

2011 Benefit Comparison

CONFIDENTIAL - FOR AGENT USE ONLY
NOT INTENDED FOR DISTRIBUTION TO POTENTIAL MEMBERS



2011 Prescription Drug Benefits for HMO, PPO, and HMO-POS MAPD Plans

| | GOLD | PLATINUM | Universal PPO | HMO-POS |
|-------------------------------------|---|------------------------|------------------------------|------------------------------|
| Annual Deductible | \$0 | \$0 | \$0 | \$0 |
| Coverage | | | | |
| Tier 1 - Preferred Generics | \$4 | \$2 | \$4 | \$3 |
| Tier 2 - Nonpreferred Generics | \$15 | \$7 | \$15 | \$15 |
| Tier 3 - Preferred Brands | \$45 | \$35 | \$40 | \$45 |
| Tier 4 - Nonpreferred Brands | \$80 | \$65 | \$80 | \$80 |
| Tier 5 - Specialty Drugs | 33% | 33% | 33% | 33% |
| Mail Order Tier 1/2/3/4 | 90-day: \$8/\$30/\$120/\$220 | 3 months for 2 co-pays | 90-day: \$8/\$30/\$100/\$200 | 90-day: \$6/\$30/\$110/\$200 |
| Drugs Covered Under Medicare Part B | 23% | 23% | 23% | 23% |
| Initial Coverage Limit | Member pays the above co-pay amounts until the total yearly drug costs (both what the Member and the Plan paid) reach \$2840. | | | |
| Coverage Gap/Donut Hole | Member pays 93% of generic drug costs and 50% of brand drug costs until the yearly out-of-pocket drug costs reach \$4550. | | | |
| Catastrophic Coverage | Then, the Member will pay the greater of \$2.50 co-pay for generic (including brand drugs treated as generic) and a \$6.30 co-pay for all other drugs, or 5% co-insurance for the rest of the year. | | | |

Dental X-Ray Co-Pays

HMO-POS, PPO, and PFFS PLANS

Radiographs: Limit of 1 radiograph service (complete series or intraoral periapicals or panoramic or bitewing) per year.

| | Frequency | co-pay |
|---|-------------|--------|
| Intraoral - Complete Series (including Bitewings) | 1 per 3 yrs | \$25 |
| Intraoral - Periapical First Film | 1 | \$0 |
| Intraoral - Periapical Each Additional Film (up to 7) | 1 | \$5 |
| Intraoral - Occlusal Film | 2 | \$10 |
| Bitewing - Single Film | 1 | \$0 |
| Bitewings - Two Films | 1 | \$5 |
| Bitewings - Four Films | 1 | \$10 |
| Panoramic Film | 1 per 3 yrs | \$25 |
| Temporomandibular Joint Film | 1 | \$75 |

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Labs and Diagnostics

HMO-POS

| | Physician Office/ Freestanding Center | Hospital |
|---------------------------------|--|----------|
| Bone Density | \$0 | \$0 |
| Simple X-Rays | \$5 | 25% |
| Ultrasonography | \$10 | 25% |
| Echocardiogram/ Echo Doppler | \$25 | 25% |
| CT Scans | \$25 | 25% |
| Nuclear Medicine | \$50 | 25% |
| Nuclear Stress Test | \$50 | 25% |
| MRI | \$100 | 25% |
| MRA | \$100 | 25% |
| PET Scan | \$100 | 25% |

PFFS and PPO PLANS

| | Physician Office/ Freestanding Center | Hospital |
|---------------------------------|--|----------|
| Bone Density | \$0 | \$0 |
| Simple X-Rays | \$5 | 25% |
| Ultrasonography | \$10 | 25% |
| Echocardiogram/ Echo Doppler | \$25 | 25% |
| CT Scans | \$25 | 25% |
| Nuclear Medicine | \$25 | 25% |
| Nuclear Stress Test | \$50 | 25% |
| MRI | 10% | 25% |
| MRA | 10% | 25% |
| PET Scan | 10% | 25% |



