Independent Health's Encompass 65® Basic (HMO) offered by Independent Health

Annual Notice of Changes for 2021

Important Plan Information

H3362_017 H3362_C7571_M E65 BASIC

INDEPENDENT HEALTH'S

2021 Evidence of Coverage (EOC)

Your EOC will not be mailed to you this year. Your EOC will be available no later than October 15th. You can access your EOC one of three ways.

1. Visit IndependentHealth.com/Medicare and click on "View 2021 Plans"

- Refer to the front of your Annual Notice of Change (ANOC) booklet to find the name of your plan.
- Find your plan name and click "Learn More".
- Under "Plan Details" click on "Annual Notice of Change/Evidence of Coverage."

– You can download and save the document or print a copy for your records.

2. Create a secure account to view your EOC online:

- Visit IndependentHealth.com/Register.
- Have your member ID card handy during setup, as you will need to provide your member ID number to register.
- Choose a username and password – and then use it to sign into your account whenever you visit us online.
- Once you have registered and logged in, click on "Documents" to view your ANOC and EOC.

Plus, once you have registered, you can select **"Go Paperless"** to receive your ANOC and EOC electronically moving forward, instead of receiving them in the mail. To let us know you would like to go paperless, follow these steps:

- Once you are logged in to your online account, select "Manage Preferences" from the "Go Paperless" section on your account home.
- Under "Paperless Preferences" select "Electronic".

Please note that you always have the option to change your preferences in the future.

3. If you prefer to receive a copy of your EOC by mail, please contact Member Services:

(716) 250-4401 or 1-800-665-1502 (TTY users call 711)

October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.

April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

Or email us at: medicareservice@servicing.independenthealth.com

Independent Health®

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INDEPENDENT HEALTH'S

2021 Medicare Advantage Provider Directories

At Independent Health, we're dedicated to helping you get the right care, at the right time, and in the right setting. That's why we offer a comprehensive network of health care providers, giving you choice and flexibility as to where you receive care.

To help you understand who participates in our network, we've compiled the names of our health care providers and wellness partners into the following directories and listings:

- Independent Health's Medicare Advantage Physician/Provider Directory
- Independent Health's Medicare Advantage Pharmacy Directory
- HealthPlex® Dental Directory (for routine/preventive dental providers)
- EyeMed® "Insight Network" Directory (for routine/refractive eye exam providers)
- SilverSneakers® Fitness Program participating facility listing
- American Hearing Benefits™ participating network provider listing

All of this information is available online at **www.independenthealth.com/Medicare.**

If you prefer to receive a copy by mail, please contact Member Services:

PHONE: (716) 250-4401 or 1-800-665-1502; (TTY users call 711)
October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.
April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.

EMAIL: medicareservice@servicing.independenthealth.com

For the most up-to-date information on our provider listings, call Member Services or use our "Find a Doctor" tool online at **www.independenthealth.com/findadoc.** This tool gives you the option to search for providers or facilities by name, location or specialty, and print your results.

Independent Health

If you need help finding a network provider, please call 1-800-665-1502 or visit www.independenthealth.com/findadoc to access our online, searchable directory. If you would like a provider directory mailed to you, you may call the number above, request one at the website link provided above, or email medicareservice@servicing.independenthealth.com.

Independent Health's Encompass 65® Basic (HMO) offered by Independent Health

Annual Notice of Changes for 2021

You are currently enrolled as a member of Independent Health's Encompass 65 Basic (HMO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2021 Drug List and look in Section 1.6 for information about changes to our drug coverage.

- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Physician/Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2020, you will be enrolled in Independent Health's Encompass 65 Basic (HMO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in Independent Health's Encompass 65 Basic (HMO).

- If you join another plan by **December 7, 2020**, your new coverage will start on **January 1, 2021.** You will be automatically disenrolled from your current plan.

Additional Resources

- Please contact our Member Services number at (716) 250-4401 or 1-800-665-1502 for additional information. (TTY users should call 711). Hours are from October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.; or April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m. Verbal translation of written materials is available via free interpreter services. For those with special needs, accessibility to benefit information or alternate formats of written materials are available upon request.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Independent Health's Encompass 65 Basic (HMO)

- Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Independent Health Association. When it says "plan" or "our plan," it means Independent Health's Encompass 65 Basic (HMO).

