Independent Health

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Primary Office Visit	Covered as required by Federal and NYS law and/or regulation	IHA-C2000, IHA-SB2003 Section XXVII: Pg. 1	NA	Pending	Adult: $10/visit Child: $0/visit	Unlimited	Yes, copay to $10 from $20	Base Plan $603.15	Base Plan $1,511.25
Speciality Office Visit	Covered as required by Federal and NYS law and/or regulation	IHA-C2000 IHA-SB2003 Section XXVII: Pg. 1	NA	Pending	$20/visit	Unlimited	No		
Chiropractic Care	Covered as required by Federal and NYS law and/or regulation	IHA-C2000 IHA-SB2003 Section XXVII: Pg. 6	NA	Pending	$20/visit	Unlimited	No		
Inpatient Hospital Care	Covered as required by Federal and NYS law and/or regulation, not subject to deductibles, copays or coinsurance	IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 5, 8, 10, 13, 15, 16, 17	NA	Pending	No copayment	Unlimited	No		
Surgery (include all settings - Physician-Inpatient , Physician-Outpatient (at a hospital, facility or surgery center), Physician's Office, Outpatient Surgery Facility		IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 2, 7, 9, 10, 12, 13, 15	NA	Pending	(Inpatient) No copayment (Outpatient/Surgery Center) Facility: $100/visit Physician: No copayment (Physician's Office-Specialty) $20/visit (Physician's Office-Primary) Adult: $10/visit Child: $0/visit	Unlimited	Yes, $10 primary office visit		
Skilled Nursing Facilities		IHA-C2000 IHA-SB2003 Section XXVII: Pg. 16	NA	Pending	No copayment	45 max days	No		
Hospice Benefits	210 Days	IHA-C2000 IHA-SB2003 Section XXVII: Pg. 15	NA	Pending	No copayment	Unlimited	No		

Independent Health

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Emergency Room	Covered as required by ACA	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 1, 3**	**NA**	**Pending**	**$100/visit**	**Unlimited**	**No**		
Urgent Care Center		**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 4**	**NA**	**Pending**	**Adult: $35/visit Child: $0/visit**	**Unlimited**	**No**		
Ambulance indicate both Non-airborne & Airborne		**IHA-C2000 IHA-SB2003 Section XXVII: Non-airborne Pg. 3 Airborne Pg. 3**	**NA**	**Pending**	**$100/trip**	**Unlimited**	**No**		
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgival Settings									
Radiology	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 3, 4, 7, 9, 11, 12**	**NA**	**Pending**	**Office/Freestanding- Adult: $20/per visit Child: $0/$20 per visit Outpatient - $40 per visit**	**Unlimited**	**No**		
Lab Tests	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 3, 7, 9**	**NA**	**Pending**	**$0/visit**	**Unlimited**	**Yes, change from $10 to $0**		
Pathology	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 3, 7, 9**	**NA**	**Pending**	**$0/visit**	**Unlimited**	**Yes, change from $10 to $0**		
EKG/EEG	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 3, 4, 7, 9, 11, 12**	**NA**	**Pending**	**Adult: $10/$20 visit Child: $0/$20 visit**	**Unlimited**	**No**		
Radiation/ Chemotherapy	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 6**	**NA**	**Pending**	**Adult: $10/$20 visit Child: $0/$20 visit**	**Unlimited**	**No**		

Independent Health

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Preventive Services									
All Members - including but not limited to: annual wellness visit/ physical, standard immunizations (recommended by ACIP), colonoscopy, screening for STDs, HIV. Alcohol/ substance abuse,tobacco use, cholesterol, diabetes and high blood pressure	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 2, 3**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		
Women's Health - including but not limited to: mammograms, bone density, pap tests, anemia, iron deficiency, etc. for pregnant women	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: pg. 2**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		
Men's Health - including but not limited to: prostate cancer screening, abdominal aoric aneurysm screening	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 2, 3**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		

Independent Health

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Children's Health - including but not limited to: certain newborn screenings, metabolic screenings, vision, autism, lead and TB screenings, obesity counseling	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 2**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		
Women's Health Care/OB GYN									
Pre- and Post Natal Visits	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 9**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 9, 10**	**NA**	**Pending**	**Applies cost share for appropriate service Lab: $0/visit Specialist: $20/visit**	**Unlimited**	**No**		
Infertility Services	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 7**	**NA**	**Pending**	**Applies cost share for appropriate service (Physician's Office) $20/visit (Outpatient Surgical Facility) $100/visit**	**Unlimited**	**No**		
Contraceptive Drugs and Devices	Covered as required by ACA and NYS law and/or regulation whichever provides the higher level of benefit	**NA**	**IHA-PR2000**	**Pending**	**No copayment**	**Unlimited**	**No**		

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Rehabilitative Care, Physical, Speech & Occupational Therapy									
Inpatient Rehabilitative Care		**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 16, 17**	**NA**	**Pending**	**No copayment**	**45 max days**	**No**		
Outpatient Rehabilitative Care		**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 13**	**NA**	**Pending**	**$20/visit**	**Max 20 visits combined per year**	**No**		

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Mental Health/Substance Abuse									
Outpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 17**	**NA**	**Pending**	**Adult: $10/visit Child: $0/visit**	**Unlimited**	**Yes, $10 for adults**		
Inpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 17**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 14**	**NA**	**Pending**	**Adult: $10/visit Child: $0/visit**	**Unlimited**	**Yes, $10 for adults**		
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS laws and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 17**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 17**	**NA**	**Pending**	**Adult: $10/visit Child: $0/visit**	**Unlimited**	**Yes, $10 for adults**		
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation.	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 17**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		
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		**NA**	**IHA-PR2000**	**Pending**	**Adult: $5 Tier 1 (most) / $30 Tier 2 / $60 Tier 3 Child: $0 Tier 1 (most) / $30 Tier 2 / $60 Tier 3**	**30-day supply 90-day supply (mail order)**	**No**	**$135.48**	**$339.05**

