



# 2027 Independent Health Medicare Advantage Plans *(Effective January 1, 2027)*

| 2027 BENEFITS                                                         |                            | Independent Health's Encompass 65®<br><b>RED 042 HMO</b><br>\$49                                                                                                                                                          | Independent Health's Encompass 65®<br><b>RED 044 HMO</b><br>\$110                                     | Independent Health's Encompass 65®<br><b>RED 045 HMO</b><br>\$286                                     | Independent Health's Encompass 65®<br><b>HMO</b><br>Without Prescription Coverage¹<br>\$0 (\$60 give back) | Independent Health's Passport®<br><b>Connect PPO</b><br>\$81                                                                                                                                                                      |                                          |
|-----------------------------------------------------------------------|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
|                                                                       |                            |                                                                                                                                                                                                                           |                                                                                                       |                                                                                                       |                                                                                                            | In-Network (IN)                                                                                                                                                                                                                   | Out-of-Network (OON)                     |
| Annual Medical Deductible²                                            |                            | \$350 on certain services                                                                                                                                                                                                 | \$175 on certain services                                                                             | \$150 on certain services                                                                             | \$0                                                                                                        | \$275 on certain services                                                                                                                                                                                                         |                                          |
| Part D Prescription Benefit Tiers 1/2/3/4/5                           |                            | \$550 Deductible on Tiers 3, 4 & 5 Only<br>\$0/\$5/18%/33%/27%<br>Catastrophic Coverage Limit \$2,400                                                                                                                     | \$510 Deductible on Tiers 3, 4 & 5 Only<br>\$0/\$4/17%/32%/27%<br>Catastrophic Coverage Limit \$2,400 | \$375 Deductible on Tiers 3, 4 & 5 Only<br>\$0/\$4/16%/42%/29%<br>Catastrophic Coverage Limit \$2,400 | No Prescription Benefit¹                                                                                   | \$700 Deductible on All Tiers 25%/25%/25%/25%/25%<br>Catastrophic Coverage Limit \$2,400                                                                                                                                          |                                          |
| Formulary³                                                            |                            | Standard                                                                                                                                                                                                                  | Standard                                                                                              | Enhanced                                                                                              | N/A                                                                                                        | Standard                                                                                                                                                                                                                          |                                          |
| Primary                                                               |                            | \$0                                                                                                                                                                                                                       | \$0                                                                                                   | \$0                                                                                                   | \$0                                                                                                        | \$0                                                                                                                                                                                                                               | Deductible then 50%                      |
| Specialist Copay                                                      |                            | \$55                                                                                                                                                                                                                      | \$35                                                                                                  | \$25                                                                                                  | \$30                                                                                                       | \$55                                                                                                                                                                                                                              | Deductible then 50%                      |
| Preventive Services⁴                                                  |                            | \$0 Copay includes preventive screenings such as Colonoscopy, Mammogram, Prostate Screening, Flu Shot and Pneumonia Vaccine.<br>NOTE: Not a complete list of covered screenings. A separate office visit copay may apply. |                                                                                                       |                                                                                                       |                                                                                                            | \$0 (IN) / 50% (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. |                                          |
| Inpatient Hospital<br><i>Unlimited Days for Medicare Covered Stay</i> |                            | Days 1-4: Deductible then \$530 per day.<br>\$6,068 Annual Maximum Member Copay.                                                                                                                                          | Days 1-5: Deductible then \$425 per day.<br>\$2,125 Annual Maximum Member Copay.                      | Days 1-6: \$300 per day.<br>\$1,800 Annual Maximum Member Copay.                                      | Days 1-5: \$300 per day.<br>\$1,500 Annual Maximum Member Copay.                                           | Days 1-5: \$450 per day.<br>\$2,250 Annual Maximum Member Copay.                                                                                                                                                                  | Deductible then 50%                      |
| Outpatient Mental Health Care                                         |                            | \$35                                                                                                                                                                                                                      | \$25                                                                                                  | \$20                                                                                                  | \$20                                                                                                       | \$35                                                                                                                                                                                                                              | Deductible then 50%                      |
| Worldwide⁵ Emergency Room/Urgent Care                                 |                            | \$115 / \$40                                                                                                                                                                                                              | \$115 / \$40                                                                                          | \$115 / \$40                                                                                          | \$130 / \$50                                                                                               | \$115 / \$40                                                                                                                                                                                                                      |                                          |
| Ambulance (Ground)                                                    |                            | Deductible then \$270                                                                                                                                                                                                     | Deductible then \$250                                                                                 | \$240                                                                                                 | \$275                                                                                                      | \$265                                                                                                                                                                                                                             | Deductible then \$265                    |
