

Independent Health

<http://www.independenthealth.com>

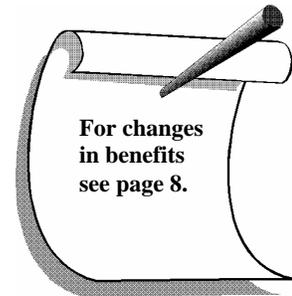


2005

A Health Maintenance Organization with a point of service product

Serving: *Western New York*

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.



This Plan has excellent accreditation from the National Committee for Quality Assurance (NCOA). See the 2005 Guide for more information on accreditation.

Enrollment code for this Plan:

QA1 Self Only

QA2 Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-103



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James
Director



Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

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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. The address for Independent Health administrative offices is:

Independent Health
511 Farber Lakes Drive
Buffalo, NY 14221

This brochure is the official statement of benefits. No oral 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. You do not have a right to benefits that were available before January 1, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized 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) that you receive from us.
- 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 (800) 501-3439 and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR 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); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 ask questions and understand answers.

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

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital 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.

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 reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. 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.talkaboutrx.org/consumer.html. 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.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO) with a Point of Service (POS) benefit (see below). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMO benefits:

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

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

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

We also have Point of Service (POS) benefits

Our HMO offers POS benefits for out-of-network services. This means you can receive covered services without referral from your primary care physician. You may self refer to a participating provider or non-participating provider for covered services. Out-of-network benefits have higher out-of-pocket costs than in-network benefits. You are also responsible for obtaining precertification for certain services before you have them done or you will pay a penalty.

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 copayments or coinsurance.

Independent Health has a POS product which offers members the flexibility of obtaining services without a referral from their primary care doctor or from non-Plan providers. You will be subject to deductibles and coinsurance. For more information regarding this benefit, see Section 5(i).

Who provides my healthcare?

The first and most important decision you must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. If you live in Western New York you have access to more than 1,324 participating primary care doctors and 1,861 specialists; more than 22,000 participating pharmacies nationwide, as well as all of the area hospitals.

Your Rights

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

- We are licensed under Article 44 of the New York State Insurance Law and in compliance with all applicable state and Federal laws.
- We have been in existence since February 1980.
- Independent Health is a not-for-profit Health Maintenance Organization.
- We have "Excellent" accreditation from the National Committee for Quality Assurance (NCQA).

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 contact us by fax at (716) 631-2083 or visit our website at www.independenthealth.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. You may enroll with us if you live in or work in the following Western New York counties:

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

Under the HMO benefit, 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 34. We will not pay for any other health care services out of our service area unless it is an emergency or urgent care service.

Under the POS benefit you may receive care from a non-Plan provider as described in Section 5(i).

Section 2. How we change for 2005

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

Program-wide changes

- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

- Your share of the non-Postal premium will increase by 23.4% for Self Only or 20.9% for Self and Family.
- Hospice Care shall also include Advance Care Planning prior to admittance to a hospice program or facility. No copayment is required for this benefit. See page 32.
- The copay for diabetic drugs, supplies and/or equipment has changed. You will pay the lesser of \$15 or the applicable prescription drug copay, whichever is less. Previously, members paid the lesser of \$8 or 20%. See page 38.
- Members now have a \$20 copay for radiology services in addition to the \$15 office visit copay. See page 16.
- We have added Point of Service benefits to our coverage. Under the Point of Service benefit, you may seek medically necessary non-emergency health care from a provider or facility without referral. See page 41.

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 provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

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

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and coinsurance, and you will not have to file claims. If you use our point of service program [see Section 5(i)], you can also get care from non-Plan providers but it will cost you more.

- **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 Web site.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Our provider directory lists primary care doctors with their locations and phone numbers. We update directories on a regular basis. We send a directory to you when you enroll. You may also request one by calling our Western New York Marketing Department at (716) 631-5392 or (800) 453-1910. You can also find out if your doctor participates with us by calling one of the numbers listed above.

- **Primary care**

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

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

- **Specialty care**

You must receive a referral from your primary care physician for most specialty care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.

You do not need to obtain a referral from your primary care doctor to see the following specialists as long as they participate with us:

- Obstetricians/Gynecologists
- Dermatologists
- Allergists
- Ophthalmologists
- Optometrists

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 work with us to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician may have to get an authorization or approval beforehand.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you 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.
- 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; or
 - 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**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (716) 631-8701, or (800) 501-3439, press 1. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

At Independent Health, we have two types of prior approval. Under the HMO benefits, we have preauthorization. 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 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. There is nothing that you need to do.

