

## Plan Year 2010 Medical Plan Comparison

Benefit Category	Self-funded PPO Plan In-network	Health Plan of Nevada Southern Nevada	Hometown Health Plan Northern Nevada
	Amount You Pay	Amount You Pay	Amount You Pay
<b>Medical Plan Deductible</b>	\$725 individual \$1,450 family	No deductible	No deductible
<b>Out-of-Pocket Maximum</b>	\$3,500 per person \$7,000 per family (per <i>plan</i> year)	\$6,200 per person (per <i>calendar</i> year)	\$3,500 per person \$7,000 per family (per <i>calendar</i> year)
<b>Hospital Inpatient Services</b>	\$105 admission copay, plus 20% coinsurance, after deductible	\$200 copay per admission	\$500 copay per day (3 day max copay)
<b>Outpatient Services</b>	20% coinsurance, after deductible	\$50 copay per admission	\$250 copay per admission
<b>Primary Care Visit</b>	\$20 copay	\$15 copay	\$20 copay
<b>Specialist Visit</b>	\$30 copay	\$15 copay	\$30 copay
<b>Urgent Care Visit</b>	\$45 copay	\$15 copay	\$35 copay
<b>Emergency Room Visit</b>	\$70 copay per visit, plus 20% coinsurance, after deductible	\$50 copay, plus \$25 physician copay	\$100 copay per visit (waived if admitted to the hospital)
<b>Routine Laboratory and X-ray Services*</b>	20% coinsurance, after deductible	No charge	No charge
<b>Chiropractic Services</b>	\$30 Copay per visit	\$15 copay per visit	\$30 copay per visit
<b>Wellness/Prevention</b>	0% coinsurance (\$2,500 annual maximum per person, not subject to deductible)	\$15 copay per visit	\$20 copay / PCP visit \$30 copay / specialist visit
<b>Vision Exam</b>	One exam every 12 months paid at 80% of U & C	\$10 copay every 12 months	\$15 copay every 12 months
<b>Hardware (frames, lenses and contacts)</b>	\$125 hardware allowance every 24 months	\$10 copay (lenses) Frames: \$100 allowance/24 mos. Elective contacts \$115 allowance in lieu of lenses/frames	15% to 20% discount

PPO Plan: For single coverage individuals, this plan has a \$725 individual deductible. For coverage of two or more persons, this plan has a \$1,450 family deductible. The family deductible could be met by any combination of eligible medical expenses from *two or more* members of the same family coverage tier. No one single family member would be required to contribute more than the equivalent of the individual deductible toward the family deductible. PPO (in-network) and non-PPO (out-of-network) out-of-pocket maximums are maintained separately. Refer to the *Self-funded PPO Master Plan Document*, or the *HMOs' Evidence of Coverage (EOC)* for more information.

## Plan Year 2010 Pharmacy Plan Comparison

Pharmacy Benefit	Self-funded PPO Plan	Health Plan of Nevada	Senior Dimensions	Hometown Health Plan	Senior Care Plus Plan
	Amount you pay	Amount you pay	Amount you pay	Amount you pay	Amount you pay
<b>Plan Year Deductible</b>	\$50 per person (excludes generics)	None	None	None	None
<b>Retail Pharmacy 30 day supply</b>					
<b>Preferred Generic, Tier 1</b>	\$5 copay no deductible	\$7 copay	\$5 copay	\$7 copay	\$4 copay
<b>Preferred Brand, Tier 2</b>	\$40 copay, after plan year deductible (if no generic equivalent)	\$35 copay (if no generic equivalent)	\$25 copay	\$30 copay	\$40 copay
<b>Non-Preferred Brand, Tier 3</b>	100% of contracted price no deductible	\$55 copay	\$45 copay	\$50 copay	\$70 copay
<b>Specialty Drugs</b>	Higher of \$50 copay or 25% of drug cost (maximum \$100) after plan year deductible	Applicable retail pharmacy copay will apply	25% coinsurance	30% coinsurance (\$2,500 max out-of-pocket per calendar year)	\$100 copay
<b>Mail Order 90 day supply</b>					
<b>Preferred Generic Tier 1</b>	\$15 copay no deductible	\$14 copay	\$5 copay	\$14 copay	\$10 copay
<b>Preferred Brand Tier 2</b>	\$120 copay, after plan year deductible (if no generic equivalent)	\$70 copay (if no generic equivalent)	\$25 copay	\$60 copay	\$100 copay
<b>Non-Preferred Tier 3</b>	100% of the contracted rate	Not available by mail order	Not available by mail order	\$100 copay	\$175 copay
<b>Specialty Drugs</b>	Not available through mail order	Applicable retail pharmacy copay will apply	25% coinsurance	90 day supply not available	\$250 copay