| Non-Emergency Transportation                                          |                            | Not Covered                                                                                                                                                                                                               | Not Covered                                                                                           | Not Covered                                                                                           | \$0; 24 One-Way Trips<br>+ <b>NEW</b> Unlimited Trips to the VA Hospital                                   | Not Covered                                                                                                                                                                                                                       |                                          |
| Personal Emergency Response System                                    |                            | Not Covered                                                                                                                                                                                                               | \$0                                                                                                   | \$0 + <b>NEW</b> Includes Wearable Smart Watch                                                        | \$0                                                                                                        | Not Covered                                                                                                                                                                                                                       |                                          |
| Lab                                                                   |                            | \$0                                                                                                                                                                                                                       | \$0                                                                                                   | \$0                                                                                                   | \$0                                                                                                        | \$0                                                                                                                                                                                                                               | Deductible then 50%                      |
| General X ray                                                         |                            | \$55                                                                                                                                                                                                                      | \$35                                                                                                  | \$30                                                                                                  | \$35                                                                                                       | \$45                                                                                                                                                                                                                              | Deductible then 50%                      |
| Advanced Radiology                                                    |                            | Deductible then \$325                                                                                                                                                                                                     | Deductible then \$250                                                                                 | \$150                                                                                                 | \$150                                                                                                      | \$225                                                                                                                                                                                                                             | Deductible then 50%                      |
| Outpatient Surgery                                                    | Ambulatory Surgical Center | Deductible then \$350                                                                                                                                                                                                     | Deductible then \$375                                                                                 | \$325                                                                                                 | \$300                                                                                                      | \$400                                                                                                                                                                                                                             | Deductible then 50%                      |
|                                                                       | Hospital Based             | Deductible then \$500                                                                                                                                                                                                     | Deductible then \$400                                                                                 | Deductible then \$375                                                                                 | \$300                                                                                                      | Deductible then \$450                                                                                                                                                                                                             |                                          |
| Skilled Nursing Facility⁷                                             |                            | Deductible then<br>Days 1-20: \$0/day; Days 21-100: \$221 per day                                                                                                                                                         | Deductible then<br>Days 1-20: \$0/day; Days 21-100: \$221 per day                                     | Days 1-20: \$0/day;<br>Days 21-100: \$221 per day                                                     | Days 1-20: \$0/day;<br>Days 21-100: \$221 per day                                                          | Days 1-20: \$0/day;<br>Days 21-100: \$221 per day                                                                                                                                                                                 | Deductible then 50%                      |
| Home Health                                                           |                            | \$0                                                                                                                                                                                                                       | \$0                                                                                                   | \$0                                                                                                   | \$0                                                                                                        | \$0                                                                                                                                                                                                                               | Deductible then 50%                      |
| Physical, Speech, Occupational Therapy                                |                            | \$20                                                                                                                                                                                                                      | \$15                                                                                                  | \$10                                                                                                  | \$35                                                                                                       | \$30                                                                                                                                                                                                                              | Deductible then 50%                      |
| % You Pay for Part B Medications or Radiation Therapy⁸                |                            | Deductible then \$0-20%                                                                                                                                                                                                   |                                                                                                       | \$0-20%                                                                                               |                                                                                                            | \$0-20%                                                                                                                                                                                                                           | Deductible then 50%                      |
| Annual Out-of-Pocket Maximum                                          |                            | \$9,850                                                                                                                                                                                                                   | \$8,000                                                                                               | \$7,000                                                                                               | \$6,750                                                                                                    | \$9,850                                                                                                                                                                                                                           | \$14,800 Combined In- and Out-of-Network |



