Independent Health

Account Name: Trustees:Erie County Bar Association
Account #: 24638
Sales Representative: Tracy D'Agostino
Plan Effective Date: January 1, 2025

Benefit Summary

Plan Name:	Independent Health's Medicare Encompass F (HMO-POS)		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
General Information			
Deductible	$0	$0	
Out-of-Pocket Maximum	$3,450 In Network	$5,150 Combined In and Out of Network	
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	20% coinsurance	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	$25 copayment	20% coinsurance	PCP Required
Specialty Physician	$40 copayment	20% coinsurance	
Outpatient Surgery (PCP's office)	$25 copayment	20% coinsurance	
Outpatient Surgery (Specialist's office)	$40 copayment	20% coinsurance	
Telemedicine Program	$20 copayment	Not Covered	Administered by Teladoc
Emergency & Urgent Care Services			
Emergency Room	$50 copayment	$50 copayment	Copayment waived if admitted to hospital
Ambulance	$50 copayment	$50 copayment	
Urgent Care Center	$35 copayment	$35 copayment	
Hospital and Other Facility Services			
Inpatient Hospital	$250 copayment per admission	20% coinsurance	
Outpatient Surgical Procedures (Hospital Facility)	$75 copayment	20% coinsurance	
Skilled Nursing Facility	$250 copayment per admission	20% coinsurance	100 days max / benefit period

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Diagnostic Testing Services			
Lab Services	Covered in full	Covered in full	
X-Rays	$20 copayment	20% coinsurance	
Advanced Radiology	$20 copayment	20% coinsurance	
Diagnostic Tests	$25 / $40 copayment	20% coinsurance	
Radiation Therapy	$20 copayment	20% coinsurance	
Mental Health & Substance Abuse			
Inpatient Mental Health	$250 copayment per admission	20% coinsurance	190 day lifetime limit
Outpatient Mental Health	$40 copayment	20% coinsurance	
Inpatient Substance Abuse - Rehab	$250 copayment per admission	Not Covered	
Outpatient Substance Abuse	$40 copayment	20% coinsurance	
Rehabilitation Services			
Chiropractic - Medicare Covered	$15 copayment	50% coinsurance	
Physical - Occupational - Speech Therapies	$20 copayment per visit	20% coinsurance	
Cardiac Rehabilitation	Covered in full	20% coinsurance	
Pulmonary Rehabilitation	Covered in full	20% coinsurance	

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Additional Services			
Durable Medical Equipment	10%-20% coinsurance	50% coinsurance to an annual total of $1,000	Reduced coinsurance for certain items through People First Mobility
Prosthetic Devices	20% coinsurance	Not Covered	
Home Health Care	Covered in full	20% coinsurance	
Fitness Benefit	Silver Sneakers $0 activation fee	Must use a SilverSneakers Network facility	16,000 participating facilities Nationwide
Renal Dialysis	20% coinsurance	20% coinsurance	
Diabetic Supplies	Covered in full	20% coinsurance	
Unique Benefits	Reward & Incentives Program	Not Applicable	Earn up to $100 per plan year for healthy behavior. Refer to your contract for additional information.
Medicare Covered Podiatry Services	$40 copayment	20% coinsurance	
Routine Foot Care	Not Covered	Not Covered	
Nutritional Therapy for ESRD or Diabetes	Covered in full	20% coinsurance	
Hearing Aids and Evaluation Exam	$45 copayment. $499 to $1,949 copay per ear - per year. Covered through Start Hearing, Inc	Must use an Start Hearing, Inc network provider	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/$20/$47/$100/$100	$0/$20/$47/$100/$100	Out Of Network Coverage is limited per situation. See your EOC, chapter 5.
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	Not Covered	
Medicare Part D Creditable Coverage Status	Creditable*	Not Applicable	For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare.

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Vision Services			
Medical Eye Exam	$40 copayment	20% coinsurance	From an EyeMed provider
Routine/ Refractive Exam	Covered in full	$65 copayment	From an EyeMed provider Includes Retinal Imaging
Eyewear - Routine - Annual Limit	Up to $200 annually	Up to $200 annually	From an EyeMed provider Combined in and out of network
Eyewear - Post Cataract Surgery	Covered in full	$30 Reimbursement	From an EyeMed provider
Dental Services			
Preventive and Routine	$0 copayment for each visit	Must use a Liberty Dental provider	2 routine cleanings, 2 exams, 2 fluoride treatments 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)	Based on place of service	20% coinsurance	
Medicare Part B Drugs			
Administered in Providers Office	Covered in full	Covered in full	
Used with DME	Covered in full	Covered in full	
Self Administered - Hemophilia	Covered in full	Covered in full	
Post Transplant Immunosuppressive	Covered in full	Covered in full	
Injectable Osteoporosis Drugs	Covered in full	Covered in full	
Antigens	Covered in full	Covered in full	
Certain Oral Cancer/Anti-nausea	Covered in full	Covered in full	
Drugs for Home Dialysis	Covered in full	Covered in full	
Interveneous Immune Globulin	Covered in full	Covered in full	

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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 $2,000 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.