


InChoice
A Medicare Advantage PPO Plan

InStil[®]Health 



Summary of
Benefits

SECTION ONE – INTRODUCTION

Summary of Benefits for InStil InChoice January 1, 2005 - December 31, 2005

Thank you for your interest in InChoice. Our plan is offered by InStil Health Insurance Company, a Medicare Advantage Preferred Provider Organization (PPO).

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call *InStil Health* and ask for the "Evidence of Coverage."

You Have Choices In Your Healthcare

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare Advantage PPO plan, like InChoice. You may have other options, too. You make the choice. No matter what you decide, you are still in the Medicare program.

How Can I Compare My Options?

You can compare InStil InChoice and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers. Our members receive all of the benefits that the Original Medicare Plan offers. We also offer additional benefits, which may change from year to year.

Where Is InChoice Available?

The service area for this plan includes: Clarke, Jackson, Madison, Oconee and Oglethorpe.

You must live in one of these counties to join the plan.

Can I Choose My Doctors?

InStil Health has formed a network of doctors, specialists and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list. Our number is listed at the end of this introduction.

What Happens If I Go To A Doctor Who's Not In Your Network?

You can be seen by doctors, specialists or hospitals in or out of network. If you should go outside of your network there usually will be an additional cost to you that you will have to pay. Going in and/or out of the network could also mean incurring special rules that could take effect prior to getting services. For more information, please call the number at the end of this introduction.

SECTION ONE – INTRODUCTION

What Should I Do If I Have Other Insurance In Addition To Medicare?

If you have Medicare supplemental insurance that fills gaps in the Original Medicare Plan, you may not need it if you join InStil InChoice. If you drop your supplemental policy, you may not be able to get the same one back. You should check into this carefully before you drop your supplemental policy to make sure you have all of the coverage you need.

You or your spouse may have, or be able to get, employer group health coverage. If so, you should talk to the employer to find out how your benefits will be affected if you join InStil InChoice. Get this information before you decide.

What Are My Protections In This Plan?

All health plans in the Medicare program agree to stay with the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare health plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for healthcare coverage in your area and give you information about your right to get Medicare supplemental insurance coverage. You can choose another health plan if one is available, or you can receive care from the Original Medicare Plan.

If *InStil Health* ever denies your claim or a service, we will explain our decision to you. You always have the right to appeal and ask us to review the claim or service that was denied. If a decision is not made in your favor, your appeal will be reviewed by an independent organization that works for Medicare.

Please call *InStil Health* for more information about this plan.

Customer Service Hours:

8:00 a.m. – 7:30 p.m., Monday through Friday

Current and prospective members should call

1-877-4-INSTIL (1-877-446-7845)

(TTY/TDD 1-800-503-3118)

www.MyInStil.com

You may also call Medicare at **1-800-MEDICARE (1-800-633-4227)** or visit www.medicare.gov for more information about Medicare. You can call this national Medicare helpline 24 hours a day, seven days a week. The TTY number is 1-877-486-2048. (You need special telephone equipment to use this number.) Calls to these numbers are free.

If you have special needs, this document may be available in other formats.

SECTION TWO – IMPORTANT INFORMATION

Benefit Category	Original Medicare	InChoice Option I		InChoice Option II	
		In-network	Out-of-network	In-network	Out-of-network
IMPORTANT INFORMATION 1 – Premium and Other Important Information	You pay the Medicare Part B premiums of \$78.20 each month.	You pay \$0 each month. You also continue to pay the Medicare Part B premiums of \$78.20 each month.		You pay \$50 each month. You also continue to pay the Medicare Part B premiums of \$78.20 each month.	
		You pay an initial annual deductible of \$200 for all plan services when received in-network or out-of-network.	There is an additional \$550 deductible applied for all plan services when received out-of-network only.	There is no annual deductible. There is a \$2,500 maximum out-of-pocket limit every year for all plan services when received in-network or out-of-network.	You pay an initial deductible of \$500 for all plan services when received out-of-network only. There is an additional \$2,500 maximum out-of-pocket limit applied every year for all services when received out-of-network only.
2 – Doctor and Hospital Choice (For more information, see Emergency #15 and Urgently Needed Care #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	You can go to doctors, specialists and hospitals in or out-of-network. Higher costs apply for out-of-network services. You do not need a referral to go to network doctors, specialists, and hospitals.			
SUMMARY OF BENEFITS					
INPATIENT CARE					
3 – Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services) Please call 1-800-MEDICARE (1-800-633-4227) for more information about lifetime reserve days. ⁽⁴⁾	You pay for each benefit period ⁽³⁾ : Days 1-60: an initial deductible of \$912 Days 61-90: \$228 each day Days 91-150: \$456 each lifetime reserve day. ⁽⁴⁾	You pay \$75 for days 1-7. You pay \$0 for days 8-90 at a network hospital.	You pay 20% of the cost for each stay at an out-of-network hospital.	There is no copayment for inpatient hospital services received at a network hospital.	You pay 20% of the cost for each stay at an out-of-network hospital.
You are covered for unlimited days each benefit period.					