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Other									
Diabetic Supplies	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 14, 15**	**NA**	**Pending**	**$10**	**Up to a 90 day supply**	**Yes, copay now $10 was $20**		
Oral Agents and Insulin	Covered as required by Federal and NYS law and/or regulation	**IHA-C2000 IHA-SB2003 Section XXVII: Pgs. 15**	**NA**	**Pending**	**$10 or Rx Copay, whichever is less**	**Up to a 90 day supply**	**Yes, office visit copay changed to $10 from $20**		
Diabetic Shoes		**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 16**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		
Durable Medical Equipment (DME)	Medically necessary DME which can with- stand repeated use & primarily used to serve a medical purpose must be covered. Examples include but not limited to: wheelchairs, walkers, respiratory equip, oxygen supplies, replacements, repairs & maintenance, not provided for under manufacturer's warranty or purchase agreement must be covered when functionally necessary.	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 16**	**NA**	**Pending**	**50% coinsurance**	**Unlimited**	**No**		

Independent Health

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
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 replace- ments, artificial joints, external breast prostheses & Ostomy Supplies. Replacements, repairs and maintenance, not provided for under manufacturer's warranty or purchase agreement must be covered when functionally necessary	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 16**	**NA**	**Pending**	**External: 20% coinsurance** **Internal: Included as part of inpatient Hospital Service cost-sharing**	**Unlimited**	**No**		
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.	**IHA-C2000 IHA-SB2003 Section XXVII: Pg. 16**	**NA**	**Pending**	**No copayment**	**Unlimited**	**No**		

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HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Additional Benefits		IHA-C2000 IHA-SB2003 Section XXVII: Pg. 18	NA	Pending	$400 allowance per plan year	$400 allowance per plan year	No		

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ATTACHMENT 36

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Medicare Benefits Charts
"Health Maintenance Organizations
Specifications for the New York State Health Insurance Program"

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Office Visit		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 99	NA	Pending	$20/visit	Unlimited	No	
Specialty Office Visit		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 99	NA	Pending	$20/visit	Unlimited	No	
Chiropractic Care		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 72	NA	Pending	$20/visit	Unlimited	No	
Inpatient Hospital Care	Not subject to deductibles, copays or coinsurance	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 84	NA	Pending	No Copayment	Unlimited days when deemed medically necessary	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Surgery (include all settings - Physician-Inpatient , Physician-Outpatient (at a hospital, facility or surgery center), Physician's Office, Outpatient Surgery Facility		H3362-801 H3362-G1116 Chapter 4 Section 2.1 OV - Page 99 O/P Hosp & ASC Page 95	NA	Pending	$20 copay for office based surgery $75 copay at an Ambulatory Surgery Center or Oupatient Hospital Facility $0 copay when inpatient	Unlimited	No	
Skilled Nursing Facilities		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 106	NA	Pending	No Copayment	Up to 100 days per benefit period	No	
Hospice Benefits		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 82	NA	Pending	Covered by Medicare	Unlimited	No	
Emergency Room		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 77	NA	Pending	$65/visit waived if admitted	Unlimited	No	
Urgent Care Facility		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 109	NA	Pending	$35/visit	Unlimited	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Ambulance indicate both Non-airborne & Airborne		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 68	NA	Pending	Ground Ambulance $100 per trip Air Ambulance 20% coinsurance	Unlimited	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgical Settings								
Radiology		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 92	NA	Pending	$20/visit	Unlimited	No	
Lab Tests		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 93	NA	Pending	$0 copay for lab test 20% coinsurance for genetic testing	Unlimited	No	
Pathology		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 92	NA	Pending	No Copayment	Unlimited	No	
EKG/EEG		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Pages 88, 94	NA	Pending	$20/visit	Unlimited	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Radiation/ Chemotherapy		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 93	NA	Pending	Radiation: $20 per visit Chemotherapy: $20 per office visit Outpatient Hospital & Ambulatory Surgical Centers: $20/visit Chemotherapy Drugs: 10% coinsurance	Unlimited	No	
Women's Health Care/OB GYN								
Pap Tests		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 71	NA	Pending	No Copayment	All preventive services are covered according to CMS and USPSTF frequency guidelines	No	
Mammograms		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 70	NA	Pending	No Copayment	All preventive services are covered according to CMS and USPSTF frequency guidelines	No	
Bone Mineral Density Measurements & Tests		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 70	NA	Pending	No Copayment	All preventive services are covered according to CMS and USPSTF frequency guidelines	No	
Pre- and Post Natal Visits	Covered as required by Federal and NYS law and/or regulation	Pre-natal and Post-natal test not specified in the EOC	NA	Pending	$20/visit	Covers the mother Baby is not covered under CMS regulations	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling	Family Planning Services are not specified in the EOC	NA	Pending	$0 Copay for Lab Tests Examinations & Counseling: $20/visit	Unlimited	No	
Infertility Services	Covered as required by Federal and NYS law and/or regulation	Fertility Services are not specified in the EOC	NA	Pending	$20/office visit	We follow CMS guidelines and cover fertility services when the guidelines are met. Fertility drugs are not covered	No	
Contraceptive Drugs and Devices		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 116	NA	Pending	Contraceptive Devices are not covered. Contraceptive drugs shown on the formulary are covered with applicable tier copayment	Unlimited	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Rehabilitative Care, Physical, Speech & Occupational Therapy								
Inpatient Rehabilitative Care		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 84	NA	Pending	No Copayment	Unlimited	No	
Outpatient Rehabilitative Care		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 98	NA	Pending	$20/visit	Unlimited	No	
Mental Health/Substance Abuse								
Outpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 97	NA	Pending	$40/visit	Unlimited	No	
Inpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 86	NA	Pending	No Copayment	Maximum of 190 days per lifetime	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)	Medicare Advantage is not subject to this regulation	Medicare Advantage is not subject to this regulation	Medicare Advantage is not subject to this regulation	Medicare Advantage is not subject to this regulation	Medicare Advantage is not subject to this regulation	Medicare Advantage is not subject to this regulation	
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS law and/or regulation	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 84	NA	Pending	No Copayment	Unlimited	No	
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 98	NA	Pending	$40/visit	Unlimited	No	
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 84	NA	Pending	No Copayment	Unlimited	No	

