Exhibit III.B.2

HMO BENEFITS FOR 2016-- Medicare Advantage Plan

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2015 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2016
		EOC	Rider					Individual
Office Visit								
Speciality Office Visit								
Chiropractic Care								
Inpatient Hospital Care	Not subject to deductibles, copays or coinsurance							
Surgery (include all settings - Physician-Inpatient , Physician-Outpatient (at a hospital, facility or surgery center), Physician's Office, Outpatient Surgery Facility								
Skilled Nursing Facilities								
Hospice Benefits								
Emergency Room								
Urgent Care Facility								
Ambulance indicate both Non-airborne & Airborne								
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgival Settings								
Radiology								
Lab Tests								
Pathology								

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		EOC	Rider					Individual
EKG/EEG								
Radiation/ Chemotherapy								
Women's Health Care/OB GYN								
Pap Tests								
Mammograms								
Bone Mineral Density Measurements & Tests								
Pre- and Post Natal Visits	Covered as required by Federal and NYS law and/or regulation							
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling							
Infertility Services	Covered as required by Federal and NYS law and/or regulation							
Contraceptive Drugs and Devices								
Rehabilitative Care, Physical, Speech & Occupational Therapy								
Inpatient Rehabilitative Care								
Outpatient Rehabilitative Care								

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		EOC	Rider					Individual
Mental Health/Substance Abuse								
Outpatient Mental Health	Covered as required by Federal and NYS law and/or regulation							
Inpatient Mental Health	Covered as required by Federal and NYS law and/or regulation							
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)							
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS law and/or regulation							
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation							
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation							
Prescription Drugs: *Medically necessary federal legend and state restricted drugs, compounded medications and injectable insulin. Coverage must include contraceptive drugs and devices, fertility drugs and enteral formulas (The copayment for injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs except drugs limited to 30 days supply at dispensing.) No annual or lifetime maximum permitted.*								
Prescription Drugs								

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		EOC	Rider					Individual
Other								
Diabetic Supplies								
Oral Agents and Insulin								
Diabetic Shoes								
Durable Medical Equipment (DME)	Medically necessary DME which can with- stand repeated use and primarily used to serve a medical purpose must be covered. Examples include but not limited to: wheelchairs, walkers, respiratory equip, oxygen supplies, replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.							
Prosthetic Devices	Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to: artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses and Ostomy Supplies. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.							

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HMO BENEFITS FOR 2016-- Medicare Advantage Plan

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., $25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2015 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2016
		EOC	Rider					Individual
Orthotic Devices	Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance, not provided for under a manufacturer’s warranty or purchase agreement, must be covered when functionally necessary.							
Additional Benefits								