Independent Health

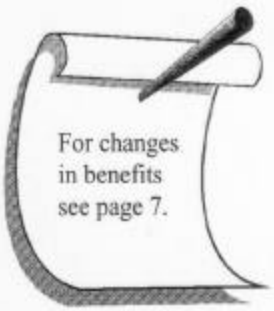
http://www.independenthealth.com

2002

A Health Maintenance Organization

Serving: Western New York

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



Enrollment codes for this Plan:

QA1 Self Only
QA2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees
Health Benefits Program

RI 73-103

Table of Contents

Introduction

Independent Health
511 Farber Lakes Drive
Buffalo, New York 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 55. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means Independent Health.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of 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. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

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 800/501-3439 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

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. Our providers follow generally accepted medical practice when prescribing any course of treatment.
When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance and deductibles 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.

Your Rights

OPM requires all FEHB Plans to provide certain information to their FEHB members. 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.
- We have 'Excellent' accreditation from the National Committee for Quality Assurance (NCQA).

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 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change now shown here is a clarification that does not change benefits.

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-Postal premium will increase by 23.2% for Self Only or 22.4% for Self and Family.
- Your hospital emergency room copay has increased from $35.00 to $50.00. (Section 5 (d)).
- Your prescription drug copays have increased and are now $5.00 for Tier 1, $15.00 for Tier 2, and $30.00 for Tier 3. (Section 5 (f)).
- You now pay 50% for infertility treatment. We no longer cover drugs and medication to treat infertility. We will not cover services for an infertility diagnosis as a result of a current or previous sterilization procedure(s) and/or procedure(s) for reversal of a sterilization. We do not pay for costs associated with the collection and donation of sperm (e.g. sperm washing).
- You have a $1,000 annual allowance for durable medical equipment per member per calendar year. (Section 5 (a)).
- We have increased the amount that you pay for prosthetic and orthopedic devices from nothing to 50%. (Section 5(a)).
- You pay $10.00 for each home health visit. (Section 5 (a)).
- You are entitled to an annual eye refraction. (Section 5 (a)).
- We now cover certain intestinal transplants. (Section 5(b)).
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a)).
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5 (a)).

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 to get covered care

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. Our provider directory lists primary care doctors with their locations and phone numbers. We update directories on a regular basis. We send a directory to you when you enroll. You may also request one 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. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return vistis unless your primary care physician give syou a referral. 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:

  – terminate 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 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. 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 benefits 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
Bipap S&ST for sleep apnea only
Blepharoplasty
Bone growth stimulator
Breast implant removal
Breast reconstruction
Breast Reduction Mammoplasty
Chiropractic Services
Continuous passive motion devices
Cosmetic procedures
Depo Provera, when used for endometriosis
Disectomy
Durable medical equipment, including equipment for diabetics
Esophagoscopy with or without dilitation or with biopsy
Home care services
Hospice benefits
Inpatient dental services
Inpatient hospitalizations
Intra-articular injections of hyalgan or synvisc
IDET (intradermal electrotherapy)
Lumbar laminectomy
Mental health services
New technology
Out-of-plan referrals
Oxygen
Physical, occupational and speech therapy services
Podiatry outpatient services
Psychological testing
Self-injectable drugs
Septorhinoplasty
Skilled nursing facility/subacute facility admissions
Surgeries that require the use of an operating room
Synagis vaccine
Transplants
UGI Endoscopy with or without dilatation with or without biopsy
UPPP

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, facility, pharmacy, etc., 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 infertility services and durable medical equipment.

Your catastrophic protection

Out-of-pocket maximum — We do not have an out-of-pocket maximum.

Section 5. Benefits - OVERVIEW

(See page 13 for how our benefits changed this year and page 57 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
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion	$10 per office visit
• At home	$10 per office visit
• During a hospital stay • In a skilled nursing facility	Nothing

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: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including – Fecal occult blood test – 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 on next page

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, annually, age 65 and over	$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
• Well-child care charges for routine examinations, immunizations and care – Examinations done on the day of immunizations	Nothing
• Examinations, for dependents up to age 22, such as: – Eye chart exams to determine the need for vision correction – Ear exams to determine the need for hearing correction	$10 per office visit for eye and ear exams.

