

Small-Group community rates for new groups 2010



CHECK DESIRED PLAN OPTION

Benefits summary	Keystone 65 HMO	Keystone 65 HMO	Personal Choice 65 PPO ⁴	MedigapSecurity Plan C ⁵ BC4J	Select Option PDP (For retirees only) #991	Select Option PDP (For retirees only) #906
Plan premium (medical only)	<input type="checkbox"/> \$271.80 ¹ H460, #M42, Y, MN	<input type="checkbox"/> \$303.90 ¹ HZ07, #M42, Y, MN	<input type="checkbox"/> \$378.80 ¹ QM54, #M43	<input type="checkbox"/> \$207.65		
Plan premium (medical and Part D) ⁶	<input type="checkbox"/> \$316.50 H460, #E96, Y, MN	<input type="checkbox"/> \$357.20 HZ07, #E97, Y, MN	<input type="checkbox"/> \$420.50 QM54, #E98		<input type="checkbox"/> \$274.95 ³	<input type="checkbox"/> \$326.45 ³
Plan premium (Select Option only)					<input type="checkbox"/> \$67.30	<input type="checkbox"/> \$118.80
Family physician copayment	\$15	\$10	\$25	\$0 ²	Select Option benefits are listed on Page 2	Select Option benefits are listed on Page 2
Specialist copayment	\$40	\$35	\$45	\$0		
Physical, speech and occupational therapy copayment	\$40	\$35	\$45	\$0		
Durable medical equipment	25%	25%	20%	\$0		
Outpatient surgery	\$300 outpatient facility; \$150 ambulatory surgical center	\$200 outpatient facility; \$100 ambulatory surgical center	\$200 per visit	\$0		
Inpatient hospital services (unlimited days each benefit period)	\$225/day, days 1-10; \$2,500 annual maximum	\$150/day, days 1-10; \$1,500 annual maximum	\$600/Medicare-covered admission	\$0		
Skilled nursing facility (100 days per benefit period)	\$0/day, days 1-10; \$100/day, days 11-100.	\$0/day, days 1-10; \$100/day, days 11-100.	\$50/day, days 1-100.	\$0		
Ambulance copayment	\$125	\$100	\$100	\$0		
Emergency room copayment	\$50 (waived if admitted); worldwide coverage	\$50 (waived if admitted); worldwide coverage	\$50 (waived if admitted); worldwide coverage	\$0		
Hearing	\$40/visit; Up to \$500 every 3 calendar years for hearing aids	\$35/visit; Up to \$500 every 3 calendar years for hearing aids	\$45 for Medicare-covered hearing exam	N/A		
Eyewear reimbursement	\$100 every 2 calendar years	\$100 every 2 calendar years	No coverage	N/A		
Dental copayment	\$10 Value Dental	\$10 Value Dental	No coverage	N/A		
Injectables copayment	\$0	\$0	\$0	N/A		

¹ Includes discount drug when "Medical only" is selected.

² For most services.

³ Includes MedigapSecurity Plan C premium.

⁴ Personal Choice 65 PPO: Out of Network – \$500 deductible, 30% coinsurance

⁵ Covers Medicare Part A and Part B deductibles and coinsurance. Rates are subject to change upon Pennsylvania Insurance Department approval.

⁶ These rates do not reflect a late enrollment penalty that some members may incur if they are transferring from non-creditable prescription coverage.

Customer name (please print) _____ CID# (if applicable) _____

Customer email address _____ Desired effective date _____

Group leader signature _____ Today's date _____ Customer phone # _____

Part D drug coverage	Keystone 65 HMO #E96	Keystone 65 HMO #E97	Personal Choice 65 PPO #E98	MedigapSecurity Plan C BC4J	Select Option PDP (For retirees only) #991	Select Option PDP (For retirees only) #906
Deductible	\$150	\$50	\$200	See Select Option	\$0	\$0
Generic copayment	\$5	\$5	\$5		\$5	\$5
Preferred brand copayment	\$30	\$35	\$35		\$30	\$20
Non-preferred brand copayment	\$70	\$75	\$75		\$50	\$40
Initial coverage limit (ICL)	\$2,830	\$2,830	\$2,830		\$2,830	\$2,830
Gap coverage	None	\$5 generic coverage	\$5 generic coverage		None	\$5 generic coverage
TrOOP	\$4,550	\$4,550	\$4,550		\$4,550	\$4,550
Catastrophic coverage	Greater of \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs; or 5% coinsurance	Greater of \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs; or 5% coinsurance	Greater of \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs; or 5% coinsurance		Greater of \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs; or 5% coinsurance	Greater of \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs; or 5% coinsurance
Mail order	2 copayments for 90-day supply	2 copayments for 90-day supply	2 copayments for 90-day supply	1 copayment for 90-day supply	1 copayment for 90-day supply	

This is a comparison summary. For additional benefits, please refer to the Evidence of Coverage (EOC).