



2021 Summary of Benefits

Medicare Advantage Plans
with Part D Prescription Drug Coverage

Independent Health's Encompass[®] 65 Element (HMO)

January 1, 2021 – December 31, 2021

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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**.” You can also see the Evidence of Coverage on our website, <http://www.independenthealth.com/medicare>.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Independent Health's Encompass 65 Element (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Independent Health's Encompass 65 Element (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <https://www.medicare.gov>.
- If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <https://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **Independent Health's Encompass 65 Element (HMO)**.
- 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).

Things to Know About Independent Health's Encompass 65 Element (HMO)

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 are open 8 a.m. – 8 p.m. Eastern Time, 7 days a week.
- From April 1 to September 30 we are open 8 a.m. – 8 p.m. Eastern Time, Monday – 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 are open 8 a.m. – 8 p.m. Eastern Time, 7 days a week.
- From December 8 to September 30 we are open 8 a.m. – 8 p.m. Eastern Time, Monday – Friday.

Our website: <http://www.independenthealth.com/medicare>.

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Who can join?

To join **Independent Health's Encompass 65 Element (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these counties in New York: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

Which doctors, hospitals, and pharmacies can I use?

Independent Health's Encompass 65 Element (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (<http://www.independenthealth.com/medicare>).

Or, call us and we will send you a copy of the physician/provider and pharmacy directories.

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, <http://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: Deductible, Initial Coverage, Coverage Gap and Catastrophic Coverage.

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

SECTION II - SUMMARY OF BENEFITS

Independent Health's Encompass 65 Element (HMO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium	You do not pay a separate monthly plan premium for Independent Health's Encompass 65 Element (HMO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: \$375 for Tiers 3, 4 and 5.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: <ul style="list-style-type: none">• \$7,550 for services you receive from in-network providers. 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. Optical dispensing, non-Medicare covered dental, premiums, 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	<u>In-Network:</u> Days 1-5: \$390 Copay per day for each admission. Days 6-90: \$0 Copay per day. \$2,000 annual copayment limit applies. Requires provider preauthorization except for emergency admissions.
Ambulatory Surgical Center	<u>In-Network:</u> Freestanding Ambulatory Surgical Center: \$500 Copay. See the provider directory for a listing of Freestanding Ambulatory Surgical Centers. Provider preauthorization may apply for some services.
Outpatient Hospital	<u>In-Network:</u> Outpatient hospital: \$550 Copay. Provider preauthorization may apply for some services.

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Doctor's Office Visits	<p><u>In-Network:</u></p> <p>Primary care physician visit: \$15 Copay.</p> <p>You pay \$0 copay for an office visit with your primary care provider within 30-days of an inpatient hospital stay.</p> <p>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.</p> <p>Specialist visit: \$50 Copay.</p>
Preventive Care <i>(e.g., flu vaccine, diabetic screenings)</i>	<p><u>In-Network:</u></p> <p>You pay nothing for all preventive services covered under Original Medicare at zero cost sharing.</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
Emergency Care	<p><u>In-Network:</u></p> <p>\$90 Copay per visit.</p> <p>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</p> <p>Worldwide Emergency Coverage: \$90 Copay.</p> <p>\$10,000 plan limit per occurrence for the combined unforeseen event outside of the United States.</p>
Urgently Needed Services	<p><u>In-Network:</u></p> <p>\$65 Copay per visit.</p> <p>Worldwide Urgent Coverage: \$65 Copay.</p> <p>\$10,000 plan limit per occurrence for the combined unforeseen event outside of the United States.</p>
Diagnostic Services / Labs/ Imaging	<p><u>In-Network:</u></p> <p>Diagnostic tests and procedures: \$15 Copay for tests performed by a Primary Care Physician. \$50 Copay for tests performed by a Specialist.</p> <p>Lab services: \$15 Copay for routine lab tests. 20% Coinsurance for molecular or predisposition genetic testing.</p>

