

SUMMARY OF BENEFITS 2011

Important Information

| | <i>Original Medicare</i> | <i>Health Care Plan</i> |
|---|--|--|
| Premium | * You pay the Medicare Part B premium of \$96.40 each month. | * You pay \$134.00 per month * You also continue to pay the Medicare Part B premium of \$96.40 each month. |
| Doctor and Hospital Choice. (For more information, see Emergency and Urgently Needed Care.) | * You may go to any doctor, specialist, or hospital that accepts Medicare. | In most cases: * You must go to network doctors, specialists, and hospitals. * You need a referral to go to network specialists. |

Summary of Benefits

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|--------------------------------------|---|--|
| Doctor Office Visits | <ul style="list-style-type: none"> * You pay 20% of Medicare approved amounts. (1) (2) * If your coverage to Medicare Part B begins on or after January 1, 2006 you may receive a one-time physical exam within the first six months of your new Part B coverage. This will not include lab tests. Please contact your physician for further details. | <ul style="list-style-type: none"> * You pay nothing for each primary care doctor office visit for Medicare-covered benefits. * You pay nothing for each specialist visit for Medicare-covered benefits. * See Routine Physical Exams for more information. |
| Outpatient Mental Health Care | <ul style="list-style-type: none"> * 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) | <ul style="list-style-type: none"> * You pay nothing for each individual visit for Medicare-covered benefits. * You pay nothing for each group visit for Medicare-covered benefits. |

- 1 Each year, you pay a total of one \$155 Deductible.
- 2 If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
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| Outpatient Substance Abuse Care | <p>* You pay 20% of Medicare approved amounts. (1) (2)</p> | <p>* You pay nothing for each individual visit for Medicare-covered benefits.</p> <p>* You pay nothing for each group visit for Medicare-covered benefits.</p> |
| Outpatient Surgery | <p>* You pay 20% of Medicare approved amounts for the doctor (1) (2)</p> <p>And</p> <p>* You pay 20% of outpatient facility charges. (1) (2)</p> | <p>* You pay nothing for each Medicare-covered visit to an ambulatory surgical center.</p> <p>* You pay nothing for each Medicare-covered visit to an outpatient hospital facility.</p> |

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| <p>Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p> | <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 1-3 days of the emergency room visit. (1) (2)</p> <p>And</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 nothing for each Medicare-covered emergency room visit.</p> <p>* NOT covered outside the U.S. except under limited circumstances.</p> |

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| <p>Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p> | <p>* You pay 20% of Medicare approved amounts or applicable Copayment. (1) (2)</p> <p>* NOT covered outside the the U.S. except under limited circumstances.</p> | <p>* You pay nothing for Medicare covered urgently needed care.</p> <p>* NOT covered outside the U.S. except under limited circumstances.</p> |
| <p>Ambulance Services</p> <p>(medically necessary ambulance services)</p> | <p>* You pay 20% of Medicare approved amount or applicable fee schedule charge. (1) (2)</p> | <p>* You pay nothing for Medicare-covered ambulance services.</p> |
| <p>Outpatient Medical Services and Supplies</p> | | |
| <p>Durable Medical Equipment</p> <p>(includes wheelchairs, oxym, etc.)</p> | <p>* You pay 20% of Medicare approved amounts. (1) (2)</p> | <p>* You pay nothing for Medicare-covered benefits.</p> |

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| Prosthetic Devices and Medical Supplies (includes pacemakers, braces, artificial limbs and eyes, etc.) | * You pay 20% of Medicare approved amounts. (1) (2) | * You pay nothing for Medicare-covered benefits. |
| Diagnostic Tests X-rays, and Lab Services | * You pay 20% of Medicare amounts, except for approved lab services. (1) (2) * You \$0 for Medicare approved lab services. | * You pay nothing for each Medicare-covered clinical lab service. * You pay nothing for each Medicare-covered diagnostic service. * You pay nothing for each Medicare-covered x-ray visit. |
| Radiation Therapy | * You pay 20% of Medicare approved amounts. (1) (2) | * You pay nothing for each Medicare-covered therapeutic radiological lab service. |

