2010 Any, Any, Any Fee Schedule (Member Co-Pay)			
Benefit Description	**Gold Plan H5820-002, H5820-003 H5820-004, H5820-011**	**Platinum Plan H5820-088, H5820-009 H5820-010, H5820-013**	**Gold MA Only Plan H5820-026, H5820-027 H5820-028,H5820-029**
Out-of-Pocket Maximum	$3400 in Network; The limit includes Medicare covered Part A & B services only	$3400 in Network; The limit includes Medicare covered Part A & B services only	$3400 in Network; The limit includes Medicare covered Part A & B services only
Yearly Deductible	$0	$0	$0
Inpatient Hospital Care	$300 co-pay days 1-7; $275 days 1-7 w/prior notification	$900/ stay; $800 stay w/prior notification	$300 co-pay days 1-7; $275 days 1-7 w/prior notification
Inpatient Mental Health Care	$300 co-pay days 1-7; $275 days 1-7 w/prior notification	$900/ stay; $800 stay w/prior notification	$300 co-pay days 1-7; $275 days 1-7 w/prior notification
Skilled Nursing Facility	$150 days 6-20; $125 days 6-20 w/prior notification	$150 days 6-20; $100 days 6-20 w/prior notification	$150 days 6-20; $125 days 6-20 w/prior notification
Home Health Care	$20 co-pay per visit	$10 co-pay per visit	$20 co-pay per visit
Hospice	Medicare Certified	Medicare Certified	Medicare Certified
Doctor Office Visits	$15 co-pay per visit	$10 co-pay per visit	$15 co-pay per visit
Specialist Office Visits	$40 co-pay per visit	$30 co-pay per visit	$40 co-pay per visit
Chiropractic Services	$40 co-pay per visit	$30 co-pay per visit	$40 co-pay per visit
Podiatry Services	$40 co-pay per visit	$30 co-pay per visit	$40 co-pay per visit
Outpatient Mental Health Care	$40 co-pay per visit	$30 co-pay per visit	$40 co-pay per visit
Outpatient Substance Abuse - Individual or Group Therapy	$40 co-pay per visit	$30 co-pay per visit	$40 co-pay per visit
Cardiac Rehabilitation Services	$40 co-pay or 20% of the total cost in an outpatient hospital; 25% co-pay in a Comprehensive Outpatient Rehabilitation Facility	$30 co-pay or 20% of the total cost in an outpatient hospital; 25% co-pay in a Comprehensive Outpatient Rehabilitation Facility	$40 co-pay or 20% of the total cost in an outpatient hospital; 25% co-pay in a Comprehensive Outpatient Rehabilitation Facility
Outpatient Services – Ambulatory Surgery Center (ASC)	10% co-pay per visit	10% co-pay per visit	10% co-pay per visit
Ambulance Services	$125	$100	$125
Emergency Care	$50 co-pay; $30,000 limit for "emergency services only" outside the U.S. every year	$50 co-pay; $30,000 limit for "emergency services only" outside the U.S. every year	$50 co-pay; $30,000 limit for "emergency services only" outside the U.S. every year
Urgently Needed Care	$15-$40; (PCP or SCP co-pay)	$10-$30; (PCP or SCP co-pay)	$15-$40; (PCP or SCP co-pay)
Outpatient Rehab – Occupational Therapy, Physical, Speech & Language Therapy	$40 co-pay; 20% in Comprehensive Outpatient Rehab Facility; 25% in Outpatient Hospital	$30 co-pay; 20% in Comprehensive Outpatient Rehab Facility; 25% in Outpatient Hospital	$40 co-pay; 20% in Comprehensive Outpatient Rehab Facility; 25% in Outpatient Hospital
Durable Medical Equipment	20% co-pay	20% co-pay	20% co-pay
Prosthetic Devices	20% co-pay	20% co-pay	20% co-pay
Diabetes Self-Monitoring Training	$0 co-pay	$0 co-pay	$0 co-pay
Diabetes Nutrition Therapy	$40 co-pay per visit	$30 co-pay per visit	$40 co-pay per visit

