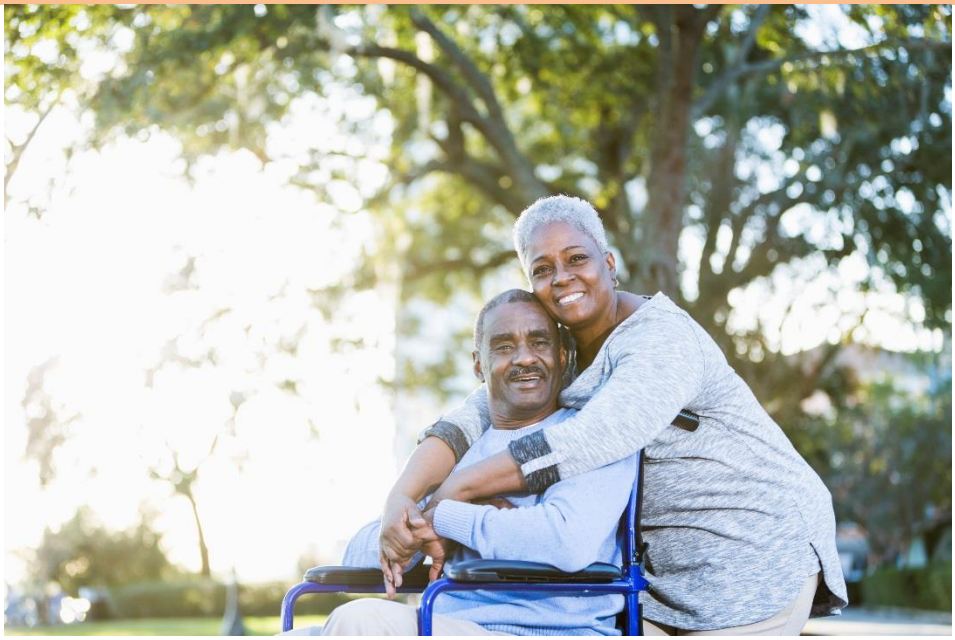
2020 SUMMARY OF BENEFITS



This is a summary of drug and health services covered by

Kalos Health Gold Plus (HMO-SNP) Plan

January 1, 2020 - December 31, 2020

Kalos Health

800.399.1954
(TTY for hearing impaired 711)
Hours of Operation 8 A.M. – 8 P.M.

Member Services is available seven days per week between October 1 and March 31.

For the period April 1 to September 30, Member Services is available Monday - Friday.

"Making a Difference Together"

2424 Niagara Falls Blvd.
Niagara Falls, NY 14304
www.kaloshealth.org

SUMMARY OF BENEFITS

Kalos Health Gold Plus HMO-SNP H3227-001

This is a summary of drug and health services covered by Kalos Health Gold Plus HMO-SNP January 1, 2020 – December 31, 2020.

Kalos Health Gold Plus is a Health Maintenance Organization (HMO) Special Needs Plan (SNP) with a Medicare Contract and a coordination of benefits agreement with the New York State Department of Health. Enrollment in the Plan is voluntary and depends on contract renewal.

Kalos Health Gold Plus (HMO-SNP) is a Medicare Advantage Plan designed specifically for those who have Medicare and full New York State Medicaid benefits.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for Medicare-covered services. Individuals with full Medicaid benefits will have the lower 0% coinsurance. You may also have additional benefits through the New York State Medicaid program. To get a complete list of services we cover, please request the "Evidence of Coverage."

To join **Kalos Health Gold Plus**, you must be age 21 or older, have Medicare Parts A and B, full New York State Medicaid benefits and live in our service area. Our service area includes the following counties in New York: Cattaraugus, Erie, Niagara and Orleans.

If you use the providers that are not in our network, we may not pay for these services. You can see our plan's provider directory, pharmacy directory, and the complete plan formulary (list of Part D prescription drugs) at our website at www.kaloshealth.org. The formulary, pharmacy network may change at any time. You will receive notice when necessary.

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at 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.

This information is not a complete description of benefits. Call us at 1-800-399-1954 (TTY users should call 711) Hours of Operation 8 A.M. – 8 P.M. for more information. Member Services is available seven days per week between October 1 and March 31. For the period April 1 to September 30, Member Services is available Monday through Friday, or visit us at www.kaloshealth.org.

Section I
Summary of Medicare and Medicaid Covered Benefits under Kalos Health Gold Plus (HMO-SNP)

PREMIUMS & BENEFITS	KALOS HEALTH GOLD PLUS (HMO-SNP)	WHAT YOU SHOULD KNOW
Monthly Plan Premium	You pay $0	You must continue to pay your Medicare Part B premium.
Deductible	No deductible	You pay nothing
Maximum Out-of-Pocket Responsibility (*does not include prescription drugs*)	You pay no more than $6,700 annually Includes copays and other costs for medical services for the year.	In this plan, you will pay nothing for Medicare covered services due to your level of NY State Medicaid eligibility.
Inpatient Hospital Coverage **	You pay $0	Our plan covers 90 days for an inpatient hospital stay under your Medicare benefit. Our plan covers additional medically necessary inpatient hospital days under your NY State Medicaid benefit. Authorization rules apply.
Outpatient Hospital	You Pay $0	We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
Doctor Visits	You pay $0	
Preventive Care	You pay $0	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	You pay $0	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized; you must have your inpatient care at the out-of-network hospital authorized by the plan.

