2024 Independent Health Medicare Advantage HMO Plans *(Effective January 1, 2024)*

2024 HMO Plans **With** Prescription Coverage

2024 BENEFITS	Independent Health's **Encompass 65® Edge HMO - GIVE BACK PLAN***	Independent Health's **Encompass 65® Element HMO**	Independent Health's **Encompass 65® Core HMO**	Independent Health's **Encompass 65® Basic HMO**
Monthly Plan Premium	$0 **Independent Health pays $30 per month toward your Part B premium**	$0	$65	$129
Part D Prescription Benefit Tiers 1/2/3/4/5 Shingrix included in Tier 1	$545 deductible on tiers 3, 4 & 5 only $3/$20/$47/41%/25% to initial coverage limit of $5,030	$150 deductible on tiers 3, 4 & 5 only $0/$15/$47/49%/30% to initial coverage limit of $5,030	$50 deductible on tiers 3, 4 & 5 only $0/$12/$42/50%/32% to initial coverage limit of $5,030	**No deductible** $0/$10/$42/49%/33% to initial coverage limit of $5,030
Primary Copay	$0, Including your **Enhanced Annual Visit**			
Specialty Copay	$45	$40	$30	$20
Preventive Services[1]	$0 includes preventive screenings such as Colonoscopy, Mammogram, Prostate Screening, Flu Shot and Pneumonia Vaccine. NOTE: Not a complete list of covered screenings. A separate office visit copay may apply.			
RedShirt Rewards℠	It pays to get and stay healthy! **Earn up to $100 in RedShirt Rewards just for completing actions that can help you manage your health and wellness. NEW! Redeem as a gift card of your choice from participating retailers.** Talk with a RedShirt® for details.			
Inpatient Hospital Copay	Days 1–5: $425 per day; Unlimited days for Medicare Covered Stay. No annual maximum.	Days 1–6: $320 per day; Unlimited days for Medicare Covered Stay. $1,920 annual maximum member copay.	Days 1–6: $295 per day; Unlimited days for Medicare Covered Stay. $1,770 annual maximum member copay.	Days 1–6: $275 per day; Unlimited days for Medicare Covered Stay. $1,650 annual maximum member copay.
Home Delivered Meals	Not Covered	Not Covered	14 Days, up to 28 Meals Post Inpatient Stay	14 Days, up to 28 Meals Post Inpatient Stay
Outpatient Mental Health Care	$40	$35	$25	$20
Worldwide[2] **Emergency Room/Urgent Care**	**Emergency Room Coverage:** (waived if admitted) $100 / **Urgent Care:** $55			
Ambulance	$240	$240	$225	$225
Non-Emergency Transportation	Not Covered	Not Covered	$0; 6 One-Way Trips	$0; 12 One-Way Trips
Personal Emergency Response System	Not Covered	Not Covered	$0	$0
Lab Copay[3]	$20	$0	$0	$0
X-ray Copay	General X-ray: $50/Advanced Radiology: $300	General X-ray: $40/Advanced Radiology: $200	General X-ray: $35/Advanced Radiology: $175	General X-ray: $30/Advanced Radiology: $125
Outpatient Surgery	Ambulatory Surgical Center: $425/Hospital Based: $475	Ambulatory Surgical Center: $290/Hospital Based: $315	Ambulatory Surgical Center: $275/Hospital Based: $325	Ambulatory Surgical Center: $250/Hospital Based: $325
Skilled Nursing Facility[4]	Days 1–20: $0/Days 21–100: $203 per day			
Home Health	$0			
Physical, Speech, Occupational Therapy	$35	$20	$10	$5
% You Pay for Part B Medications or Radiation Therapy[5]	Part B Medications: 0 - 20% / Radiation Therapy: 20%			
Annual Out-of-Pocket Maximum for Medicare Covered Services	$8,850	$7,550	$7,300	$7,300

Wellness Benefits *(In Network)*

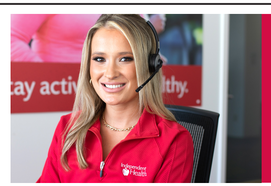
Dental - New Enhanced Benefit NEW!	$0 per visit preventive dental: 2 routine cleanings, exams & bitewing X-rays per calendar year; 1 full-mouth series (every 36 months).	Up to $2,000 service coverage limit. Includes preventive and comprehensive coverage.	Up to $1,000 service coverage limit. Includes preventive and comprehensive coverage.
Over-the-Counter (OTC)[6]	$15 per quarter (benefit rolls over quarterly)	$25 per quarter (benefit rolls over quarterly)	$100 per quarter (benefit rolls over quarterly)
Fitness (SilverSneakers®)[7]	$0 fitness benefit with access to thousands of locations nationwide.		
Vision (EyeMed®)	$0 routine eye exam; $200 coverage allowance for routine eyewear every year.		
Hearing Aid Coverage	$45 hearing aid evaluation exam. Member pays $499 – $2,199 (per ear) for select hearing aid devices. You must use a provider in the Start Hearing benefits network. Included on all plans.		
Telemedicine (Teladoc®)	Speak with a doctor anytime, anywhere by phone or online for a $25 copay. Included on all plans.		
Enhanced Diabetes Benefits	For those with a diabetes diagnosis all plans include $0 glucose monitors, diabetic shoes and inserts, and supplies, including lancets and test strips, $35 insulins and more.		
Chiropractic Services	$15 for Chiropractic evaluation, management and medicare-covered services.		$10 for Chiropractic evaluation, management and medicare-covered services.

