

2009 Any, Any, Any Fee Schedule

Benefit Description	Gold MA-PD Plan H5820-002, H5820-003 H5820-004, H5820-011	Platinum MA-PD Plan H5820-008, H5820-009 H5820-010, H5820-013	Gold MA-ONLY Plan H5820-026, H5820-027 H5820-028, H5820-029
Out-of-Pocket Maximum	\$3,350	\$3,350	\$3,250
Yearly Deductible	\$0	\$0	\$0
Inpatient Hospital Care	\$300 co-pay per day (Days 1-7)	\$150 co-pay per day (Days 1-5)	\$300 co-pay per day (Days 1-7)
Inpatient Mental Health Care	\$300 co-pay per day (Days 1-7)	\$150 co-pay per day (Days 1-5)	\$300 co-pay per day (Days 1-7)
Skilled Nursing Facility	\$150 co-pay per day (Days 6-20)	\$150 co-pay per day (Days 6-20)	\$150 co-pay per day (Days 6-20)
Home Health Care	\$10 co-pay per visit	\$5 co-pay per visit	\$10 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	\$35 co-pay per visit	\$25 co-pay per visit	\$35 co-pay per visit
Chiropractic Services	\$35 co-pay per visit	\$25 co-pay per visit	\$35 co-pay per visit
Podiatry Services	\$35 co-pay per visit	\$25 co-pay per visit	\$35 co-pay per visit
Outpatient Mental Health Care	\$35 co-pay per visit	\$25 co-pay per visit	\$35 co-pay per visit
Outpatient Substance Abuse - Individual or Group Therapy	\$35 co-pay per visit	\$25 co-pay per visit	\$35 co-pay per visit
Cardiac Rehabilitation Services	\$35 co-pay per visit	\$25 co-pay per visit	\$35 co-pay per visit
Outpatient Services – Ambulatory Surgery Center (ASC)	\$50 co-pay per visit	\$25 co-pay per visit	\$50 co-pay per visit
Ambulance Services	\$125 co-pay	\$125 co-pay	\$125 co-pay
Emergency Care	\$50 co-pay per visit	\$50 co-pay per visit	\$50 co-pay per visit
Urgently Needed Care	\$15-\$35 co-pay per visit	\$10-\$25 co-pay per visit	\$15-\$35 co-pay per visit
Outpatient Rehab – Occupational Therapy	\$35 co-pay per visit	\$25 co-pay per visit	\$35 co-pay per visit
Outpatient Rehab – Physical, Speech & Language Therapy	\$35 co-pay per visit	\$25 co-pay per visit	\$35 co-pay per visit
Durable Medical Equipment	20% co-pay	20% co-pay	20% co-pay

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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	\$35 co-pay	\$25 co-pay	\$35 co-pay
Diabetes Supplies	20% co-pay	20% co-pay	20% co-pay
Outpatient Services – Hospital	\$200 co-pay	\$100 co-pay	\$200 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 to \$50 co-pay	\$0 to \$25 co-pay	\$5 to \$50 co-pay
Radiation Therapy	20% co-pay	20% co-pay	20% co-pay
Advanced X-ray/ Radiology	\$10 to \$200 co-pay	\$0 to \$200 co-pay	\$0 to \$200 co-pay
Blood – Pathology – Lab Services	5% co-pay	5% co-pay	5% co-pay
Bone Mass Measurement	\$0 co-pay	\$0 co-pay	\$0 co-pay
Colorectal Screening Exams	\$0 co-pay	\$0 co-pay	\$0 co-pay
Immunizations	\$0 co-pay	\$0 co-pay	\$0 co-pay
Pneumonia Vaccine	\$0 co-pay	\$0 co-pay	\$0 co-pay
Mammograms	\$0 co-pay	\$0 co-pay	\$0 co-pay
Pap Smears and Pelvic Exams	\$0 co-pay	\$0 co-pay	\$0 co-pay
Prostate Cancer Screening	\$0 co-pay	\$0 co-pay	\$0 co-pay
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	\$35 co-pay	\$25 co-pay	\$35 co-pay
Dental Benefits	\$0 Oral Exam (1 per year) \$0 Routine Cleaning (1 per year) \$0 Fluoride (1 per year) \$0-\$75 Dental X-Ray (every 2 yrs.)	\$0 Oral Exam (1 per year) \$0 Routine Cleaning (2 per year) \$0 Fluoride (1 per year) \$0-\$75 Dental X-Ray (every 2 yrs.)	\$0 Oral Exam (1 per year) \$0 Routine Cleaning (1 per year) \$0 Fluoride (1 per year) \$0-\$75 Dental X-Ray (every 2 yrs.)

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Hearing – Routine Exam	\$30 co-pay	\$20 co-pay	\$30 co-pay
Hearing – Diagnostic & Treatment	\$30 co-pay	\$20 co-pay	\$30 co-pay
Hearing Aids	N/A	N/A	N/A
Vision – Routine Exam	\$30 co-pay (1 per year)	\$15 co-pay (1 per year)	\$30 co-pay (1 per year)
Vision – Diagnostic & Treatment	\$30 co-pay	\$15 co-pay	\$30 co-pay
Vision – After Surgery	\$30 co-pay	\$15 co-pay	\$30 co-pay
Vision – Lenses, Frames, Contacts	\$30 co-pay for one pair of glasses or contacts after cataract surgery	\$15 co-pay for one pair of glasses or contacts after cataract surgery	\$30 co-pay for one pair of glasses or contacts after cataract surgery
Vision – Lenses, Frames, Contacts	N/A	\$15 co-pay (\$100 per year total)	N/A
Smoking Cessation	\$0 co-pay	\$0 co-pay	\$0 co-pay
Gym Membership	\$0 co-pay	\$0 co-pay	\$0 co-pay
World Wide Coverage Benefit	\$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	\$2,700	\$2,700	N/A
Tier 1 – Generics	\$4 co-pay	\$0 co-pay	N/A
Tier 2 – Preferred Brands	\$30 co-pay	\$25 co-pay	N/A
Tier 3 – Non-Preferred Brands	\$60 co-pay	\$60 co-pay	N/A
Tier 4 – Specialty Drugs	33% co-pay	33% co-pay	N/A