



# Health Benefits Proposal

Prepared for:

**PORTVILLE, TOWN OF**  
1102 OLEAN-PORTVILLE RD PO BOX 630  
PORTVILLE, NY 14770

Prepared by:  
Kari Wilson  
Benefit Consultant

May 27, 2008



Prepared by: Kari Wilson  
Benefit Consultant

Product Name: Passport Plan Select

**Group Information**

PORTVILLE, TOWN OF  
1102 OLEAN-PORTVILLE RD PO BOX 630  
PORTVILLE, NY 14770

Proposed Effective Date: June 01, 2008  
Rates Invalid After: June 30, 2008  
Eligibles: 9  
Group #: 15260h

Health Plan Highlights	In-Network	Out-Network
Network Selected For a listing of participating providers, please visit <a href="http://www.independenthealth.com">www.independenthealth.com</a>	Independent Health Corp. participating providers	
Deductible	\$500/ \$1,000 (Combined In- and Out-of-Network)	\$500/\$1,000 (Combined In- and Out-of-Network)
Coinsurance	80%-20%	60%-40%
Out of Pocket Maximum	\$1,000/ \$2,000	\$1,000/\$2,000
Lifetime Maximum Benefit	Unlimited maximum	Unlimited maximum
Office Visit	\$20	Subject to deductible and coinsurance
Hospitalization	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Emergency Room Copayment waived if admitted. (Not waived on products with deductible/coinsurance)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Rehabilitation Therapies	Subject to deductible and coinsurance (up to 20 visits per year)	Subject to deductible and coinsurance (up to 20 visits per year)
Substance Abuse (inpatient)	Not covered	Not covered
Durable Medical Equipment	Subject to deductible and 50% coinsurance, with an annual allowance of \$1,000 (in and out of network combined)	Subject to deductible and 50% coinsurance, with an annual allowance of \$1,000 (in and out of network combined)
Prosthetics and Appliances	Subject to deductible and 50% coinsurance	Subject to deductible and 50% coinsurance
Dependent Eligibility	Students to 23	Students to 23
Additional Eligibility Options	Coverage includes spouse and dependent children	Coverage includes spouse and dependent children
Dependent Eligibility Extension	Dependents terminate at the end of the month in which their eligibility expires.	Dependents terminate at the end of the month in which their eligibility expires.

Prescription Plan Highlights	
Prescription Drug Coverage	\$10/ \$20/ \$35
Contraceptive drugs and devices	Tier 1 oral contraceptives: \$0 copayment
For Additional Information	Learn more about Medicare Creditability. Visit <a href="http://www.IndependentHealth.com">www.IndependentHealth.com</a>

Dental Plan Highlights	
Dental Coverage	Not covered

Vision Plan Highlights	
Vision Coverage	Premier Vision Plan



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RATE AGREEMENT

**PORTVILLE, TOWN OF**

1102 OLEAN-PORTVILLE RD PO BOX 630  
PORTVILLE, NY 14770

Group # 15260h

12-Month Rate  
Quarter beginning June 01, 2008

PROPOSED RATES: *Subject to New York State Approval*

Coverage Type	Estimated Monthly Premium
Single	\$296.54
Double	\$711.69
Family	\$835.88

Rates quoted are for the benefit packages(s) outlined on this page(s), to become effective on June 01, 2008 and will continue for 12 months from that effective date. Please note: The above quoted rates are subject to approval by the New York State Department of Insurance, and could change prior to effective date.

Rates will be adjusted with only 30 days written notice from Independent Health on each succeeding 12-month anniversary of the effective date. The rate for each succeeding 12-month period shall be the rate approved by the New York State Superintendent of Insurance to be in effect for the quarter in which the applicable anniversary date falls, unless:

- 1) the group elects to change the benefit package; or
- 2) New York State or Federal benefit mandates must be implemented prior to the next anniversary date; or the filed rate may be adjusted to account for underpayments or overpayments made by the group in the previous year if the group had a fixed premium rate with recoupment (shown as the rate adjustment on the preceding page).

If at any succeeding 12-month anniversary date, no change in the premium rates has been requested by Independent Health and approved by the Superintendent of Insurance, then the last approved rate which is then in effect shall become the rate.

By signing this rate agreement, you are confirming that each of your Independent Health subscribers has received at least thirty (30) days written notice of any rate change prior to your group's renewal date.

Accepted By: Group Independent Health Association, Inc.

Signature: \_\_\_\_\_

Name: Harry W. Keeley

Title: Supervisor

Date: May 30, 2008

UH;KC;VC;CK;DV;E46;B92;

## Benefit Summary

### BENEFITS

	Passport Plan Select	
	In-Network	Out-Network
<b>Part D Creditability</b>		
Medicare Creditability of Prescription Drug Benefits	For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare, therefore this plan provides you with CREDITABLE COVERAGE.	
<b>At a glance:</b>		
Primary Care Physician Office Visit	\$20	Subject to deductible and coinsurance
Specialty Care Physician Office Visit	\$20	Subject to deductible and coinsurance
Routine Physical Exams (some restrictions apply)	\$20	Subject to deductible and coinsurance
Inpatient Hospital	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Emergency Room Copayment waived if admitted. (Not waived on products with deductible/coinsurance)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Outpatient Services</b>		
Office Visit	\$20	Subject to deductible and coinsurance
Adult Immunizations	\$20	Subject to deductible and coinsurance
Well-Child Visits / Immunizations	Covered in full	Covered in full
Allergy Testing/Treatment	\$20	Subject to deductible and coinsurance
Chemotherapy	Subject to deductible and coinsurance	Subject to deductible and coinsurance
EKGs and Other Diagnostic Procedures	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Diagnostic X-rays	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Mammogram	\$0	Subject to deductible and coinsurance
Laboratory Testing, Including Pap Smears	\$0	Subject to deductible and coinsurance
Rehabilitation Therapies (physical, occupational, and speech)	Subject to deductible and coinsurance (up to 20 visits per year)	Subject to deductible and coinsurance (up to 20 visits per year)
Outpatient Surgical Procedures	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Medical Eye Exam	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Chiropractic Services For manual or mechanical manipulation to treat subluxation	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Maternity Services</b>		
Physician Services (pre-natal and one post-partum visit)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Inpatient Hospital Services	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Hospital Services</b>		
Inpatient Hospital	Subject to deductible and coinsurance	Subject to deductible and coinsurance

