Cochlear®
Hear now. And always

Implantable hearing solutions

A step-by-step guide to the insurance process

Your journey to better hearing is worth every step

We understand that getting a hearing implant can be a life-changing event for you and your family. We know the insurance approval process for any surgery can be confusing and overwhelming. We are here to help you every step of the way.

You should be aware of your health plan coverage and the process of requesting and obtaining insurance approval for a hearing implant.

We have information that can help you find the answers you need to move forward in your treatment process.

Mathias – Nucleus® System recipient

Health plan benefits—what you should know

Health plan—did you know?

- Your health plan policy is a contract between you and the insurance company
- This contract details the specifics of what is covered and what is not covered under your health plan (insurance plan)
- Your health plan is required by law to follow the terms of the health plan policy
- Most health plans have a glossary of important terms within your plan documents

What are your rights?

- Your health plan must provide you a dispute process for any unfavorable decisions or denials
- Your health plan must provide access to the health plan policy (benefit handbook or summary of benefits)
- Your health plan must provide you with a list of in-network doctors and facilities. This allows you to have the option to use your in-network benefit

Understand your health plan coverage

- Review documentation provided to you by your health plan (i.e., request a copy of your benefit handbook or summary of benefits)
- Find out which services are covered and which are not
- Be aware of the processes involved in requesting and obtaining coverage

You should contact your health plan to determine coverage as well as your estimated out-of-pocket expenses before surgery. You will need to determine coverage for the following:

- Hearing evaluation and test cost
- Implant system costs (hearing implant and sound processor)
- Implant procedure (hospital, doctor, surgery and anesthesia)
- Battery costs (rechargeable, disposable)
- Follow-up care
- Sound Processor replacements

How your health plan should work for you

1. Your doctor recommends a hearing implant for your hearing loss.
2. You or your doctor submit a written request to obtain and verify predetermination* and/or pre-certification* of benefits based on your health plan policy for the procedure and device.
3. Your health plan notifies you and your doctor in writing if the procedure and device is covered or is not covered.
4. You and your doctor move forward if your health plan approves the request. Your plan's deductible, coinsurance and/or co-payment will apply.

* See page 7 for the definition of predetermination and pre-certification.

Michael – Nucleus System recipient

Predetermination, pre-authorization and pre-certification

Predetermination is a process that allows your physician to submit a treatment plan to your health plan before surgery. The health plan reviews the treatment plan, your insurance benefit plan and medical policy to determine:

- If the treatment is covered
- Your plan's maximum benefits or limitations

It is strongly recommended that a predetermination of benefits for a hearing implant system is submitted to the health plan before surgery, except for Medicare beneficiaries. Your provider will assist you in this process. If you are a candidate for a Cochlear™ Bone Conduction Implant System, please refer to the insurance information on pages 10-11 to understand how this authorization may impact your benefit.

Predetermination is an optional process offered by many health plans. Pre-authorization/pre-certification is mandatory for most health plans.

What is the difference between pre-certification and pre-authorization?

Pre-certification

Pre-certification confirms eligibility and collects information before inpatient admissions and select ambulatory procedures and services. It is comprised of two components:

- Notification – process of documenting coverage requests
- Coverage Determination – review of plan documents and submitted clinical information to determine whether the health plan's clinical guidelines and criteria are met for coverage

The pre-certification process:

- Encourages the health plan to communicate with your doctor and/or you in advance of the procedure, service or supply
- Enables the health plan to identify patients who may require continued disease management

Pre-authorization

Pre-authorization is the process used to confirm whether a proposed service or procedure is:

- Medically necessary
- Covered for the proposed care
- Covered for the proposed length of stay (if applicable)
- Scheduled for review

Most health plans require doctors to:

- Seek advanced approval for most outpatient surgeries
- Obtain approval within a specific time frame
- Verify coverage and benefits of the proposed treatment plan
- Provide applicable coding and medical necessity for services/procedures requested

Insurance coverage for cochlear implants

The cost of a cochlear implant system may be covered by your insurance plan. Every health insurance plan is different. We know that the insurance approval process can be confusing. Here are guidelines to help you through the process.

