



2027 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

Independent Health's Encompass 65 RED 044 (HMO)

January 1, 2027 – December 31, 2027

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, 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 Encompass 65 RED 044 (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Independent Health's Encompass 65 RED 044 (HMO)** 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 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 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 Encompass 65 RED 044 (HMO)**.
- 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 Encompass 65 RED 044 (HMO)

Hours of Operation & Contact Information

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

- From October 1 to March 31 we are open 8 a.m. – 8 p.m. Eastern Time, 7 days a week.
- From April 1 to September 30 we are open 8 a.m. – 8 p.m. Eastern Time, Monday –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 are open 8 a.m. – 8 p.m. Eastern Time, 7 days a week.
- From December 8 to September 30 we are open 8 a.m. – 8 p.m. Eastern Time, Monday –Friday.

Our website: independenthealth.com/medicare.

Who can join?

To join **Independent Health's Encompass 65 RED 044 (HMO)**, 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 Encompass 65 RED 044 (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these 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 (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, independenthealth.com/medicare.
- Or, call us and we will send you a copy of the formulary.

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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: Deductible, Initial Coverage 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 Encompass 65 RED 044 (HMO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

Monthly Plan Premium	\$110 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: \$175 deductible applies to certain services. See the benefit grid below for details. Prescription Drug Deductible: \$510 for Tiers 3, 4 and 5.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • \$8,000 for services you receive from in-network providers. 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. Premiums, deductible, routine vision exams, routine eyewear, optical dispensing, non-Medicare covered dental, 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	<u>In-Network:</u> Plan deductible applies then: Days 1-5: \$425 Copay per day for each admission. Days 6-90: \$0 Copay per day. \$2,125 annual copayment limit applies. Our plan covers an unlimited number of days for an inpatient hospital stay. Requires provider preauthorization except for emergency admissions.
Outpatient Hospital	<u>In-Network:</u> Plan level deductible applies, then: Outpatient hospital: \$400 Copay. Provider preauthorization may apply for some services.
Ambulatory Surgical Center	<u>In-Network:</u>

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	Plan level deductible applies, then: Freestanding Ambulatory Surgical Center: \$375 Copay. See the provider directory for a listing of Freestanding Ambulatory Surgical Centers. Provider preauthorization may apply for some services.
Doctor's Office Visits	<u>In-Network:</u> Primary care physician visit: \$0 Copay. 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: \$35 Copay.
Preventive Care (e.g., flu vaccine, diabetic screenings)	<u>In-Network:</u> 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.
Emergency Care	<u>In-Network:</u> \$115 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: \$115 Copay. \$10,000 plan limit per occurrence for the combined unforeseen event outside of the United States.
Urgently Needed Services	<u>In-Network:</u> \$40 Copay per visit. Worldwide Urgent Coverage: \$40 Copay.

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	\$10,000 plan limit per occurrence for the combined unforeseen event outside of the United States
Diagnostic Services / Labs/ Imaging	<u>In-Network:</u> Diagnostic tests and procedures: Primary Care Physician - \$0 Copay. Specialist Visit - \$35 Copay. Lab services: You pay nothing for routine lab tests. Plan level deductible applies, then 20% Coinsurance for molecular or predisposition genetic testing. Diagnostic Advanced Radiology Services (such as MRI, CAT Scan): Plan level deductible applies, then \$250 Copay. X-rays: \$35 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): Plan level deductible applies, then 20% Coinsurance. Provider preauthorization may apply for some services.
Hearing Services	<u>In-Network:</u> Exam to diagnose and treat hearing and balance issues: You pay \$35 Copay for a Specialist. Routine hearing exam: You pay nothing for a Primary Care Provider. \$35 Copay for a Specialist. Hearing Aid Evaluation Exam: \$45 Copay. Hearing Aid: \$499 - \$1949 Copay. \$250 allowance towards member cost share per ear per year. Copayment structure per hearing aid: \$499, \$699, \$999, \$1,499, \$1,949. 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 benefit. Call Member Services for additional information about the network, or visit IndependentHealth.com/Medicare.

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Dental Services	<u>In-Network:</u> Medicare Covered: Plan level deductible applies if in an outpatient hospital or ambulatory surgical center. \$35 Copay if seen by a Specialist Annual maximum allowance of \$2,000 combined In-Network and Out-of-Network applies for preventive and comprehensive dental services combined. For preventive dental services through a LIBERTY provider, 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) • For Comprehensive Dental services through a LIBERTY provider, you pay 50% Coinsurance.
Vision Services	<u>In-Network:</u> Exam to diagnose and treat diseases and conditions of the eye: You pay \$35 Copay for a Specialist. Routine eye exam, including yearly glaucoma screening (up to 1 visit every year): You pay nothing from an EyeMed Provider. Eyeglasses or contact lenses after cataract surgery: \$0 Copay. Eyeglasses (frames and lenses) or contact lenses: Our plan pays up to \$200 every year for eyewear. Any costs incurred above this amount for lenses, frames or contacts are the member's responsibility.
Mental Health Care	<u>In-Network:</u> Outpatient group therapy visit: \$25 Copay. Individual therapy visit: \$25 Copay. Inpatient Mental Health Care: Plan level deductible applies, then: Days 1-4: \$395 Copay per day for each admission.