Offeror name:

HMO BENEFITS FOR 2021 - Medicare Advantage Plan

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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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
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		H3362-801 H3362-G1116 Chapter 6 Section 5.2 Page 150	NA	Pending	Tier 1: $0 Tier 2: $15 Tier 3: $30 Tier 4: $50 Tier 5: $50 copays for a 30-day supply	90-day supply of Tier 1 - 4 drugs is 2.5x the 30-day copay. See formulary for tiers Unlimited when medically necessary	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Other								
Diabetic Supplies		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 74	NA	Pending	No Copayment	Limited to one 30-day or 90-day supply at a time	No	
Oral Agents and Insulin		H3362-801 H3362-G1116 Chapter 6 Section 5.2 Page 74 See Drug Formulary	NA	Pending	Based on Part D tier. Please refer to formulary	90-day supply of Tier 1 - 4 drugs is 2.5x the 30-day copay. See formulary for tiers Unlimited when medically necessary	No	
Diabetic Shoes		H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 76	NA	Pending	No Copayment	One pair per year and two pairs of inserts when medically necessary	No	
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.	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 76	NA	Pending	20% Coinsurance per covered item	Unlimited	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
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.	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Internal: Page 89 External: Page 103	NA	Pending	Internal Prosthetics: No copayment External Prosthetics: 20% coinsurance	Unlimited	No	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		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.	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 103	NA	Pending	No Copayment	Excludes shoe inserts	No	
Additional Benefits	Hearing Aids and Hearing Aid Evaluation Exam	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 80	NA	Pending	$45 copay for Hearing Aid Evaluation Exam Hearing Aid copays: $499; $799; $999; $1,499 and $2,799 per hearing aid.	Unlimited	Yes, we have a new vendor - American Hearing Benefits - so members will have more choices	
Additional Benefits	Telemedicine and Teladoc	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 100	NA	Pending	Teladoc: $20 copay Telemedicine: The copay is the same as a face-to-face visit	Telemedicine is limited to network providers. Covered services are: PT/OT/ST PCP & Specialist visits O/P Mental Healthcare and Substance Abuse Kidney Disease Education Diabetic Self-management Training	No The member cost sharing remains the same. This gives more ways to access care	

Offeror name:

HMO BENEFITS FOR 2021 - 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 2020 Enter: Yes/No and change, e.g., $5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Additional Benefits	Vision	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 110	NA	Pending	$20 routine eye exam	1 routine eye exam per year Increasing eyewear allowance from $150 to $200 per year	Yes, the eyewear allowance is better	
Additional Benefits	Fitness Benefit	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 79	NA	Pending	No Copayment	Must use a Silver Sneakers participating facility, avaialble nationwide, or Silver Sneakers online programs	Yes, Silver Sneakers is a new vendor	
Additional Benefits	Preventive Dental	H3362-801 H3362-G1116 Chapter 4 Section 2.1 Page 73	NA	Pending	$20/visit	Covers Oral Exam, Cleaning, X-rays and Fluoride Treatments twice a year and a whole mouth x-ray every 36 months	No	

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5.2 Member Communication Material Requirements

The Offeror must:

1. Submit drafts of the Cover Letter for the Member communications materials mailing to HMO Members, federally mandated Summary of Benefits and Coverage (SBC) and Schedule of Benefits, in both hard copies and PDF with their Proposals. In addition, those HMOs that participated in NYSHIP in 2020 are required to submit drafts of the Side by Side Comparison of Benefits in both hard copies and PDF with their Proposals. HMOs that did not participate in NYSHIP in 2020 will not be required to furnish the Side by Side Comparison with their Proposals.

   Please refer to the following documents located in Section 5.2 Member Communication Material Requirements of this submission:

   - **Cover Letter_Commercial**
   - **Cover Letter_Medicare**
   - **Summary of Benefits and Coverage (SBC)_with Rx_DRAFT**
   - **Summary of Benefits and Coverage (SMC)_without Rx_DRAFT**
   - **Summary of Benefits_Medicare_DRAFT**
   - **Side by Side Comparison of Benefit Changes from 2020 to 2021_Commercial**
   - **Side by Side Comparison of Benefit Changes from 2020 to 2021_Medicare**
   - **Side by Side Comparison of Commercial Plan Benefits to Medicare Advantage Plan Benefits for 2021**

   The Schedule of Benefits for the Commercial plan can be found on Independent Health's pages 119 - 136 in the Certificate of Coverage document located in Section 5.2 Member Communication Material Requirements of this submission.

   The Schedule of Benefits for the Medicare plan can be found on Independent Health's pages 231 - 287 in the Evidence of Coverage document located in Section 5.2 Member Communication Material Requirements of this submission.

2. The Offeror must provide a list of wellness programs/activities held or scheduled for 2020 and a summary of planned activities for 2021 using the Wellness Programs/Activities chart (Attachment 15).

   Independent Health is dedicated to improving the health and well-being of the Western New York community. Through partnerships with various local organizations, it is able to promote the importance of healthy choices and offer a number of free or low-cost opportunities for the community to become more engaged in their own health.

