Independent Health Association, Inc.

www.independenthealth.com
Customer Service 716-631-8701 or 800-501-3439

2018

Health Maintenance Organization (High and Standard Option) with a point of service product and a high deductible health plan option (iDirect)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 4 for details. This plan is accredited. See page 13 for details.

Serving: *Western New York*

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 16 for requirements.

Enrollment codes for this Plan:

QA1 High Option - Self Only
QA3 High Option - Self Plus One
QA2 High Option - Self and Family

C54 Standard Option - Self Only
C56 Standard Option - Self Plus One
C55 Standard Option - Self and Family

QA4 High Deductible Health Plan (HDHP) - Self Only
QA6 High Deductible Health Plan (HDHP) - Self Plus One
QA5 High Deductible Health Plan (HDHP) - Self and Family

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 17
- Summary of benefits: Page 143

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Independent Health About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Independent Health's HMO prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare, but you still need to follow the rules in this brochure for us to cover your prescriptions. We will only cover your prescription if it is written by a Plan provider and obtained at a Plan pharmacy or through our Plan mail service delivery program, except in an emergency or urgent care situation.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that at least as good as Medicare prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 (TTY: 800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call **800-MEDICARE 800-633-4227, TTY: 877-486-2048**

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Introduction

This brochure describes the benefits of Independent Health under our contract (CS 1933) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 716 631-8701 or 800-501-3439 or through our website: www.independenthealth.com. The address for Independent Health's administrative offices is:

Independent Health Association, Inc.
511 Farber Lakes Drive
Buffalo, NY 14221

This brochure is the official statement of benefits. No statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on page 17. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

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

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud- Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

  - Call the provider and ask for an explanation. There may be an error.

  - If the provider does not resolve the matter, call us at 716-631-8701 or 800-501-3439 and explain the situation.

  - If we do not resolve the issue:

CALL --THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone if you are not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

Independent Health complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, Independent Health does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks.
Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps insure that you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your health care Provider and ask for results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - 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;
  - What happens when your enrollment ends
  - 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. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 or Self Plus One 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 Plus One or 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 Plus One or 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 are married.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLE's, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events If you need assistance, please contact your employing agency, Tribal Benefits Office, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2018 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2017 benefits until the effective date of your coverage with your new plan. 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.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **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.

  Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce** — If you are divorced from a Federal employee, Tribal employee, or an annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You an also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **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). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rates. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26.

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

  Enrolling in TCC. Get the RI 79-27, which describes TCC from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premiums, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage** — If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 716-631-8701 or visit our website at www.independenthealth.com.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Independent Health holds the following accreditation:

- National Committee for Quality Assurance (www.ncqa.org)

To learn more about this plan's accreditation, please visit the following website: www.ncqa.org

We offer three types of coverage. You may enroll in our High or Standard Health Maintenance Organization (HMO) coverage with a Point of Service (POS) or you may enroll in our High Deductible Health Plan (HDHP) with a health savings account/health reimbursement arrangement.

General features of our HMO with POS Plans

The enrollment codes for our High Option HMO with POS coverage are QA1 (Self Only), QA3 (Self Plus One) and QA2 (Self and Family). The enrollment codes for our Standard Option HMO with POS coverage are C54 (Self Only), C56 (Self Plus One) and C55 (Self and Family). For the highest level of coverage (In-network benefits), we require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMO coverage emphasizes preventive care such as physical exams, well-baby care, and immunizations. In-network preventive care services are covered in full. Please refer to Section 5(a) for a list of In-network preventive care services. Our providers follow generally accepted medical practice when prescribing any course of treatment.

In the High Option, your annual in-network out-of-pocket expenses for covered in-network medical and prescription drug services, including deductibles, co-payments, and coinsurance, cannot exceed $6,850 for Self Only enrollment, or $13,700 for Self Plus One or Self and Family enrollment. Member liability for routine vision services and routine dental do not apply to the out-of-pocket maximum. See section 5(i) for more information on out-of-network benefits.

In the Standard Option, your annual in-network out-of-pocket expenses for covered in-network medical and prescription drug services, including deductibles, co-payments, and coinsurance, cannot exceed $6,850 for Self Only enrollment, or $13,700 for Self Plus One or Self and Family enrollment. Member liability for routine vision services and routine dental do not apply to the out-of-pocket maximum. See section 5(i) for more information on out-of-network benefits.

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

Your decision to join an HMO should be 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.

We have Point of Service (POS) benefits

Our HMO options offer POS benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket costs than in-network benefits. For more information regarding this benefit, see HMO Benefits Section 5(i) Point of Service Benefits.

How we pay providers

We contract with individual physicians, other health care providers, 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 cost-sharing (copayments, coinsurance, deductibles and non-covered services and supplies).

Under our POS, you will be subject to an annual deductible and coinsurance. You will owe all balances for covered services in excess of our plan allowance. For more information regarding this benefit, see HMO Benefits Section 5(i) Point of Service Benefits.

General features of our High Deductible Health Plan (HDHP)

The enrollment codes for our HDHP are QA4 (Self Only), QA6 (Self Plus One) and QA5 (Self and Family). We call our HDHP coverage, iDirect. Our HDHP is a consumer driven health plan with separate medical and dental funds that help you pay for covered medical and dental expenses. This health plan product combines HDHP health care coverage with a tax-advantaged program to help you build savings for future medical needs. You may seek covered services from the iDirect network of participating providers or you may use non-participating or out-of-network providers at a higher member liability.

Your annual in-network out-of-pocket expenses for covered in-network services, including deductibles, co-payments, and coinsurance, cannot exceed $6,550 for Self Only enrollment, or $13,100 for Self Plus One or Self and Family enrollment. Your annual out-of-pocket expenses for covered out-of-network services, including deductibles, co-payments, and coinsurance, cannot exceed $10,000 for Self Only enrollment, or $20,000 for Self Plus One or Self and Family enrollment. Member liability for routine vision services, routine dental, and penalties for failure to preauthorize do not apply to the out-of-pocket maximum.

Preventive care services

A complete list of the preventive services covered under this paragraph is available on our website at www.independenthealth.com, or will be mailed to you upon request. You may request the list by calling the Member Services number on your identification card.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

HDHP Funds

Two different funds are available to offset out-of-pocket medical costs under the HDHP Plan – a Health Savings Account (HSA) or a Health Reimbursement Account (HRA). The Plan will contribute funds once you have verified your HSA/HRA eligibility. The funds are passed from FEHB to the plan, who in turn, will pass the funds directly into your HSA or HRA depending on your qualifications; this process is referred to as a premium pass-through. Forms will be provided to you to complete for this verification and must be returned to us for contributions to begin.

Annual Self Only pass-through contribution: **$999.96**

Annual Self Plus One pass-through contribution: **$1,654.20**

Annual Family fund pass-through contribution: **$1,999.92**

You may use the money in your HSA or HRA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not have received VA or Indian Health Services (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.

- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $6,650 for Self Only enrollment, and $13,300 for a Self Plus One or Self and Family. Your plan specific limits may differ.

Health Education Resources and Accounts Management Tools

Key additional features of iDirect are the tools we provide to help you manage your health, monitor your claims and manage your money. Our decision support programs provide the information you need to take greater control of your healthcare cost management.

The Health Management programs include:

- Health risk appraisal
- Health wellness programs
- Healthcare options and alternatives
- Health coaching
- In-depth health information and advice
- The latest news from Independent Health that impacts your health
- Calculators to measure personal statistics
- Tools to help manage your costs for medical and pharmacy
- Information on network providers
- Information on hospital quality
- Information on approximate cost of specific health care services in your area

An HDHP with an HSA or HRA is designed to give greater flexibility and discretion over how you use your health care benefits. You decide how to utilize your plan coverage and you decide how to spend the dollars in your HSA or HRA.

Your rights and responsibilities

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, our providers and our facilities. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Independent Health Association Inc., incorporated in March 1977, is a not-for-profit health maintenance organization licensed under Article 44 of the New York Public Health Law.
- Independent Health Association Inc's wholly owned subsidiary, Independent Health Benefit Corporation was incorporated in June 1995 and is licensed under Article 43 of the New York State Insurance Law
- Independent Health Association Inc. and its subsidiaries and affiliates are in compliance with all applicable state and federal laws.
- We also have accreditation from the National Committee for Quality Assurance (NCQA).

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website at www.independenthealth.com. You can also contact us to request that we mail a copy to you.

If you would like more information, call the Western New York Marketing Department at 716-631-5392 or 800-453-1910, or write to Independent Health, Marketing Department, 511 Farber Lakes Drive, Buffalo, NY 14221. You may also visit our website at www.independenthealth.com.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.independenthealth.com. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area includes the following counties: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

Under the HMO benefits, you must get your care from providers who contract with us. If you or a covered family member moves outside our service area, you can enroll in another plan. You do not have to wait until Open Season to change plans. Contact your employing or retirement office. If you receive care outside our service area, we will pay only for emergency or urgent care benefits, as described on page 57. We will not pay for any other health care services out of our service area unless it is an emergency,urgent care service or services which have prior plan approval.

Under the POS benefits you may receive care from a non-Plan provider and we will provide benefits for covered services as described in Section 5(i).

Under the HDHP benefit you may receive care from Plan and non-Plan providers as described in Section 5 HDHP. If you or a covered family member moves outside our service area, you can enroll in another plan.

Section 2. Changes for 2018

Do not rely only on these change descriptions; this Section 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 not shown here is a clarification that does not change benefits.

Changes to our High, Standard and HDHP Options

- The preauthorization requirement for inpatient substance use disorder treatment at a participating New York State Office of Alcoholism and Substance Abuse Services (OASAS) certified facility has been removed. Preauthorization will still be required for non-participating facilities. See pages 21-22.
- Immediate access will be allowed without preauthorization to a five day emergency supply of a prescribed substance use disorder treatment medication. The copayment will be prorated based on the supply. Deductible applies on HDHP option. See pages 63 and 111.
- Your limitation on orthopedic and prosthetic devices has changed to a limit of one prosthetic device, per artificial limb, per lifetime. Replacement limbs may be covered based on medical necessity. See pages 41 and 93.
- Your limitation on diabetic test strips has changed to 100 test strips for a 30-day supply and 300 test strips for a 90-day supply for non-insulin dependent members. For insulin dependent members, there will be a limit of 300 test strips for a 30-day supply and a 900 test strips limit for a 90-day supply. See pages 65 and 113.
- You will no longer have any member liability for statin medications used for the primary prevention of cardiovascular disease for adults aged 40-75 with no history of cardiovascular disease (CVD), one or more CVD risk factors, and a calculated ten year CVD event risk of 10% or greater. Deductible does not apply on HDHP option. See pages 65 and 113.
- Your in-network member liability for ultrasounds, magnetic resonance imaging (MRI), and diagnostic mammograms for the prevention and treatment of breast cancer will be covered in full. Deductible does not apply on HDHP option. See pages 31 and 87.
- Your in-network telemedicine benefit provided through the Teladoc network of providers for non-emergent care is now covered in full. Deductible applies on HDHP option. See pages 31 and 87.
- Your Tier 1 drug copayment will increase to $7 for a 30-day supply. Deductible applies on HDHP option. See page 64 and 112.
- Your plan now provides coverage for drugs and supplies related to abortions at no in-network member liability when the life of the mother would be endangered if the fetus was carried to term or when the pregnancy is a result of an act of rape or incest. Deductible applies on HDHP option. See pages 46 and 97.

Changes to our HMO (High Option) Plan Only

- Your share of the non-Postal and Postal premium will increase for Self Only, Self Plus One and Self and Family. See page 146.
- Your plan now provides coverage for telehealth services with cost share dependent on the servicing provider. For in-network primary care services, you will pay a $25 copayment. For in-network specialist services, you will pay a $40 copayment. For out-of-network services, you will pay 25% coinsurance, after deductible. See page 30.
- Your out-of-network preventive services will now be covered at 25% coinsurance, after deductible. See page 69.

Changes to our HMO (Standard Option)Plan Only

- Your share of the non-Postal and Postal premium will increase for Self Only, Self Plus One and Self and Family. See page 146.

- Your plan now provides coverage for telehealth services with cost share dependent on the servicing provider. For in-network primary care services, you will pay a $30 copayment. For in-network specialist services, you will pay a $50 copayment. For out-of-network services, you will pay 30% coinsurance, after deductible. See page 30.
- Your out-of-network preventive services will now be covered at 30% coinsurance, after deductible. See page 69.

Changes to our High Deductible Health Plan (HDHP) Only

- Your share of the non-Postal and Postal premium will increase for Self Only, Self Plus One and Self and Family. See page 146.
- Your plan now provides coverage for telehealth services with cost share dependent on the servicing provider. For in-network services you will pay a $20 copayment, after deductible. For out-of-network services, you will pay 40% coinsurance, after deductible. See page 87.
- Providers will assume responsibility for preauthorization from the Plan for in-network services. You will continue to be responsible for preauthorization for out-of-network services. See page 21.
- Premium pass-through for Self Only members will increase to $83.33 per month. The premium pass-through for Self Plus One members will increase to $137.85 per month. See page 77.

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 letter (for annuitants), or your electronic enrollment system (such as 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, or visit our website at www.independenthealth.com

Where you get covered care

You get care from "Plan providers" and "Plan facilities". If you enroll in an HMO option and use the POS program or enroll in the HDHP program, you can also get care from non-Plan providers.

- **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 national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **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 website.

What you must do to get covered care

It depends on the type of plan in which you are enrolled. Our provider directory lists primary care and specialty care physicians with their locations and phone numbers. We update the directories on a regular basis. We send you a directory when you enroll. You may also request one by calling our Member Services Department at 716-631-8701 or 800-501-3439. You may also access our website at www.independenthealth.com for our provider listing.

- **Primary care**

HMO (High and Standard Options) -Your primary care physician can be any physician designated by the Plan to be a primary care physician, i.e., general practitioner, internist, family practitioner, etc. Your primary care physician is responsible for coordinating all of your health care as well as helping you maintain good health through preventive care.

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.

HDHP-Although we encourage members to select a primary care physician, the HDHP plan does not require you to notify us of your choice.

- **Specialty care**

Independent Health offers a wide choice of participating specialists. Your primary care physician will refer you when you need to see a specialist. However, a referral is not required. All you need to do is contact the specialist's office to schedule an appointment.

If you have started treatment with a specialist and wish to change to another specialist, you should contact your primary care physician to keep him or her aware of this change in medical care.

Here are some 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 develop a treatment plan and recommend a specialist. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get our 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 recommends that you see a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you may use your POS benefit.
- 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, up to a maximum of 90 days.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program 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**

HMO (High and Standard Options) - 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.

HDHP - Your physician will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility. It is your responsibility to preauthorize any inpatient admissions except for maternity admissions.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 716-631-8701, or 800-501-3439. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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;
- 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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

We allow you to use non-Plan providers, you do not need to obtain our approval before you receive certain services. The pre-service claim approval processes for inpatient hospital admissions(called precertification) and for other services, are detailed in this Section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a denial or reduction of benefits if you do not obtain precertification, prior approval or a referral.

You must get prior approval for certain services. Failure to do so will result in a minimum 50% penalty for the High and Standard Option and a 50% penalty up to a maximum of $500 for the HDHP Option.