## Plan Year 2010 Medicare Advantage Plans

(Medicare Parts A and B Required)

Benefit Category	Senior Dimensions Retiree Choice Plus Plan (Offered in Clark, Esmeralda and Nye Counties)	Senior Care Plus Plan (Offered in Washoe County)
	No deductible	No deductible
<b>Medicare Parts A and B required</b>	Yes	Yes
<b>Calendar Year Out-of-Pocket Maximum</b>	\$1,500 per person per calendar year	\$3,500 per person per calendar year
<b>Hospital Inpatient Services</b>	No copay, unlimited days per calendar year	Days 1 - 4: \$200 copay/day (Service Period) Days 5 - 90 \$0 copay (Service Period)
<b>Hospital Outpatient Services</b>	No copay	\$200 copay for Medicare Ambulatory Surgical Center
<b>Primary Care Visit</b>	\$3 copay	\$15 copay for Medicare-covered visit
<b>Specialist Visit</b>	\$10 copay	\$40 copay for Medicare-covered visit
<b>Urgent Care Visit</b>	\$15 copay	\$20 copay for Medicare-covered urgent care; \$0 copay if immediately admitted to hospital.
<b>Emergency Room Visit</b>	\$25 copay per admission	\$50 copay for Medicare-covered visit
<b>Diagnostic Tests, Laboratory and X-ray Services</b>	\$0 copay for Medicare-covered X-rays and diagnostic procedures, 0% to 50% for Medicare covered lab services	\$50 copay for Medicare-covered lab services, \$0 to \$50 copay for Medicare-covered diagnostic procedures and tests and X-rays
<b>Chiropractic Services (spinal manipulation)</b>	\$10 copay for Medicare covered visits	\$40 copay per visit
<b>Wellness/Preventive Services</b>	\$0 to \$55 depending on type of service	\$0 to \$50 copay for Medicare-covered screenings
<b>Vision Exam</b>	\$3 copay every 12 months	\$20 copay every 12 months
<b>Hardware (frames, lenses and contacts)</b>	\$0 copay (limited to \$60 every 24 months)	\$0 copay (limited to \$125 every 24 months)

- To enroll in the Senior Dimensions Retiree Choice Plus or the Senior Care Plus Plan, you must have Medicare Parts A & B. In addition, you will need to complete two enrollment forms. The two forms include: Retiree Benefit Enrollment and Change Form and the enrollment application that applies to your plan selection above. Please contact the applicable plan administrator to request their specific enrollment application.
- Pre-authorization may apply to services listed above. For specific pre-authorization requirements, contact the plan administrator.

**Plan Year 2010 Dental Plan**  
All PPO and HMO Eligible Participants

<b>Benefit Category</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Plan Year Maximum</b>	\$1,500 per person	\$1,000 per person
<b>Plan Year Deductible</b>	\$50 per person or \$150 per family (family of 3 or more)	\$50 per person or \$150 per family (family of 3 or more)
<b>Preventive Services</b> Four cleanings per plan year, Exams, bitewing X-rays (2/year)	100%, no deductible	80%, no deductible
<b>Basic Services</b> Fillings, extractions, root canals, full-mouth X-rays	80%, after deductible	50%, after deductible
<b>Major Services</b> Bridges, crowns, dentures, tooth implants	50%, after deductible	\$50%, after deductible

Note: The combination of in-network and out-of-network dental benefit payments will not exceed the plan year maximum of \$1,500.

**Basic Life & Accidental Death and Dismemberment (AD & D) Insurance**

<b>Benefit Description</b>	<b>Benefit Summary</b> All Eligible Participants
<b>Basic Life and Accidental Death &amp; Dismemberment Insurance</b>	\$10,000 per eligible retiree \$ 1,000 per eligible dependent

**Life Insurance Beneficiary Designation**

When was the last time you updated your beneficiary designation? Open Enrollment is the perfect time to update your records. The Beneficiary Designation and Change Form is available for download at [www.standard.com/mybenefits/nevada/](http://www.standard.com/mybenefits/nevada/) or by visiting [www.pebp.state.nv.us](http://www.pebp.state.nv.us), select Vendor Contact Information, and Standard Insurance.