   Please refer to the Wellness Programs/Activities Chart (Attachment 15), as well as 2019 Health Fairs and Events (Attachment 20) **documents located in Section 5.2 member Communication Material Requirements of this submission.**

   Members can also visit independenthealth.com/events for more information on Independent Health's upcoming programs and events.

3. The Offeror must provide a list of its current five largest employer groups in descending order by number of contracts using the *Current Five Largest Employer Groups* chart (Attachment 16).

   Please refer to the Current Five Largest Employer Groups (Attachment 16) **document located in Section 5.2 member Communication Material Requirements of this submission.**

4. Federally required Summary of Benefits and Coverage (SBC) for the proposed benefit package offered through NYSHIP. If the final 2021 SBC is not available for inclusion with this submission, please submit a draft version and advise when it is expected to be finalized. A finalized SBC must be submitted as soon as it is available, but no later than October 1, 2020.

   Confirmed. Independent Health has provided a draft version of the Summary of Benefits and Coverage for the proposed 2021 benefit package offered through NYSHIP.

   Please refer to the Summary of Benefits and Coverage (SBC)_with Rx_DRAFT, as well as the Summary of Benefits and Coverage (SBC)_without Rx_DRAFT **documents located in Section 5.2 member Communication Material Requirements of this submission. Final SBC's will be sent to the Department of Civil Service prior to October 1, 2020.**

5. Additional Member Communication Materials to Members for 2021 – Cover Letters, Marketing Materials. Refer to Section 3.6 of these Specifications for specific details. To ensure all Members have plan information prior to the NYSHIP Option Transfer Period, HMOs must submit confirmation to the Department that all Required Communications Materials have been mailed to Members by October 21, 2020.

   Confirmed. Independent Health has provided additional member communication materials to members for 2021 in its submission. Additional Member Communications will be sent to all members by October 21, 2020.

   Please refer to the following documents located in Section 5.2 Member Communication Material Requirements of this submission:

   - **Cover Letter_Commercial**
   - **Cover Letter_Medicare**
   - **Summary of Benefits and Coverage (SBC)_with Rx_DRAFT**
   - **Summary of Benefits and Coverage (SMC)_without Rx_DRAFT**
   - **Summary of Benefits_Medicare_DRAFT**
   - **Side by Side Comparison of Benefit Changes from 2020 to 2021_Commercial**
   - **Side by Side Comparison of Benefit Changes from 2020 to 2021_Medicare**
   - **Side by Side Comparison of Commercial Plan Benefits to Medicare Advantage Plan Benefits for 2021**

   The Schedule of Benefits for the Commercial plan can be found on Independent Health's pages 119 - 136 in the Certificate of Coverage document located in Section 5.2 Member Communication Material Requirements of this submission.

   The Schedule of Benefits for the Medicare plan can be found on Independent Health's pages 231 - 287 in the Evidence of Coverage document located in Section 5.2 Member Communication Material Requirements of this submission.

6. Choices Page, for both Commercial and Medicare Advantage Plans, as applicable. HMOs will have ten business days to complete their HMO e-page(s), after which time, access will be denied. All HMOs submitting Proposals will be required to access a Department online data interface (HMO ePage) through which plan benefit details will be electronically submitted to the Department. Additionally, HMOs are required to print a hard copy of their Choices page information from the database and submit it with their Proposal. This process will enable the Department to implement their online health benefit plan comparison tool. [**Note:** HMOs will ONLY be granted access to the Department's online data interface with their ePage if they have completed and submitted an affirmative *Notice of Intent* (Attachment 28) to participate in the 2021 NYSHIP plan year. The *Notice of Intent* will only be considered valid if it is sent to both the Department and the *JLMC Contact Members* (Attachment 13).]

   HMOs that participate in NYSHIP during 2020 will be able to edit selected fields of their 2021 Choices page content in the electronic templates to accurately describe plan benefits for the 2021 Plan Year. HMOs that did not participate in NYSHIP during 2020 will access blank electronic templates to electronically submit their Choices page information.

   The Department's Communications Unit will use the electronic information submitted by each HMO to format a version of their pages for the Choices guide. HMOs will receive copies of their final Choices pages for sign off for accuracy via e-mail from the Communications Unit. Benefits described on an HMO's Choices pages will be binding upon such HMO, even in the event of erroneous oversight during such review.

   Please refer to the Choices Page_Commercial, as well as the Choices Page_Medicare **documents located in Section 5.2 Member Communication Material Requirements of this submission.**

   Please refer to the Notice of Intent (Attachment 28) **located in Section 5.2 Member Communication Material Requirements of this submission.**

7. Schedule of Benefits required for Commercial Plan and Medicare Advantage Plan enrollees, if applicable. [Note: If this is part of the Offeror's Certificate of Coverage and/or Evidence of Coverage, indicate page numbers where this information can be found].

   Confirmed.

   The Schedule of Benefits for the Commercial plan can be found on Independent Health's pages 119 - 136 in the Certificate of Coverage document located in Section 5.2 Member Communication Material Requirements of this submission.

   The Schedule of Benefits for the Medicare plan can be found on Independent Health's pages 231 - 287 in the Evidence of Coverage document located in Section 5.2 Member Communication Material Requirements of this submission.

8. Side by Side Comparison of Benefit Changes 2020 to 2021 (document must be titled as such) identifying changes from 2020 (current year) to 2021 (upcoming year) for Commercial Plan and Medicare Advantage Plan Enrollees, if applicable. In the event there are no changes in the benefits offered, the HMO is required to mail an affirmative statement to Members confirming that there are no changes from the previous year; a copy of the statement of "no change" should be included in this submission, if applicable. This requirement is only for HMOs that participated in NYSHIP in 2020. See *SAMPLE Side-by-Side Comparison* (Attachment 25).

