2023 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Independent Health's Medicare Passport® Prime (PPO)

January 1, 2023 – December 31, 2023

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SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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 **Independent Health's Medicare Passport Prime (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Independent Health's Medicare Passport Prime (PPO)** 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 **Independent Health's Medicare Passport Prime (PPO).**
- 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 Independent Health's Medicare Passport Prime (PPO)

Hours of Operation & Contact Information

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

If you are a member of this plan, call us at 1-800-665-1502, TTY: 711.

- From October 1 to March 31 we're open 8 a.m. – 8 p.m. local time, Monday through Sunday.
- From April 1 to September 30 we're open 8 a.m. – 8 p.m. local time, Monday through Friday.

If you are not a member of this plan, call us at 1-800-958-4405, TTY: 711.

- From October 1 to December 7 we're open 8 a.m. – 8 p.m. local time, Monday through Sunday.
- From December 8 to September 30 we're open 8 a.m. – 8 p.m. local time, Monday through Friday.

Our website: http://www.independenthealth.com/medicare.

Who can join?

To join **Independent Health's Medicare Passport Prime (PPO)**, 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?

Independent Health's Medicare Passport Prime (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, your costs may be higher for covered 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 physician/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 Independent Health's Medicare Passport Prime (PPO)	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	$225 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $6,900 for services you receive from in-network providers. • $11,300 for services you receive from in and out-of-network providers combined. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. Optical dispensing, non-Medicare covered dental, premiums, hearing aids, hearing aid evaluation, and Medicare Part D prescription drugs do NOT count towards the out-of-pocket maximum.
COVERED MEDICAL AND HOSPITAL BENEFITS	
Inpatient Hospital	**In-Network:** Days 1-6: $210 Copay per day for each admission. Days 7-90: $0 Copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. $1,470 annual copayment limit applies. Requires provider preauthorization except for emergency admissions. **Out-of-Network:** Inpatient Mental Health Care: 30% Coinsurance per stay.
Outpatient Hospital	**In-Network:** Outpatient hospital: $275 Copay. Provider preauthorization may apply for some services. **Out-of-Network:** Outpatient hospital: 20% Coinsurance.
Ambulatory Surgical Center	**In-Network:**

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	Freestanding Ambulatory Surgical Center: $225 Copay. See the provider directory for a listing of Freestanding Ambulatory Surgical Centers. Provider preauthorization may apply for some services. **Out-of-Network:** Ambulatory Surgical Center: 20% Coinsurance.
Doctor's Office Visits	**In-Network:** Primary care physician visit: You pay nothing. Primary Care Physician is defined as Family Practitioners, General Practitioners, Internal Medicine, OB/GYN, Pediatricians and Gerontologists with no secondary specialty. If the Primary Care Physician has a secondary specialty other than internal medicine, General Practice, Family Practice, Geriatrics, Pediatrics or Obstetrics/Gynecology, the Specialist copayment associated with the physician will apply. Specialist visit: $30 Copay. **Out-of-Network:** Primary care physician visit: $45 Copay. Specialist visit: $45 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. **Out-of-Network:** 20% Coinsurance for all preventive services covered under Original Medicare.
Emergency Care	**In-Network and Out-of-Network:** $95 Copay per visit. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $95 Copay. $10,000 plan limit per occurrence for the combined unforeseen event outside of the United States.

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Urgently Needed Services	**In-Network and Out-of-Network:** $60 Copay per visit. Worldwide Urgent Coverage: $60 Copay. $10,000 plan limit per occurrence for the combined unforeseen event outside of the United States
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $0 Copay for tests performed by a Primary Care Physician. $30 Copay for tests performed by a Specialist. Lab services: $5 Copay for routine lab tests. 20% Coinsurance for molecular or predisposition genetic testing. Diagnostic Advanced Radiology Services (such as MRI, CAT Scan): $100 Copay. X-rays: $30 Copay. Two copayments apply if both a diagnostic x-ray and an advanced diagnostic radiologic service are billed on the same day by the same provider. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. Provider preauthorization may apply for some services. **Out-of-Network:** Diagnostic tests and procedures: 20% Coinsurance. Lab services: 20% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 20% Coinsurance. X-rays: 20% Coinsurance. Therapeutic radiology services (such as radiation treatment for cancer): 40% Coinsurance.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $30 Copay for a Specialist. Routine hearing exam: You pay nothing for a Primary Care Provider. $30 Copay for a Specialist. Hearing Aid Evaluation Exam: $45 Copay. Hearing Aid: $499 - $2,199 Copay. Copayment structure per hearing aid: $499, $699, $999, $1,499, $2,199. Benefit is limited to preferred hearing aids, which come in various styles and colors. You must see a Start Hearing, Inc. provider to use this benefit. You cannot combine any promotional offers with our Hearing Aid