Procedures that Require Preauthorization (HMO)

- All alcohol/substance abuse services or treatment
- Autologous chondrocyte transplantation
- Chiropractic services
- Coronary stent brachytherapy for re-stenosis
- Cosmetic procedures
- CT Scan, PET Scan, MRI & MRA
- Dental services related to accidental injury or congenital anomaly
- Durable medical equipment (including diabetes equipment), prosthetics, and orthopedic appliances
- Ductal lavage
- Elective inpatient hospitalizations
- Enhanced external corporeal pulsation (EECP)
- Follow-up for urgent care out of area
- Gamma knife surgery, gamma stereotactic knife, stereotactic radiosurgery
- Gastric bypass surgery
- HDL/LDL sub type testing for assessment of coronary artery disease risk
- Infertility drugs
- Inpatient dental services
- Intra-articular injections of hyalgan or synvisc
- IDET (intradermal electrotherapy)
- Investigational/Experimental procedures/New technology

- Lung reduction surgery
- Mental health services including psychological testing
- Non-formulary insulin and diabetic supplies
- Non-emergent ambulance/planned transfer
- Out-of-area hospital admissions
- Out-of-plan referrals
- Oxygen
- Photodynamic therapy
- Physical, occupational and speech therapy services
- Prosofba column for rheumatoid arthritis
- Pulmonary rehabilitation
- Reconstructive procedures (congenital)
- Rhinoplasty
- Self-injectable drugs
- Septorhinoplasty
- Spinal procedures to include Discectomy, Lumbar laminectomy and Spinal fusion
- Synagis vaccine
- Transplants

Procedures that require precertification (POS)

Under POS benefits, we call the prior approval process precertification. You are ultimately responsible for obtaining our prior approval before obtaining certain services. If you do not obtain precertification 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 precertification from us for the following services:

- Elective facility/inpatient admissions
- Reconstructive Surgery
- Accidental dental injuries
- DME Items:
 - BiPAP S/BiPAP ST
 - Bone Growth Stimulator
 - Breast pumps
 - CPAP
 - CPM
 - Light Boxes
 - LTV Ventilators
 - TENS
 - Ventilators
- Home infusion services
- Medical supplies
- Pulmonary rehabilitation therapy
- Skilled home care services (including home infusion services) prior to the beginning of the initial visit

Section 4. Your costs for covered services

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

Additional Expenses	Under the POS benefit, you pay the difference between the non-Plan provider's charges and the amount that we pay for a covered service.
Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for certain types of care. Example: In our Plan, you pay 50% of our allowance for durable medical equipment. Coinsurance also applies when you use the POS benefit.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your Plan primary care physician you pay a copayment of \$15 per office visit.
Deductible	We do not have a deductible except as noted under the POS benefits.
Your catastrophic protection out-of-pocket maximum	We do not have an out-of-pocket maximum under the HMO benefits. You pay the copay or coinsurance for a covered service as indicated in the brochure. Under the Point of Service (POS) benefits, your out-of-pocket maximum is \$2,000 under Self Only and \$4,000 under Self and Family coverage. After you have met the out-of-pocket maximum under the POS benefits, you will not pay coinsurance for covered POS services. However, you may owe additional expenses after our payment up to the provider's charge for a covered service. See the POS benefits (Section 5i).

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 63 for a benefits summary.)

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

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Summary of benefits for the Independent Health - 2005 63

2005 Rate Information for Independent Health 64

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

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

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- 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 under the HMO benefits that you receive from Plan providers.
- Please see Section 5(i) for information regarding POS benefits for out-of-network services.
- Your physician must obtain preauthorization for certain services. Please see page 11 for a list of procedures that require preauthorization.
- 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.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$15 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • Office medical consultations • Second surgical opinion 	\$15 per office visit
<ul style="list-style-type: none"> • At home 	\$15 per visit
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology 	Nothing

Lab, X-ray and other diagnostic tests continued	You pay
Radiology procedures such as: <ul style="list-style-type: none"> • X-rays • CT Scans/MRI • Ultrasound • Radiation therapy 	\$20 per visit for radiology services in addition to any copayment for office services
Diagnostic tests, such as: <ul style="list-style-type: none"> • Electrocardiogram and EEG 	\$15 per office visit for diagnostic tests
<ul style="list-style-type: none"> • Non-routine Mammograms 	Nothing
Preventive care, adult	
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Colonoscopy screening – Double contrast barium enema 	\$15 per office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see Diagnosis and Treatment, above.	\$15 per office visit
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing
Routine bone density screening for: <ul style="list-style-type: none"> • Women age 65 and over • Women at increased risk age 60 and over 	\$20 per office visit