   Please refer to the following documents located in Section 5.2 Member Communication Material Requirements of this submission:

   - **Side by Side Comparison of Benefit Changes from 2020 to 2021_Commercial**
   - **Side by Side Comparison of Benefit Changes from 2020 to 2021_Medicare**
   - **Side by Side Comparison of Commercial Plan Benefits to Medicare Advantage Plan Benefits for 2021**

9. Listing of Certificate/Group Contract, Riders and/or Amendments (see SAMPLE Contract and Rider Summary (Attachment 30)). Include both Commercial HMO and Medicare Advantage Plan documents.

   Please refer to the Listing of Certificate/Group Contract, Riders and/or Amendment (Attachment 30) **document located in Section 5.2 Member Communication Material Requirements of this submission.**

October 2020

Dear New York State Employee:

Thank you for your membership with Independent Health. As a member of Independent Health, you have access to top quality products and services that have earned us recognition by nationally respected organizations.

We are pleased to announce that there will be benefit enhancements effective January 1, 2021 to your benefit plan. Please see the enclosed side by side comparison and benefit summary for more detail.

Please note, your Eligibility Guidelines may be different from those guidelines listed in the Certificate of Coverage. Please refer to your NYSHIP General Information Book for these guidelines or visit the New York State Department of Civil Service's web site at www.cs.ny.gov.

When it comes to seeking care, we have you covered – whether you are in Western New York or across the country. Independent Health contracts directly with more than 98% of Western New York providers.* Many of our providers offer Telehealth services so you can continue to see your network provider from anywhere in the country. Members also have access to all Western New York hospitals, labs, pharmacies, and emergency/urgent care centers worldwide.

As part of your open enrollment time, we are providing you with the enclosed benefit summary so you may review your benefits for the coming year. If you have any questions regarding your Independent Health coverage, please contact us at (716) 631-8701 or (800) 501-3439, Monday through Friday, from 8:00 a.m. to 8:00 p.m. Thank you for choosing Independent Health for your health coverage needs.

Sincerely,

Joel Marinaccio
Senior Strategic Account Manager

* New York State Office of the Professions data and Independent Health contracted physicians. Data subject to change without notification.

October 2020

Dear New York State Retiree:

Thank you for your membership with Independent Health's Medicare Advantage Plan. As a member of Independent Health, you have access to top quality products and services that have earned us recognition by nationally respected organizations.

We are pleased to announce that there will be benefit enhancements effective January 1, 2021 to your benefit plan. Please see the benefit summary and side by side comparison for more detail.

When it comes to seeking care, we have you covered – whether you are in Western New York or across the country. Independent Health contracts directly with more than 98% of Western New York providers.* Many of our providers offer telehealth services so you can continue to see your network provider from anywhere in the country. Members also have access to all Western New York hospitals, labs, pharmacies, and emergency care anywhere in the world.

Please note, your Eligibility Guidelines may be different from those guidelines listed in your Evidence of Coverage. Please refer to your NYSHIP General Information Book for these guidelines or visit the New York State Department of Civil Service's web site at www.cs.ny.gov. Medicare eligibility guidelines are established by CMS. Eligibility requirements can be reviewed at https://www.medicare.gov/eligibilitypremiumcalc/

As part of your open enrollment information, we are providing you with the enclosed benefit summary so you may review your benefits for the coming year. If you have any questions regarding your Independent Health coverage, please contact us at (716) 250-4401or (800) 665-1502, (TTY:711) Monday through Sunday, from 8:00 a.m. to 8:00 p.m. Thank you for choosing Independent Health for your health coverage needs.

Sincerely,

Joel Marinaccio
Senior Strategic Account Manager

* New York State Office of the Professions data and Independent Health contracted physicians. Data subject to change without notification.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-501-3439 or visit www.independenthealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.independenthealth.com or call 1-800-501-3439 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual and Family: $0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, preventive care and other major categories of service, as identified in the SBC, are not subject to deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 Individual/$8,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalty amounts, and non-covered services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.independenthealth.com or call 1-800-501-3439** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Adult: $10 copay / visit Child: $0 copay / visit	Not Covered	---None---
	Specialist visit	$20 copay / visit	Not Covered	---None---
	Preventive care/screening/immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Office: $20 copay / visit Hospital: $40 copay / visit; Blood work: $0 copay / visit EKG: Adult: $10 copay / visit Child: $0 copay / visit	Not Covered	Authorization may be required.
	Imaging (CT/PET scans,MRIs)	Office: $20 copay / visit Hospital: $40 copay / visit	Not Covered	Authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.independenthealth.com	Preferred Generic Drugs (Tier 1)	Adult: $5 Child: $0	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
	Non-Preferred Generic Drugs (Tier 2)	$30	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
	Non-Preferred Brand Name Drugs (Tier 3)	$60	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay / visit	Not Covered	Authorization may be required
	Physician/surgeon fees	$0 copay / visit	Not Covered	Authorization may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay / visit	$100 copay / visit	Waived if admitted
	Emergency medical transportation	$100 copay / trip	$100 copay/trip	Must be deemed medically necessary
	Urgent care	Adult: $35 copay / visit Child: $0 copay / visit	Not Covered	Coverage based on Participating After Hours Care Centers
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copay / admission	Not Covered	Semi-private room, per admission Authorization may be required
	Physician/surgeon fees	$0 copay / visit	Not Covered	Authorization may be required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / visit	Not Covered	---None---
	Inpatient services	$0 copay / admission	Not Covered	Semi-private room, per admission Authorization may be required
If you are pregnant	Office visits	$0 copay / visit	Not Covered	No charge after the initial diagnosis
	Childbirth/delivery professional services	Physician: No charge	Physician: Not Covered	Semi-private room, per admission
	Childbirth/delivery facility services	Delivery: $0 copay / admission	Delivery: Not Covered	Semi-private room, per admission
If you need help recovering or have other special health needs	Home health care	$20 copay / visit	Not Covered	Up to 40 visits per contract year Authorization may be required
	Rehabilitation services	$20 copay / visit	Not Covered	Up to 20 visits per contract year
	Habilitation services	$20 copay / visit	Not Covered	Up to 20 visits per contract year
	Skilled nursing care	$0 copay / admission	Not Covered	Semi-private room, per admission Up to 45 days per contract year Authorization may be required
	Durable medical equipment	50% coinsurance	Not Covered	Authorization may be required
	Hospice services	$0 copay / admission	Not Covered	---None---
If your child needs dental or eye care	Children's eye exam	$0 copay / visit	Not Covered	One routine exam every 12 months
	Children's glasses	Single: $50 Bifocal: $70	Not Covered	Contact EyeMed for additional options at 1-877-842-3348
	Children's dental check-up	Not Covered	Not Covered	---None---