PREMIUMS & BENEFITS	KALOS HEALTH GOLD PLUS (HMO-SNP)	WHAT YOU SHOULD KNOW
Urgently Needed Services	You pay 20% of the cost of the visit up to $65	Urgent care is covered within the United States and not worldwide.
Diagnostic Services/Labs/ Imaging **	You pay $0	Prior authorization is required for some services by your doctor or other network provider. Please contact the plan for more information.
Hearing Services	You pay $0	Your Medicare benefit covers an exam to diagnose and treat hearing and balance issues. Our plan covers routine hearing exams, hearing aids and their care and maintenance under the NY State Medicaid benefit. Prior authorization is required for replacement of hearing aids or instruments before they are five years old.
Dental Services	You pay $0	Limited dental services are covered under Medicare. Our plan covers additional dental services including emergency care visits, x-rays, extractions, implants and oral surgery under the NY State Medicaid benefit. Authorization rules apply except for diagnostic and preventative dental services.
Vision Services	You pay $0	Our plan covers routine eye exams, eyeglasses and frames under the NY State Medicaid benefit.
Mental Health Services • Inpatient Visit • Outpatient Group Therapy • Outpatient Individual Therapy	 You pay $0 You Pay $0 You Pay $0	Our plan covers your inpatient hospital stay beyond the Medicare limit under the NY State Medicaid benefit. Authorization rules apply.

PREMIUMS &BENEFITS	KALOS HEALTH GOLD PLUS (HMO-SNP)	WHAT YOU SHOULD KNOW
Skilled Nursing Facility **	You pay $0	Our plan covers up to 100 days in a SNF under your Medicare benefit. Additional days are covered under the NY State Medicaid benefit. We do not require a 3-day hospital stay prior to admission. Authorization rules apply
Physical Therapy/Speech Language Pathology	You pay $0	Our plan covers additional outpatient rehabilitation services under the NY State Medicaid benefit. Authorization rules apply.
Ambulance	You pay $0	
Transportation	You Pay $0	Our plan covers nonemergency transportation under the NY State Medicaid benefit. Authorization rules apply.
Medicare Part B Drugs **	You pay nothing for chemotherapy drugs You pay nothing for other Part B drugs	Diabetic Test Strips are limited to the following manufacturers: LifeScan Inc., Abbott Diabetes Care
Ambulatory Surgery Center **	You Pay $0	Authorization rules apply.

** Authorization may be required. Call Kalos Health Gold Plus (HMO-SNP) for more information.

You may not have any copayment/coinsurance responsibility for Medicare covered services, depending on your level of Medicaid eligibility. Additional benefits may be available to you through the New York State Medicaid program.

OUTPATIENT PRESCRIPTION DRUGS			
	PREFERRED RETAIL RX 30-DAY SUPPLY	NON-PREFERRED RETAIL RX 30-DAY SUPPLY	MAIL ORDER 90-DAY SUPPLY
Phase: Initial Coverage (After you pay you deductible, if applicable)			
Tier 1: ALL RX	25%	25%	25%

Cost sharing may change when entering another phase of the Part D benefit. Please call Kalos Health Gold Plus for more information at 1-800-399-1954, 8 A.M. – 8 P.M. Member Services is available seven days per week between October 1 and March 31. For the period April 1 to September 30, Member Services is available Monday through Friday, or access the Evidence of Coverage online at www.kaloshealth.org.

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 http://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.

SUPPLEMENTAL BENEFITS	KALOS HEALTH GOLD PLUS (HMO-SNP)	WHAT YOU SHOULD KNOW
Over-The-Counter (OTC) Supplemental Benefit	You pay $0	Up to $75 is available every month for the purchase of certain covered items for personal use only.
Healthy Foods Incentive Program	You Pay $0	Up to $20 is available every month for the purchase of nutritious foods like fruit, vegetables, eggs, and milk at local retailers.
Transportation for Non-Medical Needs**	You Pay $0	16 one-way trips per year at plan approved locations.
24/7 Nurse HelpLine	You Pay $0	24-hour access to a nurse helpline, 7days a week, 365 days a year.

**** Authorization is required.**

Section II

Summary of Medicaid-Covered Benefits

People who qualify for Medicare and Medicaid are known as dual eligibles. As a dual eligible, you are eligible for benefits under both the federal Medicare program and the state-operated Medicaid program.

The kind of Medicaid benefits you receive are determined by your state and may vary based upon your income and resources. With the assistance of Medicaid, some dual eligibles do not have to pay for certain Medicare costs.

