Independent Health

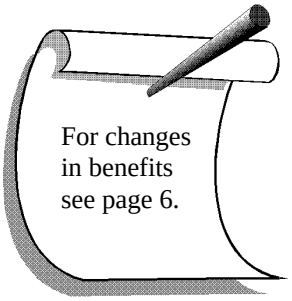
http://www.independenthealth.com

2001

A Health Maintenance Organization

Serving: Western New York

Enrollment in this Plan is limited; see page 5 for requirements.



Enrollment codes for this Plan:

QA1 Self Only
QA2 Self and Family

Special notice: We have eliminated Metro/Hudson New York from our 2001 service area. You will no longer have access to plan providers in this area. If you are an Independent Health member under enrollment code C11 (Self Only) or C12 (Self and Family), you must select a new health plan during the Federal Employees Health Benefits (FEHB) Program Open Season.

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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FEHB
Federal Employees
Health Benefits Program

RI 73-103

Table of Contents

Introduction

Independent Health
511 Farber Lakes Drive
Buffalo, NY 14221

This brochure describes the benefits of Independent Health under our contract (CS 1933) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Independent Health.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my healthcare?

The first and most important decision you must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. If you live in Western New York you have access to more than 981 participating primary care doctors and 1,676 specialists; more than 19,500 participating pharmacies nationwide, as well as all of the area hospitals.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Independent Health is a not-for-profit Health Maintenance Organization
- We are licensed under Article 44 of the New York State Insurance Law.
- Independent Health celebrated its 20th anniversary in 2000.

If you would like more information, contact the Western New York Marketing Department at (716) 631-5392 or (800) 453-1910.

Service Area

You must live or work in our service area to enroll with us. Our service area is where our providers practice. You may enroll with us if you live in the following Western New York counties:

Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care, as described on page 31. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. You do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard the coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling contact the Western New York Marketing Department at (716) 631-5392 or (800) 453-1910. You can also check our website at www.independenthealth.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 10.1% for Self Only or 10.1% for Self and Family
- The copay for out-of-area emergency services received at doctor's offices and urgent care centers has decreased.
- You now have coverage for dental care that is medically necessary due to congenital disease or anomaly.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call our Member Services Department at (716) 631-8701 or (800) 501-3439, press 1.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and coinsurance, and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to NCQA standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our web site at www.independenthealth.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our web site at www.independenthealth.com.

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

The Plan's provider directory lists primary care doctors with their locations and phone numbers. We update directories on a regular basis. Directories are available at the time of enrollment or upon request by calling our Western New York Marketing Department at (716) 631-5392 or (800) 453-1910. You can also find out if your doctor participates with us by calling one of the numbers listed above.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, a woman may see her OB/GYN of record directly, with no need to be referred from her primary care doctor.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with us to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician may have to get an authorization or approval beforehand.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - do not renew our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the FEHB Program, contact your new Plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (716) 631-5392 in Western New York. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefit of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process pre-authorization. Independent Health is committed to working with your doctor to ensure you receive the best possible medical care in the most appropriate medical setting. Because some medical conditions can be treated in a variety of ways, Independent Health's Medical Director has developed a list of procedures that need to be approved before they are performed. Your doctor will work with Independent Health to receive this approval before they are performed. There is nothing that you need to do.

Procedures that Require Pre-Authorization

Alcohol/substance abuse services
Bone growth stimulator
Breast implant removal
Breast reconstruction
Continuous passive motion
Cosmetic procedures
Depo Provera, when used for endometriosis
Durable medical equipment, including equipment for diabetics
Home care services
Hospice benefits
Inpatient dental services
Inpatient hospitalizations
Intra-articular injections of hyalgan or synvisc
Mental health services
New technology
Nutritional counseling
Out-of-plan referrals
Oxygen
Physical, occupational and speech therapy services
Podiatry outpatient services
Psychological testing
Self-injectable drugs
Skilled nursing facility/subacute facility admissions
Surgeries that require the use of an operating room
Synagis vaccine
Transplants

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

• **Copayments**	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit.
• **Deductible**	We do not have a deductible.
• **Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for certain types of care. Example: In our Plan, you pay 50% of our allowance for durable medical equipment.
Your out-of-pocket maximum	We do not have an out-of-pocket maximum.

Section 5. Benefits - OVERVIEW

(See page 6 for how our benefits changed this year and page 55 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact our Member Services Department at (716) 631-8701 or (800) 501-3439, press 1, or visit our web site at www.independenthealth.com.

Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit
Outpatient professional services of physicians • In an urgent care center in the Plan's service area • Office medical consultations • Second surgical opinion	$10 per office visit
Inpatient professional services of physicians • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing
At home	$10 per office visit

Diagnostic and treatment services - Continued on next page

Diagnostic and treatment services *(Continued)*	**You pay**
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per office visit
• Non-routine Mammograms	Nothing
Preventive care, adult	
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test	$10 per office visit
•• Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	$10 per office visit

Preventive care, adult *(Continued)*	**You pay**
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, such as: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines	$10 per office visit Note: If the only reason for your office visit is an Influenza or Pneumococcal vaccine, you pay nothing.
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Examinations, for dependents up to age 22, such as: •• Eye chart screening to determine the need for vision correction. •• Refractive eye exams once every two calendar years. •• Ear exams to determine the need for hearing correction. •• Examinations done on the day of immunizations • Well-child care charges for routine examinations, immunizations and care	$10 per visit for eye and ear exams. You pay nothing for well-child care.

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to pre-authorize your vaginal delivery; see page 8 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services for the delivery of a child the same as we do for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing because you are covered in full from the initial diagnosis of pregnancy.
Not covered: Sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* Note: We cover fertility drugs under the prescription drug benefits. Please see page 36 for an explanation of that coverage and copayment information.	$10 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing, sublingual allergy desensitization, special foods, air conditioners, air purifiers, and humidifiers	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) is covered under the prescription drug benefits. Note: – We will only cover GHT when we pre-authorize the treatment. Your prescribing physician will request prior authorization from us if GHT is medically necessary for your treatment. We review most prior authorization requests within 24 hours of receipt of all necessary information.	$10 per office visit

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy - • Up to two consecutive months per condition for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury.	$15 per office visit
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions	$10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children up to age 22 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit
• Eye chart screening to determine the need for vision correction for children up to age 22 (see preventive care) • Eye refractions once every two calendar years	$10 per office visit
Not covered: • *Eyeglasses or contact lenses and, after the attainment of age 22, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing
Not covered: • *hearing aids* • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. Note: Coverage for DME requires pre-authorization from the Medical Director. When physicians prescribe this equipment, they will contact us to receive this approval.	50% copayment per device. Blood glucose monitors and insulin pumps have a $10 copayment per item.
Not covered: • *Motorized wheel chairs*	*All charges.*

Home health services	You pay
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Home health services are covered only when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. Home health services must be in lieu of confinement in a hospital or skilled nursing facility.	$10 per visit
Home health services	
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Alternative treatments	
Chiropractic care • Coverage will be provided for Medically Necessary care by a Plan licensed chiropractor. This care must be provided in connection with the detection and correction by manual or mechanical means, of any structural imbalance, distortion or subluxation in the human body. Chiropractic care is provided only when your Plan Primary Care Physician issues a referral for such services.	$10 per visit
Not covered: • *Acupuncture* • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management We offer other classes through our Feeling Fit program, see page 41.	$10 per visit

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.).
- YOU MUST GET PRE-AUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the pre-authorization information shown in Section 3 to be sure which services require pre-authorization and identify which surgeries require pre-authorization.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity - a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prostethic devices. See 5(a) - Orthopedic braces and prosthetic devices for device coverage information.	$10 per office visit for outpatient services and nothing for inpatient services

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for procedures received as an inpatient and office visit benefits for procedures received as an outpatient.	$10 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$10 per visit for outpatient services Nothing for inpatient services

Reconstructive surgery *(Continued)*	**You pay**
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form and not otherwise medically necessary, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Note: We cover related medical and hospital expenses of the donor when we cover the recipient. These benefits are subject to the approval of the Medical Director.	$10 per office visit
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Costs related to travel, food or lodging for the transplant recipient or donor*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Skilled nursing facility • Office	Nothing

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOU MUST GET PRE-AUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require pre-authorization.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines received during the visit • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Prescribed drugs and medicines filled at a Plan pharmacy as part of follow-up care are covered under the prescription drug benefit. Please see page 36 for copayment information.	$10 per visit
Not covered: blood and blood derivatives not donated or replaced by the member	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): We provide a comprehensive range of benefits for up to 45 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by us. All necessary services are covered, including: • bed, board and general nursing care • drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: custodial care	*All charges*
Hospice care	
We cover up to 210 days of Hospice services on an inpatient or outpatient basis (including medically necessary supplies and drugs) for a terminally ill member. Covered care is provided in the home or hospice facility under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. As a part of hospice care, we cover up to five (5) visits of bereavement counseling for covered family.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate See 5(d) for emergency service.	Nothing when transferred between facilities and $25 per incidence when transferred to or from your home

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you reasonably believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area:

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are an Independent Health member so they can notify us. You or a family member should notify us within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been timely notified.