Preventive care, adult <i>(continued)</i>	You pay
Routine immunizations, such as: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine 	\$15 per office visit Note: If the only reason for your office visit is an Influenza or Pneumococcal vaccine, you pay nothing.
<i>Not covered: Physical examinations and services required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care <ul style="list-style-type: none"> – Examinations done on the day of immunizations 	Nothing
<ul style="list-style-type: none"> • Examinations, for dependents up to age 22, such as: <ul style="list-style-type: none"> – Eye chart exams to determine the need for vision correction – Ear exams to determine the need for hearing correction 	\$15 per office visit for eye and ear exams.
Maternity care	
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: <ul style="list-style-type: none"> • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex.	All charges.

Family planning	You pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives and certain contraceptive devices under the prescription drug benefit.</p>	<p>\$15 per office visit</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic counseling. 	<p>All charges</p>
Infertility services	
<p>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.</p> <p>We limit infertility coverage to correctable medical conditions that have resulted in infertility. Your applicable office visit, inpatient and outpatient facility copayments 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.</p> <p>In order to be eligible for Infertility services, you must:</p> <ul style="list-style-type: none"> • 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 	<p>\$15 per visit for services performed at an office, outpatient facility or ambulatory surgical center</p> <p>Nothing for inpatient and laboratory services</p> <p>\$20 per visit for radiology services</p>

Infertility Services <i>(continued)</i>	You pay
<p>Covered diagnostic tests and procedures including but not limited to the following procedures:</p> <ul style="list-style-type: none"> • hysterosalpingogram • hysteroscopy • endometrial biopsy • laparoscopy • sonohysterogram • post coital tests • testis biopsy • semen analysis • blood tests • ultrasound • sperm washing • electroejaculation <p>We cover the following types of artificial insemination:</p> <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) <p>Note: The number of allowable artificial insemination procedures is based on accepted medical practices.</p> <ul style="list-style-type: none"> • Fertility drugs <p>Note: We cover self injectable fertility drugs and oral fertility drugs under the prescription drug benefit.</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services for an infertility diagnosis as a result of current or previous sterilization procedures (s) and/or procedures(s) for reversal of sterilization.</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Costs associated with the collection and donation of sperm</i> • <i>Cost of donor sperm or donor egg and all related services</i> • <i>Over-the-counter medications, devices or kits, such as ovulation kits</i> • <i>Cloning or any services incident to cloning</i> 	<p><i>All charges</i></p>

Allergy care	You pay
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$15 per office visit
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 28.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Your prescribing physician will request prior authorization from us if GHT is medically necessary for your treatment. We review most prior authorization requests within 24 hours or receipt of all necessary information.</p>	\$15 per office visit
<ul style="list-style-type: none"> • Radiation Therapy 	\$20 per office visit
<ul style="list-style-type: none"> • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	Nothing
Physical and occupational therapies	
<ul style="list-style-type: none"> • Up to two consecutive months per condition for the services of each of the following: <ul style="list-style-type: none"> – qualified physical therapists and – occupational therapists • Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. 	\$15 per outpatient visit Nothing per visit during covered inpatient admission
<ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions. 	\$15 per outpatient visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges.</i>