## Benefit Summary

### BENEFITS

	Passport Plan Select	
	In-Network	Out-Network
<b>Hospital Services</b>		
Hospice	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Emergency Services</b>		
Medically Necessary Ambulance Transportation	Subject to deductible and coinsurance	Subject to deductible and coinsurance
Emergency Room Copayment waived if admitted. (Not waived on products with deductible/coinsurance)	Subject to deductible and coinsurance	Subject to deductible and coinsurance
After Hours Care Center	\$35	If a member pre-certifies, office visit copay applies If member does not, subject to deductible and coinsurance
<b>Outpatient Mental Health Services</b>		
Mental Health (outpatient)	\$20 Visit limits may apply for certain mental health diagnoses	Subject to deductible and coinsurance
<b>Substance Abuse Treatment</b>		
Detoxification	Subject to deductible and coinsurance	Subject to deductible and coinsurance
<b>Inpatient Rehabilitation</b>	Not covered	Not covered
Outpatient Treatment 60 visits/year	Subject to deductible and 50% coinsurance	Subject to deductible and 50% coinsurance
<b>Additional Services</b>		
Durable Medical Equipment	Subject to deductible and 50% coinsurance, with an annual allowance of \$1,000 (in and out of network combined)	Subject to deductible and 50% coinsurance, with an annual allowance of \$1,000 (in and out of network combined)
Prosthetics and Appliances	Subject to deductible and 50% coinsurance	Subject to deductible and 50% coinsurance
Skilled Nursing Facility	Subject to deductible and coinsurance (up to 45 days per year)	Subject to deductible and coinsurance (up to 45 days per year)
Home Care Services	Subject to deductible and coinsurance (up to 40 visits per year)	Subject to deductible and coinsurance (up to 40 visits per year)
<b>Diabetic Supplies and Services</b>		
Durable Medical Equipment (for Diabetes)	\$20	Subject to deductible and coinsurance
Insulin and Other Oral Agents	Office copay or your prescription copay, whichever is less.	Subject to deductible and coinsurance
Up to a 30 day supply of outpatient diabetic medical supplies (test strips, syringes, etc.)	20% member copay, or the office visit copay, whichever is less	Subject to deductible and coinsurance
<b>Vision Plan</b>		
Vision Coverage	Premier Vision Plan	Not covered
Annual Refractive Examination	Covered in full	Not covered
Standard Plastic Lenses	Single Vision: \$10 Bifocal: \$10 Trifocal: \$10 Lenticular: \$10 Progressive: \$10	Not covered



## Benefit Summary

### BENEFITS

	Passport Plan Select	
	In-Network	Out-Network
<b>Vision Plan</b>		
Lens Options	UV Coating: \$12 Tint: \$12 Standard Anti-Reflective: \$45 Standard Polycarbonate: \$35 Standard Scratch Resistance: \$12 Other Services: 20% Discount	Not covered
Frames	Frames: \$60 allowance, then member pays 80% of the balance over \$60	Not covered
Contact Lenses	Conventional contact lenses: \$90 allowance. 15% discount for any balance Disposable contact lenses: \$90 allowance. Specialty contact lenses: \$250 allowance (provided based on EyeMed's medically necessary criteria)	Not covered
Laser Vision Correction	U.S. Laser Network for LASIK or PRK: 15% discount on standard fees or 5% off promotional pricing	Not covered
Frequency Limitations	Examinations: Once every 12 months Contact Lenses: Once every 12 months Frames: Once every 12 months Lenses: Once every 12 months	
<b>Dental Plan</b>		
Dental Coverage	Not covered	Not covered
<b>Prescription Plan</b>		
Prescription Drug Coverage	\$10/ \$20/ \$35	When outside of WNY, prescriptions should be filled using Independent Health's nationwide pharmacy network. In-network benefits apply.
Contraceptive drugs and devices	Tier 1 oral contraceptives: \$0 copayment	See above
<b>Limitations</b>		
Deductible	\$500/ \$1,000 (Combined In- and Out-of-Network)	\$500/\$1,000 (Combined In- and Out-of-Network)
Coinsurance	80%-20%	60%-40%
Out of Pocket Maximum	\$1,000/ \$2,000	\$1,000/\$2,000
Lifetime Maximum Benefit	Unlimited maximum	Unlimited maximum



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Dependent Eligibility		
Dependent Eligibility	Students to 23	Students to 23
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**Exclusions**  
This is a summary of covered benefits and exclusions, and is not intended as an actual contract. Not all benefits, limitations and exclusions are listed here. A detailed contract is issued upon enrollment. Please check your contract for detailed information on your benefits and exclusions.