Your hospital stay and other services requiring member preauthorization

You must obtain preauthorization from us for all out-of-network inpatient services (except maternity admissions and medical emergencies) and certain out-of-network outpatient services listed below under Procedures that Require Member preauthorization) that you receive from a facility. Your physician will make necessary hospital arrangement and supervise your care. You must contact our Member Services Department at 716-631-8701 or 800-501-3439 to obtain preauthorization from us before the service is rendered.

- **Services requiring our prior approval**

We require provider preauthorization for certain services. 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 provider preauthorization. We are 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, our Medical Director has developed a list of procedures that we must approve before they are performed. Your doctor will work with us to obtain our prior approval and you do not have to do anything.

Certain out-of-network services require preauthorization by You. We call the prior approval process member preauthorization.

***Note: Member preauthorization is only applicable for out-of-network services**

- **Procedures that require member preauthorization**

You are ultimately responsible for obtaining our prior approval before obtaining certain out-of-network services. If you do not obtain preauthorization from us, we will apply a penalty to the covered charges or we may not cover the service at all in the event that we determine it is not medically necessary. You must obtain preauthorization from us for the following out-of-network services:

- Applied Behavior Analysis (ABA) for Diagnosis and Treatment of Autism Spectrum Disorder
- Assistive Communication Devices (ACD) for Autism Spectrum Disorder
- Clinical trials
- Continuous glucose monitoring devices, short and long term
- Durable Medical Equipment
  - Bi-level Positive Airway Pressure Spontaneous – timed (Bipap-St)
  - Bi-level Positive Airway Pressure Spontaneous (Bipap-S)
  - Customized items/equipment
  - Hearing Aids
  - Hospital Beds, Adult and Pediatric including accessories
  - Jaw Motion Rehabilitation system and accessories
  - Lift equipment/devices
  - Light Boxes
  - Non-standard wheel chair accessories
  - Power wheelchairs and accessories
  - Wearable Defibrillator Vest
- Elective hospital/facility admissions to include but not limited to:
  - Admissions for transplants

- Behavioral health admissions including mental health
- *Note: Preauthorization is not required for substance use admissions at participating New York State OASAS (Office of Alcoholism and Substance Abuse Services) certified facilities.
- Medical admissions
- Inpatient Rehabilitation and Habilitation Admissions (Physical, Speech and Occupational Therapy)
- Intensive Outpatient Services for Mental Health
- Intensive Outpatient Services for Substance Abuse
- Skilled nursing facility admission
- Surgical admissions

- Extracorporeal Shock Wave Therapy (ECSWT) for Chronic Plantar Fasciitis
- Genetic Testing including BRCA
- Gender Dysphoria-Surgical Treatment
- Home Births
- Home Health Care Services including Home Infusion Nursing Visits
- Medical Supplies with approved home care services excluding ostomy
- Neuropsychological Testing
- Non-Emergent Ambulance, Planned Transfer
- Specialized blood testing for breast and colon cancer (Oncotype Dx)
- Partial Hospitalization for Mental Health Services
- Partial Hospitalization for Substance Misuse
- Prosthetic Devices External
  - Artificial Limbs
  - Orthopedic Braces and Footwear
- Psychological Testing (Psychometric)
- Residential Treatment except inpatient substance use admissions to Independent Health contracted, New York State Office of Alcoholism and Substance Abuse Services credentialed facilities
- Surgical Procedures:
  - Back and Neck Surgery
  - Bariatric Surgery (weight loss surgery)
  - Breast Surgery: Implant Removal, non-cancer diagnosis Breast Reconstruction, Non Cancer Diagnosis, Breast Reduction Mammoplasty (male and female)
  - Cosmetic Procedures (medically necessary)
  - Oral Surgeries
  - Reconstructive Procedures
  - Septorhinoplasty & Rhinoplasty
  - Temporal Mandibular Joint Surgery
- Transcranial Magnetic Stimulation
- Transplant Procedures

How to preauthorize an admission or other services

First, you, or your representative, must call us at 716-631-8701 or 800-501-3439 before admission or services requiring preauthorization are rendered. Your provider may call on your behalf.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed services or surgery;
- name and phone number of admitting physician;
- name of provider; and
- number of days requested for hospital stay (if applicable)

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-501-3439. You may also call OPM's Health Insurance 3 at 202 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-501-3439. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Complete Maternity (obstetric) care is covered for in-network prenatal delivery and postnatal care.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Benefits provided for health care by non-Plan providers in and out of the service area (HMO)**

Services received from Non-Plan Providers are subject to the deductibles, coinsurance and limitations of the plan, unless you receive an authorization to a Non-Plan provider and the following conditions are met:

- There is no Plan Provider in the service area with appropriate training and experience to meet your particular needs
- The care or services are medically necessary
- You obtain a written authorization from Independent Health prior to a service being rendered. Such authorization from Independent Health may be obtained through your primary physician or directly from Independent Health.

- **What happens when you do not follow the preauthorization rules when using non-network providers**

You are ultimately responsible for requesting preauthorization from us for certain out-of-network covered services. Failure to obtain preauthorization will result in a drastic reduction of benefits or a complete denial of coverage. You will be responsible for 50% of our allowed amount as a penalty. We will reduce our allowance by 50% before calculating our payment. Under POS and HDHP, we base our allowance on the lesser of the provider's or facility's charges, the negotiated rate, or the usual, customary and reasonable (UCR) charge at the 90th percentile, and the 80th percentile for the POS Standard Option. The additional 50% that you must pay is a penalty. It is not reduced by the POS or HDHP coinsurance, out-of-pocket maximum, or annual deductible. You must pay the balance after our payment up to the facility's charges.

After receiving your request for preauthorization, our Medical Director will make the determination as to whether a service is medically necessary within three (3) business days from the date we receive the preauthorization request and all necessary documentation for review. We strongly recommend that you contact us to confirm whether or not a service is covered and requires preauthorization before you have the service.

- **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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding preauthorization of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Preauthorize your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: Under our High Option benefits, you pay a copayment of $25 per office visit when you see a primary care physician who is part of our network.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. You do not have a in-network deductible on the High or Standard options. Annual deductibles apply to POS benefits (see HMO Section 5(i) Point of Service Benefits). If you are enrolled in the HDHP option an annual combined deductible is applicable.

- Under our HDHP coverage, the annual combined deductible is $2,000 under Self Only and $4,000 under Self Plus One or Self and Family enrollment. The deductible must be satisfied in full by one or more family members before we will begin paying benefits. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $2,000. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $4,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $4,000.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for certain types of care. Under the POS benefits and the HDHP plan, coinsurance does not begin until you have met your calendar year deductible.

Example: Under the HMO benefits, you pay 50% of our allowance for durable medical equipment. Coinsurance also applies when you use the POS benefit and to our HDHP benefits.

Differences between our Plan allowances and the bill

For out-of-network services, you pay the difference between the non-Plan provider's charges and the amount that we pay for a covered service in addition to the deductible amount applied, copay, coinsurance, and/or any non-covered service. Additional expenses may also result from charges that exceed a benefit maximum.

Your catastrophic protection out-of-pocket maximum

For the High and Standard Options, after your in-network out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $6,850 for Self Only, or $13,700 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $6,850 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic in-network protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

• Dental Discount benefits

• Eyeglasses or contact lenses

• Expenses for services and supplies that exceed the stated maximum dollar or day limit

• Expenses from utilizing out-of-network providers

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

For the High Deductible Health Plan (HDHP) Option, after your in-network out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $6,550 for Self Only, or $13,100 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. Reference section 5 High Deductible Health Plan Benefits Overview for details.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option (if applicable).

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. HMO (High and Standard Option) Benefits

See page 17 for how our benefits changed this year. This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection.

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

Important things you should 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We do not have a calendar year deductible for services that you receive under the HMO benefits.
- Please see Section 5(i) for information regarding POS benefits for out-of-network services. An annual deductible and coinsurance will apply to covered POS benefits.
- Your physician must obtain preauthorization for certain services.
- If preventive routine screenings are billed with an office visit, the applicable primary copay or specialist copay will apply.
- 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.

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • In a skilled nursing facility • At home	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit
• During a hospital stay • During a covered skilled nursing facility • Advanced care planning	Nothing	Nothing
Telehealth services	**High Option**	**Standard Option**
Telehealth - the use of electronic and communication technologies by a provider to deliver covered services when the member's location is different than the provider's location. Note: You may inquire with a provider to see if he/she offers telehealth or contact Member Services at 716-631-8701.	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit

Telehealth services - continued on next page

Benefit Description	You pay	
Telehealth services (cont.)	**High Option**	**Standard Option**
Telemedicine program - The telemedicine program is an online video or phone consultation service administered by a unique network of U.S. board-certified physicians who participate in our telemedicine program. Teladoc physicians use electronic health records to diagnose and treat conditions, including writing prescriptions. The service is intended to provide a solution for non-emergency medical situations and should not be used if you are experiencing a medical emergency. Telemedicine offers you an alternative option to an urgent care facility or when you are unable to obtain services from your primary care physician for many common medical issues including but not limited to cold and flu symptoms, allergies, pink eye, urinary tract infection, respiratory infection, and ear infection. Note: To utilize the telemedicine program visit teladoc.com or call 800-TELADOC (800-835-2362). This service is available 24/7 and may be accessed if traveling throughout most of the United States.	Nothing	Nothing
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology Radiology procedures and advanced radiology procedures - for the detection of breast cancer: • Ultrasound • MRI • Diagnostic Mammograms	Nothing	Nothing
Radiology procedures such as: • Routine X-rays • Ultrasound	$25 per visit for radiology procedures in addition to any copayment for office services	$40 per visit for radiology procedures in addition to any copayment for office services
Advanced Radiology such as: • CT Scans • MRI/MRA • PET Scans • Myocardial Perfusion Imaging	$40 per visit for advanced radiology services in addition to any copayment for office services.	$75 per visit for advanced radiology services an addition to any copayment for office services.

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
Note Standard Option Only: Subject to a $750 advanced radiology copayment maximum per calendar year.	$40 per visit for advanced radiology services in addition to any copayment for office services.	$75 per visit for advanced radiology services an addition to any copayment for office services.
Diagnostic tests, such as: • Electrocardiogram and EEG	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit
Preventive care, adult	**High Option**	**Standard Option**
Routine physical examination - once every 12 months Routine well-woman examination • Two OB/GYN visits annually Maternity care limited to: • Routine prenatal office visits • One routine postnatal office visit Note: The preventive care benefits will not apply to complications of pregnancy. See Section 5(a) Maternity Care for information on the physician's charges for delivery, anesthesia, laboratory tests, and radiological procedures. See Section 5(c) for information on hospitalization. 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 - Colonoscopy screening - every ten years starting at age 50	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test - one annually for men age 50 and older	Nothing for laboratory services	Nothing for laboratory services
Well woman care; based on current recommendations such as: • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screening • Counseling for sexually transmitted infections	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing	Nothing
Routine mammogram - covered for women	Nothing	Nothing
Routine bone density screening for: • Women age 65 and over • Women at increased risk age 60 and over	Nothing	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule	Nothing	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations HHS: www.healthcare.gov/preventive-care-benefits CDC: www.cdc.gov/vaccines/schedules/index.html **Women's preventive services:**www.healthcare.gov/preventive-care-women/. For additional information: healthfinder.gov/myhealthfinder/default.aspx.		
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, biometric screening	**High Option**	**Standard Option**
• Body mass index • Total cholesterol • Blood pressure screening • Glucose screening	Nothing	Nothing
Preventive care, children	**High Option**	**Standard Option**
Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics	Nothing	Nothing
Note: Any procedure, injection, diagnostic service, laboratory or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to: brightfutures.aap.org/Pages/default.aspx		
Preventive care, adults and children	**High Option**	**Standard Option**
The following additional preventive services are covered in full when rendered by a participating provider: • Chlamydia Screening • General Health Panel with Basic Metabolic Panel • Hemoglobin and Hematocrit • HIV Screening • HPV Screening • Lead Screen in childhood and pregnancy	Nothing	Nothing

Preventive care, adults and children - continued on next page

Benefit Description	You pay	
Preventive care, adults and children (cont.)	**High Option**	**Standard Option**
• Lipid Panel • Periodic Routine Health Examination • Rh Screen • Rubella Screen Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care (excluding diagnostic testing) • Screening for gestational diabetes for pregnant women after 24 weeks • Delivery • Postnatal care	Nothing	Nothing
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing
Sonograms	$25 per visit	$40 per visit
Note: Here are some things to keep in mind: • You do not need to preauthorize your vaginal delivery; see pages 35-36 for other circumstances, such as extended stays for your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).		

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.		
Family planning	**High Option**	**Standard Option**
Contraceptive counseling on an annual basis	Nothing	Nothing
Voluntary sterilization for men (See Surgical procedures Section 5(b))	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit
A range of family planning services, limited to: • Voluntary sterilization for women (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives (See Surgical procedures Section 5 (b)) • Injectable contraceptive drugs (such as Depo provera) (see Surgical procedures Section 5 (b)) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives and certain contraceptive devices under the prescription drug benefit.	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Covered diagnostic tests and procedures including but not limited to the following procedures: • Hysterosalpingogram • Hysteroscopy • Endometrial biopsy • Laparoscopy • Sonohysterogram	Primary: $25 per visit for services performed at an office Specialist: $40 per visit for services performed at an office $75 for surgical services provided at an outpatient facility or ambulatory surgical center Nothing for inpatient and laboratory services $25 per visit for routine radiology $40 per visit for advanced radiology services	Primary: $30 per visit for services performed at an office Specialist: $50 per visit for services performed at an office $100 for surgical services provided at an outpatient facility or ambulatory surgical center Nothing for inpatient and laboratory services $40 per visit for routine radiology services $75 for advanced radiology services

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• Post Coital tests • Testis biopsy • Semen analysis • Blood tests • Ultrasound • Sperm washing • Electroejaculation • Fertility drugs Note: We cover self injectable and oral fertility drugs under the prescription drug benefit. Note: Advanced radiology is subject to a $750 copayment maximum per calendar year.	Primary: $25 per visit for services performed at an office Specialist: $40 per visit for services performed at an office $75 for surgical services provided at an outpatient facility or ambulatory surgical center Nothing for inpatient and laboratory services $25 per visit for routine radiology $40 per visit for advanced radiology services	Primary: $30 per visit for services performed at an office Specialist: $50 per visit for services performed at an office $100 for surgical services provided at an outpatient facility or ambulatory surgical center Nothing for inpatient and laboratory services $40 per visit for routine radiology services $75 for advanced radiology services
Note: We will cover medical or surgical procedures which are medically necessary to diagnose or correct a malformation, disease, or dysfunction, resulting in infertility, and diagnostic tests and procedures that are necessary to determine infertility. We limit infertility coverage to correctable medical conditions that have resulted in infertility. Your applicable office visit copayment or outpatient facility coinsurance (inpatient is covered in full) will depend 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. In order to be eligible for Infertility services, you must: • be at least 21 years of age and no older than 44; except for diagnosis and treatment for a correctable medical condition which incidentally results in infertility • have a treatment plan submitted in advance to us by a physician who has the appropriate training, experience and meets other standards for diagnosis and treatment of infertility as promulgated by New York State • have a treatment plan that is in accordance with standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the American Hospital Formulary Service		