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| <p>Manual Manipulation of the Spine. (to correct subluxation provided by chiropractors or qualified other providers)</p> | <p>* You pay 20% of Medicare approved amounts. (1) (2)</p> | <p>* You pay nothing for Medicare-covered benefits.</p> <p>* (See Chiropractic Services for more information)</p> |
| <p>Medically Necessary Foot Care (includes care for medical conditions affecting the lower limbs, including routine foot care)</p> | <p>* You pay 20% of Medicare approved amounts. (1) (2)</p> | <p>* You pay nothing for Medicare-covered benefits.</p> <p>*(See Podiatry Services for more information.)</p> |

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|---|--|--|
| <p>Outpatient Rehabilitation Services</p> <p>* Occupational Therapy * Physical Therapy * Speech and Language Therapy.</p> | <p>* You pay 20% of Medicare approved amounts. (1) (2)</p> | <p>* You pay nothing for each Medicare-covered Occupational Therapy visit.</p> <p>* You pay nothing for each Medicare-covered Physical Therapy and/or Speech Language Pathology visit.</p> |

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|---|--|---|
| Inpatient Care | | |
| Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services) | * You pay for each benefit period. (3) Days 1-60: an initial deductible of \$1,100.00 Days 61-90: \$275.00 each day Day 91-150: \$550.00 each lifetime reserve days (4) | * You pay nothing for each Medicare-covered stay in a network hospital. * You pay nothing for each Medicare-covered day in a network hospital. * You pay 100% per day for each additional day beyond 150 days for each benefit period in a network hospital. * You are covered for 150 days each benefit period. |

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- 4 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 benefit limit to the number of benefit periods you can have. Lifetime reserve days can only be used once.

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| Inpatient Mental Health Care | * You pay the same initial deductible and Copayments as inpatient hospital care (above) except there is a 190 day lifetime limit in a psychiatric hospital. | * You pay nothing for each Medicare-covered hospital stay for days 1-190. * You pay nothing for each Medicare-covered hospital day for days 1-190. * There is a 190-day lifetime limit in a psychiatric hospital. |

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| <p>Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p> | <p>* You pay for each benefit period, following at least a 3-day covered hospital stay:</p> <p>Days 1-20: \$0 for each day</p> <p>Days 21-100: \$137.50 for each day</p> <p>* There is a limit of 100 days for each benefit period. (3)</p> | <p>* You pay nothing each day for days 1-20 each benefit period for Medicare-covered services</p> <p>AND</p> <p>* You pay nothing each day for days 21-100 each benefit period for Medicare-covered services.</p> <p>* You pay 100% for each additional day beyond 100 days each benefit period.</p> <p>* You pay 100% for each non-Medicare-covered stay.</p> <p>* There is a limit of 100 days for each benefit period.</p> <p>* 3-day prior hospital stay is required.</p> |

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4 A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have 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 benefits periods you can have.

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| <p>Home Health Care (included medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p> | <p>* You pay \$0 for all covered home health visits.</p> | <p>* You pay nothing for Medicare-covered home health visits.</p> <p>* You pay 100% for Custodial care.</p> <p>* You pay 100% for Respite Care.</p> <p>* You pay 100% for Homemaker services.</p> |
| <p>Hospice</p> | <p>* You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>AND</p> <p>* You must receive care from any Medicare-certified hospice.</p> | <p>You may receive care from any Medicare-certified hospice.</p> |

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| Preventive Services | | |
| Annual Screening Mammograms (for women with Medicare age 40 and older) | * You pay 20% of Medicare approved amounts. (2) * No referral necessary for Medicare-covered screenings. | * You pay nothing for Medicare-covered benefits. * You need a referral for each additional screening; no referral necessary for Medicare-covered screenings. |
| Pap Smears and Pelvic Exams (for women with Medicare) | * You pay \$0 for the Pap Smear once every 2 years, annually if high risk. (2) * You pay 20% of Medicare approved amounts for Pelvic Exam. (2) | * You pay nothing for a Medicare-covered Pap Smear. * You pay nothing for a Medicare-covered Pelvic Exam. * No referral necessary for network primary care providers. |