⁽³⁾ A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

⁽⁴⁾ Lifetime reserve days can only be used once.

SECTION TWO – IMPORTANT INFORMATION

Benefit Category	Original Medicare	InChoice Option I		InChoice Option II	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
4 – Inpatient Mental Health Care	You pay the same deductible and copayments as inpatient hospital care (above) except there is a 190-day lifetime limit in a psychiatric hospital.	You pay \$100 each day for days 1-7, then \$0 for each day 8-90 for a Medicare-covered stay at a network hospital.	You pay 20% of the cost for each stay at an out-of-network hospital.	There is no copayment for services received at a network hospital.	You pay 20% of the cost for each stay at an out-of-network hospital.
Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime					
5 – Skilled Nursing Facility (In a Medicare-certified skilled nursing facility)	You pay for each benefit period ⁽³⁾ , following at least a 3-day covered hospital stay: Days 1-20: \$0 for each day Days 21-100: \$114.00 for each day There is a limit of 100 days for each benefit period. ⁽³⁾	You pay: \$0 each day for day(s) 1-5 \$75 each day for day(s) 6-100 For a Medicare-covered stay at a Skilled Nursing Facility 3-day prior hospital stay is required You are covered for 100 days each benefit period.	You pay 20% of the cost for services at an out-of-network Skilled Nursing Facility. 3-day prior hospital stay is required You are covered for 100 days each benefit period.	You pay: \$0 each day for day(s) 1-5 \$75 each day for day(s) 6-100 For a Medicare-covered stay at a Skilled Nursing Facility 3-day prior hospital stay is required You are covered for 100 days each benefit period.	You pay 20% of the cost for services at an out-of-network Skilled Nursing Facility. 3-day prior hospital stay is required You are covered for 100 days each benefit period.
6 – Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for all covered home health visits.	There is no copayment for Medicare-covered home health visits.	You pay 20% for out-of-network home health visits.	There is no copayment for Medicare-covered home health visits.	You pay 20% for out-of-network home health visits.

(3) A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

SECTION TWO – IMPORTANT INFORMATION

Benefit Category	Original Medicare	InChoice Option I		InChoice Option II	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
7 – Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.			
OUTPATIENT CARE					
8 – Doctor Office Visits	You pay 20% of Medicare-approved amounts. ^{(1),(2)} If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your physician for further details.	You pay \$15 for each primary care doctor office visit for Medicare-covered services. You pay \$30 for each specialist visit for Medicare-covered services.	You pay 20% for each out-of-network primary care office visit. You pay 20% for each out-of-network specialist visit.	You pay \$10 for each primary care doctor office visit for Medicare-covered services. You pay \$20 for each specialist visit for Medicare-covered services.	You pay 20% for each out-of-network primary care office visit. You pay 20% for each out-of-network specialist visit.
See 32 – Routine Physical Exams for more information. If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further details.					
9 – Chiropractic Services	You pay 20% of Medicare-approved amounts. ^{(1),(2)} You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers. You pay 100% for routine care.	You pay \$30 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	You pay \$50 for out-of-network chiropractic services.	You pay \$20 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	You pay \$50 for out-of-network chiropractic services.