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	benefit. Call Member Services for additional information about the network, or visit IndependentHealth.com/Medicare. **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: $45 Copay. Routine hearing exam: $45 Copay. Hearing Aid Evaluation Exam: Not covered. You must use a provider in the national Start Hearing, Inc network. Hearing Aid: Not covered. You must use a provider in the national Start Hearing, Inc network.
Dental Services	**In-Network:** Medicare Covered: $30 Copay. Preventive dental services, now administered by LIBERTY Dental Plan: You pay nothing. • Oral exam (up to 2 visits every year) • Cleaning (up to 2 visits every year) • Fluoride treatment (up to 2 visits every year) • Dental X-rays (up to 2 visits every year) • Full mouth X-ray (once every 36 months) **Out-of-Network:** Medicare Covered: $45 Copay Preventive dental services: $0 Copay. • Oral exam (up to 2 visits every year) • Cleaning (up to 2 visits every year) • Fluoride treatment (up to 2 visits every year) • Dental X-rays (up to 2 visits every year) • Full mouth X-ray (once every 36 months) Care rendered by a provider that is not part of our supplemental dental network is covered as out-of-network. You may be asked to pay up front for these services and therefore you must complete a dental reimbursement form to be reimbursed for your preventive dental service . You will be reimbursed up to the allowed amount determined by LIBERTY Dental.

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Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye: $30 Copay for a Specialist. Routine eye exam, including yearly glaucoma screening (up to 1 visits every year): You pay nothing from an EyeMed Provider. Eyeglasses or contact lenses after cataract surgery: You Pay Nothing. Eyeglasses (frames and lenses) or contact lenses:In and Out-of-Network combined – Our plan pays up to $200 every year for eyewear. Any costs incurred above this amount for lenses, frames or contacts is the member's responsibility. **Out-of-Network:** Exam to diagnose and treat diseases and conditions of the eye: $45 Copay. Routine eye exam, including yearly glaucoma screening, (up to 1 visits every year): $65 Copay. Eyeglasses (frames and lenses) or contact lenses: In and Out-of-Network combined – Our plan pays up to $200 every year for eyewear. Any costs incurred above this amount for lenses, frames or contacts is the member's responsibility. Eyeglasses or contact lenses after cataract surgery: You Pay Nothing. Maximum $150 allowance.
Mental Health Care	**In-Network:** Outpatient group therapy visit: $20 Copay. Individual therapy visit: $20 Copay. Following a diagnosis of depression, $0 copayment for first office visit with an outpatient mental health professional. Inpatient Mental Health Care: Days 1-6: $270 Copay per day for each admission. Days 7-90: $0 Copay per day. **Out-of-Network:** Outpatient group therapy visit: 40% Coinsurance. Individual therapy visit: 40% Coinsurance. Inpatient Mental Health Care: 30% Coinsurance per stay.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $196 Copay per day.

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	Provider preauthorization is required. **Out-of-Network:** Days 1 - 100: 30% Coinsurance per stay.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $10 Copay per visit. Physical therapy and speech and language therapy visit: $10 Copay per visit. If you have been diagnosed with back pain: $0 copayment for initial evaluation with a physical therapist and $0 copayment for first physical therapy session. **Out-of-Network:** Occupational therapy visit: 20% Coinsurance. Physical therapy and speech and language therapy visit: 20% Coinsurance.
Ambulance	**In-Network:** Ground Ambulance: $200 Copay for each one-way trip. Wheelchair van is not covered. Air Ambulance: $200 Copay. Provider preauthorization is required for planned transportation only. **Out-of-Network:** Ground Ambulance: $200 Copay for each one-way trip. Air Ambulance: $200 Copay.
Transportation	**In-Network:** Not Covered. **Out-of-Network:** Not Covered.
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 20% Coinsurance. Provider preauthorization may be required. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 40% Coinsurance. Other Part B drugs: 40% Coinsurance.

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Foot Care (Podiatry Services)	**In-Network:** Foot exams: $30 Copay from a Podiatrist. **Out-of-Network:** Foot exams: 40% Coinsurance from a Podiatrist.
Durable Medical Equipment	**In-Network:** 10% Coinsurance - 20% Coinsurance. 10% Coinsurance applies when member uses our preferred DME provider for designated mobility devices. 20% Coinsurance for all other covered DME. Provider preauthorization may apply. **Out-of-Network:** 50% Coinsurance.
Diabetic Supplies and Services	**In-Network:** Diabetes monitoring supplies: You pay nothing. Diabetic Monitor: You pay nothing Limited to preferred products. Diabetes self-management training: You pay nothing. Therapeutic shoes or inserts: You pay nothing. **If you have been diagnosed with diabetes** You pay nothing for diabetic lab tests for HbA1c and GFR. You pay nothing for Endocrinologist with diagnosis of Diabetes. You pay nothing for diabetic retinopathy exam. You pay nothing for Specialist administering the exam **Out-of-Network:** Diabetes monitoring supplies: 20% Coinsurance. Diabetic Monitor: 20% Coinsurance. Diabetes self-management training: 20% Coinsurance. Therapeutic shoes or inserts: 20% Coinsurance.
Prosthetic Devices (braces, artificial limbs, etc.)	**In-Network:** Prosthetic devices: 20% Coinsurance. Related medical supplies: You pay nothing.