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• the number of allowable artificial insemination procedures is based on accepted medical practices.		
Not covered: • *Services for an infertility diagnosis as a result of current or previous sterilization procedures(s) and/or procedures(s) for reversal of sterilization.* • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or donor egg and all related services* • *Over-the-counter medications, devices or kits, such as ovulation kits* • *Cloning or any services incident to cloning*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit
Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on pages 47-52. • Respiratory and inhalation therapy • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions • Dialysis – hemodialysis and peritoneal dialysis • Applied Behavior Analysis (ABA) – Children with autism spectrum disorder	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
• Intervenous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Growth hormone therapy (GHT) • Hormone therapies Note: Growth hormone is covered under the prescription drug benefits. We only cover GHT when we preauthorize treatment. You or your doctor must submit information that establishes that the GHT is medically necessary and ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary.	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit
Physical and occupational therapies – Rehabilitative and Habilitative	**High Option**	**Standard Option**
High Option: Up to 60 visits combined per calendar year Standard Option: Up to 20 visits combined per calendar year • Qualified physical therapists • Occupational therapists Note: The visit limits apply to any combination of physical, occupational, and/or speech therapy.	$25 per outpatient visit Nothing per visit during covered inpatient admission	$30 per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy – Rehabilitative and Habilitative	**High Option**	**Standard Option**
High Option: Up to 60 visits combined per calendar year Standard Option: Up to 20 visits combined per calendar year Note: The visit limits apply to any combination of physical, occupational, and/or speech therapy.	$25 per outpatient visit Nothing per visit during covered inpatient admission	$30 per outpatient visit Nothing per visit during covered inpatient admission
Assistive communication devices for the diagnosis of Autism Spectrum Disorder	$40 copay per item	$50 copay per item

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For hearing treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. Note: See 5(b) for coverage of the surgery to insert the device.	Nothing	Nothing
Not covered: • *Hearing services that are not shown as covered* • *Hearing aids, supplies, examinations and fitting*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts). Benefits are limited to one pair of replacement lenses, or contact lenses per incident prescribed within one year of injury • One pair of eyeglasses to correct an impairment directly caused by accidental ocular injury or intraocular surgery. Benefits are limited to one pair of eyeglasses per incident prescribed within one year of injury • Eye examinations for medical conditions such as glaucoma, retinitis pigmentosa, and macular degeneration Note: See *Preventive care, children* for eye example for children	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eye glasses or contact lenses, except as shown above*	*All charges*	*All charges*

Benefit Description	You pay	
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 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*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs* • Artificial eyes • Stump hose • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Compression stockings** *Note: One prosthetic device per limb, per lifetime. Replacement limbs may be considered based on medical necessity **Note: Compression stockings including below the knee and thigh, limited to a total of 12 units (6 pair) per year with a compression type of 30-40 mmHg and 40-50 mmHg	50% coinsurance per device/ supply	50% coinsurance per device/ supply
• Implanted hearing-related devices, such as bone-anchored hearing aids (BAHA) and cochlear implants. • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. • Ostomy supplies	Nothing	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.*	Nothing	Nothing
Not covered: • *Hearing aids* • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Diabetic shoes and inserts* • *Lumbosacral supports* • *Corsets, trusses, and other supportive devices* • *Compression stockings with a compression of less than 30 mmHg* • *Wigs and hair prosthesis* *Note: Call us at 716-631-8701 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about the service when you call.	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Under this benefit, we cover: • Oxygen and oxygen equipment • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers	50% coinsurance per device	50% coinsurance per device
Diabetic equipment such as: • Insulin pumps • Blood glucose monitors	$25 per item	$30 per item
Not covered: • *Personal convenience items* • *Humidifiers, air conditioners* • *Athletic or exercise equipment*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *Computer assisted communication devices (except for the diagnosis of Autism Spectrum Disorder)* Note: Call us at 716-631-8701 as soon as your Plan physician prescribes this equipment. We will arrange a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• 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. Service include oxygen therapy, intravenous therapy and medications. - High Option: Unlimited visits per year as long as medically necessary - Standard Option: Up to 40 visits per year as long as medically necessary	$25 per visit	$30 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• 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.	$25 per office visit	$30 per office visit

Benefit Description	You pay	
Alternative treatments	**High Option**	**Standard Option**
No benefit.	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: • Tobacco Cessation programs, including individual/group/telephone counseling, over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Diabetes self-management • Nutritional counseling • Childhood obesity education	Nothing	Nothing

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

Important things you should 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 for services that you receive under the HMO benefits.
- Please see Section 5(i) for information regarding POS benefits for out-of-network services. An annual deductible and coinsurance will apply to covered POS benefits.
- 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 services listed below are for the charges billed by a physician or other health care professionals for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
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 procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Voluntary sterilization (E.G., tubal ligation, vasectomy) • Surgical treatment of morbid obesity (bariatric surgery) • Surgeries related to sex transformation • Insertion of internal prosthetic devices. See 5 (a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: Reference www.independenthealth.com for medical policy criteria for bariatric surgery.	Primary: $25 per office visit Specialist: $40 per office visit Nothing for outpatient surgery or inpatient services	Primary: $30 per office visit Specialist: $50 per office visit Nothing for outpatient surgery or inpatient services

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Primary: $25 per office visit Specialist: $40 per office visit Nothing for outpatient surgery or inpatient services	Primary: $30 per office visit Specialist: $50 per office visit Nothing for outpatient surgery or inpatient services
Abortions Note: Services, drugs or supplies covered at no member liability only when the life of the mother would be endangered if the fetus were carried to full term or when the pregnancy is a result of rape or incest.	Nothing	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Foot care)* • *Abortions, except those stated above*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• 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: severe protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - 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.	Primary: $25 per office visit Specialist: $40 per office visit Nothing for outpatient surgery or inpatient services	Primary: $30 per office visit Specialist: $50 per office visit Nothing for outpatient surgery or inpatient services
Not covered:	*All charges*	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• *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*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
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.	Primary: $25 per office visit Specialist: $40 per office visit Nothing for outpatient surgery or inpatient services	Primary: $30 per office visit Specialist: $50 per office visit Nothing for outpatient surgery or 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*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/ investigational review by the Plan. Refer to *other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants • Isolated Small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**

• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis
 	
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity for review by the Plan. Please refer to *Section 3* for prior authorization procedures.
• Autologous tandem transplants for
  • AL Amyloidosis
  • Multiple myeloma (de novo and treated)
  • Recurrent germ cell tumors (including testicular cancer)
	Nothing	Nothing

Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced myeloproliferative disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow Failure and related disorders (i.e. Fanconi's, PNH, pure red cell aplasia) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Advanced Hodgkin's lymphoma with reccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) • Amyloidosis • Breast Cancer • Epithelial ovarian cancer • Multiple myeloma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *other services* in Section 3 for prior authorization procedures. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkins's lymphoma with reccurance (relapsed) - Advanced non-Hodgkin's lymphoma with reccurance (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very sever aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced Hodgkin's lymphoma with reccurance (relapsed) - Advanced non-Hodgkin's lymphoma with reccurance (relapsed) - Amyloidosis - Neuroblastoma	Nothing	Nothing
These **blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Allogeneic transplants for: • Advanced Hodgkins lymphoma • Advanced non-Hodgkins lymphoma • Beta Thalessemia Major • Chronic inflammatory demyelination polyneuropathy (CIDP) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Sickle Cell Anemia Mini Transplants (Nonmyeloblative allogeneic transplants or Reduced intensity conditioning (RIC)) for • Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle Cell disease Autologous transplants for • Advanced Childhood kidney cancers • Advanced Ewing's sarcoma • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Aggressive non-Hodgkin's lymphomas • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin's lymphoma) • Small cell lung cancer • Systemic sclerosis Note: You must obtain our preauthorization for all organ/tissue transplants. Contact us directly for information at 716-631-8701. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/ stem cell transplant donors in addition to the testing of family members.	Nothing	Nothing
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

Benefit Description	You pay	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing

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

Important things you should 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.
- We do not have a calendar year deductible for services that you receive under the HMO benefits.
- Please see Section 5(i) for information regarding POS benefits for out-of-network services. An annual deductible and coinsurance will apply to covered POS benefits.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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 Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • 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. Note: Copay is waived if readmitted within 90 days from date of last discharge.	$500 per admission	$750 copay per admission
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	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	Nothing	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*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• 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.	$75 per visit	$100 per visit
Abortions Note: Services, drugs or supplies related to abortions covered at no member liability only when the life of the mother would be endangered when the fetus were carried to term or when the pregnancy is a result of an act of rape or incest.	Nothing	Nothing
Not covered: *Abortions, except when noted above*	*All Charges*	*All Charges*

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF) and subacute facility: We provide a comprehensive range of benefits for up to 45 days per year under the High Option and 30 days per year under the Standard Option, 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 Plan. 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 Note: Copayment is not waived when discharged from a hospital/facility and admitted to a Skilled Nursing Facility.	$500 copay per admission	$750 copay per admission
Not covered: • *Custodial care, maintenance care, respite care, or convenience care*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
We cover 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 bereavement counseling for covered family.	Nothing	Nothing
Not covered: • Independent nursing • Homemaker services	*All charges*	*All charges*

Benefit Description	You pay	
End of life care	**High Option**	**Standard Option**
End of life care includes Advance Care Planning (ACP) prior to admittance to a hospice Plan program or facility. ACP means home visits from a program sponsored by a plan hospice provider to assist members in preparing for issues they face following a life threatening or terminal diagnosis. ACP is limited to a maximum of six (6) ACP visits per calendar year. This benefit is in addition to the hospice care benefit described above. • Advance care planning	Nothing	Nothing
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service when medically appropriate. See 5(d) for emergency service.	$75 per trip	$100 per trip
Not covered: • *Wheelchair van transportation*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should 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.
- We do not have a calendar year deductible for services that you receive under the HMO benefits.
- Please see Section 5(i) for information regarding POS benefits for out-of-network services. An annual deductible and coinsurance will apply to covered POS benefits.
- 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.

What is a medical emergency?

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

What to do in case of emergency within the service area:

If you believe that you have an emergency, call 911 or go to the nearest emergency room. If you aren't sure, call your primary care doctor as soon as you can. You may also contact Independent Health's 24-hour Medical Help Line at 800-501-3439. A nurse will return your call and tell you what to do at home or to go to the primary care doctor's office or the nearest emergency room.

What to do in case of emergency outside the service area:

Go to the nearest emergency room. Call Independent Health as soon as you can (within 48 hours if possible). For urgent care services, call Independent Health's 24-hour Medical Help Line at 800-501-3439. If you do not contact us, you will owe a deductible and coinsurance. Please see Section 5(i) for information regarding the POS benefits.

Benefit Description	You Pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit
• Emergency care at an urgent care center	$50 per visit	$75 per visit
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$150 per visit	$150 per visit
Not covered: • *Elective care or non-emergency care.*	*All charges*	*All charges*

Benefit Description	You Pay	
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Urgent care at a doctor's office or urgent care center	$50 per date of service	$75 per date of service
• Emergency care as an outpatient at a hospital, including doctors' services. Note: We waive the copay if the emergency results in an inpatient admission to the hospital.	$150 per visit	$150 per 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*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service for the prompt evaluation and treatment of a medical emergency and/or transportation to a hospital for the treatment of an emergency condition. Note: See 5(c) for non-emergency service.	$75 per trip	$100 per trip
Not covered: • *Wheel chair van transportation*	*All charges*	*All charges*
Telehealth Services	**High Option**	**Standard Option**
Telehealth - the use of electronic and communication technologies by a provider to deliver covered services when the member's location is different than the provider's location. Note: You may inquire with a provider to see if he/she offers telehealth or contact Member Services at 716-631-8701	Primary: $25 per office visit Specialist: $40 per office visit	Primary: $30 per office visit Specialist: $50 per office visit

Telehealth Services - continued on next page

Benefit Description	You Pay	
Telehealth Services (cont.)	**High Option**	**Standard Option**
• Telemedicine Program - The telemedicine program is an online video or phone consultation service administered by a unique network of U.S. board-certified physicians who participate in our telemedicine program. Teladoc physicians use electronic health records to diagnose and treat conditions, including writing prescriptions. The service is intended to provide a solution for non-emergency medical situations and should not be used if you are experiencing a medical emergency. Telemedicine offers you an alternative option to an urgent care facility or when you are unable to obtain services from your primary care physician for many common medical issues including but not limited to cold and flu symptoms, allergies, pink eye, urinary tract infection, respiratory infection, and ear infection.To utilize the telemedicine program visit teladoc.com or call 800-TELADOC (800-835-2362). This service is available 24/7 and may be accessed if traveling throughout most of the United States.	Nothing	Nothing

Section 5(e). Mental health and substance misuse disorder benefits

Important things you should 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.
- We do not have a calendar year deductible for services that you receive under the HMO benefits.
- Please see Section 5(i) for information regarding POS benefits for out-of-network services. An annual deductible and coinsurance will apply to covered POS benefits.
- 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.

Benefit Description	You Pay	
Professional services	**High Option**	**Standard Option**
We cover professional services by licensed professional mental health and substance misuse disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$25 per visit	$30 per visit

Benefit Description	You Pay	
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance misuse disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Inpatient diagnostic tests provided and billed by a hospital or other covered facility Note: Advanced radiology is subject to a $750 advanced radiology copayment maximum per calendar year on the Standard Option.	Nothing for laboratory tests; Primary: $25 per office visit for diagnostic tests Specialist: $40 per office visit for diagnostic tests $25 per visit for routine radiology services in addition to any copayment for office services; $40 per visit for advanced radiology services in addition to any copayment for office services;	Nothing for laboratory tests; Primary: $30 per office visit for diagnostic tests Specialist: $50 per office visit for diagnostic tests $40 per visit for radiology services in addition to any copayment for office services; $75 per visit for advanced radiology services in addition to any copayment for office services.
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Residential treatment for mental health and substance misuse Note: Preauthorization required for inpatient substance misuse treatment at a NYS OASAS certified facility is no longer necessary Note: Copayment is waived if readmitted within 90 days from date of last discharge	$500 per admission	$750 per admission
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, full-day hospitalization, or facility-based intensive outpatient treatment	$25 per visit	$30 per visit

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- We do not have a calendar year deductible for services that you receive under the HMO benefits.
- Prescription drugs are not covered under the POS benefits. You must use a Plan pharmacy to fill your prescription, including those within our National Pharmacy Network.
- Some drugs require prior authorization, including non-formulary insulin and non-formulary diabetic supplies. Your prescribing Plan physician will request required prior authorization from us when the drug is medically necessary for your treatment. We review most prior authorization requests within 1 business day of receipt of all necessary information. If the prescribing provider is a non-Plan provider, the non-Plan provider must contact us for preauthorization or we will not cover the prescription.
- Federal law prevents the pharmacy from accepting unused medications.
- 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.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner or Psychologist must prescribe your medication.
- **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 52,000 pharmacies across the country. To find a list of participating pharmacies, visit our website at www.independenthealth.com or contact our Member Services Department at 716-631-8701 or 800-501-3439.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 5-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 1,000 different medications and covers all classes of drugs prescribed for a variety of diseases. Tier 1 generally contains preferred generic and some over-the-counter drugs. Tier 2 contains preferred brand name drugs. Tier 3 contains non-preferred drugs. Tier 4 contains preferred specialty drugs. Tier 5 contains non-preferred specialty drugs.To obtain a copy of the formulary, visit our website at www.independenthealth.com or contact our Member Services Department at 716-631-8701 or 800-501-3439. 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 our Board Quality Review Oversight Committee who makes the final decision.
- **These are the dispensing limitations.** You may obtain up to a 30-day supply or up to a 90-day supply for maintenance medications. Plan pharmacies fill prescriptions using FDA-approved generic equivalents if available. All other prescriptions are filled using FDA-approved brand name pharmaceuticals. Most antibiotics are limited to a 10-day supply with one refill within 15 days of the original fill. Prescriptions written by an emergency room physician are limited to a 10-day supply with no refills. If you are in the military and called to active duty, please contact us if you need assistance in filling a prescription before your departure.
- **A generic equivalent will be dispensed if it is available,** unless your physician requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

- **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 equivalence as brand-name drugs. Generic drugs are generally less expensive than brand name drugs, in most instances are the most cost effective therapy available, and may save you money.
- **Half tablet program.** As a way to address the rising costs of prescription drugs, Independent Health now allows a tablet splitting program for select medications.Tablet splitting is the act of physically cutting a higher strength tablet in half to achieve your prescribed dosage. This provides an identical dose while increasing the number of total doses available. For example, by splitting pills in two, 30 tablets can be transformed into a 60-day supply for the same copayment/coinsurance. Not all medications are good candidates for tablet splitting. We recommend that you speak with your health care provider or pharmacist to see if your medication meets splitting requirements. **This is a voluntary program. You will be responsible for the splitting of your medication.** Independent Health does not mandate tablet splitting, however, if you are on one of the medications indicated in our prescription drug formulary with symbol "HT", tablet splitting may be an option for you.
  - Tablet splitting is an easy way for some members to save money on prescription medications. But, it is not for everyone or for every type of medication. If you are interested in having your prescription medications split in half, call your doctor. Your doctor will decide whether to write a prescription that you can split
- If you have an Emergency condition, you may immediately access, without preauthorization, a five (5) day emergency supply of a prescribed substance misuse disorder medication, including a prescription drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. If you have a copayment, it will be prorated. If you receive an additional supply of the substance misuse disorder medication within the 30-day period in which you received the emergency supply, your copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated copayment(s) total more than your copayment for a 30-day supply.