(1) Each year, you pay a total of one \$110 deductible.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

SECTION TWO – IMPORTANT INFORMATION

Benefit Category	Original Medicare	InChoice Option I		InChoice Option II	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
10 – Podiatry Services	You pay 20% of Medicare-approved amounts. ^{(1),(2)} You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.	You pay \$30 for each Medicare-covered visit (medically necessary foot care).	You pay \$50 for out-of-network podiatry services.	You pay \$20 for each Medicare-covered visit (medically necessary foot care).	You pay \$50 for out-of-network podiatry services.
11 – Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. ^{(1),(2)}	For Medicare-covered Mental Health services, you pay \$30 for each individual/group therapy visit.	You pay 50% of the cost for out-of-network Mental Health services. You pay 50% of the cost for out-of-network Mental Health services with a psychiatrist.	For Medicare-covered Mental Health services, you pay \$20 for each individual/group therapy visit.	You pay 50% of the cost for out-of-network Mental Health services. You pay 50% of the cost for out-of-network Mental Health services with a psychiatrist.
12 – Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts. ^{(1),(2)}	For Medicare-covered services, you pay \$30 for each individual/group visit.	You pay 50% of the cost for out-of-network outpatient substance abuse services.	For Medicare-covered services, you pay \$20 for each individual/group visit.	You pay 50% of the cost for out-of-network outpatient substance abuse services.
13 – Outpatient Services/Surgery	You pay 20% of Medicare-approved amounts for the doctor. ^{(1),(2)} You pay 20% of outpatient facility charges. ^{(1),(2)}	You pay \$50 for each Medicare-covered visit to an ambulatory surgical center. You pay \$100 for each visit to an outpatient hospital facility.	You pay 20% of the cost for services at an out-of-network ambulatory surgical center. You pay 30% of the cost for services at an out-of-network outpatient hospital facility.	You pay \$25 for each Medicare-covered visit to an ambulatory surgical center. You pay \$50 for each visit to an outpatient hospital facility.	You pay 20% of the cost for services at an out-of-network ambulatory surgical center. You pay 30% of the cost for services at an out-of-network outpatient hospital facility.

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Benefit Category	Original Medicare	InChoice Option I		InChoice Option II	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
14 – Ambulance Services (medically necessary ambulance services)	You pay 20% of Medicare-approved amounts or applicable fee schedule charges. (1),(2)	You pay \$50 for Medicare-covered ambulance services.	You pay \$50 for out-of-network ambulance services.	You pay \$50 for Medicare-covered ambulance services.	You pay \$50 for out-of-network ambulance services.
15 – Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	<p>You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. (1),(2)</p> <p>You pay 20% of doctor charges. (1),(2)</p> <p>NOT covered outside the U.S., except under limited circumstances.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit.</p> <p>Worldwide coverage.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit.</p> <p>If you travel outside the U.S., coverage is subject to a \$250 deductible and 20% coinsurance.</p> <p>Coverage is limited to \$25,000 each calendar year and up to 60 consecutive days of foreign travel.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit.</p> <p>Worldwide coverage.</p>	<p>You pay \$50 for each Medicare-covered emergency room visit.</p> <p>If you travel outside the U.S., coverage is subject to a \$250 deductible and 20% coinsurance.</p> <p>Coverage is limited to \$25,000 each calendar year and up to 60 consecutive days of foreign travel.</p>
16 – Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	<p>You pay 20% of Medicare-approved amounts or applicable copayment. (1),(2)</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>You pay \$50 for each Medicare-covered urgently needed care visit.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>You pay 20% of the cost for out-of-network urgent care services.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>You pay \$20 for each Medicare-covered urgently needed care visit.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>You pay 20% of the cost for out-of-network urgent care services.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>

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17 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts. ^{(1),(2)}	You pay \$30 for each Medicare-covered Occupational Therapy visit. You pay \$30 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.	You pay 20% of the cost for out-of-network Occupational Therapy services. You pay 20% of the cost for out-of-network Physical Therapy and/or Speech/Language Therapy services.	You pay \$20 for each Medicare-covered Occupational Therapy visit. You pay \$20 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.	You pay 20% of the cost for out-of-network Occupational Therapy services. You pay 20% of the cost for out-of-network Physical Therapy and/or Speech/Language Therapy services.