If you need to be hospitalized in a non-Plan facility, we must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered, any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, we must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered, any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

Additional benefits are available for emergency or urgent care services that are received in a doctor's office or urgent care center. To receive the highest level of coverage, these services should be coordinated through your Primary Care Physician or TeleSource, our medical help line.

If possible, you, or someone on your behalf, should contact your Primary Care Physician first to determine the best treatment option. Also, you must call our medical help line, TeleSource, at 1-800-501-3439, press 2. Registered nurses will assist you in seeking care and any related follow-up care, and ensure that out-of-area urgent care services are covered at the highest possible rate.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per doctor's office or urgent care center visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: We waive the copay if the emergency results in an inpatient admission to the hospital.	$35 per hospital emergency room visit
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center Note: For emergency care received at a doctor's office or urgent care center, we reimburse the lesser of billed charges or the 90th percentile of the usual and customary rate (the fee that is regularly charged by providers for a given service) minus your $10 office visit copay.	$10 per visit plus the difference, if any, between the Plan's reimbursement and the provider's billed charges. Note: We require a $10 copay for each provider per date of service.
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services. Note: We waive the copay if the emergency results in an inpatient admission to the hospital.	$35 per hospital emergency room visit.
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	$25 per trip
Not covered: Emergency transport that we have not authorized.	*All charges.*

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRE-AUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	Nothing if you receive these services during your office visit; otherwise, $10 per office visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Pre-authorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes.

We are committed to working with our providers to ensure that you receive the best possible care in the most appropriate setting. Because some mental health and substance abuse conditions can be treated in a variety of ways, we require that Plan providers obtain pre-authorization from us.

You need a referral from your Plan doctor for visits to all participating psychiatrists, psychologists, counselors, and social workers. Referrals to non-participating providers require prior written authorization by Independent Health's Medical Director.

Independent Health recognizes that you and your doctor may need assistance in finding an appropriate provider. Your doctor may contact our Utilization Management Department for assistance. You will receive a copy of our provider directory when you join Independent Health. If you need an additional copy, call our Member Services Department at (716) 631-8701 or (800) 501-3439.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some drugs require prior authorization. Your prescribing physician will request require prior authorization from us when the drug is medically necessary for your treatment. We review most prior authorization requests within 24 hours of receipt of all necessary information.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription.** Plan Providers must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy. In addition to the many local pharmacies that are available, our national pharmacy network provides access to more than 19,500 pharmacies across the country.

  To take advantage of our National Pharmacy Network, simply present your member ID card, and pay the appropriate copayment at any of the following pharmacies* across the United States: CVS, Eckerd Drugs, Kmart, Quality Markets, Rite Aid Corporation, Target Stores, Tops Markets, VIX/Drug Emporium, Walgreens, Wal-Mart Pharmacy, and Wegmans.

  **These pharmacies are participating at the time of printing. Please call our Member Services Department for an updated list of pharmacies in our National Pharmacy Network.*
- **We use a formulary.** We use a 3-Tier prescription drug formulary. It is a list of drugs that we have approved to be dispensed through Plan pharmacies. Our formulary has more than 800 different medications and covers all classes of drugs prescribed for a variety of diseases. Tier 1 contains generic, select brands, and some over-the-counter drugs. Tier 2 contains preferred brand name drugs. Tier 3 contains non-formulary drugs.

  Our Pharmacy and Therapeutics Committee, which consists of local doctors and pharmacists, meets quarterly to review the formulary. The committee's recommendations are forwarded to the Independent Health Board after each meeting, and the board makes the final decision.
- **These are the dispensing limitations.** You have coverage for up to a thirty-day supply, in most instances, of Medically Necessary prescription drugs that are dispensed in accordance with Independent Health's 3-tier drug formulary. All prescriptions are filled using FDA-approved generic equivalents if available. All other prescriptions are filled using FDA-approved brand name pharmaceuticals. You pay a $5 copay for all Tier 1 drugs, a $10 copay for Tier 2 drugs and a $25 copay for all non-formulary drugs.
- **When you have to file a claim.** When you receive a bill for prescriptions filled at a non-plan pharmacy, please send a copy of the bill, with your member ID number, to:

  Independent Health
  P.O. Box 1642
  Buffalo, NY 14231-1642
  Attn: Member Services

