Account Name: NYS Employee Insurance Accounting
Account #: 22652
Sales Representative: Joel Marinaccio
Plan Effective Date: January 1, 2027

Benefit Summary

Plan Name:	NYSHIP Medicare Encompass HMO	
Benefits	**In-Network**	**Additional Information**
General Information		
Deductible	$0	
Out-of-Pocket Maximum	$3,450	Where the out of pocket max applies it accumulates as embedded. *See Important Notes section for more detail.
Preventive Services		
Abdominal Aortic Aneurysm Screen Annual Physical Exam Basic Metabolism Test Bone Mass Measurement Cholesterol Test (Lipid Panel) Colonoscopy and Sigmoidoscopy Fecal Blood Testing Flu Shot Hemoglobin and Hematocrit Testing Hepatitis B Vaccine HIV screening HPV screening Mammogram Pap Smear Pneumonia Vaccine Prenatal and Post-partum Visits Prostate Exam (Prostate Specific Antigen "PSA") Rh Screening Rubella screening	Covered in full	All preventive services are covered in full with $0 member liability when performed by an Independent Health participating provider. See independenthealth.com for additional information. Additional tests and screenings may require a copay. See your EOC, chapter 4.
Physician and Other Services		
Primary Care Physician	$20 copayment	PCP Required
Specialty Physician	$20 copayment	
Outpatient Surgery (PCP's office)	$20 copayment	
Outpatient Surgery (Specialist's office)	$20 copayment	
Telemedicine Program	$20 copayment	Administered by Teladoc
Emergency & Urgent Care Services		
Emergency Room	$65 copayment	Copayment waived if admitted to hospital
Ambulance	$100 copayment	
Urgent Care Center	$35 copayment	
Hospital and Other Facility Services		
Inpatient Hospital	Covered in full	
Outpatient Surgical Procedures (Hospital Facility)	$75 copayment	
Skilled Nursing Facility	Covered in full	100 days max / benefit period

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Diagnostic Testing Services		
Lab Services	Covered in full	20% for Genetic Testing
X-Rays	$20 copayment	
Advanced Radiology	$20 copayment	
Diagnostic Tests	$20 copayment	
Radiation Therapy	$20 copayment	
Mental Health & Substance Abuse		
Inpatient Mental Health	Covered in full	190 day lifetime limit
Outpatient Mental Health	$40 copayment	No visit limitation as long as medically necessary
Inpatient Substance Abuse - Rehab	Covered in full	
Outpatient Substance Abuse	$40 copayment	No visit limitation as long as medically necessary
Rehabilitation Services		
Chiropractic - Medicare Covered	$15 copayment	
Physical - Occupational - Speech Therapies	$20 copayment visit per visit	No visit limitation as long as medically necessary
Cardiac Rehabilitation	Covered in full	
Pulmonary Rehabilitation	Covered in full	

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Additional Services		
Durable Medical Equipment	20% Coinsurance	
Prosthetic Devices	20% Coinsurance	Compression stockings - Limit 12 per year
Home Health Care	Covered in full	
Fitness Benefit	Silver Sneakers $0 activation fee	16,000 participating facilities Nationwide
Renal Dialysis	20% coinsurance	
Diabetic Supplies	Covered in full	
Medicare Covered Podiatry Services	$20 copayment	
Routine Foot Care	Not Covered	
Nutritional Therapy for ESRD or Diabetes	Covered in full	
Hearing Aids and Evaluation Exam	$45 copayment. $499 to $1,949 copay per ear - per year. Covered through Start Hearing, Inc.	40 Additional Batteries 2 or 3 Year Warranty Copay covers 3 additional Fittings within the first year by an Start Hearing, Inc Provider
Prescription Drug Coverage		
Prescription Plan	$0/$15/$30/$50/$50	
Maintenance Medications	2.5 copayments for 100 day supply on Tier 1, 2.5 copayments for 90 supply on Tiers 2,3, and 4 through mail order or at select retail pharmacies	
Medicare Part D Creditable Coverage Status	Creditable*	For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare.
Vision Services		
Medical Eye Exam	$20 copayment	From an EyeMed provider
Routine/ Refractive Exam	Covered in full	From an EyeMed provider Includes Retinal Imaging
Eyewear - Routine - Annual Limit	Up to $200 allowance	From an EyeMed provider Combined in and out of network
Eyewear - Post Cataract Surgery	Covered in full	From an EyeMed provider
Dental Services		
Preventive and Routine	$0 copayment for each visit	2 routine cleanings, 2 exams and 2 bitewing x-rays per year. 1 full mouth x-ray every 3 years.
Medicare Covered Dental Services (excludes Preventive and Comprehensive Dental Services)	$20 copayment	

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Medicare Part B Drugs		
Administered in Providers Office	$20 copayment	
Used with DME	$0 copayment	
Self Administered - Hemophilia	$0 copayment	
Post Transplant Immunosuppressive	$0 copayment	
Injectable Osteoporosis Drugs	$0 copayment	
Antigens	$0 copayment	
Certain Oral Cancer/Anti-nausea	$0 copayment	
Drugs for Home Dialysis	$0 copayment	
Interveneous Immune Globulin	$0 copayment	

Important Notes

If PCP has a secondary specialty other than Internal Med, Gen Practice, Family Practice, Pediatrics, Geriatrics or Obstetrics/Gynecology, the specialty copay applies.

Your prescription drug coverage has two drug payment stages. How much you pay depends on what stage you are in when you get a prescription filled. During the Initial Coverage Stage, you pay your tier copayment amount.

The Initial Coverage Stage ends when you have spent $2,400 OUT OF YOUR POCKET. When the Initial Coverage Stage ends, the Catastrophic Coverage Stage begins and lasts until the end of the calendar year. During this payment stage, you pay nothing for your covered Part D drugs and your Tier 2 copayment for excluded drugs covered under our enhanced benefit

Please refer to the Independent Health Prescription Drug Formulary and Evidence of Coverage document for more details.

If you have a Medicare Part D Low Income Subsidy rider, the terms and conditions of the Low Income Subsidy rider will supersede the terms and conditions of the drug rider attached to this contract, where applicable.

This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Group Health Contract, attached Riders (if any), or Evidence of Coverage.