Speech therapy	You pay
<ul style="list-style-type: none"> Up to two consecutive months per condition for the services of a licensed Plan speech therapist 	\$15 per outpatient visit Nothing per visit during covered inpatient admission.
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> First hearing aid and testing only when necessitated by accidental injury Hearing testing for children up to age 22 to determine the need for hearing correction. (see <i>Preventive care, children</i>) 	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing Hearing aids, testing and examinations for them 	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Eye examinations for medical conditions <p>Note: Refractive eye examinations are available through Independent Health's EyeMed vision program. Please see Section 5(j) Non-FEHB benefits available to Plan members.</p>	\$15 per office visit
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts). <p>Note: Refractive eye examinations are available through Independent Health's EyeMed vision program. Please see Section 5(j) Non-FEHB benefits available to Plan members.</p>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eye exercises and orthoptics Radial keratotomy and other refractive surgery Eye glasses or contact lenses <p>Note: Discounts for eyeglasses and contact lenses are available through Independent Health's EyeMed program. Please see Section 5(j) for Non-FEHB benefits available to Plan members.</p>	<i>All charges.</i>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$15 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>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)</i> 	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>50% coinsurance per device.</p>
<ul style="list-style-type: none"> • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy 	<p>Nothing</p>
<ul style="list-style-type: none"> • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: See 5(b) for coverage of the surgery to insert the device.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing aids</i> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Wigs or hair prosthesis</i> • <i>Prosthetic replacements provided less than 3 years after the last one we covered</i> 	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; • Walkers; <p>Note: You must receive preauthorization from the Medical Director before purchasing DME. When your physician prescribes this equipment, the physician and/or DME vendor will contact us to receive approval.</p>	<p>50% coinsurance per device.</p> <p>Note: You have an annual maximum benefit of \$1,000 for DME.</p>
<ul style="list-style-type: none"> • Insulin pumps • Blood glucose monitors 	<p>\$15 per item</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Personal convenience items</i> • <i>Humidifiers, air conditioners</i> • <i>Athletic or exercise equipment</i> • <i>Computer assisted communication devices</i> 	<p><i>All charges.</i></p>
Home health services	
<ul style="list-style-type: none"> • 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. 	<p>\$15 per visit</p>
<ul style="list-style-type: none"> • Services include oxygen therapy, intravenous therapy and medications. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Private duty nursing;</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> 	<p><i>All charges.</i></p>

Chiropractic	You pay
<p>The following services by a licensed Plan chiropractor</p> <ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application <p>Note: Chiropractic care must be provided in connection with the detection and correction by manual or mechanical means, of any structural imbalance, distortion or subluxation in the human body. You must receive a referral for chiropractic care from your Primary Care Physician.</p>	<p>\$15 per office visit</p>
Alternative treatments	
<p><i>No benefit. We do not cover services such as:</i></p> <ul style="list-style-type: none"> • <i>Acupuncture</i> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> 	<p><i>All charges.</i></p>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self management • Nutritional counseling <p>Note: Please refer to Section 5(j) Non-FEHB benefits available to Plan members for other classes such as Stop Smoking Classes.</p>	<p>\$15 per office visit</p>

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

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

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- 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 received under the HMO benefits that you receive from Plan providers.
- Please see Section 5(i) for information regarding POS benefits for out-of-network services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET 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.

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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) 	<p>\$15 per office visit</p> <p>Nothing for inpatient services</p>

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards, or a body mass index (BMI) greater than 40 or greater than 35 with serious medical conditions exacerbated or caused by obesity, such as diabetes, sleep apnea, etc. Eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>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.</p>	<p>\$15 per office visit</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges.</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – 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: <ul style="list-style-type: none"> – 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) <p>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.</p>	<p>\$15 per office visit</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • Surgeries related to sex transformation 	<p><i>All charges.</i></p>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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. 	<p>\$15 per office visit</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and mediastinal, retroperitoneal and ovarian germ cell tumors • Autologous tandem transplant for the treatment of testicular and other germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. These benefits are subject to the approval of the Medical Director.</p>	<p>\$15 per office visit</p> <p>Nothing for inpatient services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>Costs related to travel, food or lodging for the transplant recipient or donor</i> 	<p><i>All charges.</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing</p>

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible under the HMO benefits that you receive from Plan providers.
- Please see Section 5(i) for information on the POS benefits for out-of-network services.
- 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.

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Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. 	Nothing

Inpatient Hospital <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 	<p><i>All charges.</i></p>
<p>Outpatient hospital or ambulatory surgical center</p> <ul style="list-style-type: none"> • 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 <p>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.</p>	<p>\$15 per visit</p>
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges.</i></p>
<p>Extended care benefits/Skilled nursing care facility benefits</p> <p>Skilled nursing facility (SNF) and subacute facility: We provide a comprehensive range of benefits for up to 45 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by us.</p> <p>All necessary services are covered, including:</p> <ul style="list-style-type: none"> • 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. 	<p>Nothing</p>
<p><i>Not covered: Custodial care, maintenance care, respite care, or convenience care</i></p>	<p><i>All charges.</i></p>

Hospice care	You pay
<p>We cover up to 210 days of Hospice services on an inpatient or outpatient basis (including medically necessary supplies and drugs) for a terminally ill member. Covered care is provided in the home or hospice facility under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. As a part of hospice care, we cover up to five (5) visits of bereavement counseling for covered family.</p> <p>Hospice 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.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>
Ambulance	
<ul style="list-style-type: none"> Local professional ambulance service when medically appropriate. See 5(d) for emergency service 	\$25 per trip
<p><i>Not covered:</i></p> <p><i>Wheelchair van transportation</i></p>	<i>All charges.</i>

Section 5(d) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible under the HMO benefits that you receive from Plan providers.
- POS benefits do not apply to emergency services. Please see Section 5(i) regarding your POS benefits. POS benefits may apply if you do not contact Independent Health for urgent care services.
- 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.