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Independent Health's Encompass 65 Basic (HMO) in several important areas. **Please note this is only a summary of changes.** A copy of the *Evidence of Coverage* is located on our website at www.IndependentHealth.com/Medicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Cost	2020 (this year)	2021 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$125	$125
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$7,550
Doctor office visits	Primary care visits: $0 copayment per visit Specialist visits: $30 copayment per visit	Primary care visits: $0 copayment per visit Specialist visits: $30 copayment per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	$275 copayment per day for days 1 through 6. $0 copayment per day for days 7 through 90. Unlimited days for Medicare-covered stays. $1,925 annual copayment limit applies.	$275 copayment per day for days 1 through 6. $0 copayment per day for days 7 through 90. Unlimited days for Medicare-covered stays. $1,925 annual copayment limit applies.

Cost	2020 (this year)	2021 (next year)
Part D prescription drug coverage (See Section 1.6 for details.) To find out which drugs are select insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call Member Services (Phone numbers for Member Services are printed on the back cover of this booklet).	Deductible: $100 on Tiers 3, 4 and 5 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $47 • Drug Tier 4: 40% • Drug Tier 5: 31%	Deductible: $150 on Tiers 3, 4 and 5 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $10 • Drug Tier 3: $40 • Drug Tier 4: 43% • Drug Tier 5: 30% There is no deductible for Independent Health's Encompass 65 Basic (HMO) for select insulins. You pay a $35 copay for select insulins.

Annual Notice of Changes for 2021
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	**$125**	**$125**
Optional Supplemental Comprehensive Dental Benefit Premium (This premium is paid in addition to your monthly premium in our plan and your Medicare Part B premium).	You pay an additional $30 premium per month.	If you enroll in the optional supplemental dental benefit in 2021, your additional premium is $25 per month. This benefit is administered by Healthplex. Call Independent Health Member Services (See Section 7.1) to request an enrollment form. You must enroll in this benefit within 30 days of the effective date of your new plan. If you do not elect to enroll in this optional benefit, this additional premium will not apply to you.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 7 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2020 (this year)	2021 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$7,550 Once you have paid $7,550 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Physician/Provider Directory is located on our website at www.IndependentHealth.com/Medicare. You may also call Member Services for updated provider information or to ask us to mail you a Physician/Provider Directory. **Please review the 2021 Physician/Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.

- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at www.IndependentHealth.com/Medicare. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network.**

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
Diabetic Supplies	You pay $10 copay for lancets and for each 30 day supply of test strips. You pay 20% of the total cost for therapeutic continuous glucose monitors. You pay 20% of the total cost for therapeutic continuous glucose monitor test strips and supplies.	You pay $0 copay for lancets and test strips You pay 0% of the total cost for therapeutic continuous glucose monitor from a network pharmacy. You pay 0% of the total cost for therapeutic continuous glucose monitor supplies from a network pharmacy.

Cost	2020 (this year)	2021 (next year)
		Limited to preferred therapeutic continuous glucose monitors and supplies. These are no longer covered through medical supply or durable medical equipment providers and only covered through network pharmacies.
Fitness Benefit	Healthy Benefits Gym Benefit You pay nothing for this benefit. Must use a participating Healthy Benefits fitness center.	SilverSneakers® You pay nothing for this benefit. SilverSneakers gives you FREE access to: • Thousands of participating fitness center locations nationwide[1] • SilverSneakers Live classes and workshops taught by instructors trained in senior fitness • 200+ workout videos in the SilverSneakers On-Demand™ online library • SilverSneakers GO™ mobile app with digital workout programs • SilverSneakers FLEX®, giving you options to get active outside of traditional gyms (like recreation centers, malls and parks) • Online fitness and nutrition tips You must use participating Silver Sneakers fitness locations and programs. For a list of participating fitness facilities, go to www.silversneakers.com. Or call SilverSneakers (toll free) at 1-888-313-5653 (TTY: 711) or Independent Health Member Services at 800-665-