Maintenance Medications

- **Retail Pharmacy.** You may obtain a 90-day supply of your maintenance medications at select Participating Pharmacies at a cost of 2.5 copayments for Tier 1 drugs or the full applicable coinsurance for all other Tiers. Please visit our website at www.independenthealth.com or contact our Member Services Department at 716-631-8701 or 800-501-3439 to obtain a list of the select participating pharmacies.
- **Mail Order Pharmacy.** In addition to Independent Health's pharmacy network, you may also obtain your maintenance medications through Wegmans or ProAct Pharmacy Services. When using mail order pharmacies, your medications are shipped to you by standard delivery at no additional cost to you (express shipping is available for an additional charge). Maintenance medications must be dispensed in 90-day supply quantities (2.5 copayments apply for Tier 1 drugs or the full applicable coinsurance for all other Tiers). Before using Wegmans or ProAct Pharmacy Services for the first time, you will have to register with the mail order pharmacy of your choice.

Here's how to register:

- **By mail:** please contact our Member Services Department at 716-631-8701 or 800-501-3439 for a registration form for the pharmacy of your choice.
- **Online:** www.wegmans.com/pharmacy or www.proactrx.com
- **By Phone:**
  - Wegmans: 888-205-8573 (TTY/TDD: 877-409-8711)
  - ProAct Pharmacy Services: 888-425-3301 (TTY National 711 Relay Service)
- **To obtain your mail order pharmacy prescription**
  - You will first need a new prescription written by your doctor. Please ask your doctor to write a new prescription for a 90-day supply for mail service plus refills for up to 1 year (as appropriate). Please check the Independent Health drug formulary for covered medications.
  - Please note: when placing your initial order, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 30-day supply to be filled at your local retail network pharmacy.

- **To order refills:**
  - You can easily refill your prescriptions online, by telephone or by mail. Have your Member ID ready and your prescription number for the medication available. If you choose to pay by credit card, please have that number available as well. To make sure you don't run out of medication, remember to re-order 14 days before your medication runs out.
- **When you do have to file a claim.** If you do not have access to a Plan pharmacy in an emergency situation and you paid for prescriptions filled at a non-plan pharmacy, please send a copy of the paid receipt along with your member ID number, to: Independent Health, 511 Farber Lakes Drive, Buffalo, NY 14221 Attn: Pharmacy Department.

Benefit Description	You Pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a licensed provider and obtained from a Plan pharmacy: • Drugs and medicines that by Federal law of the United States require a provider's prescription for their purchase, except those listed as Not covered. • Growth hormones (with preauthorization) • Contraceptives and contraceptive devices, including diaphragms • Nutritional supplements medically necessary for the treatment of phenylketonuria (PKU) and other related disorders (with preauthorization) • Self-administered inject-able drugs (with preauthorization) • Fertility drugs when you meet specific criteria (See Section 5(a) Infertility Services) • Hormonal drugs • Sexual dysfunction drugs have dispensing limitations. Contact us for details. Note: Intravenous fluids and medication for home use, implantable drugs, and inject-able or implantable contraceptives are covered under Medical and Surgical Benefits.	Unless otherwise indicated, • $7 per 30-day supply of a Tier 1 drug • 35% per 30-day supply of a Tier 2 drug • 50% per 30-day supply of a Tier 3 drug • 35% per 30-day supply of Tier 4 drug • 50% per 30-day supply of Tier 5 drug Maintenance Medications - Retail or Mail Order Pharmacy • $17.50 per 90-day supply of a Tier 1 drug • 35% per 90-day supply of a Tier 2 drug • 50% per 90-day supply of a Tier 3 drug • 35% per 90-day supply of Tier 4 drug • 50% per 90-day supply of Tier 5 drug Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 or Tier 3 member cost-share.	Unless otherwise indicated, • $7 per 30-day supply of a Tier 1 drug • 35% per 30-day supply of a Tier 2 drug • 50% per 30-day supply of a Tier 3 drug • 35% per 30-day supply of Tier 4 drug • 50% per 30-day supply of Tier 5 drug Maintenance Medications - Retail or Mail Order Pharmacy • $17.50 per 90-day supply of a Tier 1 drug • 35% per 90-day supply of a Tier 2 drug • 50% per 90-day supply of a Tier 3 drug • 35% per 90-day supply of Tier 4 drug • 50% per 90-day supply of Tier 5 drug Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 or Tier 3 member cost-share.
Oral chemotherapy	Nothing for up to a 30-day supply	Nothing for up to a 30-day supply
Women's contraceptive drugs and devices • Tier 1 and Tier 2 oral contraceptive drugs and devices • Select Tier 3 oral contraceptive drugs and devices Note: Over-the counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing per 30-day supply	Nothing per 30-day supply

Covered medications and supplies - continued on next page

Benefit Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Insulin and oral agents • Diabetic supplies such as test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets and cartridges for the visually impaired - Disposable needles and syringes needed to inject insulin Note: For non-insulin dependent members: 100 test strips limit for a 30-day supply and a 300 test strip limit for a 90-day supply. For insulin dependent members: 300 test strip limit for a 30-day supply and a 900 test strip limit for a 90-day supply.	• $25 copay or the applicable prescription member liability, whichever is less	• $30 copay or the applicable prescription member liability, whichever is less
Needles and syringes necessary to inject covered medication	20% coinsurance	20% coinsurance
Preventive medications	**High Option**	**Standard Option**
• Aspirin (81 mg) for adults age 50-59 • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 6 months - 1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Statins used for the primary prevention of cardiovascular disease (CVD) for adults age 40-75 with no history of CVD, 1 or more CVD risk factors, and a calculated 10 year CVD event risk of 10% or greater Note: Preventive medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing	Nothing
Not covered:	*All charges*	*All charges*

Preventive medications - continued on next page

Benefit Description	You Pay	
Preventive medications (cont.)	**High Option**	**Standard Option**
• *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs when you do not meet the New York State-mandated criteria for coverage or when related to non-covered infertility procedures* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except for prenatal vitamins or Vitamin D for adults below age 65* • *Drugs available without a prescription except for some over-the-counter products as listed on our formulary* • *Medical supplies such as dressings and antiseptics* • *Prescription refills beyond one year from the original date written* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit (See page 44)	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should 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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB plan. See Section 9 Coordinating benefits with other coverage.
- 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. See Section 5(c) for inpatient hospital benefits. 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.

Benefit Desription	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to repair (but not replace) sound natural teeth within twelve months of the accident. The need for these services must result from an accidental injury. Note: Please see specific benefit description for any additional services that may be rendered in an office setting for the amount you pay.	Member liability based on specific service rendered.	Member liability based on specific service rendered.
Not covered: • *Injury to the teeth caused by eating or chewing*	*All charges*	*All charges*
Dental benefits	**High Option**	**Standard Option**
We cover treatment that is medically necessary due to a congenital disease or anomaly such as cleft lip/cleft palate.	Member liability based on specific service rendered.	Member liability based on specific service rendered.
Not covered: *Dental services not shown as covered.*	*All charges*	*All charges*

Section 5(h). Wellness and Other Special features

Feature	Description
Feature	**High Option**
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24-Hour Medical Help Line	Independent Health's 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 medical resource management (MRM) 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 716-631-8701 or 800-501-3439 to get the help you need when you need it most.
Services for deaf and hearing impaired	You may contact Independent Health through a TDD machine at 716-631-3108.
Case Management	The purpose of case management is to identify high-risk members and coordinate care such that the member receives appropriate care in the appropriate setting. Members are referred from many sources. Those cases, which are referred to the Case Management team, will have an assessment and phone call to the member/family within 48 hour of the referral.
Travel benefit/services overseas	You have worldwide coverage for emergency care services. This does not include travel-related expenses. Contact us for details.
Facilities for transplants/ heart surgery/etc.	With preauthorization, you have access to certain facilities through Optum Health Care Solutions. Please contact us for any additional information.
Well-being Assessment	FitWorks: · Online tool that provides a Well-being Assessment allowing you to identify your strengths, opportunities to improve your health and well-being, and health risks. · Provides targeted recommendations for improvement of physical and mental well-being. · Allows you to take a more active role in your health by setting and tracking goals, as well as through engaging in challenges and social networking. · Get started by creating your FitWorks account at www.ihfitworks.com

Section 5(i). Point of Service benefits

Facts about this Plan's Point of Service (POS) option

Point of Service (POS) provides you flexibility in accessing covered care from non-Plan providers. When you receive medically necessary non-emergency covered out-of-network services, you are subject to the deductibles, coinsurance, and provider charges that exceed the Plan reimbursement and benefit limitations described below. Certain benefits are excluded from POS coverage and we list them in this section under "What is not covered". The exclusions that appear on page 123 in Section 6 General exclusions - things we don't cover, still apply to POS benefits.

High Option:

- Under the POS benefit, your cost share for covered out-of-network services is higher than the HMO benefit. For Self Only POS coverage, you must satisfy a deductible of $500 per member per calendar year. Under Self Plus One or Self and Family enrollment, 2 family members must each satisfy a $500 annual deductible. After the annual deductible has been met, we reimburse 75% of our allowable charges for covered medical services. We reimburse 50% of the allowable charges for covered durable medical equipment and prosthetic devices. In addition to the annual deductible and coinsurance, you are also responsible for any amount that exceeds our allowance for covered services. Our allowance is based on the lesser of the non-plan provider's charges, the negotiated rate, or the 90th percentile of Usual, Customary or Reasonable (UCR).
- The out-of-network out-of-pocket maximum is $10,000 for Self Only and $20,000 for Self Plus One or Self and Family per calendar. Your POS deductible and coinsurance apply to the out-of-network out-of-pocket maximum; in-network member liability, prescription drugs, routine vision and dental services, and penalties for failure to preauthorize do not apply. Once you have satisfied the out-of-pocket maximum, you will not pay coinsurance for covered POS benefits. However, you will still owe any amount of the provider's charge that exceeds our allowance or any applied penalties.

Standard Option:

- Under the POS benefit, your cost share for covered out-of-network services is higher than the HMO benefit. For Self Only POS coverage, you must satisfy a deductible of $1,000 per calendar year. Under the POS benefits, you must satisfy a deductible of $1,000 per member per calendar year. Under Self Plus One or Self and Family a $2,000 annual deductible must be satisfied, but no individual family member will exceed a $1,000 deductible. After you have satisfied the annual deductible, we reimburse 70% of our allowable charges for covered medical services. We reimburse 50% of the allowable charges for covered durable medical equipment and prosthetic devices. In addition to the annual deductible and coinsurance, you are also responsible for any amount that exceeds our allowance for covered services. Our allowance is based on the lesser of the non-plan provider's charges, the negotiated rate, or the 80th percentile of Usual, Customary or Reasonable (UCR).
- The out-of-network out-of-pocket maximum is $10,000 for Self Only and $20,000 for Self Plus One or Self and Family per calendar. Your POS deductible and coinsurance applies to the out-of-network out-of-pocket maximum; in-network member liability, prescription drugs, routine vision and dental services, and penalties for failure to preauthorize do not apply. Once you have satisfied the out-of-pocket maximum, you will not pay coinsurance for covered POS benefits. However, you will still owe any amount of the provider's charge that exceeds our allowance or any applied penalties.

Important things you should keep in mind about these benefits:

Limitations/Requirements

- You must select a PCP and notify us of the provider's name.
- You or a provider must report services that you receive from a non-Plan provider or facility to your primary care physician no later than seventy-two (72) hours after receiving medical services.

- You are responsible for filing a claim form with us for all services that you receive from a non-Plan provider or facility. A claim form must be submitted in its entirety and submitted within one-hundred twenty (120) days after the date you receive medically necessary health care services.
- Benefit limitations on health care services listed in this plan brochure will be applied to all such health care services, regardless of whether the health care services are rendered by Plan or non-Plan providers or facilities.

Section 5. High Deductible Health Plan Benefits

See page 17 for how our benefits changed this year. This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection.

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Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). We call this plan iDirect. The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read ***Important things you should keep in mind*** at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 716-631-8701 or 800-501-3439 or on our website at www.independenthealth.com.

Our HDHP option provides comprehensive coverage and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits. You may seek covered care from our network of Plan providers (in-network) or from non-Plan providers (out-of-network).

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. Once you have completed and returned the HSA/HRA Eligibility Form confirming your eligibility to be enrolled in an HSA or HRA, we will automatically fund a portion of the total health plan premium on a monthly basis, known as a pass-through.

Eligible preventive care services are covered in full. We apply the deductible and any other applicable member liability to all other medical and prescription care services before we will pay benefits. You can choose to use funds available in your HSA or HRA for qualified medical expenses or you can allow your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care**

  You have access to preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), well-child care, and immunizations from within our network or outside our network. Preventive care services are covered in full if you use an in-network provider. Please see Section 5 Preventive care *for a complete description of the preventive care benefits.*

- **Traditional medical coverage**

  After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays deductible, then applicable copayment or 20% coinsurance for in-network services. For out-of-network services, you are responsible for meeting your deductible, then 40% coinsurance applies.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits
  - Accidental injury dental benefits

- **Savings**

  Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 74 for more details).

- **Dental fund**

  Your dental fund is an established annual amount that is available for you to use to pay for dental expenses rendered by any licensed dentist. The dental fund is not subject to the deductible, the annual catastrophic maximum or out-of-pocket maximum. You determine how you will use your dental fund. Any unused amount at the end of the year will not roll over to subsequent year(s). You cannot use the dental fund for cosmetic dentistry (see page 115 for more details).