2011 Benefit Comparison for Nevada Plans

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| Plan Name | IMPORTANT INFORMATION | | | | | INPATIENT CARE | | | | OUTPATIENT CARE | | | | | | | | | | OUTPATIENT MEDICAL SERVICES & SUPPLIES | | | | | | | | | | PREVENTIVE SERVICES | | | | | DENTAL BENEFITS | | HEARING SERVICES | | | VISION SERVICES | | | | | OTHER BENEFITS | | | | | | | | | | | | |
|---|-----------------------|-----------------|--|------------|----------|--|---|--------------------------|------------------|----------------------|----------------|-----------------------|-------------------|-------------------------------|----------------------------|---------------------------------|----------------|--------------------|----------------|--|--|---|---------------------------|-------------------------|-----------------------------------|------------------------------|--|------------------------------|--------------------------|---------------------|-------------------------------|-----------------------|-------------------------------|---------------------|-------------------------------|---------------------|-------------------------------|---|---|-----------------|---|---|--|------------------------------|--|--|-------------------------------|--|---|-------------------------------|-------------------------------|---|-------------------|-------------------------------|-----|-----------------------|---|
| | Plan Premium | Part B Buy Down | Out-of-Pocket Max | Deductible | Referral | Inpatient Hospital Care | Inpatient Mental Health Care | Skilled Nursing Facility | Home Health Care | DOCTOR OFFICE VISITS | | Chiropractic Services | Podiatry Services | Outpatient Mental Health Care | Outpatient Substance Abuse | OUTPATIENT SERVICES | | Ambulance Services | Emergency Care | Worldwide Coverage Benefit | Urgently Needed Care | Outpatient Rehab: Occupational Therapy; Physical Therapy; Speech & Language Therapy | Durable Medical Equipment | Prosthetic Devices | Diabetes Self-Monitoring Training | Diabetes Supplies | DIAGNOSTIC TESTS, X-RAYS, & LAB SERVICES | | | | | Bone Mass Measurement | Colorectal Screening Exams | Immunizations | Pneumo Vaccine | Mammograms | Pap Smears & Pelvic Exams | Prostate Cancer Screening | Renal Dialysis | Dental Benefit | Medicare-Covered Exam | Routine Hearing Test | Hearing Aids Benefit | After Surgery | Dx Treatment | Routine Exam | Lenses, Frames & Contacts | Progressive Lenses | Photochromic Lenses (i.e., Transitions) | Glaucoma Screening | Physical Exams | Cardiac Rehab Services | Smoking Cessation | Gym Membership | POS | | |
| | | | | | | | | | | PCP | Specialist | | | | | Ambulatory Surgery Center (ASC) | Hospital | | | | | | | | | | Basic X-Ray/Radiology | Radiation Therapy | Advanced X-Ray/Radiology | Blood Lab Services | Pathology | | | | | | | | | | | | | | | | | | | | | | | | | Basic X-Ray/Radiology | Radiation Therapy |
| HMO-POS Medicare Masterpiece [®] NV H6705-001 HMO-POS | \$0 | \$20 | \$3400 | \$0 | No | \$200 Days 1-7 No limit to hospital days | \$100 Days 11-100 | \$0 | \$5 | \$30 | \$30 | \$30 | \$30 | \$30 | 10% | 25% | \$125 | \$50 | No Maximum | \$10 | \$30; 25% in Outpatient Hospital | 20% | 20% | \$0 | \$0 | \$0-\$100 or 0-25% | 20% | \$0-\$100 or 0-25% | \$0 | \$0 | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 20% | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$30 | \$10; 1/yr | \$0 co-pay; \$250 limit 1/yr | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery | \$30 | \$0; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr | \$0; 1/yr | \$30; 25% Outpatient Hospital | Yes | 0% | POS at same co-pay for all services; \$50K limit on OON |