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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 TeleSource 24-hour Medical Help Line at (800) 501-3439, press 2. A nurse will return your call and talk to you and tell you what to do at home or tell you 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 TeleSource 24-hour Medical Help Line at (800) 501-3439, press 2. 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	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center 	\$15 per doctor's office or urgent care center visit
<ul style="list-style-type: none"> • Emergency care in the outpatient department of a hospital, including doctors' services <p>Note: We waive the copay if the emergency results in an inpatient admission to the hospital.</p>	\$50 per hospital emergency room visit
<i>Not covered: Elective care or non-emergency care. See Section 5(i) for POS benefits.</i>	<i>All charges.</i>

Emergency outside our service area	You pay
<ul style="list-style-type: none"> • 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 	<p>\$15 per visit plus the difference, if any, between the Plan’s reimbursement and the provider’s billed charges.</p> <p>Note: We require a \$15 copay for each provider per date of service.</p>
<ul style="list-style-type: none"> • Emergency care as an outpatient or inpatient at a hospital, including doctors’ services. <p>Note: We waive the copay if the emergency results in an inpatient admission to the hospital.</p>	<p>\$50 per hospital emergency room visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term deliver of a baby outside the service area</i> <p><i>See Section 5(i) for POS benefits.</i></p>	<p><i>All charges.</i></p>
<p>Ambulance</p>	
<p>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.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>\$25 per trip</p>
<p><i>Not covered</i></p> <p><i>Wheel chair transportation</i></p>	<p><i>All charges</i></p>

Section 5(e) Mental health and substance abuse benefits

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

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

- 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 under the HMO benefits that you receive from Plan providers.
- Please see Section 5(i) for information regarding the POS benefits for out-of-network services.
- 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 OF THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$15 per visit
<ul style="list-style-type: none"> • Diagnostic tests 	Nothing for laboratory tests; \$15 per office visit for diagnostic tests; \$20 per visit for radiology services in addition to any copayment for office services
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, facility based intensive outpatient treatment 	Nothing for inpatient services \$15 per outpatient visit
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

We are committed to working with our providers to ensure that you receive the best possible care in the most appropriate setting. Because some mental health and substance abuse conditions can be treated in a variety of ways, we require that Plan providers obtain preauthorization from us. You need a referral from your Plan doctor for visits to all participating psychiatrists, psychologists, counselors, and social workers.

Independent Health recognizes that you and your doctor may need assistance in finding an appropriate provider. Your doctor may contact our Medical Resource Management (MRM) Department for assistance. You will receive a copy of our provider directory when you join Independent Health. If you need an additional copy, call our Member Services Department at (716) 631-8701 or (800) 501-3439. Please see Section 5(i) regarding your POS benefits.