- **Health Savings Accounts (HSA)**

  By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for service connected disability) and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2018, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $83.33 per month for a Self Only enrollment, $137.85 per month for a Self Plus One enrollment or $166.66 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, as long as total contributions do not exceed the limit established by law, which is $3,450 for an individual and $6,900 for a family. See maximum contribution information on page 77. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

  Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

  HSA features include:

  - Your HSA is administered by Mellon Bank. They govern your HSA account in regards to options and fees;
  - Your contributions to the HSA are tax-deductible;
  - You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
  - Your HSA earns tax-free interest;
  - Investment options are available on your HSA account and are managed by you through Mellon Bank once contributions exceed the required transactional balance. Investment earnings are also tax free;
  - You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses);
  - Your unused HSA funds and interest accumulate from year to year;
  - It’s portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire; and
  - When you need it, funds up to the actual HSA balance are available.

  Important consideration if you want to participate in a Health Care Flexible Spending Account (FSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a health care flexible spending account (such as FSAFEDS offers – see Section 11), this HDHP cannot continue to contribute to your HSA. Instead, when you inform us of your coverage in an FSA, we will establish an HRA for you.

- **Health Reimbursement Arrangements (HRA)**

If you aren't eligible for an HSA, for example, you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2018 we will give you an HRA credit of $83.33 per month for a Self Only enrollment, $137.85 for a Self Plus One enrollment or $166.66 per month for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA plans are sanctioned and regulated by the IRS. All procedures followed are required by the Federal IRS regulations. In order to maintain the tax-free status of this money, all IRS rules must be followed. As a result, in order to be reimbursed for an expense if you file a claim, you will need to submit copies of your receipts of provider billing statement. In the case where you use the debit card provided with the HRA plan to pay your provider, you may be asked to submit copies of your receipts in order to meet IRS guidelines.

Therefore, you must keep copies of all receipts and itemized statements (not the credit card receipt) for each purchase. In some cases, you'll receive a letter requesting the documentation and you will be required to submit this information to substantiate the expense according to IRS regulations.

HRA features include:

- For our HDHP option, the HRA is administered by Independent Health;
- Your HRA credit is available to you as it accumulates from month to month;
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP;
- Unused credits carryover from year to year;
- HRA credit does not earn interest;
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans; and
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account. However, you must meet FSAFEDS eligibility requirements.

- **Catastrophic protection for out-of-pocket expenses**

Your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered in-network services is limited to $6,550 per person or $13,100 for Self Plus One or Self and Family enrollment. Your annual maximum for out-of-pocket expenses (deductibles and coinsurance) for covered out-of-network services is limited to $10,000 per person or $20,000 for Self Plus One or Self Plus Family enrollment. For both the in-network and out-of-network out-of-pocket maximums, no individual in a Self Plus One or a Self and Family will exceed the Self Only out-of-pocket maximum**.** However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will facilitate an HSA for you with The Bank of New York Mellon. Mellon ACS/ HSA Solution is this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). The address for Mellon ACS/HSA Solution is: Mellon ACS/HSA Solution 150 Clove Road Little Falls, NJ 07424 The telephone number is 877-472-4200	The Plan will administer HRA credits on your behalf.
Fees	$3.50 per month maintenance fee charged by the fiduciary and taken out of the account balance until it reaches $1,000. The above fee is subject to change without notice.	None.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA and/or Indian Health Services (IHS) benefits in the last three months • Completion of all banking paperwork and confirmation of your HSA eligibility is required prior to receiving the funds that FEHB has approved for deposit into your HSA account. An HSA or HRA cannot be established without your consent.	You must enroll in this HDHP. Eligibility for credits is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment. Confirmation of your ineligibility to establish an HSA will result in the establishment of our HRA.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the first day of the month following your effective date of enrollment in the HDHP.	If you are eligible for HRA credits, a portion of your monthly health plan premium is deposited to your HRA each month. Premium pass through credits are based on the first day of the month following your effective date of enrollment in the HDHP.

	Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	
• **Self Only enrollment**	For 2018, a monthly premium pass through of $83.33 will be made by the HDHP directly into your HSA each month.	For 2018, a monthly premium pass through of $83.33 will be made by the HDHP directly into your HRA each month.
• **Self Plus One enrollment**	For 2018, a monthly premium pass through of $137.85 will be made by the HDHP directly to your HSA each month.	For 2018, your HRA annual credit is $137.85 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2018, a monthly premium pass through of $166.66 will be made by the HDHP directly into your HSA each month.	For 2018, a monthly premium pass through of $166.66 will be made by the HDHP directly into your HRA each month.
Contributions/ credits	**The maximum that can be contributed to your HSA is an annual combination of the HDHP premium pass through and enrollee contribution funds, which when combined, does not exceed the maximum contribution amount set by the IRS of $3,450 for an individual and $6,900 for a family.** If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable amount. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment through the testing period. The testing period requires that you remain an eligible individual in December of the partial year through December of the following year. If you do not remain an eligible individual, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. If you do not remain an eligible individual through the testing period, the maximum contribution amount is reduced by 1/12 for each month you were ineligible to contribute to an HSA.	The maximum that can be contributed to your HRA is an annual amount of HDHP premium pass through credits for each month you are eligible. The HRA does not earn interest. The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	To determine the maximum allowable contribution, take the amount of your deductible divided by12, times the number of full months enrolled in the HDHP. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 80.	
• **Self Only enrollment**	The total contribution to your HSA must not exceed the annual maximum of $3,450.	You cannot contribute to the HRA
• **Self Plus One enrollment**	The total contribution to your HSA must not exceed the annual maximum of $6,900.	You cannot contribute to the HRA.
• **Self and Family enrollment**	The total contribution to your HSA must not exceed the annual maximum of $6,900.	You cannot contribute to the HRA.
Access funds	You may access your funds by using your HSA debit card at point of service, by electronic transfer to another account, or by check.	You may access your funds by using your HRA debit card at point of service, reimbursement via check or direct deposit for claims submitted manually for processing.
Distributions/ withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses (as defined by IRS Code 213 (d)).

	When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	
Availability of funds	Employees have access to the funds that have been deposited in their account to date. Funds are not available for withdrawal until all the following steps are completed: Your enrollment in this HDHP is effective (effective date is determined by your agency in accordance with the event permitting the enrollment change). The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. The Plan will contribute funds once you have verified your eligibility to establish an HSA or HRA. Forms will be provided to you to complete for this verification and must be returned to us for contributions to begin. You have completed and returned the requested paperwork required by the fiduciary to establish your account.	Funds are not available for withdrawal until all the following steps are completed: Your enrollment in this HDHP is effective (effective date is determined by your agency in accordance with the event permitting the enrollment change). The HDHP receives record of your enrollment and initially establishes your HRA account and the initial premium pass through credit is applied to your account The plan will contribute funds in your HRA once you have verified your ineligible for an HSA. Forms will be provided to you to complete for this verification and must be returned to us for contribution to begin. Employees have access to the funds that have been deposited in their account to date.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 74 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If You Have an HSA

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective data is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contributions is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Website at www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

- **If you die**

  If you have not named a beneficiary, and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, **physician prescribed** over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 800-829-3676, or visit the IRS Website at www.irs.gov and click on "Forms and Publications." Note: Although **physician prescribed** over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You will receive a periodic statement that shows the "premium pass through", withdrawals, and interest earned on your account.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

If You Have an HRA

- **Why an HRA is established**

  If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare or are covered under another Health Plan, you are ineligible for an HSA and we will establish an HRA for you. You must notify us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review the chart on page 76 which details the differences between an HRA and an HSA. The major differences are:

  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 - *Traditional medical coverage subject to the deductible*.

Benefit Description	You pay After the calendar year deductible...
Preventive care, adult	
Routine screenings, such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test - one annually for men age 50 and older • Colorectal Cancer Screening, including: - Fecal occult blood test yearly starting at age 50 - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening - every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older	In-Network: Nothing Out-of-Network: Deductible and 40% coinsurance, plus any difference between our payment and the billed charges
• Well woman care - based on current recommendations such as: - Cervical cancer screening (Pap smear) - Human Papillomavirus (HPV) Testing - Chlamydia/Gonorrhea screening - Osteoporosis screening - Breast cancer screening - Counseling for sexually transmitted infections - Counseling and screening for human immune-deficiency virus - Contraceptive methods and counseling - Screening and counseling for interpersonal and domestic violence	In-Network: Nothing Out-of-Network: Deductible and 40% coinsurance, plus any difference between our payment and the billed charges
• Routine mammogram — covered for women	In-network: Nothing Out-of-Network: Deductible and 40% coinsurance, plus any difference between our payment and the billed charges
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC); based on the Advisory Committee on Immunization Practices (ACIP) schedul	In-Network: Nothing Out-of-Network: Deductible and 40% coinsurance, plus any difference between our payment and the billed charges.
• Routine physical examination, once every calendar year	In-Network: Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...
Preventive care, adult (cont.)	
• Routine exams limited to: One routine eye exam every 12 months-One routine OB/GYN exam every 12 months including 1 Pap smear and related services-One routine hearing exam every 24 months	In-Network: Nothing Out-of-Network: Deductible and 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Physical examination, immunizations, and/or services required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.* *Note: Any procedure, injection, diagnostic service, laboratory or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments*	*All charges*
Preventive care, biometric screening	
• Body mass index • Total cholesterol • Blood pressure screening • Glucose screening	In-Network: Nothing Out-of-Network: Deductible and 40% coinsurance, plus any difference between our payment and the billed charges Note: Please refer to the specific benefits description for information on the amount(s) you owe for additional services that your doctor may perform during your visit.
Preventive care, children	
Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics	In-Network: Nothing Out-of-Network: Deductible and 40% coinsurance, plus any difference between our payment and the billed charges
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org HHS: www.healthcare.gov/preventive-care-benefits ACIP recommendations on immunizations, please refer to the National Immunization Program website at: www.cdc.gov/vaccines/schedules/index.html	

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible...
Preventive care, children (cont.)	
For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Future Guidelines go to: brightfutures.aap.org/Pages/default.aspx	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*

Section 5. Traditional medical coverage subject to the deductible

Important things you should 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.
- In-network preventive care is covered at 100% (see page 82) and not subject to the calendar year deductible.
- The deductible is $2,000 for Self Only or $4,000 for Self Plus One or Self and Family. Under Self Plus One or Self and Family enrollment, the deductible must be satisfied in full by one or more family members before we will begin paying benefits. The deductible applies to all benefits except covered in-network preventive care.
- After you have satisfied your annual deductible, your traditional medical coverage begins. Under your traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $6,550 per person, $13,100 per Self Plus One enrollment or $13,100 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- You limit your liability for covered services by using providers who are part of the Independent Health network. In-network benefits apply only when you use a network provider. Out-of-network benefits apply to services from providers that are not part of the network.
- 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.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	**You Pay**
The deductible applies to almost all benefits in this Section. In the **You Pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you pay the allowable charges until you meet the deductible.	100% of allowable charges, until you meet the deductible of $2,000 under Self Only enrollment or $4,000 under Self Plus One or Self and Family enrollment. You may choose to pay the deductible from your HSA/HRA or out-of-pocket.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA/HRA or you can pay for them out-of-pocket. Out-of-network: After you meet the deductible, you pay the indicated coinsurance plus any difference between our Plan allowance and the billed amount. You may choose to pay the coinsurance or any difference between our Plan allowance and the billed amount from your HSA/HRA or you can pay for them out-of-pocket.

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

Important things you should 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.
- You limit your liability for covered services by using providers who are part of the Independent Health network. In-network benefits apply only when you use a network provider. Out-of-network benefits apply to services from providers that are not part of the network.
- The deductible is $2,000 for Self Only or $4,000 for Self Plus One or Self and Family. Under Self Plus One or Self and Family enrollment, the deductible must be satisfied in full by one or more family members before we will begin paying benefits. The deductible applies to all benefits except covered in-network preventive care.
- After you have satisfied your annual deductible, your traditional medical coverage begins.Under your traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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.).

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In a physician's office for: - Health evaluation and management - Office medical consultation - Second surgical opinion • In an urgent care center Note: The office visit copayment may not cover all services that you may receive during your visit. Please refer to the specific benefits description for information on the amount(s) you owe for additional services that your doctor may perform during your visit.	In-Network: $20 per office visit Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
• During a hospital stay • Initial examination of a newborn • In a skilled nursing facility • Advanced care planning	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Benefit Description	You pay After the calendar year deductible…
Telehealth Services	
• Telehealth - the use of electronic and communication technologies by a provider to deliver covered services when the member's location is different than the provider's location. Note: You may inquire with a provider to see if he/she offers telehealth or contact Member Services at 716-631-8701.	In-Network: $20 per office visit Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges.
• Telemedicine Program - The telemedicine program is an online video or phone consultation service administered by a unique network of U.S. board-certified physicians who participate in our telemedicine program. Teladoc physicians use electronic health records to diagnose and treat conditions, including writing prescriptions. The service is intended to provide a solution for non-emergency medical situations and should not be used if you are experiencing a medical emergency. Telemedicine offers you an alternative option to an urgent care facility or when you are unable to obtain services from your primary care physician for many common medical issues including but not limited to cold and flu symptoms, allergies, pink eye, urinary tract infection, respiratory infection, and ear infection.To utilize the telemedicine program visit teladoc.com or call 800-TELADOC (800-835-2362). This service is available 24/7 and may be accessed if traveling throughout most of the United States.	In-Network: Nothing Out-of-Network: Not covered
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology Radiology procedures and advanced radiology procedures - for the detection of breast cancer • Ultrasound • MRI • Diagnostic Mammograms	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Radiology procedures such as: • X-rays • CAT Scans/MRI • Ultrasound Diagnostic tests, such as: • Electrocardiogram and EEG	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Benefit Description	You pay After the calendar year deductible…
Maternity care	
Maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women after 24 weeks. • Postnatal care • Delivery and inpatient hospital visits • Newborn care in a hospital setting • Anesthesia services	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
• Breastfeeding support, supplies and counseling for each birth	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Here are some things to keep in mind: • You do not need to preauthorize your vaginal delivery; see page 88 for other circumstances, such as extended stays for you or your baby • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits may apply rather than maternity benefits.	
Family planning	
Contraceptive counseling on an annual basis	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Voluntary sterilization for men (See Surgical procedures Section 5(b))	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
A range of voluntary family planning services, limited to: • Voluntary sterilization for women (See Surgical procedures Section 5(b))	In-Network: Nothing