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

18 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts. ^{(1),(2)}	You pay 20% of the cost for each Medicare-covered item.	You pay 30% of the cost for durable medical equipment purchased out-of-network.	You pay 20% of the cost for each Medicare-covered item.	You pay 30% of the cost for durable medical equipment purchased out-of-network.
19 – Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts. ^{(1),(2)}	You pay 20% of the cost for each Medicare-covered item.	You pay 30% of the cost for prosthetic devices purchased out-of-network.	You pay 20% of the cost for each Medicare-covered item.	You pay 30% of the cost for prosthetic devices purchased out-of-network.
20 – Diabetes Self-Monitoring Training and Supplies (includes coverage for glucose monitors, test strips, lancets and self-management training)	You pay 20% of Medicare-approved amounts. ^{(1),(2)}	There is no copayment for Diabetes self-monitoring training. There is no copayment for Diabetes supplies.	You pay 20% of the cost for each out-of-network Diabetes self-monitoring training. You pay 20% of the cost for each Diabetes supply item purchased out-of-network.	There is no copayment for Diabetes self-monitoring training. There is no copayment for Diabetes supplies.	You pay 20% of the cost for each out-of-network Diabetes self-monitoring training. You pay 20% of the cost for each Diabetes supply item purchased out-of-network.

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Part B Covered Drugs (Certain cancer drugs and injectables, infusion medications and certain aerosolized medications.)	You pay 20% of Medicare-approved amounts. ^{(1),(2)}	You pay 20% of Medicare-approved amounts.	You pay 20% of Medicare-approved amounts.	You pay 10% of Medicare-approved amounts.	You pay 20% of Medicare-approved amounts.
21 – Diagnostic Tests, X-Rays and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services. ^{(1),(2)} There is no copayment for Medicare-approved lab services.	You pay: \$20 for each Medicare-covered clinical/diagnostic lab service. \$20 for each Medicare-covered radiation therapy service. \$20 for each Medicare-covered X-ray visit. An additional facility charge may be included in the cost for services.	You pay: 20% of the cost for each out-of-network clinical/diagnostic lab service 20% for the cost for each out-of-network radiation therapy service. 20% of the cost for out-of-network X-ray services. An additional facility charge may be included in the cost for services.	You pay: \$10 for each Medicare-covered clinical/diagnostic lab service. \$10 for each Medicare-covered radiation therapy service. \$10 for each Medicare-covered X-ray visit. An additional facility charge may be included in the cost for services.	You pay: 20% of the cost for each out-of-network clinical/diagnostic lab service 20% for the cost for each out-of-network radiation therapy service. 20% of the cost for out-of-network X-ray services. An additional facility charge may be included in the cost for services.
PREVENTIVE SERVICES					
22 – Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts. ^{(1),(2)}	There is no copayment for each Medicare-covered Bone Mass Measurement.	You pay 20% of the cost for each out-of-network Bone Mass Measurement.	There is no copayment for each Medicare-covered Bone Mass Measurement.	You pay 20% of the cost for each out-of-network Bone Mass Measurement.
23 – Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts. ^{(1),(2)}	There is no copayment for each Medicare-covered Colorectal Screening Exam.	You pay 20% of the cost for each out-of-network Colorectal Screening exam.	There is no copayment for each Medicare-covered Colorectal Screening Exam.	You pay 20% of the cost for each out-of-network Colorectal Screening exam.