Your health plan's coverage may vary based on:

- The terms of the coverage document in effect on the date of service
- Applicable laws/regulations
- Medical coverage policies

Commercial Health Plan Coverage

- Coverage of a cochlear implant system varies by plan
- Work with your surgeon's office to determine your eligibility for coverage and benefits
- Ask if your health plan will provide a voluntary predetermination of benefits review. If yes, ask your doctor's office to submit a predetermination packet to your health plan
- All health plans have their own definitions of what is medically necessary. These definitions are typically tied to a medical policy based on their own assessment criteria. The predetermination or prior authorization process is the most effective way to confirm you meet the plan's medical necessity criteria
- If your health plan considers cochlear implantation experimental or investigational, you should work through your doctor's office and the predetermination process which includes submitting a letter of medical necessity and supportive material. The predetermination process will educate the health plan on the scientific evidence supporting the use of the device and how it applies to your treatment plan
- Be aware of potential financial responsibilities regardless if you are covered or not by insurance (i.e., deductibles, co-payments, coinsurance)
- Coverage does not guarantee payment
- If your health plan denies coverage, you have a right to appeal the coverage decision
- The health plan should provide you and your surgeon information on appeal rights
- You should work with your surgeon to assist in the appeal process
- Your surgeon should prepare a letter of "medical necessity" outlining your need and value for implantation, results of medical tests, published peer-reviewed literature supporting implantation, and detailed patient history applicable to the request

* Covered for Medicare beneficiaries who meet CMS criteria for coverage.

Medicare

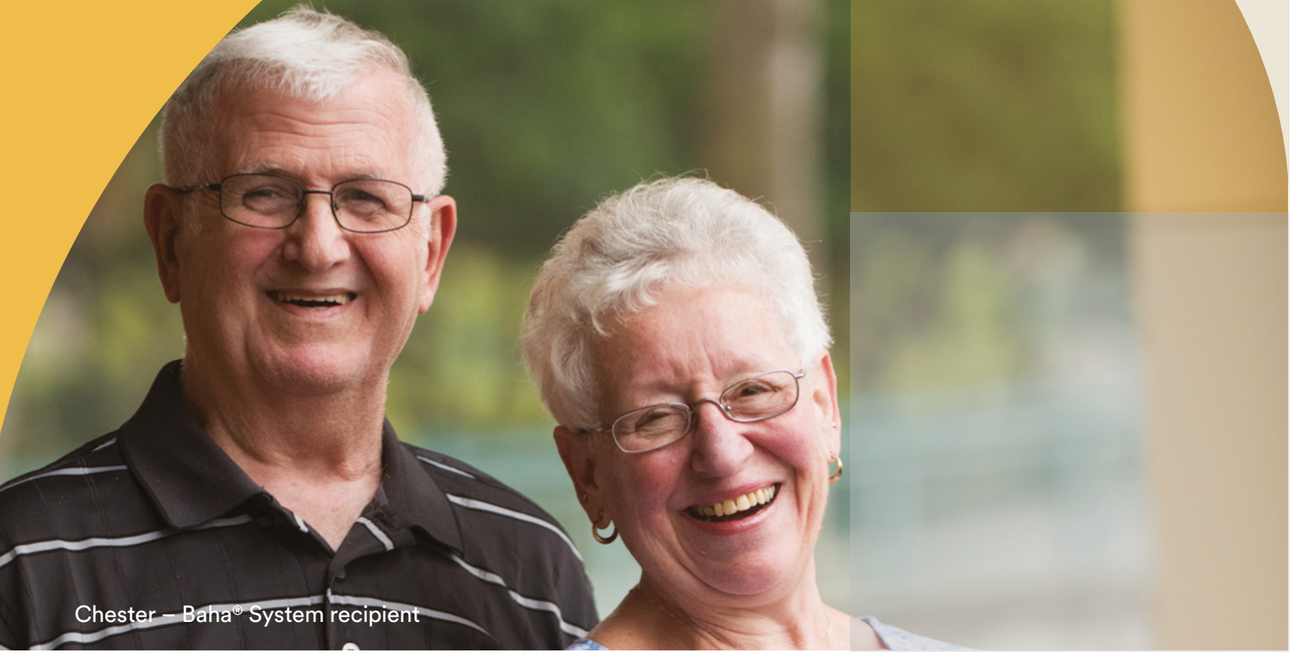
- Medicare typically covers cochlear implant systems*
- Traditional Medicare does not offer an option for predetermination or prior authorization of coverage
- Work with your surgeon's office to determine your eligibility for coverage and benefits

