SECTION II - SUMMARY OF BENEFITS	
	Independent Health's Encompass 65 Direct (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 Direct (HMO). You must continue to pay your Medicare Part B premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: $450 for Tiers 3, 4 and 5.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $6,750 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	**In-Network:** Days 1-6: $325 Copay per day for each admission. Days 7-90: $0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. $1,950 annual copayment limit applies. Requires provider preauthorization except for emergency admissions.
Outpatient Hospital	**In-Network:** Outpatient hospital: $400 Copay. Provider preauthorization may apply for some services.
Ambulatory Surgical Center	**In-Network:** Freestanding Ambulatory Surgical Center: $350 Copay. See the provider directory for a listing of Freestanding Ambulatory Surgical Centers.

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	Provider preauthorization may apply for some services.
Doctor's Office Visits	**In-Network:** Primary care physician visit: You pay nothing. 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. Specialist visit: $35 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.
Emergency Care	**In-Network:** $125 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 Emergency Coverage: $125 Copay. $10,000 plan limit per occurrence for the combined unforeseen event outside of the United States.
Urgently Needed Services	**In-Network:** $55 Copay per visit. Worldwide Urgent Coverage: $55 Copay. $10,000 plan limit per occurrence for the combined unforeseen event outside of the United States

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Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: You pay nothing for tests performed by a Primary Care Physician. $35 Copay for tests performed by a Specialist. Lab services: You pay nothing for routine lab tests. 20% Coinsurance for molecular or predisposition genetic testing. Diagnostic Advanced Radiology Services (such as MRI, CAT Scan): $200 Copay. X-rays: $40 Copay. 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. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. Provider preauthorization may apply for some services.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: You pay $35 Copay for a Specialist. Routine hearing exam: You pay nothing for a Primary Care Provider. $35 Copay for a Specialist. Hearing Aid Evaluation Exam: $45 Copay. Hearing Aid: $499 - $1949 Copay. Copayment structure per hearing aid: $499, $699, $999, $1,499, $1,949. Benefit is limited to preferred hearing aids, which come in various styles and colors. You must see a Start Hearing, Inc. 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.
Dental Services	**In-Network:** Medicare Covered: $35 Copay for a Specialist. Annual maximum allowance of $2,000 combined In-Network and Out-of-Network applies for preventive and comprehensive dental services combined. For preventive dental services through a LIBERTY provider, you pay nothing: • Oral exam (up to 2 visits every year)

SECTION II - SUMMARY OF BENEFITS	Independent Health's Encompass 65 Direct (HMO)
	• Cleaning (up to 2 visits every year) • Fluoride treatment (up to 2 visits every year) • Dental X-rays (up to 2 visits every year) • Full mouth X-ray (once every 36 months) • For Comprehensive Dental services through a LIBERTY provider, you pay 50% Coinsurance.
Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye: You pay $35 Copay for a Specialist. Routine eye exam, including yearly glaucoma screening (up to 1 visits every year): You pay nothing from an EyeMed Provider. Eyeglasses or contact lenses after cataract surgery: $0 Copay. Eyeglasses (frames and lenses) or contact lenses: Our plan pays up to $200 every year for eyewear. Any costs incurred above this amount for lenses, frames or contacts is the member's responsibility.
Mental Health Care	**In-Network:** Outpatient group therapy visit: $35 Copay. Individual therapy visit: $35 Copay. Inpatient Mental Health Care: Days 1-4: $395 Copay per day for each admission. Days 5-90: $0 Copay per day.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $214 Copay per day. Provider preauthorization is required.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $20 Copay per visit.

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	Physical therapy and speech and language therapy visit: $20 Copay per visit.
Ambulance	**In-Network:** Ground Ambulance: $225 Copay. Wheelchair van is not covered. Air Ambulance: 20% Coinsurance.
Transportation	**In-Network:** Not Covered.
Medicare Part B Drugs	**In-Network:** For Part B insulin: You pay a $35 Copay. For Part B drugs such as chemotherapy drugs: 0% - 20% Coinsurance. Other Part B drugs: 0% - 20% Coinsurance. Provider preauthorization may be required.
Foot Care (Podiatry Services)	**In-Network:** Foot exams: $35 Copay from a Podiatrist.
Durable Medical Equipment	**In-Network:** 10% Coinsurance - 20% Coinsurance. 10% Coinsurance applies when member uses our preferred DME provider for designated mobility devices. 20% Coinsurance for all other covered DME. Provider preauthorization may apply.
Diabetic Supplies and Services	**In-Network:** Diabetes monitoring supplies: You pay nothing. Diabetic Monitor: You pay nothing. Limited to preferred products. Diabetes self-management training: You pay nothing. Therapeutic shoes or inserts: You pay nothing.

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Prosthetic Devices (braces, artificial limbs, etc.)	**In-Network:** Prosthetic devices: 20% Coinsurance. Related medical supplies: You pay nothing Provider preauthorization may apply.
Wellness Program	**In-Network:** Fitness Benefit: You pay nothing. **SilverSneakers®** You pay nothing for this benefit. SilverSneakers gives you FREE access to: • Thousands of participating fitness center locations nationwide[1] • 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 • Burnalong® access with a supportive virtual community and thousands of classes for all interests and abilities • GetSetUp[3], with hundreds of interactive online classes one hour or less, ranging from nutrition to mindfulness and more. 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®	**In-Network:** Behavior Health services: You pay nothing. All other Teladoc services: $0 Copay.

PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: $450 for Tiers 3, 4, and 5.

PRESCRIPTION DRUG BENEFITS	
Initial Coverage	You pay the following until your total yearly out-of-pocket costs reach $2,000.

You pay $35 for insulins on our formulary.

Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 copay	$0 copay
Tier 2 (Generic)	$20 copay	$50 copay
Tier 3 (Preferred Brand)	$47 copay	$117.50 copay
Tier 4 (Non-Preferred Drug)	50% coinsurance	50% coinsurance
Tier 5 (Specialty Tier)	27% coinsurance	Not Applicable

Standard Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	Not Applicable	$0 copay
Tier 2 (Generic)	Not Applicable	$50 copay
Tier 3 (Preferred Brand)	Not Applicable	$117.50 copay
Tier 4 (Non-Preferred Drug)	Not Applicable	50% 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 100 days for Tier 1 and up to 90 days on Tier 2, 3, and 4) 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.

Catastrophic Amount	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. • During this payment stage, you pay nothing for your covered Part D drugs. • For excluded drugs covered under our enhanced benefit, you pay your Tier 2 copay.