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 may remain in the hospital up to 48 hours after a regular 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 (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling	*All charges.*

Infertility services	You pay
Services for the sole purpose of inducing pregnancy, including procedures, diagnostic testing, laboratory testing, hospital/facility services and physician services. • Artificial insemination: – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* Note: The number of allowable procedures is based on accepted medical practices. Note: We cover medically necessary services to treat correctable medical conditions that have resulted in infertility with applicable office visit, inpatient and outpatient facility copays depending on the type and location of treatment or services. [See section 5(a), 5(b) and 5(c)]. Correctable medical conditions include: endometriosis, uterine fibroids, adhesive disease, congenital septate uterus, recurrent spontaneous abortions, and varicocele.	50% copay
Not covered: • *Services for an infertility diagnosis as a result of current or previous sterilization procedure(s) and/or procedure(s) for reversal of sterilization.* • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer* - *Gamete intrafallopian transfer (GIFT)* - *Zygote intrafallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Costs associated with the collection and donation of sperm (e.g. sperm washing)* • *Cost of donor sperm or donor egg and all related services* • *Over-the-counter medications, devices or kits, such as ovulation kits* • *Drugs to treat Infertility*	*All charges*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*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 26. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. 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

Physical and occupational therapies	You pay
• Up to two consecutive months per condition for the services of each of the following: – Qualified physical therapists; – Occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	$15 per outpatient visit Nothing per visit during covered inpatient admission
• 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.*
Speech therapy	
• Up to two consecutive months per condition for the services of a licensed Plan speech therapist	$15 per office visit Nothing per visit during covered inpatient admission
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 to determine the need for hearing correction. (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
• Annual eye refraction exam	$10 per office visit
• 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
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eye glasses or contact lenses. Note: Discounts are available through Independent Health's optical discount program. Please see Section 5(i) for Non-FEHB benefits available to Plan members.*	*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 • 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.	50% copayment per device.
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy.	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* • *wigs or hair prosthesis* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*
Durable medical equipment (DME)	
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; and • walkers; Note: You must receive pre-authorization from the Medical Director before purchasing DME. When your physician prescribes this equipment, the physician will contact us to receive approval.	50% copayment per device. Note: You have an annual maximum benefit of $1,000 for DME.
• insulin pumps • blood glucose monitors	$10 copay per item
Not covered: • *Personal convenience items* • *Humidifiers, air conditioners* • *Athletic or exercise equipment* • *Computer assisted communication devices*	*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.	$10 per visit
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*
Chiropractic	
The following services by a licensed Plan chiropractor • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: Chiropractic 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. You must receive a referral for chiropractic care from your Primary Care Physician.	$10 per office visit
Alternative treatments	
No Benefit. We do not cover service such as: • *Acupuncture* • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management Note: Please refer to Section 5(i) Non-FEHB benefits available to Plan members for other classes such as Stop Smoking classes.	$10 per office 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 (i.e. hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET PRE-AUTHORIZATION FOR 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	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure procedures • Biopsy procedure procedures • 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 • 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
• 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 choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per visit for outpatient services Nothing for inpatient services
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, 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 office visit or Nothing for inpatient services
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 • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas 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 and Nothing for inpatient services
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 • Skilled nursing facility • Ambulatory surgical center • 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).
- **YOUR PHYSICIAN MUST GET PRE-AUTHORIZATION FOR 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.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, 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 • 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.	$10 per visit
Not covered: blood and blood derivatives not 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, maintenance care, respite care, or convenience 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, including ambulance services to a hospital, between hospitals and between a hospital and a skilled nursing facility. See 5(d) for emergency service	$25 per trip

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.

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.	$50 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	$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.	$50 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, including ambulance services to a hospital, between hospitals and between a hospital and a skilled nursing facility. See 5(c) for non-emergency ambulance service.	$25 per trip

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

IMPORTANT

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 obtain a treatment plan and follow all of 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 from 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.

Limitation

We may limit your benefits if you do not obtain a 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 at a participating pharmacy. **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. To obtain a copy of the formulary, contact Member Services at (716) 631-8701 or (800) 501-3439, press 1.

  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 may obtain up to a thirty-day supply. Plan pharmacies fill prescriptions 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 $15 copay for Tier 2 drugs and a $30 copay for all non-formulary drugs.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards for safety, purity, strength and effectiveness as brand-name drugs. Generic drugs are less expensive than brand name drugs, are the most cost effective therapy available, and save you money.
- **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

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not Covered* • 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, • $5 per 30-day supply of a Tier 1 drug or • $15 per 30-day supply of a Tier 2 drug or • $30 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	$8 per 30-day supply
• Diabetic supplies such as 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 up to a 30-day supply
• Disposable needles and syringes needed to inject covered prescribed medication • Implanted time-release medications, such as Norplant	20% copay
Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Drugs available without a prescription except for some over- the-counter products as listed on our formulary.* • *Medical supplies such as dressings and antiseptics*	*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.