HMO Without Prescription Coverage

Independent Health's **Encompass 65® HMO**[8]
$0
No prescription benefit
$0
$10
Included; See Preventive Services to the left for more information.
Earn up to $100 in RedShirt Rewards for Getting Your Preventive Services! Talk with a RedShirt® for details.
Days 1–5: $150 per day; Unlimited days for Medicare Covered Stay. $750 annual maximum member copay.
14 Days, up to 28 Meals Post Inpatient Stay
$20
Emergency Room Coverage: (waived if admitted) $100 **Urgent Care:** $55
$150
$0; 24 One-Way Trips
$0
$0
General X-ray: $25 / Advanced Radiology: $50
$100
Days 1–20: $0 copay per day; Days 21–100: $203 copay per day
$0
$10
20% of the cost of the medication or service
$6,700

Have you or a loved one received a diagnosis of Chronic Heart Failure (CHF) or a related condition? Do you or a loved one live in a nursing home?

Independent Health has Medicare Advantage plans specifically designed to help people with these unique needs. Speak with a RedShirt to learn more.



2024 Annual Enrollment Period: October 15 – December 7

WE'RE ALWAYS READY TO HELP. SPEAK WITH A LOCAL REDSHIRT TODAY.

(716) 635-4900 or 1-800-958-4405 (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.

www.IndependentHealth.com/Medicare | Medicare.Help@IndependentHealth.com

Independent Health®

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. Limitations, copayments and restrictions may apply. Benefit, premium and/or copayments/coinsurance may change on January 1 of each year. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Benefits vary by plan. Members may enroll in the plan only during specific times of the year. These plans are available to all Medicare eligibles who are entitled to Medicare Part A and enrolled in Part B. Your plan may require the use of affiliated providers, except in the case of emergency care, urgent care or out-of-area renal dialysis. You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party. Medicare beneficiaries may enroll in an Independent Health Medicare Advantage plan through the Centers for Medicare & Medicaid Services (CMS) Online Enrollment Center, located at https://www.medicare.gov. For more information, contact Independent Health. **This chart is for general reference and is not a contract. This information is not a complete description of benefits. See Evidence of Coverage for complete details.**

2024 Independent Health Medicare Advantage PPO Plans *(Effective January 1, 2024)*

PPO PLANS ARE PERFECT FOR PEOPLE WHO TRAVEL!