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	<p>Diagnostic Advanced Radiology Services (such as MRI, CAT Scan): \$225 Copay.</p> <p>X-rays: \$50 Copay.</p> <p>Two copayments apply if both a diagnostic x-ray and an advanced diagnostic radiologic service are billed on the same day by the same provider.</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.</p> <p>Provider preauthorization may apply for some services.</p>
Hearing Services	<p><u>In-Network:</u></p> <p>Exam to diagnose and treat hearing and balance issues: \$50 Copay for a Specialist.</p> <p>Routine hearing exam: \$15 Copay for a Primary Care Provider. \$50 Copay for a Specialist.</p> <p>Hearing Aid Evaluation Exam: \$45 Copay.</p> <p>Hearing Aid: \$499 - \$2,799 Copay.</p> <p>Copayment structure per hearing aid: \$499, \$799, \$999, \$1,499, \$2,799. Benefit is limited to preferred hearing aids, which come in various styles and colors. You must see an American Hearing Benefits provider to use this benefit. You cannot combine any promotional offers with our Hearing Aid benefit. Call Member Services for additional information about the network or visit IndependentHealth.com/Medicare.</p>
Dental Services	<p><u>In-Network:</u></p> <p>Medicare Covered: \$50 Copay.</p> <p>Preventive dental services from a Healthplex provider: \$30 Copay</p> <ul style="list-style-type: none">• Oral exam (up to 2 visits every year)• Cleaning (up to 2 visits every year)• Fluoride treatment (up to 2 visits per year)• Dental X-rays (up to 2 visits every year)• Full mouth X-ray (once every 36 months)
Vision Services	<p><u>In-Network:</u></p> <p>Exam to diagnose and treat diseases and conditions of the eye: \$50 Copay for a Specialist.</p> <p>Routine eye exam, including yearly glaucoma screening, (up to 1 visits every year): \$20 Copay from an EyeMed Provider.</p> <p>Eyeglasses or contact lenses after cataract surgery: Eyeglasses (frames and lenses) or Contact lenses: Our plan pays up to \$200 every two years for eyewear. Any costs incurred above this amount for lenses, frames or contacts is the member's responsibility.</p>

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Mental Health Care	<p><u>In-Network:</u></p> <p>Outpatient group therapy visit: \$35 Copay.</p> <p>Individual therapy visit: \$35 Copay.</p> <p>Following a diagnosis of depression, \$0 copayment for first office visit with an outpatient mental health professional.</p> <p>Inpatient Mental Health Care:</p> <p>Days 1-4: \$395 Copay per day for each admission.</p> <p>Days 5-90: \$0 Copay per day.</p>
Skilled Nursing Facility (SNF)	<p><u>In-Network:</u></p> <p>Days 1-20: \$0 Copay per day.</p> <p>Days 21-100: \$184 Copay per day.</p> <p>Provider preauthorization is required.</p>
Outpatient Rehabilitation	<p><u>In-Network:</u></p> <p>Occupational therapy visit: \$40 Copay per visit.</p> <p>Physical therapy and speech and language therapy visit: \$40 Copay per visit.</p> <p>If you have been diagnosed with back pain: \$0 copayment for initial evaluation with a physical therapist and \$0 copayment for first physical therapy session.</p>
Ambulance	<p><u>In-Network:</u></p> <p>Ground Ambulance: \$250 Copay. Wheelchair van is not covered.</p> <p>Air Ambulance: 20% Coinsurance.</p> <p>Provider preauthorization is required for planned transportation only.</p>
Transportation	<p><u>In-Network:</u></p> <p>Not Covered.</p>
Medicare Part B Drugs	<p><u>In-Network:</u></p> <p>For Part B drugs such as chemotherapy drugs: 20% Coinsurance.</p> <p>Other Part B drugs: 20% Coinsurance.</p> <p>Provider preauthorization may be required.</p>
Foot Care (Podiatry Services)	<p><u>In-Network:</u></p> <p>Foot exams: \$50 Copay from a Podiatrist.</p>

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Durable Medical Equipment	<u>In-Network:</u> 20% Coinsurance. Provider preauthorization may apply.
Diabetic Supplies and Services	<u>In-Network:</u> Diabetes monitoring supplies: \$0 Copay. Diabetic Monitor: \$0 Copay. Limited to preferred products. Diabetes self-management training: \$0 Copay. Therapeutic shoes or inserts: \$0 Copay. If you have been diagnosed with diabetes You pay \$0 Copay for diabetic lab tests for HbA1c and GFR. You pay \$0 Copay for Endocrinologist with diagnosis of Diabetes. You pay \$0 Copay for diabetic retinopathy exam. You pay \$0 Copay for Specialist administering the exam
Prosthetic Devices (braces, artificial limbs, etc.)	<u>In-Network:</u> Prosthetic devices: 20% Coinsurance. Related medical supplies: 0% Coinsurance. Provider preauthorization may apply.
Wellness Program	<u>In-Network:</u> Fitness Benefit: \$0 Copay. SilverSneakers® You pay nothing for this benefit. SilverSneakers gives you FREE access to: <ul style="list-style-type: none">• Thousands of participating fitness center locations nationwide¹• SilverSneakers Live classes and workshops taught by instructors trained in senior fitness• 200+ workout videos in the SilverSneakers On-Demand™ online library• SilverSneakers GO™ mobile app with digital workout programs• SilverSneakers FLEX®, giving you options to get active outside of traditional gyms (like recreation centers, malls and parks)• Online fitness and nutrition tips