Cost	2020 (this year)	2021 (next year)
		1502 or 716-250-4401 (TTY: 711) See the Chapter 4 of your Evidence of Coverage for more details. 1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. SilverSneakers and the SilverSneakers shoe logotype are registered trademarks of Tivity Health, Inc. SilverSneakers On-Demand and SilverSneakers GO are trademarks of Tivity Health, Inc. © 2020 Tivity Health, Inc. All rights reserved.
Hearing Aids	You pay $699 minimum copay for this benefit. You pay $999 maximum copay for this benefit. You must use a provider in the TruHearing provider network.	You pay $499 minimum copay for this benefit. You pay $2799 maximum copay for this benefit. You must use a provider in the American Hearing Benefits network. Copayment Structure per hearing aid: $499, $799, $999, $1,499, $2,799. Benefit is limited to preferred hearing aids, which come in various styles and colors. You must see a network provider to use this benefit. Member cannot combine any promotional offers with our Hearing Aid benefit.

Cost	2020 (this year)	2021 (next year)
Home Delivered Meals	You pay a $0 copay for up to 14 meals delivered to the member home for 7 consecutive days following an overnight stay in a hospital or skilled nursing facility. Benefit must be used within 30 days of discharge.	You pay a $0 copay for up to 28 meals delivered to the member home for 14 consecutive days following an overnight stay in a hospital or skilled nursing facility. Benefit must be used within 30 days of discharge.
If you have been diagnosed with diabetes	There is no reduced cost sharing if you have been diagnosed with diabetes.	You pay $0 copay for diabetic lab tests for HbA1c and GFR. You pay $0 copayment for Endocrinologist with diagnosis of Diabetes. You pay $0 copayment for diabetic retinopathy screening. You pay $0 copayment for Specialist administering the screening.
Optional Supplemental Comprehensive Dental (Note: there is an additional $25 monthly premium for Optional Supplemental Comprehensive Dental Benefits)	You pay $0 deductible and 50% of the cost for certain oral exams and dental procedures when you see a Healthplex dental provider. A maximum annual allowance of $2,000 applies. On the first of each quarter (January 1, April 1, July 1 and October 1) members earn $500 of the comprehensive dental benefit. Unused balances will carry over from quarter to quarter but any balance that is not used by December 31st each year will be forfeited. Coverage is based on the available balance on date of service.	You pay $0 deductible and 50% of the cost for certain oral exams and dental procedures when you see a Healthplex dental provider. A maximum annual allowance of $3,000 applies. On the first of each quarter (January 1, April 1, July 1 and October 1) members earn $750 of the comprehensive dental benefit. Unused balances will carry over from quarter to quarter but any balance that is not used by December 31st each year will be forfeited. Coverage is based on the available balance on date of service.

Cost	2020 (this year)	2021 (next year)
Outpatient Mental Health	You pay $40 copay for each outpatient mental health visit.	You pay $20 copay for each outpatient mental health visit. Following a diagnosis of depression, $0 copayment for first office visit with an outpatient mental health provider.
Physical Therapy Services	You pay a $15 copay for each physical therapy service.	You pay a $15 copay for each physical therapy visit. If you have been diagnosed with back pain: $0 copayment for initial evaluation with a Physical Therapist and $0 copayment for first PT session.
Remote Access Technologies Teladoc	You pay a $45 copay per telemedicine service through Teladoc®. See Chapter 4 of the Evidence of Coverage.	You pay a $25 copay per telemedicine service through Teladoc®. See Chapter 4 of the Evidence of Coverage.
Routine Dental	You pay $0 copay for routine dental services. Routine services limited to 2 cleanings and 2 bitewing x-rays per year and one full mouth x-ray every 3 years. Fluoride treatments are not covered. You must use a Healthplex provider.	You pay $0 copay for routine dental services. Routine services limited to 2 cleanings, 2 bitewing x-rays, and 2 fluoride treatments per year and one full mouth x-ray every 36 months. You must use a Healthplex provider.
Skilled Nursing Facility	You pay $178 copay per day for days 21-100.	You pay a $184 copay per day for days 21-100.
Worldwide Emergency Coverage	$10,000 annual plan limit outside of the United States and it's territories for Ambulance Services, Emergency Room Services and Urgent Care Services.	$10,000 plan limit per occurrence for the combined unforeseen event outside of the USA.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website (www.IndependentHealth.com/Medicare).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

For all members who received an exception in 2020 with an expiration date of 12/31/2020 a new exception request will need to be submitted.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to

reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, please call Member Services and ask for the "LIS Rider."