Limitation

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

Section 5(f) Prescription drug benefits

I M P O R T A N T	<ul style="list-style-type: none"> • Here are some important things to keep in mind about these benefits: • We cover prescribed drugs and medications, as described in the chart beginning on the next page. • All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary. • We do not have a calendar year deductible under the HMO benefits that you receive from Plan providers. • Prescription drugs are not covered under the POS benefits. You must use a plan pharmacy to fill your prescription. • 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 24 hours 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. • Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. 	I M P O R T A N T
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- **There are important features you should be aware of.** These include:
- **Who can write your prescription.** - A state licensed provider must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy. In addition to the many local pharmacies that are available, our national pharmacy network provides access to more than 22,000 pharmacies across the country. To take advantage of our National Pharmacy Network, simply present your member ID card at a participating pharmacy.
- **We use a formulary.** We use a 3-tier prescription drug formulary. It is a list of drugs that we have approved to be dispensed through Plan pharmacies. Our formulary has more than 900 different medications and covers all classes of drugs prescribed for a variety of diseases. Tier 1 contains preferred generic, select brands, and some over-the-counter drugs. Tier 2 contains preferred brand name drugs. Tier 3 contains non-preferred drugs. To obtain a copy of the formulary, contact Member Services at (716) 631-8701 or (800) 501-3439, press 1.
- Our Pharmacy and Therapeutics Committee, which consists of local doctors and pharmacists, meets quarterly to review the formulary. The committee's recommendations are forwarded to the Independent Health Board after each meeting, and the board makes the final decision.
- **These are the dispensing limitations.** You may obtain up to a 30-day supply per copay. Plan pharmacies fill prescriptions using FDA-approved generic equivalents if available. All other prescriptions are filled using FDA-approved brand name pharmaceuticals. You pay a \$10 copay for all Tier 1 drugs, a \$20 copay for Tier 2 drugs and a \$35 copay for all non-formulary drugs. 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.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards for safety, purity, strength and effectiveness as brand-name drugs. Generic drugs are less expensive than brand name drugs, are the most cost effective therapy available, and save you money.
- **When you do have to file a claim.** If you do not have access to a Plan pharmacy in an emergency situation and you receive a bill for prescriptions filled at a non-plan pharmacy, please send a copy of the bill, with your member ID number, to: Independent Health P.O. Box 9066 Buffalo, NY 14231-1642 Attn: Claims Department

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a licensed provider and obtained from a Plan pharmacy:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a provider’s prescription for their purchase, except those listed as <i>Not covered</i>. • 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 injectable drugs, with preauthorization • Infertility drugs when you meet specific criteria (See Section 5(a) Infertility Treatment) • Sexual dysfunction drugs have dispensing limitations. Contact us for details. <p>Note: Intravenous fluids and medication for home use, implantable drugs, and injectable or implantable contraceptives are covered under Medical and Surgical Benefits.</p>	<p>Unless otherwise indicated,</p> <ul style="list-style-type: none"> • \$10 per 30-day supply of a Tier 1 drug or • \$ 20 per 30-day supply of a Tier 2 drug or • \$35 per 30-day supply of a Tier 3 drug <p>Note: If there is no Tier 1 equivalent available, you will still have to pay the Tier 2 copay.</p>
<ul style="list-style-type: none"> • 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 	<p>\$15 copay or prescription copay, whichever is less, for up to a 30-day supply</p>
<ul style="list-style-type: none"> • Needles and syringes necessary to inject covered medication 	<p>20 % copay</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs used for smoking cessation. Please see non-FEHB benefits in Section 5(j)</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs when you do not meet the State-mandated criteria for coverage</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Drugs available without a prescription except for some over-the-counter products as listed on our formulary</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Prescription drugs related to infertility procedures that we do not cover</i> 	

Covered medications and supplies – continued on next page

Section 5(g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
TeleSource 24-Hour Medical Help Line	<p>Independent Health’s TeleSource 24-Hour Medical Help Line is ideal for those times when you can’t reach your doctor right away and you have concerns and questions about an illness or you need to reach a 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 (800) 501-3439, press 2 to get the help you need when you need it most.</p>
Services for deaf and hearing impaired	<p>You may contact Independent Health through a TDD machine at (716) 631-3108.</p>
Case Management	<p>The purpose of case management is to identify high-risk members and coordinate care such that the member receives appropriate, high-quality care in appropriate settings. 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.</p>
Centers of excellence for transplants/heart surgery/etc	<p>With preauthorization, you have access to the following Centers of Excellence:</p> <p>Bone Marrow – Roswell Park Cancer Institute Heart – Kaleida Health (Buffalo), Children’s Hospital of Pittsburgh, University of Wisconsin, Cleveland Clinic Foundation Heart/Lung – University of Wisconsin, Cleveland Clinic Foundation Lung – University of Wisconsin, Cleveland Clinic Foundation Kidney – Kaleida Health (Buffalo), University of Wisconsin, Cleveland Clinic Foundation Liver – Children’s Hospital of Pittsburgh, University of Wisconsin, Cleveland Clinic Foundation Kidney/Pancreas – Kaleida Health (Buffalo), University of Wisconsin Neonatal Critical Care – Kaleida Health (Buffalo)</p> <p>Contact us for details</p>
Travel benefit/services overseas	<p>You have worldwide coverage for emergency care services. This does not include travel-related expenses. Contact us for details.</p>

Section 5(h) Dental benefits

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- You must obtain preauthorization of covered services. See page 11 for a list of services that require preauthorization.
- 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.

