2020 Summary of Benefits

Medicare Advantage Plan
with Part D Prescription Drug Coverage

Independent Health's Medicare Passport® Prime (PPO)

January 1, 2020 – December 31, 2020

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS
Independent Health's Medicare Passport Prime (PPO)

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**" (EOC). The EOC is also available on-line at www.IndependentHealth.com/Medicare.

Sections in this booklet

- Things to Know About **Independent Health's Medicare Passport Prime (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-800-665-1502 (TTY: 711).

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Independent Health's Medicare Passport Prime (PPO)

Things to Know About Independent Health's Medicare Passport Prime (PPO)

Hours of Operation & Contact Information

If you are a member of this plan, call us at 1-800-665-1502, TTY: 711.

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. local time, Monday through Sunday.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. local time, Monday through Friday.

If you are not a member of this plan, call us at 1-800-958-4405, TTY: 711.

- From October 1 to December 7 we're open 8 a.m. – 8 p.m. local time, Monday through Sunday.
- From December 8 to September 30, we're open 8 a.m. – 8 p.m. local time, Monday through Friday.
- Our website: www.IndependentHealth.com/Medicare

Who can join?

To join **Independent Health's Medicare Passport Prime (PPO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and must live in our service area. Our service area includes these counties in New York: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.IndependentHealth.com/Medicare.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact Independent Health.

For coverage and costs of Original Medicare, look in your current **"Medicare and You"** handbook. View it on-line at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

SECTION II - SUMMARY OF BENEFITS Independent Health's Medicare Passport Prime (PPO)	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$215 per month. In addition, you must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drugs Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $5,500 for services you receive from in-network providers. • $10,000 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. Premiums, Optical Dispensing, Preventive/Routine Dental, Comprehensive Dental, Hearing Aids, Hearing Aid evaluation, and Medicare Part D prescription drugs do NOT count towards the out-of-pocket maximum.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	**In-Network:** Days 1-6: $210 Copay per day. Days 7-90: $0 Copay per day. Annual maximum out-of-pocket cost is $1,680. Requires provider preauthorization except for emergency admissions. **Out-of-Network:** 30% Coinsurance per stay.

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Outpatient Hospital	**In-Network:** Outpatient Hospital: $275 Copay. Outpatient Freestanding Ambulatory Surgical Center: $225 Copay. Provider preauthorization may apply for some services. **Out-of-Network:** Outpatient Hospital: 20% Coinsurance. Outpatient Freestanding Ambulatory Surgical Center: 20% Coinsurance. See the provider directory for a listing of Outpatient Hospitals and Freestanding Ambulatory Surgical Centers.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $30 Copay. Primary Care Physician is defined as Family Practitioners, General Practitioners, Internal Medicine, OB/GYN, Pediatricians and Gerontologists with no secondary specialty. If the Primary Care Physician has a secondary specialty other than Internal Medicine, General Practice, Family Practice, Geriatrics, Pediatrics or Obstetrics/Gynecology, the Specialist copayment associated with the physician will apply. **Out-of-Network:** Primary care physician visit: $45 Copay. Specialist visit: $45 Copay.
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 20% Coinsurance for all preventive services covered under Original Medicare at zero cost sharing.

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Emergency Care	**<u>In-Network and Out-of-Network:</u>** Medicare Covered: $90 Copay per visit. Worldwide Coverage: $90 Copay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Worldwide coverage: Maximum plan benefit limit of $10,000 per year for emergency/urgent care coverage outside of the USA.
Urgently Needed Services	**<u>In-Network and Out-of-Network:</u>** Medicare Covered: $65 Copay per visit. Worldwide Coverage: $65 Copay per visit. Worldwide coverage: Maximum plan benefit limit of $10,000 per year for emergency/urgent care coverage outside of the USA.
Diagnostic Services/ Labs/ Imaging	**<u>In-Network:</u>** Diagnostic tests and procedures: $0 Copay for tests performed by a Primary Care Physician. You pay a $30 Copay for tests performed by a Specialist Physician. Lab services: $5 Copay for routine labs, 20% Coinsurance for molecular or predisposition genetic testing. Advanced Radiology, MRI, CAT Scan: $75 Copay. X-rays: $30 Copay. Therapeutic Radiology: 20% Coinsurance. Provider preauthorization may apply for some services. **<u>Out-of-Network:</u>** Diagnostic tests and procedures: 20% Coinsurance. Lab services: 20% Coinsurance. Advanced Radiology, MRI, CAT Scan: 20% Coinsurance. X-rays: 20% Coinsurance. Therapeutic Radiology: 40% Coinsurance.