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the Evidence of Coverage, which is located on our website at www.IndependentHealth.com/Medicare.

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4, and Tier 5 drugs until you have reached the yearly deductible.	The deductible is $100 During this stage, you pay $0 cost sharing for drugs on Tier 1, $10 cost sharing for drugs on Tier 2, and the full cost of drugs on Tiers 3, 4 and 5 until you have reached the yearly deductible.	The deductible is $150 During this stage, you pay $0 cost sharing for drugs on Tier 1, $10 cost sharing for drugs on Tier 2, and the full cost of drugs on Tiers 3, 4 and 5 until you have reached the yearly deductible. There is no deductible for Independent Health's Encompass 65 Basic (HMO) for select insulins. You pay a $35 copay for select insulins.

Changes to Your Cost Sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. **We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 – Preferred Generic:** You pay $0 per prescription. **Tier 2 – Generic:** You pay $10 per prescription. **Tier 3 – Preferred Brand:** You pay $47 per prescription. **Tier 4 – Non-Preferred Drug:** You pay 40% of the total cost. **Tier 5 – Specialty Tier:** You pay 31% of the total cost.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 – Preferred Generic:** You pay $0 per prescription. **Tier 2 – Generic:** You pay $10 per prescription. **Tier 3 –Preferred Brand:** You pay $40 per prescription. **Tier 4 – Non-Preferred Drug:** You pay 43% of the total cost. **Tier 5 – Specialty Tier:** You pay 30% of the total cost.
	Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage). You pay $35 copay for select insulins.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. Independent Health's Encompass 65 Basic (HMO) offers additional gap coverage for select insulins. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be a $35 copay. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage.*

SECTION 2 Administrative Changes

Description	2020 (this year)	2021 (next year)
SafeRide phone number	877-593-3250 (TTY 711)	855-955-RIDE (7433) (TTY 711)

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Independent Health's Encompass 65 Basic (HMO)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Independent Health's Encompass 65 Basic.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Independent Health Association offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Independent Health's Encompass 65 Basic (HMO).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Independent Health's Encompass 65 Basic (HMO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2021.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2021, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2021. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage.*

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York, the SHIP is called Health Insurance Information, Counseling and Assistance Program (HIICAP).

HIICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. HIICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HIICAP at 1-800-701-0501. You can learn more about HIICAP by visiting their website (www.aging.ny.gov).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** New York has a program called **New York State Elderly Pharmaceutical Insurance Coverage Program (EPIC)** that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).

- **Prescription Cost sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost sharing assistance through the New

York State Department of Health. For information on eligibility criteria, covered drugs, or how to enroll in the program, please contact:
HIV Uninsured Care Programs, Empire Station
P.O. Box 2052
Albany, NY 12220
Phone Number: 1-800-542-2437 or 518-459-1641 (Out of State)
Email Address: adap@health.ny.us.

SECTION 7 Questions?

Section 7.1 – Getting Help from Independent Health's Encompass 65 Basic (HMO)

Questions? We're here to help. Please call Member Services at (716) 250-4401 or 1-800-665-1502. (TTY 711). We are available for phone calls October 1 - March 31: Monday - Sunday, 8 a.m. - 8 p.m. and April 1 - September 30: Monday - Friday, 8 a.m. - 8 p.m. Calls to these numbers are free.

Read your 2021 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2021. For details, look in the 2021 *Evidence of Coverage* for Independent Health's Encompass 65 Basic (HMO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.IndependentHealth.com/Medicare.

Visit our Website

You can also visit our website at www.IndependentHealth.com/Medicare. As a reminder, our website has the most up-to-date information about our provider network (Physician/ Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2021*

You can read the *Medicare & You 2021* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or 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.

511 Farber Lakes Drive
Buffalo, New York 14221

Important Plan Information

For more information, please contact Independent Health.
(716) 250-4401 or 1-800-665-1502 (TTY: 711).
October 1 – March 31: Monday – Sunday, 8 a.m. – 8 p.m.
April 1 – September 30: Monday – Friday, 8 a.m. – 8 p.m.