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Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly (within 12 months) repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$15 per office visit
Dental benefits	
We cover treatment that is medically necessary due to congenital disease or anomaly such as cleft lip/cleft palate.	\$15 per doctor's office visit Nothing for inpatient services

Not covered: Dental services not shown as covered.

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 participating or non-participating providers without a referral from your Primary Care Physician (PCP). When you seek treatment or services without a written referral from your primary care physician, we consider the services out-of-network. When you receive medically necessary non-emergency covered out-of-network services without a written referral, 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 44 in Section 6. General exclusion- things we don't cover still apply to POS benefits.

What is covered

POS benefits apply to any medically necessary non-emergency health care service listed as covered in this brochure that you receive from a non-Plan provider or facility, except for the services listed below under "What is not covered."

Your liability for covered out-of-network services is higher than the HMO benefits if you use the POS benefits. Under the POS benefits, you must satisfy a deductible of \$500 per member per calendar year. Under Self and Family enrollment, 2 family members must each satisfy a \$500 annual deductible. After you have satisfied the annual deductible, we reimburse 75% of our allowable charges for covered medical services. We reimburse 50% of the allowable charges for covered mental health services and covered durable medical equipment. 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).

Certain services require precertification. If you do not obtain our prior approval, we may not cover the service at all. If we determine that the service is a "covered service", we will apply a precertification penalty. Please read the section that appears below about precertification.

The out-of-pocket maximum for POS benefits is \$2,000 per individual and \$4,000 per family per calendar year. In-network copayments, deductibles, and penalties do not count toward the out-of-pocket maximum. The out-of-pocket maximum applies only to POS coinsurance. 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.

Limitations/requirements

You must have a PCP and notify us of the PCP that you have chosen.

You 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 to us for all services that you receive from a non-Plan provider or facility. The claim form must be submitted within ninety (90) days after the date you receive medically necessary health care services and must include all necessary information so we may process the claim.

Services ordered by a non-Plan provider are out-of network services. All out-of-network services are subject to the deductible and coinsurance that we describe under the POS benefits. This includes services ordered by a non-Plan provider and performed by a Plan provider or at a Plan facility.

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.

Precertification

We must determine whether or not certain services are medically necessary before you receive them. You must obtain precertification from us for all inpatient and certain outpatient services that you receive from a non-Plan provider or facility. We list those out-of network services that require precertification at the end of this section. Before you receive a service that requires precertification, you must contact us at 716-631-5392 or 1-800-501-3439.

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

After receiving your request for precertification, 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 precertification 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 precertification before you have the service.

The following services require precertification prior to receiving POS benefits:

- Elective facility/inpatient admissions
- Reconstructive surgery procedures
- Accidental dental injury treatment
- DME items:
 - BiPAP S/BiPAP ST
 - Bone Growth Stimulator
 - Breast pumps
 - CPAP
 - CPM
 - Light Boxes
 - LTV Ventilators
 - TENS
 - Ventilators
- Home infusion services
- Medical supplies
- Pulmonary rehabilitation therapy
- Skilled home care services (including home infusion services) prior to the beginning of the initial visit

What is not covered

- Primary and preventive care (except for pap smear, mammography, and maternity care)
- Prescription Drugs and other services listed in Section 5(f)
- Routine vision care
- Prosthetic devices and medical appliances (except for prostheses after mastectomy)
- All other services listed under "What is not covered" throughout the brochure including the exclusions that appear in Section 6 General Exclusions

How to obtain benefits

You must submit an itemized bill to us. We will review the itemized bill to determine charges we will pay and charges for which you are responsible. If you have not met your entire deductible, the remaining balance of the deductible will be applied to our allowed charges. If you have met your deductible, then you are responsible for paying a percentage of our allowed charges based on your coinsurance level. Once you have met your total out-of-pocket maximum, we will pay the lesser of the billed charges, the negotiated rate or UCR at the 90th percentile for the services rendered, and you will be responsible for any remaining balance.

Submit your claims to:

Independent Health
P.O. Box 9066
Buffalo, NY 14231-1642
Attn: Claims Department

Section 5(j) 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.

Fitness Programs

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

Independent Health's EyeMed vision program

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

Stop Smoking Program

Please contact us for the details of our smoking cessation program. Smoking cessation classes are available at a discounted rate through our Feeling Fit Discount Program.