Medicare Advantage Plans

- Medicare Advantage plans must offer the same benefits defined by traditional Medicare but often cover additional services
- Medicare Advantage plans may have policies for predetermination of benefits or pre-authorization requirements. Work with your surgeon's office in contacting your Medicare Advantage plan to determine your eligibility for coverage and benefits

Medicaid

- Coverage for implantation varies by state
- Work with your surgeon's office to check on your state's Medicaid plan or Medicaid HMO to determine coverage and benefits
- State Medicaid plans and Medicaid HMOs have processes to appeal claims on an individual basis based on medical necessity
- Prior authorizations of implantations are generally required



Insurance coverage for bone conduction systems

The cost of a Cochlear™ Bone Conduction System may be covered by your insurance plan. Every health insurance plan is different. Here are guidelines to help you through the process.

Your health plan's coverage may vary based on:

- The terms of the coverage document in effect on the date of service
- Applicable laws/regulations
- Medical coverage policies
- Plan's designation/classification of bone conduction system
- If the plan considers bone conduction systems to be a prosthetic device or if they classify the implant system as a hearing aid

Commercial Health Plan Coverage

- Coverage of a bone conduction system varies by plan
- Work with your surgeon's office to determine your eligibility for coverage and benefits
- Ask if your health plan will provide a voluntary predetermination of benefits review. If yes, ask your doctor's office to submit a predetermination packet to your health plan
- All health plans have their own definitions of what is medically necessary. These definitions are typically tied to a medical policy based on their own assessment criteria
- Some health plans consider a bone conduction system to be a hearing aid and will limit coverage to the hearing aid benefits under the plan
- The predetermination or prior authorization process is the most effective way to confirm you meet the plan's medical necessity criteria and confirm your plan's specific benefit coverage
- Be aware of potential financial responsibilities regardless if you are covered or not by insurance (i.e., deductibles, co-payments, coinsurance)
- Coverage does not guarantee payment
- If your health plan denies coverage, you have a right to appeal the coverage decision
- The health plan should provide you and your surgeon information on appeal rights
- You should work with your surgeon to assist in the appeal process
- Your surgeon should prepare a letter of "medical necessity" outlining your need and value for implantation, copies and results of medical tests, published peer-reviewed literature supporting implantation, and detailed patient history applicable to the request

Medicare

- Medicare typically covers bone conduction implant systems*
- Medicare refers to bone conduction implants as auditory osseointegrated implants
- Medicare considers auditory osseointegrated implants, like Cochlear's bone conduction systems, to be prosthetic devices
- Traditional Medicare does not offer an option for predetermination or prior authorization of coverage
- Work with your surgeon's office to determine your eligibility for coverage and benefits