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible…
Family planning (cont.)	
• Surgically implanted contraceptives (See Surgical procedures Section 5 (b)) • Injectable contraceptive drugs (such as Depo provera) (see Surgical procedures Section 5(b)) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives and certain contraceptive devices under the prescription drug benefit.	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Covered diagnostic tests and procedures including but not limited to the following procedures: • Hysterosalpingogram • Hysteroscopy • Endometrial biopsy • Laparoscopy • Sonohysterogram • Post Coital tests • Testis biopsy • Semen analysis • Blood tests • Ultrasound • Sperm washing • Electroejaculation • Fertility drugs Note: We cover self injectable and oral fertility drugs under the prescription drug benefit. Note: Advanced radiology is subject to a $750 copayment maximum per calendar year.	In-Network: $20 per office visit; 20% coinsurance for outpatient medical/ surgical procedures and radiology; nothing for laboratory and inpatient procedures. Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
Note: We will cover medical or surgical procedures which are medically necessary to diagnose or correct a malformation, disease, or dysfunction, resulting in infertility, and diagnostic tests and procedures that are necessary to determine infertility. We limit infertility coverage to correctable medical conditions that have resulted in infertility. Your applicable office visit copayment or outpatient facility coinsurance (inpatient is covered in full) will depend 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. In order to be eligible for Infertility services, you must: • be at least 21 years of age and no older than 44; except for diagnosis and treatment for a correctable medical condition which incidentally results in infertility • have a treatment plan submitted in advance to us by a physician who has the appropriate training, experience and meets other standards for diagnosis and treatment of infertility as promulgated by New York State • have a treatment plan that is in accordance with standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the American Hospital Formulary Service • the number of allowable artificial insemination procedures is based on accepted medical practices.	In-Network: $20 per office visit; 20% coinsurance for outpatient medical/ surgical procedures and radiology; nothing for laboratory and inpatient procedures. Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Services for an infertility diagnosis as a result of current or previous sterilization procedures(s) and/or procedures(s) for reversal of sterilization.* • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or donor egg and all related services* • *Over-the-counter medications, devices or kits, such as ovulation kits* • *Cloning or any services incident to cloning*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections	In-Network: $20 per office visit Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Allergy serum	In-Network: Nothing

Allergy care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Allergy care (cont.)	
	Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	In-Network: $20 per office visit Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 98-102. • Respiratory and inhalation therapy • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions • Dialysis – hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Injections administered in a physician's office (for example, B-12 and steroid injections) • Hormonal therapies Note: Growth hormone is covered under the prescription drug benefits. We only cover GHT when we preauthorize treatment. You or your doctor must submit information that establishes that the GHT is medically necessary and ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary.	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges.
Physical and occupational therapies – Rehabilitative and Habilitative	
Up to 60 combined visits per calendar year: • Qualified physical therapists • Occupational therapists Note: The 60-visit limit applies to any combination of physical, occupational, and/or speech therapy.	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Long-term rehabilitative therapy*	*All charges*

Physical and occupational therapies – Rehabilitative and Habilitative - continued on next page

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies – Rehabilitative and Habilitative (cont.)	
• *Exercise programs*	*All charges*
Speech therapy – Rehabilitative and Habilitative	
Up to 60 total visits combined per calendar year for the services from a licensed speech therapist Note: The 60-visit limit applies to any combination of physical, occupational, and/or speech therapy.	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
• Assistive communication devices for the diagnosis of Autism Spectrum Disorder	In-Network: $20 Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Hearing services (testing, treatment, and supplies)	
• For hearing treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. Note: See 5(b) for coverage of the surgery to insert the device.	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Hearing services that are not shown as covered* • *Hearing aid, supplies, examinations, fitting*	*All charges*
Vision services (testing, treatment, and supplies)	
• Contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts). Benefits are limited to one pair of replacement lenses, or contact lenses per incident prescribed within one year of injury • One pair of eyeglasses to correct an impairment directly caused by accidental ocular injury or intraocular surgery. Benefits are limited to one pair of eyeglasses per incident prescribed within one year of injury • Eye examinations for medical conditions such as glaucoma, retinitis pigmentosa, and macular degeneration.	In-Network: 20% coinsurance Out of Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eye glasses or contact lenses, except as shown above*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	In-Network: $20 per office visit; 20% for medical/surgical procedures Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
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	
• Artificial limbs* • Artificial eyes • Stump hose • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Compression stockings** *Note: One prosthetic device per limb, per lifetime. Replacement limbs may be considered based on medical necessity. **Note: Compression stockings including below the knee and thigh, limited to a total of 12 units (6 pair) per year with a compression type of 30-40 mmHg and 40-50 mmHg	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
• Implanted hearing-related devices, such as bone-anchored hearing aids (BAHA) and cochlear implants. • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Ostomy supplies Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Hearing aids*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
• *Orthopedic and corrective shoes , arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, and other supportive devices* • *Compression stockings with a compression of less than 30 mmHg* • *Wigs and hair prosthesis* *Note: Call us at 716-631-8701 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about the service when you call.	*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. Under this benefit, we cover: • Oxygen and oxygen equipment • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Diabetic equipment such as; • Insulin pumps • Blood glucose monitors • Diabetic supplies such as test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets and cartridges for the visually impaired • Disposable needles and syringes needed to inject insulin	In-Network: $20 per item Out-of-Network: 40% coinsurance per item, plus any difference between our payment and the billed charges
Not covered: • *Personal convenience items* • *Humidifiers, air conditioners* • *Athletic or exercise equipment* • *Computer assisted communication devices (except for the diagnosis of Autism Spectrum Disorder)* Note: Call us at 716-631-8701 as soon as your Plan physician prescribes this equipment. We will arrange a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	*All charges*

Benefit Description	You pay After the calendar year deductible…
Home health services	
• 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. - Unlimited visits per year as long as medically necessary	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Private duty nursing*	*All charges*
Chiropractic	
• 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.	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Alternative treatments	
No benefit.	*All charges*
Educational classes and programs	
Coverage is provided for: • Tobacco Cessation programs, including individual/group/telephone counseling, and over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	In-Network: Nothing for counseling for up to two quit attempts per year. In-Network: Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
• Diabetes self-management • Nutritional counseling • Childhood obesity education	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

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

Important things you should 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.
- The deductible is $2,000 for Self Only or $4,000 for Self Plus One or Self and Family. Under Self Plus One or Self and Family enrollment, the deductible must be satisfied in full by one or more family members before we will begin paying benefits. The deductible applies to all benefits except covered in-network preventive care.
- After you have satisfied your annual deductible, your traditional medical coverage begins.
- Under the Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- YOU MUST GET PREAUTHORIZATION FOR SOME SURGICAL PROCEDURES. Please refer to Section 3 to be sure which procedures require preauthorization.

Benefit Description	You pay After the calendar year deductible…
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 procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies *(see Reconstructive surgery)* • Voluntary sterilization (E.G., tubal ligation, vasectomy) • Surgical treatment of morbid obesity (bariatric surgery) • Surgeries related to sex transformation • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: Reference www.independenthealth.com for medical policy criteria for bariatric surgery. Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	In-Network: Office and Outpatient: 20% coinsurance Inpatient: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
Abortions Note: Services, drugs or supplies covered at no member liability only when the life of the mother would be endangered if the fetus were carried to full term or when the pregnancy is a result of rape or incest.	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Abortions, except those stated above*	*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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - 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.	In-Network: Inpatient: Nothing Office and Outpatient: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
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*	*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	In-Network: Office and Outpatient: 20% coinsurance Inpatient: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	
• Other surgical procedures that do not involve the teeth or their supporting structures.	In-Network: Office and Outpatient: 20% coinsurance Inpatient: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
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	
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants • Isolated Small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-Network: Inpatient: Nothing Outpatient: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below Allogeneic transplants for	In-Network: Inpatient: Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced myeloproliferative disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infantile malignant osteoporosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) • Mucoploysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medullablastoma • Pineoblastoma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	In-Network: Inpatient: Nothing Outpatient: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *other services* in Section 3 for prior authorization procedures. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkins's lymphoma with reccurance (relapsed) - Advanced non-Hodgkin's lymphoma with reccurance (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reccurance (relapsed) - Advanced non-Hodgkin's lymphoma with reccurance (relapsed) - Amyloidosis - Neuroblastoma	In-Network: Inpatient: Nothing Outpatient: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
These **blood or marrow stem cell transplants** covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Allogeneic transplants for • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma	In-Network: Inpatient: Nothing Outpatient: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Beta Thalassemia Major • Chronic inflammatory demyelination polyneuropathy (CIDP) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Sickle cell anemia Mini-transplants (non myeloblative allogeneic, reduced intensity conditioning or RIC) for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders (MPDs) • Myelodysplasia/Myelodysplastic Syndromes • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle Cell anemia Autologous Transplants for • Advanced Childhood kidney cancers • Advanced Ewing's sarcoma • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Aggressive non-Hodgkin's lymphomas • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin's lymphoma)	In-Network: Inpatient: Nothing Outpatient: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Small cell lung cancer • Systemic sclerosis Note: You must obtain our preauthorization for all organ/tissue transplants. Contact us directly for information at 716-631-8701. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	In-Network: Inpatient: Nothing Outpatient: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-Network: Inpatient: Nothing Outpatient: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

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

Important things you should 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.
- The deductible is $2,000 for Self Only or $4,000 for Self Plus One or Self and Family. Under Self Plus One or Self and Family enrollment, the deductible must be satisfied in full by one or more family members before we will begin paying benefits. The deductible applies to all benefits except covered in-network preventive care.
- After you have satisfied your annual deductible, your traditional medical coverage begins.
- Under your traditional medicinal coverage, you will be responsible for your coinsurance amounts or co-payments for eligible medical expenses or prescriptions.
- Be sure to read Section 4, ***Your costs for covered services*** for valuable information about how cost-sharing works. The office visit copay may not cover all services that you may receive during your visit. Please refer to the specific benefits description for information on the amount(s) you owe for additional services that your doctor may perform during your visit. 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

Benefit Description	You pay After the calendar year deductible…
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. Note: Copay is waived if readmitted within 90 days from date of last discharge.	In-Network: $250 per admission Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
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, blood plasma and other plasma • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Take-home items • Medical supplies and equipment, including oxygen	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible…
Inpatient hospital (cont.)	
• Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
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 • 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.	In-Network: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Abortions Note: Services, drugs or supplies covered at no member liability only when the life of the mother would be endangered if the fetus were carried to full term or when the pregnancy is a result of rape or incest.	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Abortions, except those stated above*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Skilled nursing facility (SNF) and subacute facility: We provide a comprehensive range of benefits for up to 45 days per calendar year combined in and out-of-network 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 Plan. 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	In-Network: $250 per admission Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
Extended care benefits/Skilled nursing care facility benefits (cont.)	
Note: Copayment is not waived when discharged from a hospital/facility and admitted to a Skilled Nursing Facility.	In-Network: $250 per admission Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Custodial care, maintenance care, respite care, or convenience care*	*All charges*
Hospice care	
We cover 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 bereavement counseling for covered family.	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Not covered: • *Independent nursing, homemaker services*	*All charges*
End of life care	
End of life care includes Advance Care Planning (ACP) prior to admittance to a hospice Plan program or facility. ACP means home visits from a program sponsored by a plan hospice provider to assist members in preparing for issues they face following a life threatening or terminal diagnosis. ACP is limited to a maximum of six (6) ACP visits per calendar year. This benefit is in addition to the hospice care benefit described above. • Advanced Care Planning	Nothing
Ambulance	
• Local professional ambulance service when medically appropriate. See 5(d) for emergency service	In and Out-of-Network: 20% coinsurance per trip
Not covered: • *Wheelchair van transportation*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should 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.
- The deductible is $2,000 for Self Only or $4,000 for Self Plus One or Self and Family. Under Self Plus One or Self and Family enrollment, the deductible must be satisfied in full by one or more family members before we will begin paying benefits. The deductible applies to all benefits except covered in-network preventive care.
- After you have satisfied your annual deductible, your traditional medical coverage begins.
- Under your traditional medical coverage, you will be responsible for your coinsurance amounts and co-payments for eligible medical expenses and prescriptions.
- 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.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area:

If you believe that you have an emergency, call 911 or go to the nearest emergency room. If you aren't sure, call your primary care doctor as soon as you can. You may also contact Independent Health's 24-hour Medical Help Line at 800-501-3439. A nurse will return your call and tell you what to do at home or to go to the primary care doctor's office or the nearest emergency room.

Emergencies outside our service area:

Go to the nearest emergency room. Call Independent Health as soon as you can (within 48 hours if possible). For urgent care services, call Independent Health's 24-hour Medical Help Line at 800-501-3439. If you do not contact us, you will owe a deductible and coinsurance.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	In-Network doctor's office: $20 per office visit Urgent Care Center: $50 per visit Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Emergency care in the outpatient department of a hospital, including doctors' services	In and Out-of-Network: 20% coinsurance

Emergency within our service area - continued on next page

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area (cont.)	
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 • Urgent care at a doctor's office or urgent care center	$50 per date of service
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	In and Out-of-Network: 20% coinsurance
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*	*All charges*
Ambulance	
Professional ambulance service for the prompt evaluation and treatment of a medical emergency and/or transportation to a hospital for the treatment of an emergency condition. Note: See 5(c) for non-emergency service.	In and Out-of-Network: 20% coinsurance per trip
Not covered: • *Wheel chair van transportation*	*All charges*
Telehealth Services	
Telehealth - the use of electronic and communication technologies by a provider to deliver covered services when the member's location is different than the provider's location. Note: You may inquire with a provider to see if he/she offers telehealth or contact Member Services at 716-631-8701	In-Network: $20 per office visit Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
• Telemedicine Program - The telemedicine program is an online video or phone consultation service administered by a unique network of U.S. board-certified physicians who participate in our telemedicine program. Teladoc physicians use electronic health records to diagnose and treat conditions, including writing prescriptions. The service is intended to provide a solution for non-emergency medical situations and should not be used if you are experiencing a medical emergency. Telemedicine offers you an alternative option to an urgent care facility or when you are unable to obtain services from your primary care physician for many common medical issues including but not limited to cold and flu symptoms, allergies, pink eye, urinary tract infection, respiratory infection, and ear infection. To utilize the telemedicine program visit teladoc.com or call 800-TELADOC (800-835-2362). This service is available 24/7 and may be accessed if traveling throughout most of the United States.	In-Network: Nothing Out-of-Network: Not covered

Section 5(e). Mental health and substance misuse disorder benefits

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.
- The deductible is $2,000 for Self Only or $4,000 for Self Plus One or Self and Family. Under Self Plus One or Self and Family enrollment, the deductible must be satisfied in full by one or more family members before we will begin paying benefits. The deductible applies to all benefits except covered in-network preventive care.
- After you have satisfied your annual deductible, your traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- 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 PREAUTHORIZATION FOR CERTAIN SERVICES.** Please see pages 21-23 for a list of procedures that require preauthorization.

Benefit Description	You pay After the calendar year deductible…
Professional services	
We cover professional services by licensed professional mental health and substance misuse disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater that for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-Network: Office visit and outpatient: Nothing In-Network Inpatient: Nothing Out-of-Network: 40% coinsurance plus any difference between our payment and the billed charges.