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too,including buying individual insurance through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York at 1-888-614-5400 or http://www.communityhealthadvocates.org/.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace,

Language Access Services:
Please refer to Nondiscrimination statement and language assistance services contained within.

———————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$20

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	$160

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$20

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,460

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$20

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$320

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Independent Health Member Services at 1-800-501-3439.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination statement and language assistance services

English

If you, or someone you're helping, has questions about Independent Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-501-3439.

Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independent Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-501-3439.

Independent Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Chinese

如果您，或是您正在協助的對象，有關於[插入 Independent Health 項目的名稱 Independent Health 方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-501-3439。

Independent Health 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Russian

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Independent Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-501-3439.

Independent Health соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

French Creole

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Independent Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-501-3439.

Nondiscrimination statement and language assistance services (cont'd)

Independent Health konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Korean

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Independent Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-501-3439 로 전화하십시오.

Independent Health은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Italian

Se tu o qualcuno che stai aiutando avete domande su Independent Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-501-3439.

Independent Health è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.

Yiddish

אויב איר, אודר עמצער איר העלפסט, האט פראגעס וועגן, Independent Health איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך
אומזיסט. צו רעדן מיט דער אי'בערזעצער, קלונג 1-800-501-3439

קומט נאך פעדעראלע ציווילע רעכטן גענצן און דיסקרימינירט נישט Independent Health
אויפן באזיס פון ראסע, קאליר, נאציאנאלע אפשטאם, דיסאביליטי, אדער געשלעכט.

Bangala-Bangali

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, সম্পর্কে প্রশ্ন আছে Independent Health, আপনার অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন 1-800-501-3439.

Independent Health প্রযোজ্য ফেডারেল নাগরিক অধিকার আইন মেনে চলে এবং জাতি, রঙ, জাতীয় উৎপত্তি, বয়স, অক্ষমতা, বা লিঙ্গের ভিত্তিতে বৈষম্য করে না।

Nondiscrimination statement and language assistance services (cont'd)

Polish

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Independent Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-501-3439.

Independent Health postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.

Arabic

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص ndependent Health، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-501-3439.

يلتزم Independent Health بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

French

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Independent Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-501-3439.

Independent Health respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Urdu

اگر اپ کسی کو مدد دے رہے ہیں اور اپ دونوں کو سوال ہے Independent Health کے بارے میں، تو اپ دونوں کو اپنی زبان میں مفت مدد اور معالومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، 1-800-501-3439 فون کریں۔

Independent Health قابلِ اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

Nondiscrimination statement and language assistance services (cont'd)

Tagalog

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Independent Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-501-3439.

Sumusunod ang Independent Health sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Greek

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Independent Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-501-3439.

Independent Health συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο.

Albanian

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Independent Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-800-501-3439.

Independent Health vepron në përputhje me ligjet e zbatueshme federale të të drejtave civile dhe nuk ushtron diskriminim mbi baza si raca, ngjyra, prejardhja etnike, mosha, aftësia e kufizuar ose gjinia.

Nondiscrimination statement and language assistance services (cont'd)

Discrimination is Against the Law

Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Independent Health's Member Services Department.