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Benefit Category	Original Medicare	InChoice Option I		InChoice Option II	
		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
24 – Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	<p>There is no copayment for Pneumonia and Flu vaccines.</p> <p>You pay 20% of Medicare-approved amounts. ^{(1),(2)}</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.</p>	<p>There is no copayment for Pneumonia and Flu vaccines.</p> <p>No referral necessary for Medicare-covered influenza and pneumococcal vaccines.</p> <p>There is no copayment for the Hepatitis B vaccine.</p>	<p>You pay 20% of the cost for each out-of-network Immunization.</p> <p>No referral necessary for Medicare-covered influenza and pneumococcal vaccines.</p>	<p>There is no copayment for Pneumonia and Flu vaccines.</p> <p>No referral necessary for Medicare-covered influenza and pneumococcal vaccines.</p> <p>There is no copayment for the Hepatitis B vaccine.</p>	<p>You pay 20% of the cost for each out-of-network Immunization.</p> <p>No referral necessary for Medicare-covered influenza and pneumococcal vaccines.</p>
25 – Mammograms (Annual Screening) (for women with Medicare age 40 and older)	<p>You pay 20% of Medicare-approved amounts. ⁽²⁾</p> <p>No referral necessary for Medicare-covered screenings.</p>	<p>There is no copayment for Medicare-covered Screening Mammograms.</p> <p>No referral necessary for Medicare-covered screenings.</p>	<p>You pay 20% of the cost for each out-of-network Screening Mammogram.</p> <p>No referral necessary for Medicare-covered screenings.</p>	<p>There is no copayment for Medicare-covered Screening Mammograms.</p> <p>No referral necessary for Medicare-covered screenings.</p>	<p>You pay 20% of the cost for each out-of-network Screening Mammogram.</p> <p>No referral necessary for Medicare-covered screenings.</p>
26 – Pap Smears and Pelvic Exams (for women with Medicare)	<p>There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk.</p> <p>You pay 20% of Medicare-approved amounts for Pelvic Exams. ⁽²⁾</p>	<p>There is no copayment for Medicare-covered Pap Smears and Pelvic Exams.</p>	<p>You pay 20% of the cost for each out-of-network Pap Smear and Pelvic Exam.</p>	<p>There is no copayment for Medicare-covered Pap Smears and Pelvic Exams</p>	<p>You pay 20% of the cost for each out-of-network Pap Smear and Pelvic Exam.</p>

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		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
27 – Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no copayment for Medicare-approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. ⁽²⁾	There is no copayment for Medicare-covered Prostate Cancer Screening exams.	You pay 20% of the cost for each out-of-network Prostate Screening Exam.	There is no copayment for Medicare-covered Prostate Cancer Screening exams.	You pay 20% of the cost for each out-of-network Prostate Screening Exam.
ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)					
28 – Outpatient Prescription Drugs	You pay 100% for most prescription drugs.	You pay 100% for most prescription drugs. <i>Medicare-approved drug discount card available.</i>			
29 – Dental Services	In general, you pay 100% for dental services.	In general, you pay 100% for dental services.			
30 – Hearing Services	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams. ^{(1),(2)}	In general, you pay 100% for routine hearing exams and hearing aids. You pay \$30 for each Medicare-covered hearing exam (diagnostic hearing exams).	In general, you pay 100% for routine hearing exams and hearing aids. You pay 20% of the cost for out-of-network hearing exams.	In general, you pay 100% for routine hearing exams and hearing aids. You pay \$20 for each Medicare-covered hearing exam (diagnostic hearing exams).	In general, you pay 100% for routine hearing exams and hearing aids. You pay 20% of the cost for out-of-network hearing exams.

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		<i>In-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Out-of-network</i>
31 – Vision Services	<p>You are covered for one pair of eye-glasses or contact lenses after each cataract surgery. ^{(1),(2)}</p> <p>For people with Medicare who are at risk, you are covered for annual glaucoma screenings. ^{(1),(2)}</p> <p>You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye. ^{(1),(2)}</p> <p>You pay 100% for routine eye exam and glasses.</p>	<p>You pay 100% for non-Medicare covered eye exams and glasses.</p> <p>You pay: \$30 for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery) \$30 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye)</p>	<p>You pay 100% for non-Medicare covered eye exams and glasses.</p> <p>You pay: 20% of the cost for out-of-network eye exams. 20% of the cost for out-of-network eye wear.</p>	<p>You pay 100% for non-Medicare covered eye exams and glasses.</p> <p>You pay: \$20 for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery) \$20 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye)</p>	<p>You pay 100% for non-Medicare covered eye exams and glasses.</p> <p>You pay: 20% of the cost for out-of-network eye exams. 20% of the cost for out-of-network eye wear.</p>
32 – Routine Physical Exams	<p>You pay 100% for routine physical exams.</p>	<p>There is no copayment for routine physical exams.</p> <p>You are covered up to one exam every year.</p>	<p>You pay 20% of the cost for each out-of-network routine physical exam.</p> <p>You are covered up to one exam every year.</p>	<p>There is no copayment for routine physical exams.</p> <p>You are covered up to one exam every year.</p>	<p>You pay 20% of the cost for each out-of-network routine physical exam.</p> <p>You are covered up to one exam every year.</p>
Health/Wellness Education	<p>You pay 100%.</p>	<p>You are covered for the following (where available):</p> <ul style="list-style-type: none"> • Health Ed Classes • Newsletter • Nutritional Training • Smoking Cessation • Congestive Heart Program • Alternative Medicine Program (discount card) • Nursing Hotline • Case Management 			