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan provider and obtained from a Plan pharmacy: • Drugs and medicines that by law require a physician's prescription for their purchase • Growth hormones • Oral contraceptives and contraceptive devices, including contraceptive diaphragms • Nutritional supplements medically necessary for the treatment of phenylketonuria (PKU) and other related disorders • Self-administered injectable drugs, with pre-authorization • Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs, such as Depro Provera, are covered under Medical and Surgical Benefits. • Sexual dysfunction drugs have dispensing limitations. Contact us for details.	Unless otherwise indicated, you pay: • $5 per 30-day supply of a Tier 1 drug • $10 per 30-day supply of a Tier 2 drug • $25 per 30-day supply of a Tier 3 drug Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 copay.
• Insulin, with a copayment charge applied per 30-day supply	$8 copay for insulin
• Up to a thirty (30) day supply of test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets and cartridges for the legally blind	$8 copay or 20% per item, whichever is less, for diabetic supplies
• Disposable needles and syringes needed to inject covered prescribed medication • Implanted time-release medications, such as Norplant • Infertility drugs	20% copay

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. • To obtain a copy of the formulary, contact Member Services at (716) 631-8701 or (800) 501-3439, press 1.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
TeleSource 24-Hour Medical Help Line	Independent Health's TeleSource 24-Hour Medical Help Line is ideal for those times when you can't reach your doctor right away and you have concerns and questions about an illness or you need to reach a utilization management case manager. Our registered nurses are on call to assist you 24 hours a day, 7 days a week, and can even coordinate a trip to the hospital in case of an emergency. Call 1-800-501-3439, press 2 to get the help you need when you need it most.
TeleSource Audio Health Library	The TeleSource Audio Health Library features more than 1,500 pre-recorded health-related messages. Learn how to stay healthy, get parenting tips, or just find out about your Independent Health benefits. To try this member benefit, call 1-800-501-3439, press 3 anytime, 24 hours a day, 7 days a week. Press 1, then enter a four-digit code, such as one of the following examples: **4994** Quit Smoking **4452** Ear infection in children **4293** Chest pain and angina **4398** What is diabetes? **4192** Causes of back pain **6406** Breast Cancer For more instructions, press 1, then dial 1000. Make sure you have a pen handy to jot down any notes. For a complete directory of topics and codes, please visit our web site at www.independenthealth.com. Please note that Independent Health's TeleSource should not be used for diagnosis, or as a substitute for a physician.
Services for deaf and hearing impaired	Members may contact Independent Health through a TDD machine at (716) 631-4840.

Case Management	Independent Health has case management programs for geriatric, pediatric, mental health, chemical dependency, pre-natal, chronic diseases and catastrophic cases. Physicians are the main source for identifying high-risk members. The most suitable cases are members that have or are anticipated to have complex care needs, and/or long-term care needs. If you think you and/or one of your dependents may benefit from one of our case management programs, call your doctor. Together you can decide on the appropriate treatment plan, and if you are referred to case management, one of our case managers will contact you to obtain additional information.
Centers of excellence for transplants/heart surgery/etc	With pre-authorization, you have access to the following Centers of Excellence: **Bone Marrow** – Roswell Park Cancer Institute **Heart** – Kaleida Health (Buffalo), Children's Hospital of Pittsburgh, University of Wisconsin, Cleveland Clinic Foundation **Heart/Lung** – University of Wisconsin, Cleveland Clinic Foundation **Lung** – University of Wisconsin, Cleveland Clinic Foundation **Kidney** – Kaleida Health (Buffalo), University of Wisconsin, Cleveland Clinic Foundation **Liver** – Children's Hospital of Pittsburgh, University of Wisconsin, Cleveland Clinic Foundation **Kidney/Pancreas** – Kaleida Health (Buffalo), University of Wisconsin **Neonatal Critical Care** – Kaleida Health (Buffalo) Contact us for details.
Travel benefit/ services overseas	Independent Health members have worldwide coverage for emergency care services. This does not include travel-related expenses. Contact us for details.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization medically necessary; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

The Plan's benefits

We cover restorative services and supplies necessary to promptly (within 12 months) repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. You pay a $10 copay per office visit.

We also cover treatment that is Medically Necessary due to congenital disease or anomaly. You pay a $10 copay per office visit.

Not Covered:

- *Any dental care not shown as covered*
- *Orthodontia*
- *Dental implants*

Dental benefits

We have no other dental benefits.

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Fitness Programs

Independent Health covers a number of wellness programs through our Feeling Fit program. These include: Stop Smoking classes, Nutritional Consulting, Parenting Classes, and Stress Management workshops to name just a few. Please contact Independent Health's Feeling Fit Department Line at **1-800-501-3439, press 4** in Western New York for more information on these expanded benefits as well as our new member discount program. The discount program includes savings on vision, dental services, entertainment, sporting goods and more.