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Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $30 Copay from a Specialist. Routine hearing exam: $0 Copay from a Primary Care Provider, $30 Copay from a Specialist. **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: $45 Copay. Routine hearing exam: $45 Copay.
Supplemental Hearing Services ○ Hearing Aid Evaluation Exam ○ Hearing Aids	**In-Network:** You pay a $45 Copay for a hearing evaluation to see if you need a hearing aid from a TruHearing provider. You pay a $599 Copay per ear for TruHearing Advanced hearing aids. You pay a $899 Copay per ear for TruHearing Premium hearing aids. **Out-of-Network:** $75 Copay for a hearing evaluation to see if you need a hearing aid.
Dental Services (This is not routine/preventive dental)	**In-Network:** Medicare Covered: $30 Copay. You pay a $30 Copay for Medicare-covered dental services in a Specialist's office. You pay a $225 Copay for Medicare-covered services in a Freestanding Ambulatory Surgical Center. You pay a $275 Copay for Medicare-covered services in an Outpatient Hospital Facility. Requires provider preauthorization unless services are provided in an Emergency Room or Urgent Care Facility. **Out-of-Network:** Medicare Covered: You pay a $45 Copay for Medicare-covered dental services in a Specialist's office. You pay 20% Coinsurance for Medicare-covered dental services in a Freestanding Ambulatory Surgical Center. You pay 20% Coinsurance for Medicare-covered dental services in an Outpatient Hospital Facility.

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Supplemental Dental Services ○ Routine Dental Exam ○ Bitewing x-rays ○ Full Mouth x-rays	**In-Network:** Preventive dental services from a Healthplex provider: • Oral exam (for up to 2 every year): $0 Copay. • Cleaning (for up to 2 every year): $0 Copay. • Dental x-rays (for up to 2 every year): $0 Copay. **Out-of-Network:** Preventive dental services: • $20 Copay then 50% Coinsurance. If you visit a dentist that is not in our dental network you will pay a $20 copayment then you will be reimbursed 50% of the amount the network dental provider allows for that treatment by that dentist and you will be responsible for the other 50% plus additional permitted charges.
Supplemental Comprehensive Dental Services (No additional premium)	**In-Network:** Comprehensive dental services from a Healthplex provider. You pay $0 Deductible followed by a 50% coinsurance. $3,000 annual benefit maximum applies combined in and out-of-network. Covers dental services, for example: Periodontal cleaning, crowns, dentures, extractions, fillings, fluoride treatments and more. **Out-of-Network:** 50% coinsurance. If you visit a dentist that is not in our dental network you will you will be reimbursed 50% of the amount the network dental provider allows for that treatment by that dentist and you will be responsible for the other 50% plus additional permitted charges. $3,000 annual benefit maximum applies combined in and out-of-network.

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Vision Services	**In-Network:** Medicare-covered Eye Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $30 Copay from a Specialist. Eyeglasses or contact lenses after cataract surgery: $0 Copay. **Out-of-Network:** Medicare-covered Medical Eye Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $45 Copay from a Specialist.
Supplemental Vision Services Routine Eye Exam Eyeglasses (lenses and frames) or contacts	**In-Network:** You pay $0 for a routine eye exam. Includes retinal imaging if service is provided during your routine eye exam from an EyeMed provider. Limit one exam every twelve months. $200 allowance towards frames and lenses, or contacts combined in and out-of-network. Limit once every twelve months from an EyeMed provider. **Out-of-Network:** You pay $65 for a routine eye exam from a non-participating optometrist. Retinal imaging is not covered. Limit one exam every twelve months. **In and Out-of-Network combined:** $200 allowance towards frames and lenses, or contacts. Limit once every twelve months.
Mental Health Care	**In-Network:** Outpatient group therapy visit: $40 Copay. Individual therapy visit: $40 Copay. **Out-of-Network:** Outpatient group therapy visit: 45% Coinsurance. Individual therapy visit: 45% Coinsurance.

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Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $178 Copay per day. Provider preauthorization is required. **Out-of-Network:** 30% Coinsurance per stay. Our plan covers up to 100 days in a SNF.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $25 Copay per visit. Physical therapy and speech and language therapy visit: $25 Copay per visit. **Out-of-Network:** Occupational therapy visit: 20% Coinsurance. Physical therapy and speech and language therapy visit: 20% Coinsurance.
Ambulance	**In-Network:** Ground Ambulance: $200 Copay for each one-way trip. Air Ambulance: 20% Coinsurance. Provider preauthorization is required for planned transportation only. Wheelchair van is not covered. **Out-of-Network:** Ground Ambulance: $200 Copay for each one-way trip. Air Ambulance: 20% Coinsurance.
Transportation (Non-emergency)	**In-Network:** Not Covered. **Out-of-Network:** Not Covered.