Section 5 (g). Special Features

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 necessary to safeguard the health of the patient; 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

Accidental injury benefit	You pay
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.	$10 per office visit
Dental benefits	
We cover treatment that is Medically Necessary due to congenital disease or anomaly such as cleft lip/cleft palate.	$10 per office visit

Not covered: Dental services not shown as covered.

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 vision discount program

Benefit	You pay
The following plastic lenses are available: • Single Vision • Bifocal • Trifocal • Lenticular, and • Progressive	 $35 Copayment $55 Copayment $90 Copayment $90 Copayment $100 Copayment
Conventional Contact Lenses Frames	85% of retail price 50% of retail price up to $130 and 80% of the balance over $130
No discount for disposable contact lenses	

Stop Smoking Program

Benefit	You pay
Smoking Cessation Programs	$10 copay (reimbursed upon presentation of certificate of completion of program.)
Smoking Cessation Classes	A discounted rate through our Feeling Fit Discount Program
Smoking Cessation Drug Therapy – Nicotine Replacement Therapy.	The full price of the nicotine replacement product. Upon completion of a Smoking Cessation program or Feeling Fit discount program. The member submits the receipt and the certificate of completion or other written evidence to Independent Health. The member is reimbursed for up to a 3-month supply of the nicotine replacement product up to the maximum reimbursement, which is 95% of the average wholesale price of the drug.

Note: The Member is eligible to receive reimbursement for one participating program per calendar year.

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 5 p.m.

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

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.**

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:

- Covered member's 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 3, 1900 E Street, NW, Washington, D.C. 20415-3630.

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 or from the year in which you were denied precertification or prior approval. 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) 635-3951, Member Services at (800) 501-3934, press 1 or send a fax to (716) 635-3504, attention: Review Specialist 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 3 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. We will not pay more than our allowance.

• 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 (Part A or B)

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

When you are enrolled in Original Medicare along with this Plan, 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 **the Original Medicare Plan** 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		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

- 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 any 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 another type of Medicare+Choice plan -- 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 provide all the benefits that Original Medicare covers. 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:

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. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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.

If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for 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 illness 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 care. You must use our providers.

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.

Section 10. Definitions of terms we use in this brochure

Allowable Expense	The necessary, reasonable, and customary item of expense for covered health care.
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.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.
Copayment	A copayment is a fixed amount of money you pay to the provider when you receive covered services. See page 11.
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 Director	This person is a licensed physician that we have designated to exercise general supervision over medical care.
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.
Referral	Written authorization for specialty care services from a participating physician or Independent Health's Medical Director.
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 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 joined this Plan during Open Season, your coverage begin on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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.

- **Temporary Continuation of coverage 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, if you lose your job, if you are a covered dependent child and you turn 22 or you marry, etc.

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

Enrolling in TCC. 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. It explains what you have to do to enroll.

- **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 it 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**

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPPA" frequently asked questions. These highlight HIPPA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPPA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think their health plan and/or Medicare covers long-term care. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need? Consider buying long term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for care in a nursing home, in an assisted living facility, in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but you should have a plan just in case. *LTC insurance may be vital to your financial and retirement planning.*

Is long term care expensive?

- Yes. A year in a nursing home can exceed $50,000 and only three 8- hour shifts a week can exceed $20,000 a year, that's before inflation!
- LTC can easily exhaust your savings but LTC insurance can protect it.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look under "*Not covered*" in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

- Employees will get more information from their agencies during the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

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 - 2002

- **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	27 28
Emergency benefits: • In-area..... • Out-of-area	$10 per visit to doctor's office or urgent care center; $50 hospital emergency room copay per visit $10 plus difference (if any) in Plan's payment for doctor's and urgent care center visits; $50 hospital emergency room copay per visit	30 31
Mental health and substance abuse treatment.....	Regular cost sharing.	32
Prescription drugs ..... Up to a 30 day supply	$5 for Tier 1 drugs, $15 for Tier 2 drugs, or $30 for Tier 3 drugs per prescription unit or refill	34
Dental Care ..... For accidental injury to sound natural teeth For congenital disease or anomaly	$10 per office visit	38
Vision Care ..... Annual Eye refractions	$10 per office visit	20
Special features: Telesource Medical Help Line and Audio Health Library, Transplant Centers of Excellence, World-wide Travel Benefits		36
Protection against catastrophic costs (your out-of-pocket maximum).....	Stated copays and coinsurance of covered benefits	11

2002 Rate Information for
Independent Health

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; 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 who are not career postal employees. 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	$70.47	$23.49	$152.69	$50.89	$83.39	$10.57
Self and Family	QA2	$196.46	$65.48	$425.66	$141.88	$232.47	$29.47