebate:	The Business shall earn a rebate from qualifying Net unit orders made during their Quarterly Period.
Measurement Period:	Per calendar quarterly term.
Rebate Value:	For Net Orders made during the Quarterly Period, the Provider shall receive the aggregate rebate value earned. See Exhibit B, the Widex Managed Care Rebate Schedule for rates.
Rebate Payout:	The rebates earned during a Quarterly Period shall be applied to the Business account as a statement credit within one month following the end of the Quarterly Period. Accounts must be in current financial standing in order to receive a rebate. Past due accounts will receive a statement credit.
Effective Date:	The start of the program will occur on the day of processing of the agreement within 48 hours of it being signed.

By signing below, the Provider agrees to and accepts all of the Terms and Conditions of the Widex Managed Care Rebate Agreement (the "**Agreement**"). The Agreement consists of this Rebate Form (the "**Rebate Form**"), the attached Rebate Agreement Terms and Conditions (the "**Terms and Conditions**"), and such additional agreements and exhibits, if any, as are attached hereto.

WIDEX USA, INC.	[PROVIDER]
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

Once completed, please return this form to commercialprograms.us@widexsound.com.

WIDEX

SOUND LIKE NO OTHER

Rebate Agreement Terms and Conditions

WHEREAS, the Hearing Benefit Managers (defined below) are leading hearing benefits administrators that provide or arrange for the provision of hearing care items and services to members of government-sponsored, commercial, and employer-sponsored health plans ("**Members**"), some of which are EMCOs (defined below);

WHEREAS, the Hearing Benefit Managers contract with hearing care professionals, like Provider, to furnish professional hearing care services, including testing, fitting, and dispensing of hearing aids, to Members;

WHEREAS, the Hearing Benefit Managers also contract with Widex to supply hearing aids (and related accessories and supplies) to the Hearing Benefit Managers' network of hearing care professionals that shall be dispensed to Members, as appropriate;

WHEREAS, Widex, in its capacity as a Downstream Contractor (defined below) of the Hearing Benefit Managers, desire to offer price reductions to Provider, in its capacity as another Downstream Contractor of the Hearing Benefit Managers;

NOW, THEREFORE, in consideration of the foregoing Recitals and the mutual covenants and promises contained herein, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

Terms and Conditions

1. **Incorporation By Reference.** The Rebate Form, introductory paragraph and Recitals set forth above are hereby made a part of this Agreement and incorporated herein by reference

2. **Definitions.**

2.1 **"Anti-Kickback Statute"** means the federal health care program anti-kickback statute, set forth at 42 U.S.C. § 1320a-7b(b).

2.2 **"Downstream Contractor"** has the meaning given to that term under 42 C.F.R. § 1001.952(t)(2)(i).

2.3 **"Eligible Managed Care Organization"** (or "**EMCO**") has the meaning given to that term under 42 C.F.R. § 1001.952(t)(2)(ii).

2.4 **"Eligible Order"** means the order of a Product for dispensing to a Member.

2.5 **"Federal Health Care Program"** has the meaning set forth at 42 U.S.C. § 1320a-7b(f) and includes Medicare, Medicaid, TRICARE, and certain other government-funded health care programs and plans.

2.6 **"Hearing Benefit Managers"** are the hearing benefits administrators listed on Exhibit A, which is attached hereto and incorporated herein by reference.

2.7 **"HMO"** means a health maintenance organization.

2.8 **"Net Orders"** means the aggregate dollar amount of Eligible Orders, net of returns, made by, or on behalf of, Provider.

2.9 **"Products"** include those Widex-branded hearing aids listed on Exhibit B, which is attached hereto and incorporated herein by reference.

3. **Eligibility.** For each [quarter] during the Term (the "**Measurement Period**"), Provider shall earn a Rebate for Provider's Net Orders during the Measurement Period. Notwithstanding the foregoing, Provider shall not be eligible for any Rebate if the representations and warranties set forth in Section 6.1 are not true and accurate during the entirety of the applicable Measurement Period. To the extent that a Provider recommends any Widex Products, they shall do so in an honest, accurate, complete, and non-coercive manner that respects each patient's freedom of choice and is designed to serve the patient's best clinical interests.

