SECTION II - SUMMARY OF BENEFITS Independent Health's Medicare Passport Access (PPO)	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$19 per month. In addition, you must keep paying your Medicare Part B premiums.
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. • $10,100 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. 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 1-5: $320 Copay per day for each admission. Days 6-90: $0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. $1,600 annual copayment limit applies. Requires provider preauthorization except for emergency admissions. **Out-of-Network:** 40% Coinsurance per stay.
Outpatient Hospital	**In-Network:** Outpatient hospital: $375 Copay. Provider preauthorization may apply for some services.

SECTION II - SUMMARY OF BENEFITS Independent Health's Medicare Passport Access (PPO)	
	Out-of-Network: Outpatient hospital: 40% Coinsurance.
Ambulatory Surgical Center	**In-Network:** Freestanding Ambulatory Surgical Center: $350 Copay. See the provider directory for a listing of Freestanding Ambulatory Surgical Centers. Provider preauthorization may apply for some services. **Out-of-Network:** Ambulatory Surgical Center: 40% Coinsurance.
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: $40 Copay. **Out-of-Network:** Primary care physician visit: 40% Coinsurance. Specialist visit: 40% Coinsurance.
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:** 40% Coinsurance for all preventive services covered under Original Medicare.
Emergency Care	**In-Network and Out-of-Network:** $125 Copay per visit.

SECTION II - SUMMARY OF BENEFITS Independent Health's Medicare Passport Access (PPO)	
	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 and Out-of-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
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: You pay nothing for tests performed by a Primary Care Physician. $40 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: $30 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. **Out-of-Network:** Diagnostic tests and procedures: 40% Coinsurance. Lab services: 40% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 40% Coinsurance. X-rays: 40% Coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 50% Coinsurance.

SECTION II - SUMMARY OF BENEFITS Independent Health's Medicare Passport Access (PPO)	
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: You pay $40 Copay for a Specialist. Routine hearing exam: You pay nothing for a Primary Care Provider. $40 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. **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: 40% Coinsurance. Routine hearing exam: 40% Coinsurance. Hearing Aid Evaluation Exam: Not covered. You must use a provider in the national Start Hearing, Inc network. Hearing Aid: Not Covered. You must use a provider in the national Start Hearing, Inc
Dental Services	**In-Network:** Medicare Covered: $40 Copay for a Specialist. Annual maximum allowance of $1,000 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) • 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. **Out-of-Network:** Medicare Covered: 40% coinsurance Annual maximum allowance of $1,000 combined In-Network and Out-of-Network applies for preventive and comprehensive dental services combined. Preventive Dental: You Pay Nothing. Comprehensive Dental: 50% Coinsurance. Care rendered by a provider that is not part of our supplemental dental network is covered as out-of-network. You may be asked to pay up front for these services and therefore you must complete a dental reimbursement form to be reimbursed for your preventive dental service. You will be reimbursed up to the allowed amount determined by LIBERTY Dental.
Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye: You pay $40 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: In and Out-of-Network combined – 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. **Out-of-Network:** Exam to diagnose and treat diseases and conditions of the eye: 40% Coinsurance. Routine eye exam, including yearly glaucoma screening, (up to 1 visits every year): $65 Copay. Eyeglasses (frames and lenses) or contact lenses: In and Out-of-Network combined – 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. Eyeglasses or contact lenses after cataract surgery: You pay Nothing. Maximum $150 allowance.

SECTION II - SUMMARY OF BENEFITS Independent Health's Medicare Passport Access (PPO)	
Mental Health Care	**In-Network:** Outpatient group therapy visit: $35 Copay. Individual therapy visit: $35 Copay. Inpatient Mental Health Care: Days 1-5: $375 Copay per day for each admission. Days 6-90: $0 Copay per day. **Out-of-Network:** Outpatient group therapy visit: 40% Coinsurance. Individual therapy visit: 40% Coinsurance. Inpatient Mental Health Care: 40% Coinsurance per stay
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $214 Copay per day. Provider preauthorization is required. **Out-of-Network:** Days 1 - 100: 40% Coinsurance per stay.
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: 40% Coinsurance. Physical therapy and speech and language therapy visit: 40% Coinsurance.
Ambulance	**In-Network:** Ground Ambulance: $275 Copay for each one-way trip. Wheelchair van is not covered. Air Ambulance: 20% Coinsurance. **Out-of-Network:** Ground Ambulance: $275 Copay for each one-way trip.

	Air Ambulance: 20% Coinsurance.
Transportation	**In-Network:** Not Covered. **Out-of-Network:** Not Covered.
Medicare Part B Drugs	**In-Network:** For Part B insulin: $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. **Out-of-Network:** For all Part B drugs: 40% Coinsurance.
Foot Care (Podiatry Services)	**In-Network:** Foot exams: $40 Copay from a Podiatrist. **Out-of-Network:** Foot exams: 40% Coinsurance 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. **Out-of-Network:** 50% Coinsurance.

SECTION II - SUMMARY OF BENEFITS Independent Health's Medicare Passport Access (PPO)	
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. **Out-of-Network:** Diabetes monitoring supplies: 40% Coinsurance. Diabetic Monitor: 40% Coinsurance. Diabetes self-management training: 40% Coinsurance. Therapeutic shoes or inserts: 40% Coinsurance.
Prosthetic Devices (braces, artificial limbs, etc.)	**In-Network:** Prosthetic devices: 20% Coinsurance. Related medical supplies: You pay nothing Provider preauthorization may apply. **Out-of-Network:** Prosthetic devices: 50% Coinsurance. Related medical supplies: 50% Coinsurance.
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, 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. **Out-of-Network:** You must use a participating SilverSneakers facility.
Remote Access Technologies: Teladoc®	**In-Network:** You pay $0 Copay for each behavioral health session with a Teladoc provider. You pay $25 Copay for each consult for other services with a Teladoc Provider over the phone or on-line. Teladoc is available 24 hours a day, 7 days a week. **Out-of-Network:** You must use a Teladoc provider.

PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: $450 for Tiers 3, 4, and 5. There is no deductible for insulins. You pay $35 for insulins on our formulary.
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

<table>
<tr><th colspan="2">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td></td><td>
<table>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>50% coinsurance</td><td>50% coinsurance</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>27% coinsurance</td><td>Not Applicable</td></tr>
</table>
Standard Mail Order
<table>
<tr><th>Tier</th><th>One-month supply</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>Not Applicable</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>Not Applicable</td><td>$50 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>Not Applicable</td><td>$117.50 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>Not Applicable</td><td>50% coinsurance</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>Not Applicable</td><td>Not Applicable</td></tr>
</table>
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.
</td></tr>
<tr><td>Catastrophic Amount</td><td>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.</td></tr>
</table>