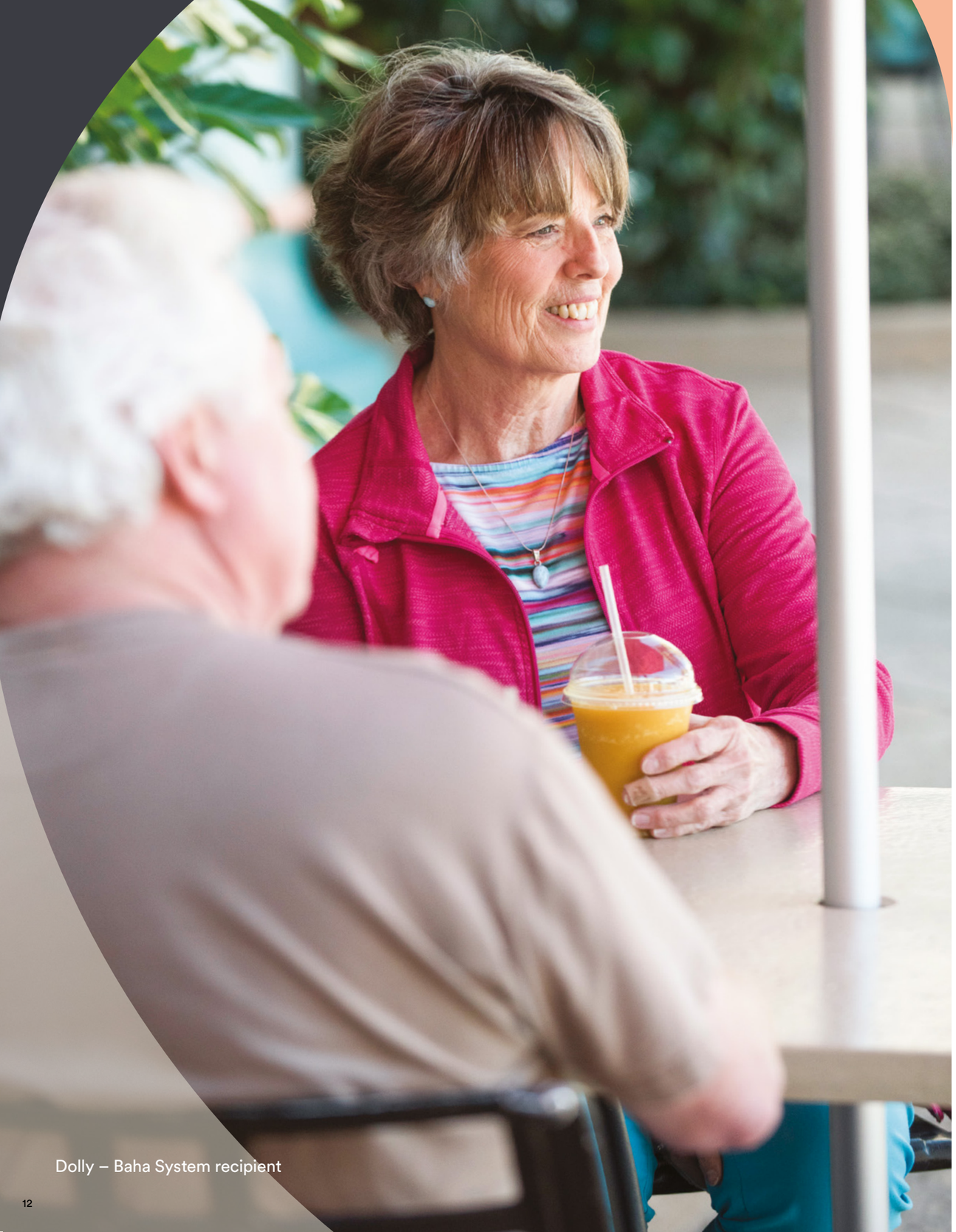
Medicare Advantage Plans

- Medicare Advantage plans must offer the same benefits defined by traditional Medicare but often cover additional services
- Medicare Advantage plans may have policies for predetermination of benefits or pre-authorization requirements. Work with your surgeon's office in contacting your Medicare Advantage plan to determine your eligibility for coverage and benefits

Medicaid

- Coverage for a bone conduction system varies by state
- Work with your surgeon's office to check on your state's Medicaid plan or Medicaid HMO to determine coverage and benefits
- State Medicaid plans and Medicaid HMOs have processes to appeal claims on an individual basis based on medical necessity
- Prior authorizations of implantations are generally required

* Covered for Medicare beneficiaries who meet CMS criteria for coverage.



Dolly – Baha System recipient

Managing Denials

There are a few reasons that your health plan may deny your proposed treatment, including:

- The requested procedure is specifically listed as non-covered under the terms of your health plan policy
- The procedure may be covered but only under certain circumstances. You may have to utilize a physician that is in your health plan's network
- Your physician is requesting a procedure using technology that your health plan considers to be an experimental or investigational procedure
- Your health plan determined the procedure being requested is not medically necessary based on the diagnosis and medical documentation that was submitted
- Your health plan misunderstands the technology and denies the implant system stating it is a hearing aid

When this happens you can work with the Cochlear™ Otologic Management Services (OMS) to appeal your denial. We also recommend that you contact your Hearing Implant Specialist to find out information regarding current federal and state programs and resources that may be available in your community.

When all of your options for receiving coverage through your health plan have been exhausted, consider the options below:

- Employer-Sponsored Health Plans: Check to see if your employer offers other health insurance plans and if those plans provide you with coverage for your hearing implant. It may be possible to switch during your open enrollment period
- State Health Insurance Marketplace: Research and explore the option of purchasing an individual plan that may provide you with hearing implant coverage
- Medicaid Coverage: Coverage for hearing implants varies by state and eligibility is subject to change. Some states have expanded eligibility under the Patient Protection and Affordable Care Act. Contact your Hearing Implant Specialist or your state Medicaid program for more details
- If seeking coverage for your child, check to see if there are any special state programs that offer assistance to children with disabilities or check to see if they qualify for state Medicaid benefits

Cochlear's Otologic Management Services (OMS) is available to help you obtain necessary insurance approval and provide assistance in appealing denied coverage for Cochlear's portfolio of implantable solutions.