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	You must use participating Silver Sneakers fitness locations and programs. For a list of participating fitness facilities, go to www.silversneakers.com . Or call SilverSneakers (toll free) at 1-888-313-5653 (TTY: 711) or Independent Health Member Services at 800-665-1502 or 716-250-4401 (TTY: 711) See the Chapter 4 of your Evidence of Coverage for more details.
Remote Access Technologies: Teladoc®	<u>In-Network:</u> You pay \$25 Copay for each consult with a Teladoc Provider over the phone or on-line 24 hours a day, 7 days a week.
Optional Supplemental Comprehensive Dental Note: there is an additional \$25 monthly premium for the Optional Supplemental Comprehensive Dental Benefit.	You pay \$0 deductible and 50% of the cost for certain oral exams and dental procedures when you see a Healthplex dental provider A maximum annual allowance of \$3,000 applies. On the first of each quarter (January 1, April 1, July 1 and October 1) members earn \$750 of the comprehensive dental benefit. Unused balances will carry over from quarter to quarter but any balance that is not used by December 31st each year will be forfeited. Coverage is based on the available balance on date of service You must enroll in this optional supplemental benefit within 30 days of joining the plan.

PRESCRIPTION DRUG BENEFITS

Deductible	Prescription Drug Deductible: \$375 for Tiers 3, 4 and 5. There is no deductible for select insulins. You pay \$35 for select insulins.																		
Initial Coverage	You pay the following until your total yearly drug costs reach \$4,130. Total yearly drug costs are the drug costs paid by both you and our Part D plan. You pay \$35 for select insulins. Standard Retail Cost-Sharing																		
	<table border="1"> <thead> <tr> <th>Tier</th> <th>One-month supply</th> <th>Three-month supply</th> </tr> </thead> <tbody> <tr> <td>Tier 1 (Preferred Generic)</td> <td>\$4 copay</td> <td>\$10 copay</td> </tr> <tr> <td>Tier 2 (Generic)</td> <td>\$20 copay</td> <td>\$50 copay</td> </tr> <tr> <td>Tier 3 (Preferred Brand)</td> <td>You pay deductible then \$47 copay</td> <td>You pay deductible then \$117.50 copay</td> </tr> <tr> <td>Tier 4 (Non-Preferred Drug)</td> <td>You pay deductible then 41% coinsurance</td> <td>You pay deductible then 41% coinsurance</td> </tr> <tr> <td>Tier 5 (Specialty Tier)</td> <td>You pay deductible then 26% coinsurance</td> <td>Not Applicable</td> </tr> </tbody> </table>	Tier	One-month supply	Three-month supply	Tier 1 (Preferred Generic)	\$4 copay	\$10 copay	Tier 2 (Generic)	\$20 copay	\$50 copay	Tier 3 (Preferred Brand)	You pay deductible then \$47 copay	You pay deductible then \$117.50 copay	Tier 4 (Non-Preferred Drug)	You pay deductible then 41% coinsurance	You pay deductible then 41% coinsurance	Tier 5 (Specialty Tier)	You pay deductible then 26% coinsurance	Not Applicable
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Standard Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	Not Applicable	\$10 copay
Tier 2 (Generic)	Not Applicable	\$50 copay
Tier 3 (Preferred Brand)	Not Applicable	You pay deductible then \$117.50 copay
Tier 4 (Non-Preferred Drug)	Not Applicable	You pay deductible then 41% coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

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 (<http://www.independenthealth.com/medicare>) for complete information about your costs for covered drugs.

Coverage Gap

The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,130.

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 \$6,550, which is the end of the coverage gap.

Independent Health offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be \$35.

Catastrophic Amount

After your yearly out-of-pocket drug costs reach \$6,550, you pay the greater of:

- \$3.70 copay for generic (including brand drugs treated as generic) and a \$9.20 copayment for all other drugs, or
- 5% of the cost.

Part D Senior Savings Program**Deductible Stage:**

There is no deductible for select insulins. You pay \$35 for select insulins.

Initial Coverage Stage:

You pay \$35 for select insulins.

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Coverage Gap Stage:

Independent Health offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be \$35 for select insulins.

The Part D Senior Savings Model is a voluntary model that enables participating Part D enhanced plans to lower Medicare members' out-of-pocket costs for insulin to a maximum \$35 copay per thirty-day supply. This fixed cost share applies to all stages of coverage: the deductible stage (if applicable), the initial coverage stage, AND the coverage gap stage. Since this is a Part D program only self-injected insulin meets the criteria for a Part D covered drug and is eligible for the cost savings under the Senior Savings Model (insulin received through a pump or oral diabetic medication is not eligible). This benefit is built into the plan.

This does not apply to people who are already getting LIS "Extra Help" for their Part D drugs.

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-665-1502 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-665-1502 (TTY: 711).

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.

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.

¹Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

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Health coverage is offered by Independent Health Association, Inc..

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 for which you routinely see a doctor. Visit <http://www.independenthealth.com/medicare> or 1-800-665-1502 (TTY 711) to view 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 medicine 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

- 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, 2022.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

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.