Independent Health's Medicare Advantage Plan: Encompass 65

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

If you are interested in enrolling, contact your retirement system for information on canceling your FEHB enrollment and joining Independent Health's Encompass 65[®]. You may also choose to enroll in Independent Health's Encompass 65[®] and retain your enrollment in Independent Health's FEHB plan. For more information on plan benefits, copayments, and premiums, contact Independent Health's Marketing Department at (716) 631-9452 or (800) 453-1910, Monday through Friday, 8 a.m. until 5 p.m.

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

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree as discussed under *Services requiring our prior approval on page 11.***

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;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- 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: or
- Services, drugs, or supplies for which the contributing cause was your commission of, or attempt to, commit a felony.

Section 7. Filing a claim for covered services

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

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

Medical, Hospital and Drug benefits

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

- Covered member’s name and ID number;
- Name and address of the 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 payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Independent Health
P.O. Box 9066
Buffalo, NY 14231-1642
Attn: Claims Department

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Independent Health-Benefit Administration Department, P.O. Box 2090, Buffalo, New York 14231; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The disputed claims process (*continued*)

Send OPM the following information:

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

Note: If you want OPM to review 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.

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

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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 sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call our Member Services Department at (800) 501-3934, press 1 or send a fax to (716) 635-3504, attention: Review Specialist and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

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.

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 two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

• 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 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both 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 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 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.

- **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. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us 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 payer.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	✓
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
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 payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
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

• Medicare Advantage

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) 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 copayments 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), but we will not waive any of our copayments, 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.

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 the program.

Workers' Compensation

We do not cover services that:

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

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

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 injuries

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

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

Section 10. Definitions of terms we use in this brochure

Allowable Expense	The necessary, reasonable, and customary item of expense for covered health care.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for certain types of care. See page 13.
Copayment	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. See page 13.
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 benefit. See page 41.
Experimental or investigational services	Medical, surgical or other treatments, procedures, techniques, and drug or pharmacological therapies that have not yet been proven to be safe and efficacious treatment. We do not cover procedures that are ineffective or are in a stage of being tested or researched with question(s) as to safety and efficacy.
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.
Out-of-Network Services	A term that applies to POS benefits. These are services that you obtain without a written referral from your primary care physician. Out-of-network services may include services from non-Plan providers as well as Plan providers.
Out-of-Pocket-Maximum	The dollar limit (or ceiling) that you are responsible for in a calendar year. The Out-of-Pocket-Maximum applies only to POS insurance.
Point of Service (POS) Benefits	Coverage that we provide for services that you seek without a written referral from your Primary Care Physician.
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.
Precertification	Certification that you must obtain from us prior to receiving any of the services that are identified in this brochure as needing precertification in order to receive the maximum allowable coverage.

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.

Referral

Written authorization for specialty care services from a participating provider or Independent Health's Medical Director.

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.

Us/We

Us and We refer to Independent Health

You

You refers to the enrollee and each covered family member.

Section 11. 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.

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

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about 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;
- When your enrollment ends; and
- When the next open season for enrollment begins.

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

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

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

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

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

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

- **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 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 for 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 and Family coverage 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 and Family 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 and Family 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. 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 2005 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 2004 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.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under 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 RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

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

Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS.

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 13 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later. In order to qualify for coverage under the FLTCIP,** you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of Benefits for Independent Health - 2005

- **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 benefit, we only cover services provided or arranged by Plan providers, except in emergencies.
- Under the POS benefit, you may receive care from a non-Plan provider as described in Section 5(i).

Benefits	You pay	Page
Medical services provided physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$15 specialist	16
Services provided by a hospital: • Inpatient..... • Outpatient	Nothing \$15 per visit	30 31
Emergency benefits • In-area..... • Out-of-area	\$15 per physician's office visit or urgent care center; \$50 hospital emergency room visit \$15 plus difference (if any) in Plan's payment for doctor's and urgent care center visits; \$50 hospital emergency room visit	33 34
Mental health and substance abuse treatment	Regular cost sharing	35
Prescription drugs	\$10 Tier 1/ \$20 Tier 2/ \$35 Tier 3 drugs per prescription unit or refill	38
Up to a 30 day supply		
Dental care	\$15 per office visit	40
For accidental injury to sound natural teeth		
For congenital disease or anomaly		
Vision care		43
Annual Eye refractions	\$10 per office visit	
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2005 Rate Information for Independent Health

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	QA1	\$ 97.23	\$ 32.41	\$210.67	\$ 70.22	\$115.06	\$ 14.58
Self and Family	QA2	\$266.67	\$ 88.89	\$577.79	\$192.59	\$315.56	\$ 40.00