Independent Health's Medicare+Choice Plan: Encompass 65

Independent Health's Encompass 65® is a comprehensive, flexible health plan for Medicare beneficiaries in Western New York. To be eligible for Independent Health's Encompass 65 coverage, you must be entitled to Medicare Part A and enrolled in Medicare Part B. You must live in Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, or Wyoming county in New York State and not be out of the service area for more than 90 consecutive days.

If you are interested in enrolling, contact your retirement system for information on canceling your FEHB enrollment and joining Independent Health's Encompass 65®. You may also choose to enroll in Independent Health's Encompass 65® and retain your enrollment in Independent Health's FEHB plan. For more information on plan benefits, copayments, and premiums, contact Independent Health's Marketing Department at 716-631-9452 or 1-800-453-1910, Monday through Friday, 8 a.m. until 8 p.m.

For more information, be sure to visit our web site at www.independenthealth.com.

Benefits on this page are not part of the FEHB contract.

Section 6. General exclusions - things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree. See *What Services Require Our Prior Approval* on page 9.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, Hospital and Drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at (716) 631-8701 or (800) 501-3439, press 1. When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Your name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:
Independent Health
P.O. Box 1642
Buffalo, NY 14231-1642
Attn: Member Services

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies - including a request for pre-authorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Independent Health – Benefit Administration Department, P.O. Box 2090, Buffalo, New York 14231; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

The Disputed Claims Process *contintued*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call our Benefits Admnistration Department at (716) 635-3950, Member Services at (800) 501-3934, press 1 or send a fax to (716) 635-3504, attention: Member Advocate and we will expedite our review; or

(b) We denied your initial request for care or pre-authorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at (202) 606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit, whichever is less. We will not pay more than our allowance. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

• What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

• The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your primary care physician. We do not waive copayments or coinsurance when you are enrolled in Medicare.

(Primary payer chart begins on next page.)

The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) the position is excluded from FEHB	✓	
b) or, the position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability,		
a) And are an annuitant	✓	
b) And are an active employee		✓

Claims process - You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (716) 631-8701 or (800) 501-3439 or visit our website at www.independenthealth.com.

We do not waive costs when you have Medicare

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you: *{RV 5/12}*

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

- **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for members, eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

We do not provide benefits when mandatory automobile or no fault benefits are recovered or recoverable. This exclusion also applies when you or your health care practitioner does not file a timely claim.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 10. *{{ Section 4 }}*
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 10. *{{ Section 4}}*
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial care is care which does not require the continuing attention of a trained medical person. Examples of custodial care are activities of daily living, such as bathing, dressing, feeding and toileting. Custodial care is not covered under this contract.
Experimental or investigational services	Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies that have not yet been proven to be safe and efficacious treatment. We do not cover procedures that are ineffective or are in a stage of being tested or researched with questions(s) as to safety and efficacy.
Medical necessity	Medical necessity is the term we use for health services that are required to preserve and maintain your health as determined by acceptable standards of medical practice. Independent Health's Medical Director has the right to determine whether any health care rendered to you meets medical necessity criteria.
Us/We	Us and we refer to Independent Health
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **TCC**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (716) 631-5392 in Western New York and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE – (202) 418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for the Independent Health - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	13
Services provided by a hospital: • Inpatient ..... • Outpatient.....	Nothing $10 per visit	30 31
Emergency benefits: • In-area ..... • Out-of-area	$10 per visit to doctor's office or urgent care center; $35 hospital emergency room copay per visit $10 plus difference (if any) in Plan's payment for doctor's and urgent care center visits; $35 hospital emergency room copay per visit	35 35
Mental health and substance abuse treatment	Regular cost sharing.	36
Prescription drugs ..... Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy	$5 for Tier 1 drugs, $10 for Tier 2 drugs, or $25 for Tier 3 drugs per prescription unit or refill	39
Dental Care..... For accidental injury to sound natural teeth For congenital disease or anomaly	$10 per office visit	44
Vision Care..... Limited to 1 eye refraction every 2 calendar years	$10 per office visit	20
Special features: Telesource Medical Help Line and Audio Health Library, Transplant Centers of Excellence, World-wide Travel Benefits		42
Protection against catastrophic costs (your out-of-pocket maximum).....	Stated copays and coinsurance of covered benefits	11

2001 Rate Information for
Independent Health Association

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	QA1	$57.18	$19.06	$123.89	$41.30	$67.66	$8.58
Self and Family	QA2	$160.52	$53.51	$347.80	$115.93	$189.95	$24.08