| PPO Universal PPO H8319-001 PPO MA-PD | \$0 | \$0 | \$6700 IN & OON | \$0 | No | \$269 Days 1-6 IN & OON No limit to hospital days | \$299 Days 1-6 IN & OON \$50 Days 1-20; \$128 Days 21-100 IN & OON | \$0; 30% OON | \$15; \$30 OON | \$30; \$40 OON | \$30; \$40 OON | \$30; \$40 OON | \$30; \$40 OON | \$30; \$40 OON | 10% IN & OON | 25% IN & OON | \$125 IN & OON | \$50 | No Maximum | \$10 | \$30; 25% in Outpatient Hospital; IN & OON | 20%; 25% OON | 20%; 25% OON | 0%; 30% OON | 20%; 30% OON | \$0-\$50 or 0%-25%; IN & OON | 20%; IN & OON | \$0-\$50 or 0%-25%; IN & OON | \$0; 30% OON | \$0; 30% OON | Outpatient Hospital; IN & OON | 25% | Outpatient Hospital; IN & OON | 25% | Outpatient Hospital; IN & OON | 25% | Outpatient Hospital; IN & OON | 20%; 30% OON | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$30; 30% OON | \$10; 30% OON; 1/yr | \$0 co-pay; \$250 limit 1/yr; 30% OON | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery; 30% OON | \$30; 30% OON | \$0; 30% OON; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr; IN & OON | \$0; 1/yr; IN & OON | \$30; 25% Outpatient Hospital; IN & OON | Yes | \$0 | N/A | | |
| Network PFFS Any, Any, Any [®] Gold H8098-001 PFFS MA-PD | \$0 | \$40 | \$6700 IN & OON | \$0 | No | \$269 Days 1-6 No limit to hospital days | \$299 Days 1-6 \$50 Days 1-20; \$128 Days 21-100 | \$0 | \$15 | \$40 | \$20 | \$40 | \$40 | \$40 | 10% | 25% | \$125 | \$50 | No Maximum | \$15 | \$40; 25% in Outpatient Hospital | 20% | 20% | \$0 (mail order) or 20% | \$0-\$50 or 0%-25% | 20% | \$0-\$50 or 0%-25% | 5% | 5% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 20% | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$40 | \$40; 1/yr | N/A | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery | \$40 | \$0; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr | \$0; 1/yr | \$40; 25% Outpatient Hospital | Yes | \$0 | N/A | | | |
| Any, Any, Any[®] Gold MA-Only H8098-003 PFFS MA-Only | \$0 | \$60 | The limit includes Medicare-covered Parts A & B services only. | \$0 | No | \$269 Days 1-6 No limit to hospital days | \$299 Days 1-6 \$50 Days 1-20; \$128 Days 21-100 | \$0 | \$15 | \$40 | \$20 | \$40 | \$40 | \$40 | 10% | 25% | \$125 | \$50 | No Maximum | \$15 | \$40; 25% in Outpatient Hospital | 20% | 20% | \$0 (mail order) or 20% | \$0-\$50 or 0%-25% | 20% | \$0-\$50 or 0%-25% | 5% | 5% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 20% | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$40 | \$40; 1/yr | N/A | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery | \$40 | \$0; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr | \$0; 1/yr | \$40; 25% Outpatient Hospital | Yes | \$0 | N/A | | | |
| Any, Any, Any[®] Platinum H8098-009 PFFS MA-PD | \$69 | \$0 | The limit includes Medicare-covered Parts A & B services only. | \$0 | No | \$1000/stay No limit to hospital days | \$1000/stay | \$0 | \$10 | \$30 | \$30 | \$30 | \$30 | \$30 | 10% | 25% | \$100 | \$50 | No Maximum | \$10 | \$30; 25% in Outpatient Hospital | 20% | 20% | 20% | \$0-\$50 or 0%-25% | 20% | \$0-\$50 or 0%-25% | 5% | 5% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 20% | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$30 | \$30; 1/yr | \$30 | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery | \$30 | \$0; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr | \$0; 1/yr | \$30; 25% Outpatient Hospital | Yes | \$0 | N/A | | | |