If you believe that Independent Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 1-800-432-1110, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-501-3439 or visit www.independenthealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.independenthealth.com or call 1-800-501-3439 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual and Family: $0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, preventive care and other major categories of service, as identified in the SBC, are not subject to deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 Individual/$8,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalty amounts, and non-covered services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.independenthealth.com or call 1-800-501-3439** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Adult: $10 copay / visit Child: $0 copay / visit	Not Covered	---None---
	Specialist visit	$20 copay / visit	Not Covered	---None---
	Preventive care/screening/immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Office: $20 copay / visit Hospital: $40 copay / visit; Blood work: $0 copay / visit EKG: Adult:$10 copay / visit Child: $0 copay / visit	Not Covered	Authorization may be required.
	Imaging (CT/PET scans,MRIs)	Office: $20 copay / visit Hospital: $40 copay / visit	Not Covered	Authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.independenthealth.com	Preferred Generic Drugs (Tier 1)	Not Covered	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
	Non-Preferred Generic Drugs (Tier 2)	Not Covered	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
	Non-Preferred Brand Name Drugs (Tier 3)	Not Covered	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay / visit	Not Covered	Authorization may be required
	Physician/surgeon fees	$0 copay / visit	Not Covered	Authorization may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay / visit	$100 copay / visit	Waived if admitted
	Emergency medical transportation	$100 copay / trip	$100 copay/trip	Must be deemed medically necessary
	Urgent care	Adult: $35 copay / visit Child: $0 copay / visit	Not Covered	Coverage based on Participating After Hours Care Centers
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copay / admission	Not Covered	Semi-private room, per admission Authorization may be required
	Physician/surgeon fees	$0 copay / visit	Not Covered	Authorization may be required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / visit	Not Covered	---None---
	Inpatient services	$0 copay / admission	Not Covered	Semi-private room, per admission Authorization may be required
If you are pregnant	Office visits	$0 copay / visit	Not Covered	No charge after the initial diagnosis
	Childbirth/delivery professional services	Physician: No charge	Physician: Not Covered	Semi-private room, per admission
	Childbirth/delivery facility services	Delivery: $0 copay / admission	Delivery: Not Covered	Semi-private room, per admission
If you need help recovering or have other special health needs	Home health care	$20 copay / visit	Not Covered	Up to 40 visits per contract year Authorization may be required
	Rehabilitation services	$20 copay / visit	Not Covered	Up to 20 visits per contract year
	Habilitation services	$20 copay / visit	Not Covered	Up to 20 visits per contract year
	Skilled nursing care	$0 copay / admission	Not Covered	Semi-private room, per admission Up to 45 days per contract year Authorization may be required
	Durable medical equipment	50% coinsurance	Not Covered	Authorization may be required
	Hospice services	$0 copay / admission	Not Covered	---None---
If your child needs dental or eye care	Children's eye exam	$0 copay / visit	Not Covered	One routine exam every 12 months
	Children's glasses	Single: $50 Bifocal: $70	Not Covered	Contact EyeMed for additional options at 1-877-842-3348
	Children's dental check-up	Not Covered	Not Covered	---None---

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too,including buying individual insurance through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York at 1-888-614-5400 or http://www.communityhealthadvocates.org/.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace,

Language Access Services:
Please refer to Nondiscrimination statement and language assistance services contained within.

———————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$20

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	$160

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$20

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,460

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other copayment	$20

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$320

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Independent Health Member Services at 1-800-501-3439.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination statement and language assistance services

English

If you, or someone you're helping, has questions about Independent Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-501-3439.

Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independent Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-501-3439.

Independent Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Chinese

如果您，或是您正在協助的對象，有關於[插入 Independent Health 項目的名稱 Independent Health 方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-501-3439。

Independent Health 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Russian

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Independent Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-501-3439.

Independent Health соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

French Creole

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Independent Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-501-3439.

Nondiscrimination statement and language assistance services (cont'd)

Independent Health konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Korean

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Independent Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-501-3439 로 전화하십시오.

Independent Health은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Italian

Se tu o qualcuno che stai aiutando avete domande su Independent Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-501-3439.

Independent Health è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.

Yiddish

אויב איר, אודר עמצער איר העלפסט, האט פראגעס וועגן, Independent Health איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך
אומזיסט. צו רעדן מיט דער אי'בערזעצער, קלונג 1-800-501-3439

קומט נאך פעדעראלע ציווילע רעכטן גענצן און דיסקרימינירט נישט Independent Health
אויפן באזיס פון ראסע, קאליר, נאציאנאלע אפשטאם, דיסאביליטי, אדער געשלעכט.

Bangala-Bangali

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, সম্পর্কে প্রশ্ন আছে Independent Health, আপনার অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন 1-800-501-3439.

Independent Health প্রযোজ্য ফেডারেল নাগরিক অধিকার আইন মেনে চলে এবং জাতি, রঙ, জাতীয় উৎপত্তি, বয়স, অক্ষমতা, বা লিঙ্গের ভিত্তিতে বৈষম্য করে না।

Nondiscrimination statement and language assistance services (cont'd)

Polish

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Independent Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-501-3439.

Independent Health postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.

Arabic

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص ndependent Health، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-501-3439.

يلتزم Independent Health بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

French

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Independent Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-501-3439.

Independent Health respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Urdu

اگر اپ کسی کو مدد دے رہے ہیں اور اپ دونوں کو سوال ہے Independent Health کے بارے میں، تو اپ دونوں کو اپنی زبان میں مفت مدد اور معالومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، 1-800-501-3439 فون کریں۔

Independent Health قابلِ اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

Nondiscrimination statement and language assistance services (cont'd)

Tagalog

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Independent Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-501-3439.

Sumusunod ang Independent Health sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Greek

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Independent Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-501-3439.

Independent Health συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο.

Albanian

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Independent Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-800-501-3439.

Independent Health vepron në përputhje me ligjet e zbatueshme federale të të drejtave civile dhe nuk ushtron diskriminim mbi baza si raca, ngjyra, prejardhja etnike, mosha, aftësia e kufizuar ose gjinia.

Nondiscrimination statement and language assistance services (cont'd)

Discrimination is Against the Law

Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Independent Health's Member Services Department.

If you believe that Independent Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 1-800-432-1110, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

2021 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Medicare Encompass B HMO (HMO)

January 1, 2021 – December 31, 2021

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 Medicare Encompass B HMO).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what Medicare Encompass B 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 Medicare Encompass B 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 Medicare Encompass B HMO

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. Eastern Time, 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m. Eastern Time, Monday through Friday.
- If you are a member of this plan, call us at 1-800-665-1502, TTY: 711.
- If you are not a member of this plan, call us at 1-800-958-4405, TTY: 711.
- Our website: http://www.independenthealth.com/medicare.

Who can join?

To join Medicare Encompass B 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?