2027 Annual Enrollment Period: October 15 – December 7  
www.IndependentHealth.com/Medicare



(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.



Medicare.Help@IndependentHealth.com



| 2027 WELLNESS BENEFITS                                                                                                                                                     | Independent Health’s Encompass 65®<br><b>RED 042 HMO</b><br>\$49                                                                                                                                             | Independent Health’s Encompass 65®<br><b>RED 044 HMO</b><br>\$110                                                                                     | Independent Health’s Encompass 65®<br><b>RED 045 HMO</b><br>\$286                                                                                     | Independent Health’s Encompass 65®<br><b>HMO</b><br>Without Prescription Coverage¹<br>\$0 (\$60 give back)                                            | Independent Health’s Passport®<br><b>Connect PPO</b><br>\$81                                                                                          |                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
|                                                                                                                                                                            |                                                                                                                                                                                                              |                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                       | Out-of-Network (OON)                                                                                                                                  |                           |
|  <b>Dental</b> Includes both in- and out-of-network preventive and comprehensive coverage. | Up to \$1,500 annual allowance toward services (IN and OON).<br>Includes \$0 preventive dental PLUS comprehensive dental coverage at 50% coinsurance.                                                        | Up to \$2,000 annual allowance toward services (IN and OON).<br>Includes \$0 preventive dental PLUS comprehensive dental coverage at 50% coinsurance. | Up to \$2,000 annual allowance toward services (IN and OON).<br>Includes \$0 preventive dental PLUS comprehensive dental coverage at 50% coinsurance. | Up to \$2,000 annual allowance toward services (IN and OON).<br>Includes \$0 preventive dental PLUS comprehensive dental coverage at 50% coinsurance. | Up to \$1,500 annual allowance toward services (IN and OON).<br>Includes \$0 preventive dental PLUS comprehensive dental coverage at 50% coinsurance. |                           |
|  <b>Over-the-Counter (OTC) (benefit rolls over quarterly)⁹</b>                             | Not Covered                                                                                                                                                                                                  | Not Covered                                                                                                                                           | Not Covered                                                                                                                                           | \$75 per quarter                                                                                                                                      | Not Covered                                                                                                                                           |                           |
|  <b>Fitness (SilverSneakers®)¹⁰</b>                                                        | \$0 fitness benefit with access to thousands of locations nationwide.                                                                                                                                        |                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                       | \$0                                                                                                                                                   | \$500 Deductible then 50% |
|  <b>Vision (EyeMed®)</b>                                                                   | \$0 routine eye exam; \$200 coverage allowance toward routine eyewear every year.                                                                                                                            |                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                       | \$0 (IN) / \$65 (OON) routine eye exam. \$200 annual allowance toward routine eyewear every year.                                                     |                           |
|  <b>Hearing Aid Coverage</b>                                                               | \$45 hearing aid evaluation exam. \$250 allowance per ear.<br>\$499 - \$1,949 price per hearing aid (per ear) for select hearing aid devices. You must use a provider in the Start Hearing benefits network. |                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                       | Not Covered                                                                                                                                           |                           |
|  <b>Telemedicine (Teladoc®)</b>                                                            | Speak with a doctor anytime, anywhere by phone or online now for a \$0 Copay. Behavioral Health is covered at \$0 Copay.                                                                                     |                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                       | Not Covered                                                                                                                                           |                           |
|  <b>Chiropractic Evaluation &amp; Management</b>                                           | \$15                                                                                                                                                                                                         | \$15                                                                                                                                                  | \$15                                                                                                                                                  | \$10                                                                                                                                                  | \$15                                                                                                                                                  | 50%                       |

IN – In-Network / OON – Out-of-Network



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

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

### Understanding Your Annual Deductible(s) and Formulary

²**Deductibles** – A **medical deductible** is the amount you must pay for covered services before your plan starts to pay its share. Once you reach your medical deductible, you only pay either a set “copay,” or “coinsurance” (a percentage of the cost). A **prescription deductible** is the amount you must pay for covered medications before your plan starts to pay its share. Once you reach your prescription deductible, you only pay either a set “copay,” or “coinsurance” (a percentage of the cost).

**Most of our plans require members to pay a deductible on certain services. You may have both a medical and prescription deductible. In this case, each deductible needs to be met separately before the plan pays its share for a service or medicine and you pay your copays or coinsurance.**

³**Standard vs. Enhanced Formulary:**  
Independent Health uses two formularies, Standard and Enhanced, for our Individual Medicare Advantage plans. When selecting your plan, it is very important to review the formulary to make sure your medicine is included.

## 2027 Annual Enrollment Period: October 15 – December 7

[www.IndependentHealth.com/Medicare](http://www.IndependentHealth.com/Medicare)



(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.



[Medicare.Help@IndependentHealth.com](mailto:Medicare.Help@IndependentHealth.com)



A sales person will be present with information and applications. For accommodations of persons with special needs at sales meetings, please call 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. Benefits vary by plan. 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. Must use network providers. 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. Out-of-network/non-contracted providers are under no obligation to treat Independent Health’s Medicare Passport PPO members, except in emergency situations. 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. **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.

¹This 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. ²Not 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. ³The \$10,000 plan limit is per occurrence for the combined unforeseen event outside of the USA. ⁴Member pays 20% (IN) for genetic testing. Deductible may apply. ⁵Skilled nursing facility benefit is not covered after day 100, per benefit period. ⁶Member pays the applicable Part B medication coinsurance plus applicable outpatient/office visit copay. ⁷Must use Nations Benefits. 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. ⁸SilverSneakers is a registered trademark of Tivity Health, Inc. ©Tivity Health, Inc. All rights reserved.