| Nonnetwork PFFS Any, Any, Any [®] Gold Plan A H5820-002 PFFS MA-PD | \$0 | \$25 | The limit includes Medicare-covered Parts A & B services only. | \$0 | No | \$269 Days 1-6 No limit to hospital days | \$299 Days 1-6 \$50 Days 1-20; \$128 Days 21-100 | \$0 | \$15 | \$40 | \$20 | \$40 | \$40 | \$40 | 10% | 25% | \$125 | \$50 | No Maximum | \$15-\$40 (PCP or SCP co-pay) | \$40; 25% Outpatient Hospital | 20% | 20% | \$0 | 20% | \$0-\$50 or 0%-25% | 20% | \$0-\$50 or 0%-25% | 5% | 5% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 20% | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$40 | \$40; 1/yr | N/A | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery | \$40 | \$0; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr | \$0; 1/yr | \$40; 25% Outpatient Hospital | Yes | \$0 | N/A | | |
| Any, Any, Any[®] Gold Plan B H5820-011 PFFS MA-PD | \$0 | \$0 | \$6700 IN & OON | \$0 | No | \$269 Days 1-6 No limit to hospital days | \$299 Days 1-6 \$50 Days 1-20; \$128 Days 21-100 | \$0 | \$15 | \$40 | \$20 | \$40 | \$40 | \$40 | 10% | 25% | \$125 | \$50 | No Maximum | \$15-\$40 (PCP or SCP co-pay) | \$40; 25% Outpatient Hospital | 20% | 20% | \$0 | 20% | \$0-\$50 or 0%-25% | 20% | \$0-\$50 or 0%-25% | 5% | 5% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 20% | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$40 | \$40; 1/yr | N/A | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery | \$40 | \$0; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr | \$0; 1/yr | \$40; 25% Outpatient Hospital | Yes | \$0 | N/A | | |
| Any, Any, Any[®] Gold MA-Only Plan A H5820-026 PFFS MA-Only | \$0 | \$45 | The limit includes Medicare-covered Parts A & B services only. | \$0 | No | \$269 Days 1-6 No limit to hospital days | \$299 Days 1-6 \$50 Days 1-20; \$128 Days 21-100 | \$0 | \$15 | \$40 | \$20 | \$40 | \$40 | \$40 | 10% | 25% | \$125 | \$50 | No Maximum | \$15-\$40 (PCP or SCP co-pay) | \$40; 25% Outpatient Hospital | 20% | 20% | \$0 | 20% | \$0-\$50 or 0%-25% | 20% | \$0-\$50 or 0%-25% | 5% | 5% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 20% | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$40 | \$40; 1/yr | N/A | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery | \$40 | \$0; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr | \$0; 1/yr | \$40; 25% Outpatient Hospital | Yes | \$0 | N/A | | |
| Any, Any, Any[®] Gold - MA-Only Plan B H5820-029 PFFS MA-Only | \$0 | \$20 | The limit includes Medicare-covered Parts A & B services only. | \$0 | No | \$269 Days 1-6 No limit to hospital days | \$299 Days 1-6 \$50 Days 1-20; \$128 Days 21-100 | \$0 | \$15 | \$40 | \$20 | \$40 | \$40 | \$40 | 10% | 25% | \$125 | \$50 | No Maximum | \$15-\$40 (PCP or SCP co-pay) | \$40; 25% Outpatient Hospital | 20% | 20% | \$0 | 20% | \$0-\$50 or 0%-25% | 20% | \$0-\$50 or 0%-25% | 5% | 5% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 20% | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$40 | \$40; 1/yr | N/A | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery | \$40 | \$0; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr | \$0; 1/yr | \$40; 25% Outpatient Hospital | Yes | \$0 | N/A | | |
| Any, Any, Any[®] Platinum H5820-008 PFFS MA-PD | \$69 | \$0 | The limit includes Medicare-covered Parts A & B services only. | \$0 | No | \$1000/stay No limit to hospital days | \$1000/stay | \$0 | \$10 | \$30 | \$30 | \$30 | \$30 | \$30 | 10% | 25% | \$100 | \$50 | No Maximum | \$10-\$30 (PCP or SCP co-pay) | \$30; 25% Outpatient Hospital | 20% | 20% | \$0 | 20% | \$0-\$50 or 0%-25% | 20% | \$0-\$50 or 0%-25% | 5% | 5% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 25% | Outpatient Hospital | 20% | \$0 Oral Exam; \$0 Routine Cleaning 2/yr; \$0 Fluoride; \$0-\$75 Dental X-Ray | \$30 | \$30; 1/yr | \$30 | \$10 co-pay for 1 pair of eyeglasses or contact lenses after cataract surgery | \$30 | \$0; 1/yr | \$10 co-pay for up to 1 pair of glasses every year, if combined with new frame | \$10 co-pay for lenses | 20% discount on amount >\$100 | \$50 | \$0; 1/yr | \$0; 1/yr | \$30; 25% Outpatient Hospital | Yes | \$0 | N/A | | |