Medicare Encompass B 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 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: 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 Medicare Encompass B HMO	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	You pay a monthly plan premium of $628.72 (2020 rate) for Medicare Encompass B HMO. You must continue to pay your Medicare Part B premium. Your premium amount may be less than this. Please contact your plan benefit administrator or review your rate card for your premium.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $3,450 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.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	In-Network: $0 Copay per stay May require prior authorization.
Ambulatory Surgical Center	In-Network: Ambulatory Surgical Center: $75 Copay. May require prior authorization.
Outpatient Hospital	In-Network: Outpatient hospital: $75 Copay. Outpatient Surgery: $75 Copay. May require prior authorization.
Doctor's Office Visits	In-Network: Primary care physician visit: $20 Copay. Specialist visit: $20 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.

SECTION II - SUMMARY OF BENEFITS Medicare Encompass B HMO	
Emergency Care	In-Network: $65 Copay per visit. If you are admitted to the hospital within 24 hours, your emergency care copay is waived.
Urgently Needed Services	In-Network: $35 Copay per visit.
Diagnostic Services / Labs/ Imaging	In-Network: Diagnostic tests and procedures: $20 Copay. Lab services: $0 Copay - 20% Coinsurance for genetic testing. Diagnostic Radiology Services (such as MRI, CAT Scan): $20 Copay. X-rays: $20 Copay. Therapeutic radiology services (such as radiation treatment for cancer): $20 Copay. May require prior authorization.
Hearing Services	In-Network: Exam to diagnose and treat hearing and balance issues: $20 Copay. Routine hearing exam: $20 Copay. Hearing Aid: $499 - $2,799 Copay per hearing aid. You must use an American Hearing Benefits network provider
Dental Services	In-Network: Medicare Covered: $20 Copay. Preventive dental services: $20 Copay per visit • Oral exam (up to 2 visits per year). • Cleaning (up to 2 visits per year). • Dental X-rays (up to 2 visits per year) • Fluoride Treatments (up to 2 visits per year)
Vision Services	In-Network: Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $20 Copay. Routine eye exam (up to 1 visit): $0 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay.

SECTION II - SUMMARY OF BENEFITS Medicare Encompass B HMO	
	Our plan pays up to $200 for Eyeglasses (frames and lenses) and/or Contact Lenses annually
Mental Health Care	In-Network: Outpatient group therapy visit: $40 Copay. Individual therapy visit: $40 Copay. Inpatient Mental Health Care: $0 Copay per stay
Skilled Nursing Facility (SNF)	In-Network: $0 Copay per stay May require prior authorization.
Outpatient Rehabilitation	In-Network: Occupational therapy visit: $20 Copay. Physical therapy and speech and language therapy visit: $20 Copay.
Ambulance	In-Network: Ground Ambulance: $100 Copay. Air Ambulance: 20% Coinsurance.
Transportation	In-Network: Not Covered.
Medicare Part B Drugs	In-Network: For Part B drugs such as chemotherapy drugs: 10% Coinsurance. Other Part B drugs: 10% Coinsurance. May require prior authorization.
PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: Not Applicable.
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. Standard Retail Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0.00	$0.00
Tier 2 (Non-Preferred Generic)	$15.00	$37.50

SECTION II - SUMMARY OF BENEFITS

Medicare Encompass B HMO

Tier 3 (Preferred Brand)	$30.00	$75.00
Tier 4 (Non-Preferred Drug)	$50.00	$125.00
Tier 5 (Specialty Tier)	$50.00	Not Applicable

Standard Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	Not Applicable	$0.00
Tier 2 (Non-Preferred Generic	Not Applicable	$37.50
Tier 3 (Preferred Brand)	Not Applicable	$75.00
Tier 4 (Non-Preferred Drug)	Not Applicable	$125.00
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

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.

Generic Drugs: You pay the lesser of:	Your Tiered Copay -OR- 25% of the cost of the drug
Brand Drugs: You pay the lesser of:	Your Tiered Copay -OR- 25% of the cost of the drug

Our plan covers Tier 1 in the coverage gap.

Catastrophic Amount

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

Generic Drugs: You pay the lesser of:	Your Tiered Copay -OR- The greater of 5% or $3.70
Brand Drugs: You pay the lesser of:	Your Tiered Copay -OR- The greater of 5% or $9.20

DISCLAMERS

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 1-800-958-4405 (TTY: 711).

Medicare Encompass B HMO is a HMO plan with a Medicare contract. Enrollment in Medicare Encompass B HMO 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 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 1-800-665-1502 (TTY 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

- ☐ 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, 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).

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Independent Health
Side-by-Side Comparison of Benefit Changes 2020 to 2021
NYSHIP Primary

Modified Change	2020	2021
Cover Preventive Rx	Applicable Copay Applied	$0 Copay
Prosthetics & Appliances	Covered in Full	20% Coinsurance
Primary Care Office Copay Adult	Adult: $20 Copay	Adult: $10 Copay
Laboratory Services	$10 Copay	$0 Copay
Hearing Aid Discount Program (Vendor Change)	TruHearing	American Hearing
Teladoc – General Medicine & Behavioral Health	$0 Copay	Adult: $10 Copay
Refractive Eye Exam	$10 Copay	$0 Copay
Habilitation Services		
Inpatient	Not Covered	$0 Copay for up to 45 days
Outpatient	Not Covered	$20 Copay for up to 20 Visits

Independent Health
Side-by-Side Comparison of Benefit Changes 2020 to 2021
NYSHIP Medicare Primary

Modified Change	2020	2021
Routine Eyewear Allowance	$150 per year	$200 per year
Annual Out of Pocket Maximum	$3,400	$3,450
Hearing Aid Benefit – Vendor Change	TruHearing	American Hearing Benefits
Member cost for the covered models, per hearing aid	$699 $999	$499 $799 $999 $1,499 $2,799
Fitness/Gym Membership	Healthy Benefits Approx. 100 locations $0 copay	Silver Sneakers Over 15,000 locations $0 copay
Dialysis Copay	$0	20% coinsurance