4. **Rebate.**

4.1 If Provider meets the requirements set forth in Section 3 during the Measurement Period, the Provider shall earn a rebate according to the schedule rate published on Exhibit B (the "**Rebate**").

4.2 The Rebate shall be paid to the Business account as a statement credit in accordance with the method outlined above. If the Business has an overdue balance, then the Rebate shall be applied towards the overdue balance.

4.3 The Rebate shall be calculated for the Measurement Period and paid in one lump sum payment to Provider within thirty (30) days following the end of the Measurement Period.

5. **Audit; Overpayments & Underpayments.**

5.1 Unless otherwise required by law, Widex, and its

authorized agents or a third party if required by law, may audit Provider's books and records to verify compliance with the requirements of this Agreement.

5.2 If either party becomes aware that all or any part of any payment (including, but not necessarily limited to, the Rebate) made to Provider by Widex is greater than or less than the amount Widex is obligated to pay under this Agreement (the "**Over or Under Payment Amount**"), such party shall use commercially reasonable efforts to notify the other party in writing within ten (10) business days. In the event that the Over or Under Payment Amount is disputed, the parties shall resolve the discrepancy in good faith; however, if the parties cannot agree, Widex's determination of the Over or Under Payment Amount shall prevail. In the event that all or any part of the Over or Under Payment Amount is not disputed, the undisputed amount, if any, shall be paid by Provider or Widex, as the case may be, by adding to or withholding from the amount due on the next payment.

6. Exclusion.

6.1 Provider represents and warrants that Provider is not (i) excluded, debarred, or suspended from participation in any Federal Health Care Program; (ii) declared ineligible, or voluntarily excluded by any federal department or agency; or (iii) convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7a(a). Provider shall provide Widex immediate written notice if this representation and warranty ceases to be true and accurate at any time during the Term.

6.2 Widex represents and warrants that Widex is not (i) excluded, debarred, or suspended from participation in any Federal Health Care Program; (ii) declared ineligible, or voluntarily excluded by any federal department or agency; or (iii) convicted of a criminal offense that falls within the scope of 42 U.S.C. § 1320a-7a(a).

7. Payment for Arranging for Items or Services. The parties represent and warrant that:

7.1 To the best of the parties' knowledge and belief, the Hearing Benefit Managers contract (directly or indirectly) with one or more EMCOs to arrange for the provision of hearing care items and services to the EMCO's members.

7.2 Both Widex and Provider are Downstream Contractors of the Hearing Benefit Managers.

7.3 Widex's payment of the Rebates to Provider are intended to serve as payment to Provider for arranging for Wdiex's hearing care items and/or services to be provided to Members, some of whom are enrolled in an EMCO plan, as contemplated by 42 U.S.C. § 1320a-7b(b)(3)(F) and 42 C.F.R. § 1001.952(t).

7.4 Neither party shall seek or claim separate payment in any form from a Federal Health Care Program for any hearing care items and services provided to Members under or pursuant to this Agreement, some of whom are enrolled in an EMCO plan, as contemplated by 42 U.S.C. § 1320a-7b(b)(3) (F) and 42 C.F.R. § 1001.952(t).

7.5 The exchange of remuneration under this Agreement between Widex and Provider (including Widex's payment of Rebates to Provider) is not in return for or to induce the provision or acceptance of business (other than business covered by this Agreement) for which payment may be made in whole or in part by a Federal Health Care Program on a fee-for-service or cost basis.

7.6 Neither party will shift the financial burden of this Agreement by seeking or claiming increased payments from a Federal Health Care Program.

7.7 To the best of the parties' knowledge and belief, the arrangement between the EMCO and the Hearing Benefit Managers covering the hearing care items and/or services that are covered by this Agreement do not involve (i) a federally qualified health center receiving supplemental payments, (ii) a HMO or a competitive medical plan with a cost-based contract under section 1876 of the Social Security Act, or (iii) a federally qualified HMO, unless the items or services are covered by a risk based contract under sections 1854 or 1876 of the Social Security Act.

7.8 The parties agree to be transparent (by providing documents and other information and responding to questions, as may be requested) with third-party payors, including Federal Health Care Programs, with respect to the Rebates and other remuneration exchanged under this Agreement.

8. Other Representations and Warranties.

8.1 Each party represents and warrants that it has full

power and authority to execute and perform this Agreement. Without limiting the foregoing, each party represents and warrants that neither the execution nor the performance of this Agreement will conflict with any agreement, arrangement, or understanding to which that party or any of its affiliates is a party or is subject.