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| <p>Bone Mass Measurement (for people with Medicare who are at risk)</p> | <p>* You pay 20% of Medicare approved amounts. (1) (2)</p> | <p>* You pay nothing for Medicare-covered Bone Mass measurements.</p> <p>* No referral necessary for network primary care providers.</p> |
| <p>Colorectal Screening Exams (for people with Medicare age 50 and older)</p> | <p>* You pay 20% of Medicare approved amounts. (1) (2)</p> | <p>* You pay nothing for Medicare-covered screenings.</p> <p>* No referral necessary for network primary care providers.</p> |

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| <p>Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p> | <p>* You pay \$0 for approved lab services and 20% of Medicare approved amounts for other related services. (2)</p> | <p>* You pay nothing for Medicare-covered exams.</p> <p>* No referral necessary for network primary care providers.</p> |
| <p>Diabetes Monitoring (includes coverage for glucose monitors, test strips, lancets, and self-management training)</p> | <p>* You pay 20% of Medicare approved amounts. (1) (2)</p> | <p>* You pay nothing for Medicare-covered benefits.</p> <p>* No referral necessary for network primary care providers.</p> |

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| <p>Immunizations</p> <p>Pneumococcal pneumonia vaccine</p> <p>Flu vaccine</p> <p>Hepatitis B vaccine (for beneficiaries who are at risk)</p> | <p>* You pay \$0</p> <p>* You may only need the pneumococcal vaccine once in your lifetime. Please contact your doctor for further details.</p> <p>* You pay \$0</p> <p>* You pay 20% of Medicare approved amounts. (1)</p> | <p>* No referral necessary for network primary care providers for other immunizations.</p> <p>* You pay nothing for the Pneumococcal pneumonia vaccine.</p> <p>* You pay nothing for the Influenza vaccine.</p> <p>* No referral necessary for Influenza vaccine.</p> <p>* You pay nothing for the Hepatitis B vaccine.</p> |

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| Additional Benefits (What Original Medicare Does NOT Cover) | | |
| Outpatient Prescription Drugs (Drugs that are covered by Original Medicare do NOT count toward your plan prescription drug limit. | * You pay 100% for most prescription drugs. | * You pay 100% for non-Medicare covered prescription drugs. |
| Routine Physical Exams | * You pay 100% for routine physical exams | * You pay nothing for each exam every calendar year. |
| Vision Services | * You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. (1) (2) * You pay 20% of medicare approved amounts for diagnosis and treatment for diseases and conditions of the eye. (1) (2) * You pay 100% for routine eye exams and glasses. | * You pay nothing for medicare-covered eyewear. * You pay nothing for a medicare-covered eye exam. * You 100% for Non-Medicare eye exams and glasses. |

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| Vision Services (cont.) | *For people with Medicare who are at risk, you are covered for an annual glaucoma screening. (1) (2) | * You pay nothing for a medicare-covered eye exam. |
| Dental Services | * In general, you pay 100% for dental services. | * In general, you pay 100% for non-Medicare-covered dental services. |
| Hearing Services | <p>* You pay 100% for routine hearing exams and hearing aids.</p> <p>* You pay 20% for diagnostic hearing exams. (1) (2)</p> | <p>* In general, you pay 100% for routine hearing exams and hearing aids.</p> <p>* You pay nothing for diagnostic hearing exams.</p> |

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| Acupuncture | * You pay 100% | * You pay 100% |
| Chiropractic Services (Routine care) | * In general, you pay 100%. | * In general, you pay 100%. |
| Health/Wellness Education | * You pay 100%. | * You pay 100%. |
| Podiatry Services (Routine care) | * In general, you pay 100%. | * In general, you pay 100%. |
| Transportation (Routine)/non-emergency | * In general, you pay 100%. | * In general, you pay 100%. |

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