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Benefit Description	**Gold Plan** **H5820-002, H5820-003** **H5820-004, H5820-011**	**Platinum Plan** **H5820-088, H5820-009** **H5820-010, H5820-013**	**Gold MA Only Plan** **H5820-026, H5820-027** **H5820-028,H5820-029**
Diabetes Supplies	20% co-pay	20% co-pay	20% co-pay
Outpatient Services – Hospital	25% co-pay	25% co-pay	25% co-pay
Glaucoma Screening	$0 co-pay (1 per year)	$0 co-pay (1 per year)	$0 co-pay (1 per year)
Basic X-ray/ Radiology	$5 co-pay	$5 co-pay	25%
Radiation Therapy	20% co-pay	20% co-pay	20% co-pay
Advanced X-ray/ Radiology	$0-$50 or 0%-25% of the total cost	$0-$50 or 0%-25% of the total cost	$0-$50 or 0%-25% of the total cost
Blood – Pathology – Lab Services	5%-25% co-pay	5%-25% co-pay	5%-25% co-pay
Bone Mass Measurement	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital
Colorectal Screening Exams	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital
Immunizations	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital
Pneumonia Vaccine	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital
Mammograms	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital
Pap Smears and Pelvic Exams	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital
Prostate Cancer Screening	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital	$0; 20% Outpatient Hospital
Physical Exams	$0 co-pay (1 per year)	$0 co-pay (1 per year)	$0 co-pay (1 per year)
ESRD Renal Dialysis	20% co-pay	20% co-pay	20% co-pay
ESRD Nutrition Therapy	$40 co-pay per visit	$30 co-pay per visit	$40 co-pay per visit
Dental Benefits	$0 Oral Exam (1 per year) $0 Routine Cleaning (2 per year) $0 Fluoride (1 per year) $0-$75 Dental X-Ray (1 per year)	$0 Oral Exam (1 per year) $0 Routine Cleaning (2 per year) $0 Fluoride (1 per year) $0-$75 Dental X-Ray (1 per year)	$0 Oral Exam (1 per year) $0 Routine Cleaning (2 per year) $0 Fluoride (1 per year) $0-$75 Dental X-Ray (1 per year)
Hearing – Routine Exam	$40 co-pay per visit (1 per year)	$30 co-pay per visit (1 per year)	$40 co-pay per visit (1 per year)
Hearing – Diagnostic & Treatment	$40 co-pay per visit	$30 co-pay per visit	$40 co-pay per visit
Hearing Aids	N/A	N/A	N/A
Vision – Routine Exam	$0 co-pay (1 per year)	$0 co-pay (1 per year)	$0 co-pay (1 per year)
Vision – Diagnostic & Treatment	$40 co-pay per visit	$30 co-pay per visit	$40 co-pay per visit
Vision – Lenses, Frames, Contacts after surgery	$10 co-pay for one pair of glasses or contacts after cataract surgery	$10 co-pay for one pair of glasses or contacts after cataract surgery	$10 co-pay for one pair of glasses or contacts after cataract surgery

2010 Any, Any, Any Fee Schedule (Member Co-Pay)			
Benefit Description	**Gold Plan** **H5820-002, H5820-003** **H5820-004, H5820-011**	**Platinum Plan** **H5820-088, H5820-009** **H5820-010, H5820-013**	**Gold MA Only Plan** **H5820-026, H5820-027** **H5820-028,H5820-029**
Vision – Lenses, Frames, Contacts	$10 co-pay for up to 1 pair of glasses every year; If combined with new frames no co-pay for lenses; In lieu of glasses $10 co-pay for up to 1 pair of contacts every year; $100 limit for eye wear every year	$10 co-pay for up to 1 pair of glasses every year; If combined with new frames no co-pay for lenses; In lieu of glasses $10 co-pay for up to 1 pair of contacts every year; $100 limit for eye wear every year	$10 co-pay for up to 1 pair of glasses every year; If combined with new frames no co-pay for lenses; In lieu of glasses $10 co-pay for up to 1 pair of contacts every year; $100 limit for eye wear every year
Progressive Lenses	$50 co-pay; Max Annual Limit $100; 20% discount on amount >$100	$50 co-pay; Max Annual Limit $100; 20% discount on amount >$100	$50 co-pay; Max Annual Limit $100; 20% discount on amount >$100
Photochromic Lenses (e.g. Transitions)	$50 co-pay	$50 co-pay	$50 co-pay
Tint, Scratch Coat, Polycarb, UV, AR, and LASIK	15% discount pricing	15% discount pricing	15% discount pricing
Smoking Cessation	Included at no additional cost	Included at no additional cost	Included at no additional cost
Gym Membership	Included at no additional cost	Included at no additional cost	Included at no additional cost
World Wide Coverage Benefit (to point of stabilization)	$30,000 max per year	$30,000 max per year	$30,000 max per year
Prescription Drugs Deductible	$0	$0	N/A
Initial Coverage Limit	After the total yearly drug costs (both what you and the plan paid) reach $2,830, you will pay 100% of subsequent drug costs until your yearly out-of-pocket drug costs reach $4,550. After that you will pay a maximum of only 5% of drug costs for the rest of the year	After the total yearly drug costs (both what you and the plan paid) reach $2,830, you will pay 100% of subsequent drug costs until your yearly out-of-pocket drug costs reach $4,550. After that you will pay a maximum of only 5% of drug costs for the rest of the year	N/A
Tier 1 - Value Generics	$4 co-pay	$2 co-pay	N/A
Tier 2 - Generics	$10 co-pay	$7 co-pay	N/A
Tier 3 - Preferred Brands	$35 co-pay	$30 co-pay	N/A
Tier 4 - Non-Preferred Brands	$70 co-pay	$60 co-pay	N/A
Tier 5 - Specialty Drugs	33% co-pay	33% co-pay	N/A
Mail Order:	3 Months for 2 co-pays	3 Months for 2 co-pays	N/A

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