2024 PPO Plans With Prescription Coverage

2024 BENEFITS	NEW! Independent Health's **Passport® Access PPO**		Independent Health's **Passport® Advantage PPO**		Independent Health's **Passport® Prime PPO**	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Plan Premium	$10		$104		$235	
Part D Prescription Benefit Tiers 1/2/3/4/5 Shingrix included in Tier 1	$250 deductible on tiers 3, 4 & 5 only $0/$17/$47/48%/29% to initial coverage limit of $5,030		$150 deductible on tiers 3, 4 & 5 only $0/$15/$47/43%/30% to initial coverage limit of $5,030		No deductible $0/$10/$45/50%/33% to initial coverage limit of $5,030. Tier 1 covered through the gap.	
Primary Copay	$0	40%	$0	40%	$0	$45
Specialty Copay	$40	40%	$35	40%	$30	$45
Preventive Services[1]	$0 (IN) 40% (OON) includes preventive screenings such as Colonoscopy, Mammogram, Prostate Screening, Flu Shot and Pneumonia Vaccine. NOTE: Not a complete list of covered screenings. A separate office visit copay may apply.				$0	20%
RedShirt Rewards[SM]	It pays to get and stay healthy! **Earn up to $100 in RedShirt Rewards just for completing actions that can help you manage your health and wellness. NEW! Redeem as a gift card of your choice from participating retailers.** Talk with a RedShirt® for details.					
Inpatient Hospital Copay	Days 1–5: $325 per day. Unlimited days for Medicare Covered Stay. $1,625 annual maximum member copay.	40% coinsurance	Days 1–6: $255 per day. Unlimited days for Medicare Covered Stay. $1,530 annual maximum member copay.	40% coinsurance	Days 1–7: $225 per day. Unlimited days for Medicare Covered Stay. $1,575 annual maximum member copay.	30% coinsurance
Home Delivered Meals	Not Covered					
Outpatient Mental Health Care	$35	40%	$25	40%	$20	40%
Worldwide[2] **Emergency Room/Urgent Care**	**Emergency Room Coverage**: (waived if admitted) $100 copay / **Urgent Care:** $55 copay					
Ambulance	$275	$275	$250	$250	$200	$200
Non-Emergency Transportation	Not Covered					
Personal Emergency Response System	Not Covered					
Lab Copay[3]	$0	40% coinsurance	$0	40% coinsurance	$0	20% coinsurance
X-ray Copay	General X-ray: $35/Advanced Radiology: $225	40% coinsurance	General X-ray: $40/Advanced Radiology: $150	40% coinsurance	General X-ray: $30/Advanced Radiology: $100	20% coinsurance
Outpatient Surgery	Ambulatory Surgical Center: $350/Hospital Based: $375	40% coinsurance	Ambulatory Surgical Center: $300/Hospital Based: $350	40% coinsurance	Ambulatory Surgical Center: $265/Hospital Based: $315	20% coinsurance
Skilled Nursing Facility[4]	Days 1–20: $0/Days 21–100: $203 copay per day	40% coinsurance	Days 1–20: $0/Days 21–100: $203 copay per day	40% coinsurance	Days 1–20: $0/Days 21–100: $203 copay per day	30% coinsurance
Home Health	$0	40% coinsurance	$0	40% coinsurance	$0	40% coinsurance
Physical, Speech, Occupational Therapy	$30	40% coinsurance	$20	40% coinsurance	$10	20% coinsurance
% You Pay for Part B Medications or Radiation Therapy[5]	Part B Medications: 0 - 20% / Radiation Therapy: 20%	Part B: 40% coinsurance Radiation Therapy: 50% coinsurance	Part B Medications: 0 - 20% / Radiation Therapy: 20%	Part B: 40% coinsurance Radiation Therapy: 50% coinsurance	Part B Medications: 0 - 20% / Radiation Therapy: 20%	40% coinsurance
Annual Out-of-Pocket Maximum for Medicare Covered Services	$7,500	$12,500 combined in- and out-of-network	$7,300	$12,500 combined in- and out-of-network	$7,300	$12,500 combined in- and out-of-network

Wellness Benefits

Dental - New Enhanced Benefit NEW!	Up to $1,000 service coverage limit. Includes preventive and comprehensive coverage.
Over-the-Counter (OTC)[6]	$25 per quarter (benefit rolls over quarterly)
Fitness (SilverSneakers®)[7]	$0 fitness benefit with access to thousands of locations nationwide.
Vision (EyeMed®)	$0 routine eye exam; $200 coverage allowance for routine eyewear every year.
Hearing Aid Coverage	$45 hearing aid evaluation exam. Member pays $499 – $2,199 (per ear) for select hearing aid devices. You must use a provider in the Start Hearing benefits network. Included on all plans.
Telemedicine (Teladoc®)	Speak with a doctor anytime, anywhere by phone or online for a $25 copay. Included on all plans.
Enhanced Diabetes Benefits	For those with a diabetes diagnosis all plans include $0 glucose monitors, diabetic shoes and inserts, and supplies, including lancets and test strips, $35 insulins and more.
Chiropractic Evaluation & Management	$15 Medicare Chiropractic coverage (IN)/40% coinsurance (OON)

(IN) In-Network, (OON) Out-of-Network

NEW!

EXPANDED NATIONAL NETWORK THROUGH MULTIPLAN

Enjoy In-Network costs outside of our service area — for services including routine care — by using our new expanded national network of doctors and specialists.

*Members who receive Low Income Subsidy (LIS) are not eligible for this plan. [1]Not all preventive services are medically appropriate every year. Independent Health uses the frequency guidelines adopted by CMS and the U.S. Preventive Services Task Force. This is not a complete list of services. See your Evidence of Coverage for a complete list. [2]The $10,000 plan limit is per occurrence for the combined unforeseen event outside of the USA. [3]Member pays 20%–40% for genetic testing. [4]Skilled nursing facility benefit is not covered after day 100, per benefit period. [5]Member pays the applicable Part B medication or radiation therapy coinsurance plus applicable outpatient/office visit copay. [6]For the over-the-counter allowance the amount earned each quarter needs to be used within the calendar year; amounts do not roll over year to year. [7]SilverSneakers is a registered trademark of Tivity Health, Inc. ©2023 Tivity Health, Inc. All rights reserved. [8]This plan cannot coordinate with a standalone Medicare prescription drug plan (PDP). It can coordinate with other creditable prescription coverage such as VA or employer coverage. Out-of-network/non-contracted providers are under no obligation to treat Independent Health's Medicare Passport PPO 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 Member Services at (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. or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-665-1502 (TTY: 711). 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. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-665-1502 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-665-1502 (TTY: 711).

Independent Health®

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