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Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. Provider preauthorization may apply for some services. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 50% Coinsurance. Other Part B drugs: 50% Coinsurance.
Foot Care ***(podiatry services)***	**In-Network:** Foot exams: $30 Copay. **Out-of-Network:** Foot exams: $45 Copay.
Durable Medical Equipment	**In-Network:** 20% Coinsurance. Provider preauthorization may apply. **Out-of-Network:** 50% Coinsurance.
Prosthetic Devices ***(braces, artificial limbs, etc.)***	**In-Network:** Prosthetic devices: 20% Coinsurance. Related medical supplies: 0% Coinsurance. Provider preauthorization may apply. **Out-of-Network:** Prosthetic devices: 50% Coinsurance. Related medical supplies: 50% Coinsurance.

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Diabetes Supplies and Services	**In-Network:** Diabetes monitoring supplies: $0 Copay. Limited to preferred products. Diabetic monitor: $0 Copay. Limited to preferred products. Diabetes self-management training: $0 Copay. Therapeutic shoes or inserts: $0 Copay. **Out-of-Network:** Diabetes monitoring supplies: 20% Coinsurance. Limited to preferred products. Diabetic monitor: 20% Coinsurance. Limited to preferred products. Diabetes self-management training: 40% Coinsurance. Therapeutic shoes or inserts: 20% Coinsurance.
Wellness Program (Healthy Benefits)	**In-Network:** Fitness Benefit: $0 Copay at participating fitness facilities. **Out-of-Network:** Fitness Benefit: 100% Coinsurance.
Telemedicine	**In-Network:** You pay $25 to consult with a Teladoc Provider over the phone or on-line 24 hours a day, 7 days a week. **Out-of-Network:** Not Covered.

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Independent Health's Medicare Passport Prime (PPO)

PRESCRIPTION DRUG BENEFITS

Initial Coverage

You pay the following until your total yearly drug costs reach $4,020. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay
Tier 2 (Generic)	$10 copay	$25 copay
Tier 3 (Preferred Brand)	$45 copay	$112.50 copay
Tier 4 (Non-Preferred Drug)	40% coinsurance	40% coinsurance
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable A long-term supply is not available for drugs in Tier 5.

Standard Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	Not Applicable	$0 copay
Tier 2 (Generic)	Not Applicable	$25 copay
Tier 3 (Preferred Brand)	Not Applicable	$112.50 copay
Tier 4 (Non-Preferred Drug)	Not Applicable	40% coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable A long-term supply is not available for drugs in Tier 5.

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<tr><th colspan="2">SECTION II - SUMMARY OF BENEFITS
Independent Health's Medicare Passport Prime (PPO)</th></tr>
<tr><td></td><td>Your cost-sharing may be different if you use a Long-Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Please call us or see the plan's "Evidence of Coverage" on our website (www.IndependentHealth.com/Medicare) for complete information about your costs for covered drugs.</td></tr>
<tr><td>Coverage Gap</td><td>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,020.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $6,350, which is the end of the coverage gap.

Standard Retail Cost-Sharing
<table>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr>
<tr><td>Tier 2</td><td>25% Coinsurance</td></tr>
<tr><td>Tier 3</td><td>25% Coinsurance</td></tr>
<tr><td>Tier 4</td><td>25% Coinsurance</td></tr>
<tr><td>Tier 5</td><td>25% Coinsurance</td></tr>
</table></td></tr>
<tr><td>Catastrophic Amount</td><td>After your yearly out-of-pocket drug costs reach $6,350, you pay the greater of:
• $3.60 copay for generic (including brand drugs treated as generic) and a $8.95 copayment for all other drugs, or
• 5% of the cost.</td></tr>
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DISCLAIMERS

This document is available in other formats such as Braille and large print.

Independent Health's Medicare Passport Prime (PPO) is a Local PPO plan with a Medicare contract. Enrollment in Independent Health's Medicare Passport Prime (PPO) depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat Independent Health members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Independent Health Benefits Corporation.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at

Current members call toll-free:1-800-665-1502, TTY users should call 711.

Prospective members call toll-free:1-800-958-4405, TTY users should call 711.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor for. Visit www.independenthealth.com/Medicare or call Independent Health at the phone number above to view or receive a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ Out-of-network/non-contracted providers are under no obligation to treat Independent Health's Medicare Passport Advantage (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.