Benefit Description	You pay After the calendar year deductible…
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance misuse disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility • Psychological and neuropsychological testing necessary to determine appropriate psychiatric treatment	In-Network: Laboratory tests: Nothing Inpatient diagnostic tests: Nothing All other diagnostic tests: 20% coinsurance Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semi-private or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Residential treatment for mental health and substance misuse Note: Copay is waived if readmitted within 90 days from date of last discharge. Note: Preauthorization required for inpatient substance misuse treatment at a NYS OASAS certified facility is no longer necessary	In-Network: $250 per admission Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, full-day hospitalization, or facility-based intensive outpatient treatment	In-Network: Nothing Out-of-Network: 40% coinsurance, plus any difference between our payment and the billed charges

Section 5(f). Prescription drug benefits

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.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- The deductible is $2,000 for Self Only or $4,000 for Self Plus One or Self and Family. Under Self Plus One or Self and Family enrollment, the deductible must be satisfied in full by one or more family members before we begin paying benefits. The deductible applies to all benefits except covered in-network preventive care.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- **You must get preauthorization for certain prescriptions.** In order to be covered by the Plan, certain prescriptions require preauthorization in accordance with the Independent Health Prescription Drug Formulary. These drugs are noted on the formulary with a symbol "PA" next to the drug name. Please work with your prescribing practitioner for authorization from Independent Health. You may obtain a copy of the prescription drug formulary by contacting Member Services at 716-631-8701 or 800-501-3439.
- 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.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner or Psychologist must prescribe your medication.
- **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 52,000 pharmacies across the country. To find a list of participating pharmacies, visit our website at www.independenthealth.com or contact our Member Services Department at 716-631-8701 or 800-501-3439. 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 5-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 1,000 different medications and covers all classes of drugs prescribed for a variety of diseases. Tier 1 generally contains preferred generic and some over-the-counter drugs. Tier 2 contains preferred brand name drugs. Tier 3 contains non-preferred drugs. Tier 4 contains preferred specialty drugs. Tier 5 contains non-preferred specialty drugs. To obtain a copy of the formulary, visit our website at www.independenthealth.com or contact our Member Services Department at 716-631-8701 or 800-501-3439. 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 our Board Quality Review Oversight Committee who makes the final decision.

- **These are the dispensing limitations.** You may obtain up to a 30-day supply or up to a 90-day supply for maintenance medications. Plan pharmacies fill prescriptions using FDA-approved generic equivalents if available. All other prescriptions are filled using FDA-approved brand name pharmaceuticals. Most antibiotics are limited to a 10-day supply with one refill within 15 days of the original fill. Prescriptions written by an emergency room physician are limited to a 10-day supply with no refills. If you are in the military and called to active duty, please contact us if you need assistance in filling a prescription before your departure.
- **A generic equivalent will be dispensed if it is available,** unless your physician requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **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 equivalence as brand-name drugs. Generic drugs are generally less expensive than brand name drugs, in most instances are the most cost effective therapy available, and may save you money.
- **Half tablet program.** As a way to address the rising costs of prescription drugs, Independent Health now allows a tablet splitting program for select medications.Tablet splitting is the act of physically cutting a higher strength tablet in half to achieve your prescribed dosage. This provides an identical dose while increasing the number of total doses available. For example, by splitting pills in two, 30 tablets can be transformed into a 60-day supply for the same copayment/coinsurance. Not all medications are good candidates for tablet splitting. We recommend that you speak with your health care provider or pharmacist to see if your medication meets splitting requirements. **This is a voluntary program. You will be responsible for the splitting of your medication.** Independent Health does not mandate tablet splitting, however, if you are on one of the medications indicated in our prescription drug formulary with symbol "HT", tablet splitting may be an option for you.
  - Tablet splitting is an easy way for some members to save money on prescription medications. But, it is not for everyone or for every type of medication. If you are interested in having your prescription medications split in half, call your doctor. Your doctor will decide whether to write a prescription that you can split
- If you have an Emergency condition, you may immediately access, without preauthorization, a five (5) day emergency supply of a prescribed substance misuse disorder medication, including a prescription drug to manage opioid withdrawal and / or stabilization and for opioid overdose reversal. If you have a copayment, it will be prorated. Of you receive an additional supply of the substance use disorder medication within the 30-day period in which you received the emergency supply, Your copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated copayment(s) total more than your copayment for a 30-day supply**.**

Maintenance Medications

- **Retail Pharmacy.** You may obtain a 90-day supply of your maintenance medications at select Participating Pharmacies at a cost of 2.5 copayments for Tier 1 drugs or the full applicable coinsurance for all other Tiers. Please visit our website at www.independenthealth.com or contact our Member Services Department at 716-631-8701 or 800-501-3439 to obtain a list of the select participating pharmacies.
- **Mail Order Pharmacy.** In addition to Independent Health's pharmacy network, you may also obtain your maintenance medications through Wegmans or ProAct Pharmacy Services. When using mail order pharmacies, your medications are shipped to you by standard delivery at no additional cost to you (express shipping is available for an additional charge). Maintenance medications must be dispensed in 90-day supply quantities (2.5 copayments apply for Tier 1 drugs or the full applicable coinsurance for all other Tiers). Before using Wegmans or ProAct Pharmacy Services for the first time, you will have to register with the mail order pharmacy of your choice.

Here's how to register:

- **By mail:** please contact our Member Services Department at 716-631-8701 or 800-501-3439 for a registration form for the pharmacy of your choice.
- **Online:** www.wegmans.com/pharmacy or www.proactrx.com
- **By Phone:**
  - Wegmans: 888-205-8573 (TTY/TDD: 877-409-8711)

- ProAct Pharmacy Services: 888-425-3301 (TTY National 711 Relay Service)

- **To obtain your mail order pharmacy prescription**
  - You will first need a new prescription written by your doctor. Please ask your doctor to write a new prescription for a 90-day supply for mail service plus refills for up to 1 year (as appropriate). Please check the Independent Health drug formulary for covered medications.
  - Please note: when placing your initial order, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your doctor for another prescription for a 30-day supply to be filled at your local retail network pharmacy.
- **To order refills:**
  - You can easily refill your prescriptions online, by telephone or by mail. Have your Member ID ready and your prescription number for the medication available. If you choose to pay by credit card, please have that number available as well. To make sure you don't run out of medication, remember to re-order 14 days before your medication runs out.
- **When you do have to file a claim.** If you do not have access to a Plan pharmacy in an emergency situation and you paid for prescriptions filled at a non-plan pharmacy, please send a copy of the paid receipt along with your member ID number, to: Independent Health, 511 Farber Lakes Drive, Buffalo, NY 14221 Attn: Pharmacy Department.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by a licensed provider and obtained from a Plan pharmacy: • Drugs and medicines that by Federal law of the United States require a provider's prescription for their purchase, except those listed as Not covered. • Growth hormones (with preauthorization) • Contraceptives and contraceptive devices, including diaphragms • Nutritional supplements medically necessary for the treatment of phenylketonuria (PKU) and other related disorders (with preauthorization) • Self-administered inject-able drugs (with preauthorization) • Fertility drugs when you meet specific criteria (See Section 5(a) Infertility Services) • Hormonal drugs • Sexual dysfunction drugs have dispensing limitations. Contact us for details. Note: Intravenous fluids and medication for home use, implantable drugs, and inject-able or implantable contraceptives are covered under Medical and Surgical Benefits.	Unless otherwise indicated, • $7 per 30-day supply of a Tier 1 drug • 35% per 30-day supply of a Tier 2 drug • 50% per 30-day supply of a Tier 3 drug • 35% per 30-day supply for Tier 4 drug • 50% per 30-day supply for Tier 5 drug Maintenance Medications - Retail or Mail Order Pharmacy • $17.50 per 90-day supply of a Tier 1 drug • 35% per 90-day supply of a Tier 2 drug • 50% per 90-day supply of a Tier 3 drug • 35% per 90-day supply of Tier 4 drug • 50% per 90-day supply of Tier 5 drug Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 or Tier 3 member liability.
Oral Chemotherapy	Nothing for up to a 30-day supply
Women's contraceptive drugs and devices • Tier 1 and Tier 2 oral contraceptive drugs and devices	Nothing per 30-day supply Not subject to deductible

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
• Select Tier 3 oral contraceptive drugs and devices Note: Over-the counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing per 30-day supply Not subject to deductible
• Insulin and oral agents • Diabetic supplies such as test strips for glucose monitors and visual reading and urine testing strips, syringes, lancets and cartridges for the visually impaired - Disposable needles and syringes needed to inject insulin Note: For non-insulin dependent members: 100 test strips limit for a 30-day supply and a 300 test strip limit for a 90-day supply For insulin dependent members: 300 test strip limit for a 30-day supply and a 900 test strip limit for a 90-day supply.	$20 copay or the applicable prescription member liability, whichever is less
• Needles and syringes necessary to inject covered medication	20% coinsurance
Preventive medications	
• Aspirin (81 mg) for adults age 50-59 • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 6 months - 1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Statins used for the primary prevention of cardiovascular disease (CVD) for adults age 40-75 with no history of CVD, 1 or more CVD risk factors, and a calculated 10 year CVD event risk of 10% or greater Note: Preventive medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs when you do not meet the New York State-mandated criteria for coverage or when related to non-covered infertility procedures* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies*	*All charges*

Preventive medications - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive medications (cont.)	
• *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them, except for prenatal vitamins or Vitamin D for adults below age 65* • *Drugs available without a prescription except for some over-the-counter products as listed on our formulary* • *Medical supplies such as dressings and antiseptics* • *Prescription refills beyond one year from the original date written* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit (See page 95)	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- When you join this Plan, you will have access to a Dental fund ($150 for Self Only or $300 for Self Plus One or Self and Family) to share between you and your enrolled family members. Your Dental fund is not subject to the deductible. Any unused balance at the end of the calendar year will be forfeited.
- You can visit any licensed dentists for services under the Dental fund. However, you can make your dental fund go further by taking advantage of the negotiated rates offered by participating network dentists.
- 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.
- The deductible for accidental injury is $2,000 for Self Only or $4,000 for Self Plus One or Self and Family. Under Self Plus One or Self and Family enrollment, the deductible must be satisfied in full by one or more family members before we will begin paying benefits. The deductible applies to all benefits except covered in-network preventive care.
- After you have satisfied your annual deductible, your traditional medical coverage begins. Under your traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- The office visit copay may not cover all services received during your visit. Please refer to the specific benefits description for information on the amount(s) you owe for additional services that your doctor may perform during the visit.
- 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. See Section 5(c) for inpatient hospital benefits. 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.

	You pay After the calendar year deductible…
Accidental injury benefit	
• We cover restorative services and supplies necessary to repair (but not replace) sound natural teeth within twelve months of the accident. The need for these services must result from an accidental injury.	$20 per office visit 20% for medical/surgical procedures Note: The office visit copay may not cover all services received during your visit. Please refer to the specific benefits description for information on the amount(s) you owe for additional services that your doctor may perform during your visit.

	You pay After the calendar year deductible…
Dental fund benefit	
Dental fund expenses include routine, preventive, dental and orthodontic services up to a maximum of $150 for Self Only or $300 for Self Plus One and Self and Family enrollment. Note: Any unused remaining balance in your Dental fund at the end of the calendar year cannot be rolled over to the next year. Annual deductible and catastrophic out-of-pocket maximums for expenses are excluded from your Dental fund.	Nothing, until you exhaust your Dental fund.
Not covered: • *Dental treatment for cosmetic purposes*	*All charges*

Section 5(h). Wellness and Other Special features

Feature	Description
Feature	
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24-Hour Medical Help Line	Independent Health's 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 medical resource management (MRM) 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 716-631-8701 or 800-501-3439 to get the help you need when you need it most.
Services for hearing impaired	You may contact Independent Health through a TDD machine at 716-631-3108.
Case Management	The purpose of case management is to identify high-risk members and coordinate care such that the member receives appropriate care in the appropriate setting. Members are referred from many sources. Those cases, which are referred to the Case Management team, will have an assessment and phone call to the member/family within 48 hours of the referral.
Travel Benefit/services overseas	You have worldwide coverage for emergency care services. This does not include travel-related expenses. Contact us for details.

Feature - continued on next page

Feature	Description
Feature (cont.)	
Well-being Assessment	FitWorks: · Online tool that provides a Well-being Assessment allowing you to identify your strengths, opportunities to improve your health and well-being, and health risks. · Provides targeted recommendations for improvement of physical and mental well-being. · Allows you to take a more active role in your health by setting and tracking goals, as well as through engaging in challenges and social networking. · Get started by creating your FitWorks account at www.ihfitworks.com

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources	A newsletter is published to keep you informed on a variety of issues related to your health. Visit us on our website at www.independenthealth.com for information on tools provided by Independent Health to assist in your medical decision making process
Online access	Verify coverage, view a benefit summary, check claim status, order ID cards, and update your address, phone number and e-mail address
Health coaching	Healthcare staff is available to provide guidance in assisting you in making informed health care decisions
Treatment Cost Advisor	Provides approximate costs of specific health care services in your area
Health and wellness programs	We offer a variety of wellness programs and workshops aimed at keeping you healthy-including weight management, smoking cessation, and nutrition classes.
Account management tools	You will receive an explanation of benefits which will itemize the deductible applied to your claim. If you have an **HSA**: You will receive a statement outlining your account balance and activity for the month. You may also access your account on-line at www.mybenefitwallet.com. If you have an **HRA**: Your HRA balance will be available online through www.independenthealth.com. Your balance will also be shown on your reimbursement stub.
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will receive a lower cost share when you see a Plan provider. Directories are available online at www.independenthealth.com. Pricing information for medical care is available at www.independenthealth.com. Pricing information for prescription drugs is available at www.independenthealth.com. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.independenthealth.com.
Care support	Case Managers support is available. Contact Customer Service at 716-631-8701 or 800-501-3439.

Non-FEHB benefits available to Plan members

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 catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 716-631-8701 or 800-501-3439 or visit their website at www.independenthealth.com.

Wellness Programs

Independent Health covers a number of wellness programs through our Health Education and Wellness Department. These include: Nutritional Consulting, Parenting Classes, and Stress Management workshops to name just a few. Please contact Independent Health's Member Services Department at 716-631-8701 or 800-501-3439 or visit our website at www.independenthealth.com for more information on these expanded benefits as well as our new member discount program. The discount program includes savings on alternative therapies, fitness and nutrition classes, dental services, hearing aids, and more.

EyeMed Vision Program

EyeMed is a national company that delivers vision benefits to Independent Health members. EyeMed is part of Luxottica, the world's leading frame manufacturer of quality eyeglass frames. EyeMed’s network includes many independent optical providers and retail stores. You must use a participating EyeMed provider to obtain these benefits. EyeMed will cover one refractive eye exam every twelve months. You may contact EyeMed at 877-842-3348.

Independent Health's EyeMed vision program

Benefit	HMO You Pay (High Option)	HMO You Pay (Standard Option)	HDHP You Pay
Refractive Eye Exam	$10 copayment	$20 copayment	$15 copayment
Single vision plastic lenses	$50 copayment	$50 copayment	$50 copayment
Bifocal plastic lenses	$70 copayment	$70 copayment	$70 copayment
Trifocal plastic lenses	$105 copayment	$105 copayment	$105 copayment
Lenticular plastic lenses	20% discount	20% discount	20% discount
Progressive plastic lenses	$135 copayment	$135 copayment	$135 copayment
UV coating	$15	$15	$15
Tint	$15	$15	$15
Standard scratch resistance	$15	$15	$15
Standard polycarbonate	$40	$40	$40
Standard anti-reflective	$45	$45	$45
Other services	80% of retail price	80% of retail price	80% of retail price
Conventional contact lenses	85% of retail price	85% of retail price	85% of retail price
Frames	60% of retail price	60% of retail price	60% of retail price
U.S. Laser Network for Lasik or PRK	15% off retail price or 5% off promotional pricing	15% off retail price or 5% off promotional pricing	15% off retail price or 5% off promotional pricing
Eligible discount beyond plan coverage	20% discount	20% discount	20% discount

Independent Health's Medicare Plans:

Independent Health offers Medicare recipients a wide variety of health plan options, including **HMO** and **PPO**. The Encompass plans are Independent Health's **HMO** brand of Medicare which provides more comprehensive coverage than you would receive from traditional Medicare and the option to add Medicare Prescription Drug Coverage. To be eligible for Independent Health's Medicare coverage, you must be entitled to Medicare A and enrolled in Medicare Part B. Our **HMO** service area includes Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming counties of New York State and you must not be out of the service area for more than six months. The Passport plans are Independent Health's **PPO** Medicare offering. The Passport plans offer comprehensive coverage with in-network providers along with the added flexibility of choosing a health care provider outside of our network. This allows you more flexibility and benefits with lower premiums than Medicare supplement plans.