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	Provider preauthorization may apply. **Out-of-Network:** Prosthetic devices: 50% Coinsurance. Related medical supplies: 50% Coinsurance.
Wellness Program	**In-Network:** Fitness Benefit: You pay nothing. **SilverSneakers®** You pay nothing for this benefit. SilverSneakers gives you FREE access to: • Thousands of participating fitness center locations nationwide[1] • SilverSneakers Live classes and workshops taught by instructors trained in senior fitness • 200+ workout videos in the SilverSneakers On-Demand™ online library • SilverSneakers GO™ mobile app with digital workout programs • 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 800-665-1502 or 716-250-4401 (TTY: 711) See the Chapter 4 of your Evidence of Coverage for more details. **Out-of-Network:** You must use a participating SilverSneakers facility.
Remote Access Technologies: Teladoc®	**In-Network:** You pay $25 Copay for each consult with a Teladoc Provider over the phone or on-line 24 hours a day, 7 days a week. **Out-of-Network:** You must use a Teladoc provider.
Comprehensive Dental Coverage	You pay $0 deductible and 50% of the cost for certain oral exams and dental procedures when you see a LIBERTY Dental Plan 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.
PRESCRIPTION DRUG BENEFITS	
Deductible	Prescription Drug Deductible: Not Applicable. There is no deductible for select insulins on our formulary. You pay $35 for select insulins on our formulary.
Initial Coverage	You pay the following until your total yearly drug costs reach $4,660. Total yearly drug costs are the drug costs paid by both you and our Part D plan. You pay $35 for select insulins on our formulary. **Standard Retail Cost-Sharing**

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$10 copay	$25 copay
Tier 3 (Preferred Brand)	$45 copay	$112.50 copay
Tier 4 (Non-Preferred Drug)	40% coinsurance	40% coinsurance
Tier 5 (Specialty Tier)	33% coinsurance	Not Applicable

Standard Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	Not Applicable	$0 Copay
Tier 2 (Generic)	Not Applicable	$25 copay
Tier 3 (Preferred Brand)	Not Applicable	$112.50 copay
Tier 4 (Non-Preferred Drug)	Not Applicable	40% coinsurance
Tier 5 (Specialty Tier)	Not Applicable	Not Applicable

Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Please call us or see the plan's **"Evidence of Coverage"** on our website (http://www.independenthealth.com/medicare) for complete information about your costs for covered drugs.

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Coverage Gap	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap. **Our plan covers Tier 1 Preferred Generics in the coverage gap.** Independent Health offers additional gap coverage for Tier 1 drugs and select insulins on our formulary. During the Coverage Gap stage, your out-of-pocket costs for select insulins on our formulary will be $35. **Standard Retail Cost-Sharing** **Tier** | **One-month supply** Tier 1 (Preferred Generic) | $0 Copay
Catastrophic Amount	After your yearly out-of-pocket drug costs reach $7,400, you pay the greater of: • $4.15 copay for generic (including brand drugs treated as generic) and a $10.35 copayment for all other drugs, or • 5% of the cost.
Part D Senior Savings Program	The Part D Senior Savings Model is a voluntary model that enables participating Part D enhanced plans to lower Medicare members' out-of-pocket costs for select injectable insulin to a maximum $35 copay per thirty-day supply. This fixed cost share applies to all stages of coverage: the deductible stage (if applicable), the initial coverage stage, AND the coverage gap stage. This benefit is built into the plan This does not apply to people who are already getting LIS "Extra Help" for their Part D drugs.

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 1-800-665-1502 (TTY: 711).

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

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.

[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.

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Health coverage is offered by Independent Health Benefits Corporation.

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

Current members call toll-free: 1-800-665-1502, TTY users should call 711.

Prospective members call toll-free: 1-800-958-4405, TTY users should call 711.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit http://www.independenthealth.com/medicare or call 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, 2023.
- ☐ 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).
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ Out-of-network/non-contracted providers are under no obligation to treat **Independent Health's Medicare Passport Prime (PPO)** members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information.

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