



**Account Name:** Trustees:Erie County Bar Association

**Account #:** 24638

**Sales Representative:** Tracy D'Agostino

**Plan Effective Date:** January 1, 2027

## Benefit Summary

| Plan Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Independent Health's Medicare Encompass F (HMO-POS)                      |                                        |                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | In-Network                                                               | Out-of-Network                         | Additional Information                                                                                                                                                                                                                                                           |
| <b>General Information</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                          |                                        |                                                                                                                                                                                                                                                                                  |
| Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | \$0                                                                      | \$0                                    |                                                                                                                                                                                                                                                                                  |
| Out-of-Pocket Maximum                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$3,450 In Network                                                       | \$5,150 Combined In and Out of Network |                                                                                                                                                                                                                                                                                  |
| <b>Preventive Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                          |                                        |                                                                                                                                                                                                                                                                                  |
| Abdominal Aortic Aneurysm Screen<br>Annual Physical Exam<br>Basic Metabolism Test<br>Bone Mass Measurement<br>Cholesterol Test (Lipid Panel)<br>Colonoscopy and Sigmoidoscopy<br>Fecal Blood Testing<br>Flu Shot<br>Hemoglobin and Hematocrit Testing<br>Hepatitis B Vaccine<br>HIV screening<br>HPV screening<br>Mammogram<br>Pap Smear<br>Pneumonia Vaccine<br>Prenatal and Post-partum Visits<br>Prostate Exam (Prostate Specific Antigen "PSA")<br>Rh Screening<br>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.<br><br>Additional tests and screenings may require a copay. See your EOC, chapter 4. |
| <b>Physician and Other Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                          |                                        |                                                                                                                                                                                                                                                                                  |
| 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$0 copayment for behavioral health<br>\$20 copayment for other services | Not Covered                            | Administered by Teladoc                                                                                                                                                                                                                                                          |
| <b>Emergency &amp; Urgent Care Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                          |                                        |                                                                                                                                                                                                                                                                                  |
| Emergency Room                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | \$50 copayment                                                           | \$50 copayment                         | Copayment waived if admitted to hospital                                                                                                                                                                                                                                         |
| Ambulance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$50 copayment                                                           | \$50 copayment                         |                                                                                                                                                                                                                                                                                  |
| Urgent Care Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$35 copayment                                                           | \$35 copayment                         |                                                                                                                                                                                                                                                                                  |



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|----------------------------------------------------|-----------------------------------------------------|-----------------|-------------------------------|
| Benefits                                           | In-Network                                          | Out-of-Network  | Additional Information        |
| <b>Hospital and Other Facility Services</b>        |                                                     |                 |                               |
| 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 |
| <b>Diagnostic Testing Services</b>                 |                                                     |                 |                               |
| 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 |                               |
| <b>Mental Health &amp; Substance Abuse</b>         |                                                     |                 |                               |
| 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 |                               |
| <b>Rehabilitation Services</b>                     |                                                     |                 |                               |
| 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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| Plan Name:                                 | Independent Health's Medicare Encompass F (HMO-POS)                                                                                                         |                                                 |                                                                                                                                               |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| Benefits                                   | In-Network                                                                                                                                                  | Out-of-Network                                  | Additional Information                                                                                                                        |
| <b>Additional Services</b>                 |                                                                                                                                                             |                                                 |                                                                                                                                               |
| 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<br>\$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                                 |                                                                                                                                               |
| 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                                 |                                                                                                                                               |
| Personal Emergency Response Service (PERS) | \$0 copay                                                                                                                                                   | Not Covered                                     | Must use NationsResponse.                                                                                                                     |
| Hearing Aids and Evaluation Exam           | \$45 copayment.<br>\$250 annual allowance per ear towards hearing aids<br>\$499 to \$1,949 copay per ear - per year.<br>Covered through Start Hearing, Inc. | Must use an Start Hearing, Inc network provider | 40 Additional Batteries<br>2 or 3 Year Warranty<br>Copay covers 3 additional Fittings within the first year by an Start Hearing, Inc Provider |
| <b>Prescription Drug Coverage</b>          |                                                                                                                                                             |                                                 |                                                                                                                                               |
| 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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|------------------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| Benefits                                                                                 | In-Network                                          | Out-of-Network                     | Additional Information                                                                                                  |
| <b>Vision Services</b>                                                                   |                                                     |                                    |                                                                                                                         |
| Medical Eye Exam                                                                         | \$40 copayment                                      | 20% coinsurance                    | From an EyeMed provider                                                                                                 |
| Routine/ Refractive Exam                                                                 | Covered in full                                     | \$65 copayment                     | From an EyeMed provider<br>Includes Retinal Imaging                                                                     |
| Eyewear - Routine - Annual Limit                                                         | Up to \$200 annually                                | Up to \$200 annually               | From an EyeMed provider<br>Combined in and out of network                                                               |
| Eyewear - Post Cataract Surgery                                                          | Covered in full                                     | \$30 Reimbursement                 | From an EyeMed provider                                                                                                 |
| <b>Dental Services</b>                                                                   |                                                     |                                    |                                                                                                                         |
| 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.<br>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                    |                                                                                                                         |
| <b>Medicare Part B Drugs</b>                                                             |                                                     |                                    |                                                                                                                         |
| 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                     |
| <p>If PCP has a secondary specialty other than Internal Med, Gen Practice, Family Practice, Pediatrics, Geriatrics or Obstetrics/Gynecology, the specialty copay applies.</p> <p>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.</p> <p>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</p> <p>Please refer to the Independent Health Prescription Drug Formulary and Evidence of Coverage document for more details.</p> <p>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.</p> <p>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.</p> |                                                     |