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	Days 5-90: \$0 Copay per day.
Skilled Nursing Facility (SNF)	<u>In-Network:</u> Plan level deductible applies, then: Days 1-20: \$0 Copay per day. Days 21-100: \$221 Copay per day. Provider preauthorization is required.
Outpatient Rehabilitation	<u>In-Network:</u> Occupational therapy visit: \$15 Copay per visit. Physical therapy and speech and language therapy visit: \$15 Copay per visit.
Ambulance	<u>In-Network:</u> Plan level deductible applies, then: Ground Ambulance: \$250 Copay. Wheelchair van is not covered. Air Ambulance: 20% Coinsurance. Provider preauthorization is required for planned transportation only.
Transportation	<u>In-Network:</u> Not Covered.
Medicare Part B Drugs	<u>In-Network:</u> Plan level deductible applies, then: For Part B drugs such as chemotherapy drugs: 0% - 20% Coinsurance. Other Part B drugs: 0% - 20% Coinsurance. Provider preauthorization may be required.
Foot Care (Podiatry Services)	<u>In-Network:</u> Foot exams: \$35 Copay from a Podiatrist.

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Durable Medical Equipment	<u>In-Network:</u> 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.
Diabetic Supplies and Services	<u>In-Network:</u> Limited to preferred products. Diabetes monitoring supplies: \$0 Copay for supplies with glucose a meter or therapeutic continuous glucose monitor. 20% Coinsurance for supplies with a non-therapeutic continuous glucose monitor. Diabetic Monitor: \$0 Copay for a glucose meter or therapeutic continuous glucose monitor. 20% Coinsurance for a non-therapeutic continuous glucose monitor. Diabetes self-management training: You pay nothing. Therapeutic shoes or inserts: You pay nothing.
Prosthetic Devices (braces, artificial limbs, etc.)	<u>In-Network:</u> Prosthetic devices: 20% Coinsurance. Related medical supplies: You pay nothing Provider preauthorization may apply.
Wellness Program	<u>In-Network:</u> Fitness Benefit: You pay nothing. SilverSneakers® You pay nothing for this benefit. SilverSneakers gives you FREE access to: • Thousands of participating fitness center locations nationwide¹ • 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

SECTION II - SUMMARY OF BENEFITS

Independent Health's Encompass 65 RED 044 (HMO)

	• Burnalong® access with a supportive virtual community and thousands of classes for all interests and abilities • GetSetUp³, with hundreds of interactive online classes one hour or less, ranging from nutrition to mindfulness and more. You must use participating Silver Sneakers fitness locations and programs. For a list of participating fitness facilities, go to silversneakers.com. Or call Silver Sneakers (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.
Remote Access Technologies: Teladoc®	<u>In-Network:</u> You pay \$0 Copay for behavioral health services with a Teladoc provider. You pay \$0 Copay for each consult for other services with a Teladoc Provider over the phone or on-line. Teladoc is available 24 hours a day, 7 days a week.

PRESCRIPTION DRUG BENEFITS

Deductible	Prescription Drug Deductible: \$510 for Tiers 3, 4, and 5. \$0 deductible on covered insulin products and adult Part D vaccines.		
Initial Coverage	You pay the following until your total yearly out-of-pocket costs reach \$2,400.		
	You pay \$35 for select insulins.		
	Standard Retail Cost-Sharing		
	Tier	One-month supply	Three-month supply
	Tier 1 (Preferred Generic)	\$0 copay	\$0 copay
	Tier 2 (Generic)	\$4 copay	\$10 copay
	Tier 3 (Preferred Brand)	17% coinsurance	17% coinsurance
	Tier 4 (Non-Preferred Drug)	32% coinsurance	32% coinsurance
Tier 5 (Specialty Tier)	27% coinsurance	Not Applicable	

PRESCRIPTION DRUG BENEFITS

Standard Mail Order

Tier	One-month supply	Three-month supply
Tier 1 (Preferred Generic)	Not Applicable	\$0 copay
Tier 2 (Generic)	Not Applicable	\$10 copay
Tier 3 (Preferred Brand)	Not Applicable	17% coinsurance
Tier 4 (Non-Preferred Drug)	Not Applicable	32% 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 100 days for Tier 1 and up to 90 days on Tier 2, 3, and 4) of a drug.

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

Catastrophic Amount

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$2,400 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.

DISCLAIMERS

This document is available in other alternate formats.

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.

¹Participating 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 Association, Inc.

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 independentthehealth.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.
- ☐ Review the formulary to make sure your drugs are covered.

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, 2028.
- ☐ 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).
- ☐ **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.