If you are interested in enrolling, contact your retirement system for information on joining Independent Health's Medicare Plan. You may also choose to enroll in Independent Health's Medicare Plan 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 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 – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. **There may be other exclusions and limitations listed in Section 5 of this brochure.Although we may list a specific service as a benefit, we will not cover it unless medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies 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 (see specifics regarding organ/tissue transplants).
- 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 you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior plan approval), including urgent care claims procedures. 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, coinsurance, or deductible.

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 and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 716-631-8701 or 800-501-3439, or at our Web site at www.independenthealth.com.

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statement are not acceptable substitutes for itemized bills.

Submit your claims to:
Independent Health
PO Box 9066
Buffalo, NY 14231-1642
Attn: Claims Department

Prescription drugs

Submit your claims to:
Independent Health
511 Farber Lakes Drive
Buffalo, NY 14221
Attn: Pharmacy Department

Other supplies or services	**Submit your claims to**: Independent Health PO Box 9066 Buffalo, NY 14231-1642 Attn: Claims Department
Deadline for filing your claim	Send us all 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.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.independenthealth.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing: Independent Health, 511 Farber Lakes Drive, Buffalo, NY 14221 or calling 716-631-8701 or 800-501-3439.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA OR HRA are not subject to the disputed claims process.

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, NY 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. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 4.

Step	Description
2	In the case of a post-service claim, we have up to 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information 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.
3	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: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630. 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. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, 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 include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	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. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, 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 preauthorization 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 file a lawsuit 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 you did not indicate that your claim was a claim for urgent care, then call our Member Services Department at 716-631-8701 or 800-501-3439 or send a fax to 716-635-3504. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0755 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordination of benefits, visit our website at www.independenthealth.com

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

When we are the secondary payor, 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.

If you or your health care provider fails to file a timely no-fault claim or take any other action necessary to receive no-fault benefits, we will not pay benefits for those expenses for which no-fault benefits would have been recoverable.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) 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.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

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 your injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan. Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or 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 four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800-MEDICARE (800-633-4227), (TTY 877-486-2048)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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.

For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213 (TTY 800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan. You are required to have Medicare Part B coverage in order to obtain our Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part 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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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.

Claims process when you have the Original Medicare Plan - You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call our Member Services Department at 716-631-8701 or 800-501-3439 or visit our web site at www.independenthealth.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table. It illustrates the cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. The members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	High Option: $0 for Self Only, Self Plus One or Self and Family Standard Option: $0 for Self Only, Self Plus One or Self and Family HDHP Option: $2000 Self Only, $4000 Self Plus One or Self and Family	High Option: $0 for Self Only, Self Plus One or Self and Family Standard Option: $0 for Self Only, Self Plus One or Self and Family HDHP Option: $2000 Self Only, $4000 Self Plus One or Self and Family

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Out of Pocket Maximum	High Option: $6,850 Self Only, $13,700 Self Plus One or Self and Family Standard Option: $6,850 Self Only, $13,700 Self Plus One or Self and Family HDHP Option: $6,550 Self Only, $13,100 Self Plus One or Self and Family	High Option: $6,850 Self Only, $13,700 Self Plus One or Self and Family Standard Option: $6,850 Self Only, $13,700 Self Plus One or Self and Family HDHP Option: $6,550 Self Only, $13,100 Self Plus One or Self and Family
Primary Care Physician	High Option: $25 Standard Option: $30 HDHP Option: $20	High Option: $25 Standard Option: $30 HDHP Option: $20
Specialist	High Option: $40 Standard Option: $50 HDHP Option: $20	High Option: $40 Standard Option: $50 HDHP Option: $20
Inpatient Hospital	High Option: $500 per admission Standard Option: $750 per admission HDHP Option: $250 per admission	High Option: $500 per admission Standard Option: $750 per admission HDHP Option: $250 per admission
Outpatient Hospital	High Option: $75 Standard Option: $100 HDHP Option: 20% coinsurance	High Option: $75 Standard Option: $100 HDHP Option: 20% coinsurance
Rx	Tier 1 - $7 Tier 2 - 35% Tier 3 - 50% Tier 4 - 35% Tier 5 - 50%	Tier 1 - $7 Tier 2 - 35% Tier 3 - 50% Tier 4 - 35% Tier 5 - 50%
Rx - Mail Order (90 day supply)	2.5 co-payments for Tier 1 drugs or the full applicable coinsurance for all other Tiers	2.5 co-payments for Tier 1 drugs or the full applicable coinsurance for all other Tiers

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this plan and Medicare.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

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

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our co-payments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

HSA Qualified High Deductible Health Plans that include pharmacy coverage are not considered creditable coverage for participation in Medicare Prescription Part D Drug Plans. If you are nearing retirement age consult your plan administrator for a plan option to best meet your needs.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

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.
Clinical Trials Cost Categories	• Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of our allowable expense that you must pay for certain types of care. See page 26.
Copayment	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. See page 26.
Copayment maximum	The total copayment you are responsible for in a calendar year.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and co-payments) for the covered care you receive.
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.
Deductible	We do not have a deductible except as noted under the POS and HDHP benefit. It is the amount which you must pay for covered health care services before our obligation to pay begins in a calendar year. The deductible is determined by the date a claim is processed by us, not the date services were rendered.
Group health coverage	In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.
Dental fund	Your HDHP dental fund is an established benefit amount, which is available for you to use to pay for covered dental expenses during each calendar year. Whether you have an HSA or an HRA account, you are entitled to the annual Dental fund.
Experimental or investigational service	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 question(s) as to safety and efficacy.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Health Reimbursement Arrangement (HRA)	HRAs are employer-funded accounts that repay employees' unreimbursed medical expenses (e.g. deductibles).

Health Savings Account (HSA)	An HSA is a tax-exempt savings vehicle available to individuals covered by a high deductible health plan (HDHP). Funds in the account are used to pay for qualified medical expenses.
High Deductible Health Plan (HDHP)	HDHP is a consumer driven health plan that combines a preferred provider organization (PPO) health plan with separate medical and dental funds that help you pay for covered medical and dental expenses. This new type of health plan product combines HDHP health care coverage with a tax-advantaged program to help you build savings for future medical needs.
Home Health Agency	A public or private agency that specializes in giving skilled nursing services in the home.
Medical Director	This person is a licensed provider 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.
Member Preauthorization	Authorization that you must obtain from us prior to receiving any of the services that are identified in this brochure as needing preauthorization in order to receive the maximum allowable coverage.
Out-of-Network Services	A term that applies to POS and HDHP benefits. These are services from non-Plan providers.
Out-of-Pocket-Maximum	The dollar limit (or ceiling) that you are responsible for in a calendar year.
Plan Allowance	Our plan allowance is essentially our fee schedule amount. We set our allowances at a level that is simultaneously fair and market based and allows us to maintain our robust network of high quality and efficient participating providers. In order to maintain relativity among the thousands of CPT codes, Independent Health assigns allowances based on the industry standard Relative Value Scale. Some exceptions are made for specialties and services in our area. Our participating providers have agreed to accept the allowed amount as payment in full, less any co-pay or deductibles amounts collected from the member.
Point of Service (POS) Benefits	Coverage that we provide for covered services from non plan providers.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Premium Contribution	The total monthly premium is your contribution as well as your employer contribution.
Premium Pass-through	The funds FEHB forwards to the Plan, which in turn are deposited into your HSA or HRA.
Pre-service claims	Those claims (1) that require preauthorization, prior approval, or a referral and (2) where failure to obtain preauthorization, prior approval, or a referral results in a reduction of benefits.
Private Duty Nursing	Care provided by an LPN or RN and required when the member has a continuous skilled need as opposed to an intermittent skilled need such as a dressing change. Private duty nursing is care that is provided in shifts as opposed to an episodic skilled nursing visit in the member's home. Private Duty Nursing is not covered under this Contract.
Provider Preauthorization	Authorization from us that a provider must obtain prior to receiving any of the services that are identified in this brochure as needing preauthorization.

Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Step Therapy	A process of trying to determine the most efficient way to treat a patient via use of protocols that call for one type of medication or therapy use before proceeding to something more difficult or expensive. This may mean that two medications are used together if they are more effective.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan
Telehealth	The use of electronic and communication technologies by a provider to deliver covered services when the member's location is different than the provider's location.
Telemedicine Program	The telemedicine program is an online video or phone consultation services administered by a unique network of U.S. board-certified participating physicians in the Teladoc network.
UCR	UCR means Usual, Customary and Reasonable (UCR). Usual rate means the fee regularly charged and received for a given service or supply by a provider. Customary and Reasonable means the fee for a service or supply that Independent Health determines is the most standard and reasonable amount charged by providers in the locality where the charge for such service or supply is incurred. Locality means an area whose size is large enough, in Independent Health's judgment, to give an accurate representation of standard charges for that type of service or supply. Our allowance is based on the lesser of the non-plan provider's charges, the negotiated rate, or the 90th percentile of UCR on the High Option and HDHP, and the 80th percentile on the Standard Option.
Us/We	"Us" and "We" refer to Independent Health.
You	"You" refers to the enrollee and each covered family member.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Urgent care claims usually involve Pre-services claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Member Services Department at 800-501-3439. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about four Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program,** also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose Self Only, Self Plus One, or Self and Family Coverage for yourself and any qualified dependents.

Third, the **Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

The Federal Flexible Spending Account Program - FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary BEFORE taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,600 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26). FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of- pocket expenses based on the claim information that it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA)** - Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA(DCFSA)** - Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return you is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 your must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit **www.FSAFEDS.com**or call an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS, 877-372-3337, (TTY, 1-866-353-8058), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

The Federal Employees Dental and Vision Insurance Program - FEDVIP

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia but it may be limited. Review your FEDVIP dental plan's brochure for more information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 877-888-3337 (TTY 877-889-5680).

The Federal Long Term Care Insurance Program - FLTCIP

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. Long term care can be received in your home, in a nursing home, in an assisted living facility or in adult day care. You must apply, answer health questions(called underwriting) and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Your qualified relatives can apply even if you do not. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 800-LTC-FEDS (800-582-3337) (TTY 800-843-3557) or visit www.ltcfeds.com.

The Federal Employees' Group Life Insurance Program - *FEGLI*

Peace of Mind for You and Your Family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visitwww.opm.gov/life.

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Do not rely on this page; it is for your convenience and may not show all pages where terms appear.

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Summary of benefits for the High Option HMO with POS for Independent Health – 2018

- **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.
- Under the HMO benefits, we only cover services provided or arranged by Plan providers, except in emergencies. This summary reflects the HMO benefits.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office (see section 5 for specific benefit information and applicable fees)	Office visit copayment: Primary: $25; Specialist: $40	27
Services provided by a hospital:		
• **Inpatient**	$500 per admission	49
• **Outpatient**	$75 per visit	50
Emergency benefits:		
• **In-area**	$25/$40 per physician's office visit $50 per urgent care center visit $150 hospital emergency room visit	53
• **Out-of-area**	$50 per physician's office visit and urgent care center $150 hospital emergency room visit	54
Mental health and substance misuse disorder treatment:	Outpatient: $25 per visit Inpatient: $500 per admission	55
Prescription drugs:		
• Retail pharmacy - 30 day supply	Tier 1 - $7 Tier 2 - 35%; Tier 4 - 35% Tier 3 - 50%; Tier 5 - 50%	57
Point of Service benefits:	Deductible and Coinsurance	65
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-Network: $6,850 Self-Only/$13,700 Self Plus One or Self and Family for covered services Out-of-Network: $10,000 Self-Only/$20,000 Self Plus One or Self and Family for covered services	23

Summary of benefits for the Standard Option HMO with POS of Independent Health - 2018

- **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.
- Under the HMO benefits, we only cover services provided or arranged by Plan providers, except in emergencies. This summary reflects the HMO benefits.

Standard Option Benefits	You Pay	Page
Medical Services provided by physicians:		
Diagnostic and treatment services provided in the office (see section 5 for specific benefit information and applicable fees)	Office visit copayment: Primary $30; Specialist: $50	27
Services provided by a hospital:		
• **Inpatient**	$750 per admission	49
• **Outpatient**	$100 per visit	50
Emergency benefits:		
• **In-area**	$30/$50 per physician's office visit $75 per urgent care center visit $150 hospital emergency room visit	53
• **Out-of-area**	$75 per physician's office visit and urgent care center visit $150 hospital emergency room visit	54
Mental health and substance misuse disorder treatment:	Outpatient: $30 per visit Inpatient: $750 per admission	55
Prescription drugs:		
• Retail pharmacy - 30 day supply	Tier 1 - $7 Tier 2 - 35%; Tier 4 - 35% Tier 3 - 50%; Tier 5 - 50%	57
Point of Service benefits:	Deductible and Coinsurance	65
Protection against catastrophic costs (out-of-pocket maximum):	In-Network: $6,850 Self-Only/$13,700 Self Plus One or Self and Family for covered services Out-of-Network: $10,000 Self-Only/$20,000 Self Plus One or Self and Family for covered services	23

Summary of benefits for the HDHP of Independent Health - 2018

Do not rely on this chart alone. All benefits 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.
In 2018, for each month you are eligible for the Health Savings Account (HSA), we will deposit $83.33 per month for Self Only enrollment, $137.85 for Self Plus One per month or $166.66 per month for Self and Family enrollment to your HSA. For the HSA, you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $2,000 for Self Only or $4,000 for Self Plus One or Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.
For the Health Reimbursement Arrangement (HRA), your health charges are applied to your monthly HRA Fund of $83.33 for Self Only, $137.85 for Self Plus One or $166.66 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.
Below, an asterisk (*) means the item is subject to the deductible of $2,000 for Self Only and $4,000 for Self Plus One or Self and Family enrollment per calendar year. Please see Section 5 – Preventive Care where the deductible does not apply. You are responsible for any difference between our payment and the actual charges if you use a non-participating physician or other health care professional.

HDHP Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office * (see Section 5 for specific benefit information and applicable fees)	In-network: $20 per office visit or 20% coinsurance for certain procedures	85
Services provided by a hospital:		
• Inpatient *	In-network: $250 per admission	102
• Outpatient *	In-network: 20% coinsurance	103
Emergency benefits:		
• In-area*	$20 per physician's office visit $50 per urgent care center visit 20% coinsurance for hospital emergency room visit	
• Out-of-area*	$50 per physician's office visit and urgent care center visit 20% coinsurance for hospital emergency room visit	
Mental health and misuse disorder treatment *	In-network Inpatient: $250 per admission In-network Outpatient: Nothing	107
Prescription drugs:		
• Retail pharmacy - 30 day supply *	Tier 1 - $7 Tier 2 - 35%; Tier 4 - 35% Tier 3 - 50%; Tier 5 - 50%	109
Point of Service benefits:	Deductible and Coinsurance	
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-network: $6,550 Self Only/$13,100 Self Plus One or Self and Family Out-of-network: $10,000 Self Only/$20,000 Self Plus One or Self and Family	73

2018 Rate Information

For 2018 FEHB plan premium information, please see:

https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribal employer's Human Resources department.