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(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

SECTION THREE – IMPORTANT PLAN INFORMATION

This section further explains some of the additional benefits of our plan. It doesn't explain every benefit or service that we offer. To get a complete list of our benefits and services, please call *InStil Health* and ask for the "Evidence of Coverage."

Understanding Your Additional Benefits

Outpatient Prescription Drugs

InStil Health offers a Drug Discount Card Program with the Medicare-approved seal for people with Medicare. This means Medicare has approved our drug discount card program. While Medicare has approved our drug discount card, it is separate from the Medicare program and is not intended to replace any prescription drug benefits that you get with InStil InChoice. The cost of this program is \$30.00 per year.

This program is designed to help you lower the costs of your prescription drugs. As a member of the program you will be able to receive discount prices when you use your membership card at a plan pharmacy. You may also qualify for additional assistance up to \$300 from Medicare in 2005 to be used toward the cost of your prescription drugs from plan pharmacies. This assistance is in addition to the discounts you would get through our discount drug card program.

To qualify for additional credit from Medicare you will need to complete an additional form. The additional form will ask questions about your current healthcare coverage and your income level. Please call Member Services at 1-877-446-7845 (TTY users should call 1-800-503-3118) to request a Medicare-approved Drug Discount Card enrollment form and informational packet.

You can get more information on this program from Member Services (see Section 1 for how to contact Member Services).

Complementary and Alternative Medicine

More and more people are turning to complementary and alternative medicine (CAM) to add to their traditional healthcare. Original Medicare does not cover CAM services. But as a member of InStil InChoice, you'll receive discounts of up to 30% for the following services (where available):

- Massage therapy
- Acupuncture
- Exercise programs and services
- Mind/Body therapies including meditation and guided imagery
- Nutritional counseling
- Chiropractic care
- Spa treatments
- Vitamins and supplements

You can also take advantage of discounts from 45%-75% on health and fitness magazines through the Healthy Reading program. And you can access for free an award-winning Web site. You'll find health articles, more than 750 healthy recipes, and even a directory of providers who offer CAM services in your area.

SECTION THREE – IMPORTANT PLAN INFORMATION

Case Management

InStil Health reaches out to members at risk for certain chronic conditions, including:

- Diabetes
- Asthma/COPD
- Cardiac/Chronic heart failure
- Depression
- Maternity

Our case management programs coordinate education, counseling, patient self-care and physician support to help you manage your condition. By identifying and managing your condition early, you can help avoid complications and improve your quality of life.

Understanding How To Access Care

As a PPO, InStil InChoice lets you choose your providers. However, to get the highest level of benefits, you should choose plan providers — those who are in the InChoice provider network. Generally, you will pay less out-of-pocket costs when you get care from network providers. See the Summary of Benefits chart in Section Two to compare in- and out-of-network benefits. Also, keep in mind that coinsurance amounts for out-of-network providers are based on the Medicare-allowed rate, rather than the contracted rate for network providers — so you may pay more for non-network services, even if the coinsurance percentage is the same.

Understanding Your Inpatient Coverage

Benefit periods do not apply, but where you choose to seek care will determine what your benefits are. You will pay less if you choose a plan, or network hospital. Under InChoice Option I, you will be required to pay \$75 per day for the first seven days of each in-network hospital admission. After day seven, you pay nothing. Under InChoice Option II, you do not pay anything for an inpatient stay at a network hospital.