8.2 Each party represents that it is in compliance with and shall continue to comply with all applicable federal and state laws, rules, and regulations related to this Agreement, including but not limited to the Anti-Kickback Statute and its state law counterparts.

9. Term and Termination.

9.1 The Term of this Agreement shall commence within 48 hours of the signed agreement being sent to Widex (the "**Effective Date**"), and shall continue for a period of one (1) year, unless earlier terminated in accordance with this Agreement ("**Initial Term**"). The Agreement shall automatically renew for additional terms of one (1) year (each a "**Renewal Term**") unless either party gives written notice to the other party sixty (60) days prior to the expiration of the then-current Term. The Initial Term and the Renewal Terms are collective referred to herein as the "Term."

9.2 Widex may terminate this Agreement with or without cause upon sixty (60) calendar days' written notice to Provider.

9.3 This Agreement may not be amended during the Initial Term. The Agreement may not be amended more than once during any Renewal Term.

9.4 If any Party terminates this Agreement prior to the end of the first twelve (12) months following the Effective Date, the Parties agree that they shall not enter into another agreement for the same or similar arrangement until after such twelve (12) month period.

9.5 Notwithstanding anything to the contrary in this Agreement, Widex may terminate this Agreement immediately if the representation and warranty made by Provider in Section 6.1 above ceases to be true and accurate.

10. Confidentiality and Privacy.

10.1 Subject to any disclosure and reporting obligations provided by state or federal law, the parties shall each maintain the confidentiality of any confidential and/or proprietary information of the other party, including, but not limited to, any pricing or cost information; marketing or product information; information on invoices and reports; the pricing details of this Agreement; and any other information or data designated as confidential or proprietary by the disclosing party ("**Confidential Information**").

10.2 Confidential Information shall not include such information that: (a) becomes public knowledge through no fault of the recipient; (b) is lawfully received from a third party with no obligation of confidentiality to the disclosing party; (c) as shown by written records was known to or already in the possession of recipient prior to the receipt from the disclosing party; (d) is developed by recipient independently of any disclosure; or (e) is required by law to be disclosed, so long as the procedures set forth immediately hereafter are followed.

11. Indemnification. Widex shall not be liable to Provider or its affiliates or any of their respective officers, directors, employees, subcontractors, delegates, or other agents for, and Provider shall indemnify, defend, and hold harmless Widex and its affiliates and any of their respective directors, officers, employees and other agents (collectively, the "**Widex Indemnitees**") from and against, any and all third-party liabilities, losses, suits, claims, costs, expenses (including reasonable attorney's fees and disbursements), interest, penalties, fines, judgments and actual or direct damages of any kind whatsoever (collectively, "**Losses**") to the extent and proportion that such Losses relate to or arise from (a) negligent acts or omissions or willful misconduct of Provider or any Provider employee, or (b) a material breach of this Agreement by Provider.

12. Record Keeping. Each party shall, at all times, keep and maintain accurate books, records, files and information with respect to orders of Products pursuant to this Agreement for seven (7) years from the date of orders, or such longer time as may be required by law.

13. Miscellaneous.

13.1 **Sales Policies.** Sales of Products to Provider are subject to Widex's standard terms and conditions in effect from time to time, provided that in the event of a conflict between this Agreement and

such terms and conditions, this Agreement shall prevail. Provider accepts and agrees to be bound by the terms and conditions as well as any other Widex policy then in effect in connection with the price, supply and sale of Products. Widex's obligations hereunder are subject to Provider's compliance with those terms and conditions. Widex's price list and all other Widex policies in connection with the price, supply and sale of Products are subject to change by Widex from time to time without notice.

13.2 **Independent Contractors.** The parties hereto are independent contractors engaged in the operation of their own respective businesses. Nothing therein shall be deemed or construed to create any other relationship between the parties.

13.3 **Governing Law.** This Agreement will be construed under and in accordance with the applicable laws of the State of New York without regard to its conflict of laws provisions. Any legal action, suit, or other proceeding arising out of or in any way connected with, this Agreement may be brought in the courts of the State of New York, or in the United States District Court for the Eastern District of New York. With respect to any such proceeding in any such court: (a) each party generally and unconditionally submits itself and its property to the nonexclusive jurisdiction of such court; and (b) each party waives, to the fullest extent permitted by law, any objection it has or hereafter may have to the venue of such proceeding, as well as any claim it has or may have that such proceeding is in an inconvenient forum.