866 433 4876 **OMS@cochlear.com**

Programming and evaluation for rehabilitation

Medicare, Medicaid, Medicare Advantage and commercial health plans all have guidelines for aural rehabilitation (hearing implants mapping/programming).

Medicare and Medicare Advantage coverage

- Medicare covers aural rehabilitation services which includes cochlear implant mapping/programming services
- Traditional Medicare does not offer an option for predetermination or prior authorization of coverage
- Work with your surgeon's office to determine your eligibility for coverage and benefits
- Medicare Advantage plans must offer the same benefits defined by Traditional Medicare but may require predetermination or prior authorization for mapping/programming services. Work with your surgeon's office to determine your eligibility for coverage and benefits

Medicaid coverage

- Coverage of aural rehabilitation varies by state
- Work with your surgeon's office to check your state's Medicaid plan or Medicaid HMO to determine your coverage and benefits

Commercial Health Plan coverage

- Typically, health plans cover aural rehabilitation services following cochlear implantation surgery
- Work with your surgeon's office to determine your eligibility for coverage and benefits
- Ask if your health plan will provide a voluntary predetermination of benefits or prior authorization review. If yes, work with your doctor's office to submit a predetermination or prior authorization packet to your health plan

Aural rehabilitation
(cochlear implant mapping/programming)

Billing Code:	Description:
92601	Diagnostic analysis of cochlear implants, patient younger than seven years of age; with programming
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming
92603	Diagnostic analysis of cochlear implants, age seven years or older; with programming
92604	Diagnostic analysis of cochlear implant, age 7 years or older; with subsequent reprogramming
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes.

Auditory Osseointegrated Implant Programming

Billing Code:	Description:
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes

Replacements, parts and accessories, and batteries

Health plans also have guidelines for when they might cover a replacement for a sound processor (or other parts and accessories).

Commercial health plan replacement coverage

Typically, health plans cover replacement sound processors based upon the following two requirements:

- Before and after test results or information and data clearly predicting improved performance with use of the technology (i.e., medical necessity)
- If the current processor has been continuously used for five years, replacement with improved technology may be possible

Your clinic may assist in the process by:

- Testing your performance with your current processor and comparing it to the performance results with the replacement sound processor
- Predicting improved performance based on the group average clinical data available

Medicare replacement coverage

Medicare classifies Cochlear's sound processors, associated parts and accessories as prosthetics. This means they are subject to the durable medical equipment, prosthetics, orthotics and supplies ("DMEPOS") requirements under Medicare.

Medicare's Claim Processing Manual provides that Medicare will cover replacement of DME equipment if the equipment is lost, has irreparable damage or wear, or when required because of a change in the patient's condition.

Medicaid replacement coverage

Coverage for replacement sound processors is subject to each state's Medicaid Plan guidelines.

To find out if a replacement is covered by your health plan you can provide the below codes to the insurance representative.

Replacement sound processors

Billing Code:	Description:
HCPCS Code L8619	Cochlear Implants
HCPCS Code L8691 and L8694	Baha Implants
HCPCS Code L8691	Osia Implants

Battery Coverage

Many health plans cover batteries. Medicare and typically Medicaid will cover disposable batteries. Medicare will cover 180 disposable batteries per ear every three months. This is subject to change. Contact your health plan to determine if disposable batteries are covered and how many are covered in the given year.

Each health plan is different and has its own criteria. It is important to check your plan regarding coverage criteria on replacement parts and upgrades.

Hear now. And always

Cochlear is dedicated to helping people with moderate to profound hearing loss experience a world full of hearing. As the global leader in implantable hearing solutions, we have provided more than 750,000 devices and helped people of all ages to hear and connect with life's opportunities.

We aim to give people the best lifelong hearing experience and access to next generation technologies. We collaborate with leading clinical, research and support networks to advance hearing science and improve care.

That's why more people choose Cochlear than any other hearing implant company.

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