If you choose to go to an out-of-network hospital, you must pay 20% of the Medicare-allowed amounts. This applies to both InChoice Options.

Prior authorization is not required. However, notification of hospital admission is requested. This is one way we can let your doctor know about InStil's programs that may be of assistance to you during this time.

You may also choose to contact us to confirm that planned inpatient services are Medicare-covered services and therefore covered by your plan. See your InStil card for the telephone number.

Understanding Your Outpatient Coverage

You can receive outpatient services at different types of facilities. Your out-of-pocket cost will generally depend on the type of medical facility you use, rather than the particular service, or services you are receiving. Your cost will also depend on whether the provider you visit is in the InChoice network, or out-of-network. Your costs will be less if you stay in-network. See the Summary of Benefits chart in Section Two to compare these costs.

Remember, only one copayment will be charged for each visit to an office or facility, no matter how many services are received during the visit or the actual costs for the services received. But if, for example, you receive care in a primary care physician's office and are then sent to another facility for additional services, two copayments may apply.

SECTION THREE – IMPORTANT PLAN INFORMATION

Understanding Emergency and Urgently Needed Care

In the event of an emergency, call 911 for assistance or go the nearest emergency room. You are covered wherever you are.

An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

NOTE: If you are traveling outside of the United States, your coverage is subject to a service specific \$250 annual deductible and 20% coinsurance. Coverage is limited to \$25,000 each calendar year and up to 60 consecutive days of foreign travel.

Urgently needed services are covered services that are not emergency services as defined in this section, and provided when an enrollee is temporarily absent from the InStil InChoice's service area when the services are medically necessary and immediately required:

- As a result of an unforeseen illness, injury, or condition; and
- It was not reasonable given the circumstances to obtain the services through InStil Choice.

Note that under unusual and extraordinary circumstances, services may be considered urgently needed services when the enrollee is in the service or continuation area, but the organization's provider network is temporarily unavailable or inaccessible.

Your coverage is not limited by service area. If you need medical attention, you may go to any doctor, specialist or hospital that is approved for Medicare and accepts our payment terms. Remember to carry your InStil card with you and to show it to each provider prior to receiving services. This will give the provider the opportunity to send your claim to us. If your ID card is not made available because of an emergency situation, you are still covered.

You may be required to pay an office or facility copayment based on where the services are received as outlined below:

For in-network facilities, you pay:

	Option I	Option II
Primary care physician's office	\$15	\$10
Specialist's office	\$30	\$20
Urgent care facility	\$50	\$20
Hospital emergency room	\$50	\$50

For out-of-network care, you pay 20% of the Medicare-allowed amount. Both facility and physician charges apply at an emergency room.

SECTION THREE – IMPORTANT PLAN INFORMATION

Understanding Appeals and Grievances

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call Member Services at 1-877-4-INSTIL.

You have the right to make a complaint if you have concerns or problems related to your coverage or care. “Appeals” and “grievances” are the two different types of complaints you can make.

An “**appeal**” is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service.**

A “**grievance**” is the type of complaint you make **if you have any other type of problem with *InStil Health* or a healthcare provider.** For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor’s office.

To file an appeal, please write to us at the address below:

For regular mail:

InStil Health
PO Box 100298
Columbia, SC 29202-3298

For UPS or Federal Express:

InStil Health c/o PGBA
2300 Springdale Drive, Building 1
Camden, SC 29020

To file a grievance, please call us at 1-877-4-INSTIL.

Please call *InStil Health* with questions about this plan.

Customer Service Hours:

Monday through Friday, 8 a.m. to 7:30 p.m.

Current and prospective members should call

1-877-4-INSTIL (1-877-446-7845)

(TTY/TDD 1-800-503-3118)

www.MyInStil.com

Please call Medicare at **1-800-MEDICARE (1-800-633-4227)** or visit **www.medicare.gov** for more information about Medicare. You can call this national Medicare helpline 24 hours a day, seven days a week.

The TTY number is 1-877-486-2048. (You need special telephone equipment to use this number.)