13.4 **Legal Construction.** In case any one or more of the provisions contained in this Agreement will for any reason be held invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability will not affect any other provision of this Agreement and this Agreement will be construed as if the invalid, illegal, or unenforceable provision had never been contained in it.

13.5 **Amendment.** Except as otherwise specified herein, this Agreement may be modified only by a written instrument signed by Widex and Provider.

13.6 **Entire Agreement.** This Agreement, including all exhibits attached hereto, constitute the entire agreement and understanding of the parties with respect to the subject matter hereof and supersedes any and all prior negotiations, correspondence, agreements, understandings, duties or obligations between the parties with respect to the subject matter hereof.

13.7 **Third Parties.** Except as otherwise provided herein, nothing in this Agreement shall confer any benefits or rights on any person or entity other than the parties to this Agreement.

13.8 **Headings.** The headings of various articles and sections in this Agreement are for convenience of reference only and shall not define, limit or otherwise affect any of the terms or sections or provisions hereof.

13.9 **Notices.** All notices required or permitted under this Agreement shall be in writing and shall be deemed duly given when given in person or mailed by first class, certified mail to the following address, or to such other address or to such other person as may be designated by written notice given from time to time during the Term of this Agreement by one party to the other:

IF TO WIDEX:
Widex USA, Inc.
185 Commerce Drive
Hauppauge, New York 11788
Attn: Legal Department

IF TO PROVIDER:
The address listed on the Rebate Form

13.10 **Survival.** Any provision of this Agreement that contemplates performance, observance, or enforcement subsequent to the termination or expiration of this Agreement, including requirements pertaining to record-keeping, shall survive and remain in full force and effect between the parties.

13.11 **Jury Trial Waiver. IN ANY LITIGATION RELATING TO THIS AGREEMENT OR ANY OTHER DOCUMENT OR INSTRUMENT DELIVERED IN CONNECTION WITH THIS AGREEMENT OR ANY OBLIGATION, WIDEX AND PROVIDER EACH HEREBY WAIVE THE RIGHT TO TRIAL BY JURY. PROVIDER ACKNOWLEDGES THAT IT HAS HAD THE OPPORTUNITY TO CONSULT WITH COUNSEL ON THE RAMIFICATIONS OF WAIVING THE RIGHT TO REQUEST TRIAL BY JURY.**

13.12 **Counterparts.** The parties may execute this Agreement in one or more counterpart copies, each of which shall be deemed an original.

WIDEX

SOUND LIKE NO OTHER

Exhibit A.

LIST OF HEARING BENEFIT MANAGERS

- United HealthCare Hearing
- Hearing Care Solutions, Inc
- HearUSA
- Your Hearing Network, LLC
- TruHearing, Inc
- Amplifon Hearing Healthcare, Corp
- AudioNet America, Inc.
- Simpli Hearing, LLC
- Advanced Hearing Providers, LLC
- One Call
- Nations Benefits, LLC

Exhibit B.

MANAGED CARE REBATE SCHEDULE

Product	Rebate
Moment™ 440 Lithium Ion	$60
Moment 440 2.4	$60
Moment 440 Non 2.4	$60
Moment 330 Lithium Ion	$30
Moment 330 2.4	$30
Moment 330 Non 2.4	$30
Moment 220 Lithium Ion	$20
Moment 220 2.4	$20
Moment 220 Non 2.4	$20
Moment 110 Lithium Ion	$10
Moment 110 2.4	$10
Moment 110 Non 2.4	$10

Product	Rebate
Magnify 440 Lithium Ion	$60
Magnify 440 2.4	$60
Magnify 440 Non 2.4	$60
Magnify 330 Lithium Ion	$30
Magnify 330 Lithium Ion	$30
Magnify 330 2.4	$30
Magnify 220 Lithium Ion	$20
Magnify 220 2.4	$20
Magnify 220 Non 2.4	$20
Magnify 110 Lithium Ion	$10
Magnify 110 2.4	$10
Magnify 110 Non 2.4	$10