The following table contains services that are available under Medicaid for people who qualify for full Medicaid benefits. If our plan does not provide the benefit, members who qualify for full Medicaid benefits can obtain the service from Medicaid fee-for-service using their Medicaid Benefit Identification card. It is important to know that Medicaid benefits can vary based on your income level and other standards. Also, your Medicaid benefits can change throughout the year. For the most current and accurate information regarding your eligibility and benefits, contact your local Department of Social Services.

Benefit Category	**New York State Medicaid Coverage**
Adult Day Health Care Medicaid covers Adult Day Health Care services provided in a residential health care facility or approved extension. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services	Covered
AIDS Adult Day Health Care Medicaid covers AIDS Adult Day Health Care Programs (ADHCP), designed to assist individuals with HIV disease to live more independently in the community or eliminate the need for residential health care services.	Covered
Assisted Living Program Medicaid covers personal care, housekeeping, supervision, home health aides, personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, a range of home health services and the case management services of a registered professional nurse. Services are provided in an adult home or enriched housing setting.	Covered

Benefit Category	New York State Medicaid Coverage
Certain Mental Health Services Including: • Intensive psychiatric rehabilitation treatment programs • Day treatment • Continuing day treatment • Case management for seriously and persistently mentally ill • Partial hospitalization • Assertive community treatment (ACT) • Personalized recovery oriented services (PROS)	Covered
Comprehensive Medicaid Case Management Provides “social work” case management referral services to a targeted population. A CMCM case manager will assist a client in accessing necessary services in accordance with goals outlined in a written case management plan.	Covered
Dental Services Necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.	Covered
Directly Observed Therapy for Tuberculosis (TB) Disease Medicaid covers Tuberculosis Directly Observed Therapy (TB/DOT), which is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen.	Covered
Hearing Services Services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing: e.g., hearing aid selecting, fitting and dispensing; hearing aid checks following dispensing; conformity evaluations and hearing aid repairs.	Covered
Home and Community Based Waiver Program Services Medicaid covers personal care services to a participant who requires assistance with personal care services tasks and whose health and welfare in the community is at risk because oversight and supervision of the participant is required when no personal care task is being performed. These services are provided under the direction and supervision of a Registered Professional Nurse.	Covered
Hospice	Covered

Benefit Category	New York State Medicaid Coverage
Medical Social Services	Covered
Medical and Surgical Supplies	Covered
Methadone Maintenance Treatment Programs	Covered
Non-Emergency Transportation Expenses are covered when transportation is essential in order for a member to obtain necessary medical care and services, which are covered under the Medicaid program. For members with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.	Covered
Non-Medicare Covered Durable Medical Equipment Including devices and equipment other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury; and are usually fitted, designed or fashioned for a particular individual's use. Must be ordered by a qualified practitioner. This includes but not limited to Personal emergency Response Systems (PERS), Grab Bars for Tub and Toilet, Incontinence Supplies.	Covered
Office for People With Developmental Disabilities (OPWDD) Services	Covered
Personal Care Services Personal care services (PCS), which involve the provision of some or total assistance with personal hygiene, dressing and feeding, nutritional, and environmental support (meal preparation and housekeeping). Personal care services must be medically necessary, ordered by a physician, and provided by a qualified person in accordance with a plan of care	Covered
Vision Services Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes, low vision aids and low-vision services. Also includes the repairs or replacement of parts. Also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two years unless otherwise medically justified.	Covered

Discrimination is Against the Law

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

Kalos Health Gold Plus:

- 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 Kalos Health Gold Plus Member Services Department at 1-800-399-1954 (TTY 711). If you believe that Kalos Health Gold Plus 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:

Kalos Health Gold Plus
Member Services Department – Nondiscrimination
2424 Niagara Falls Blvd.
Niagara Falls, NY 14304
1-800-399-1954, (TTY-711),
Fax: 716-731-2013
Email: info@kaloshealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kalos Health Gold Plus Member Services at 1-800-399-1954 (TTY 711) 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.htm

MULTI-LANGUAGE INTERPRETIVE SERVICE

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-399-1954 (TTY:711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-399-1954 (TTY:711).

Chinese: 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Call 1-800-399-1954 (TTY:711)。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-399-1954. (телетайп: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-399-1954 (TTY-711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-399-1954 (TTY:711) 번으로 전화해 주십시오.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero1-800-399-1954 (TTY:711) .

Yiddish: אויפמערקזאם: אויב איר רעדט אידיש, זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופ 1-800-399-1954 (TTY:711)

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-399-1954 (TTY:711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-399-1954 (TTY:711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم 1-800-399-1954 هاتف الصم والبكم:- (TTY:711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-399-1954 (TTY:711).

Urdu: خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-800-399-1954 (TTY:711). کریں

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-399-1954 (TTY:711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-399-1954 (TTY:711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-399-1954 (TTY: 711).