

MEDICARE SUPPLEMENT INSURANCE PREMIUM COMPARISON GUIDE



State of Nevada

Department of Business & Industry

Division of Insurance

2009

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To be used with the Guide to Health Insurance for People with Medicare as developed by the National Association of Insurance Commissioners (NAIC) and the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services (CMS).

JIM GIBBONS
Governor

STATE OF NEVADA

SCOTT J. KIPPER
Commissioner of Insurance

DIANNE CORNWALL
Director



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Dear Fellow Nevadan:

We are pleased to provide you with a copy of Nevada's Medicare supplement insurance and Premium Comparison Guide. This Guide provides valuable information that will assist you in comparing many of the Medicare supplement policies and Medicare Advantage plans currently being offered in Nevada.

You may wish to seek the advice of a licensed agent, broker, producer or consultant to assist you in selecting a Medicare supplement policy or Medicare Advantage plan.

Additionally, the Nevada Department of Health and Human Services, Division for Aging Services, administers the Nevada State Health Insurance Assistance Program (SHIP). The program director and volunteer counselors are also available to provide you with individual counseling concerning your questions on Medicare or Medicare supplement products.

Your insurance concerns are very important to us at the Division of Insurance. We are here to assist you with any insurance questions or problems that you may have.

Our offices in northern Nevada are located in Carson City. For information please call our consumer services section at (775) 687-4270. In southern Nevada, our offices are located in Las Vegas, and you may reach a consumer services officer at (702) 486-4009. The toll free number for use in Nevada is 1-888-872-3234. The Nevada SHIP advisers may be reached at (702) 486-3478 in Las Vegas or toll free in Nevada at 1-800-307-4444.

Sincerely,

A handwritten signature in blue ink, appearing to read "Scott J. Kipper".

SCOTT J. KIPPER
Commissioner of Insurance

INTRODUCTION

Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill "gaps" in original Medicare plan coverage. Medicare does not pay for every medical expense. That is why many people purchase supplemental insurance to fill the "gap" left by Medicare.

As of December 15, 2008, 331,873 Nevadans were eligible to receive benefits through the federal Medicare program. Of these, 100,390 individuals (30%) received their benefits through Medicare Advantage Plans. The remaining 228,312 Medicare recipients (70%) received their benefits through traditional fee-for-service Medicare.

Insurance companies may offer 12 standard and two high deductible Medicare supplement policies, Plans A through L. These plans are explained later in the Guide.

The Nevada Department of Business and Industry, Division of Insurance surveyed the companies writing Medicare supplement coverage in Nevada to collect information on the premiums for the policies. The results of that survey are summarized in the section of the Guide titled "Premium Comparisons."

The comparisons shown in the Guide will give you a start in shopping for Medicare supplement coverage by offering a ready means for comparing premium costs on policies.

Although Medicare supplement insurance is sold mainly to senior citizens, a few insurance companies offer coverage for disabled persons under the age of 65 who qualify for Medicare benefits.

This Comparison Guide is designed to help you decide on health insurance coverage to supplement your Medicare. It does not explain Medicare itself. If you are already on Medicare, you may want to read "Medicare and You," a guide published by CMS. The "Medicare and You" summarizes Medicare benefits, rights and obligations, and answers to the most frequently asked questions about Medicare. This information is also available on the CMS Web site by clicking on to <http://www.cms.hhs.gov/>.

If you are not yet on Medicare, or if you have misplaced your copy of the handbook, you may obtain another copy and other information from the Division of Insurance, the Nevada State Health Insurance Assistance Program (SHIP) or your local Social Security office. Go to page 41 and 42 of this Guide for contact information.

DEFINITIONS

The following terms are commonly used in Medicare supplement and long-term care insurance policies. Definitions differ from policy to policy, so it is important to understand the definition used in a specific insurance policy before you purchase it.

Allowed, approved, or eligible charges: The basis by which Medicare pays for health care costs. The approved charge paid by Medicare may be only 60% to 70% of the actual charge.

Assignment: In the original Medicare plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the original Medicare plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

Benefit period: A specified number of days, months or years for which benefits will be payable during any one confinement or spell of illness, or for successive confinements for the same condition.

Chronic: A chronic condition is one lasting 3 months or more.

Co-insurance or co-payment: The portion of a charge for a covered medical service that you must pay out of your own pocket. For example, Part B of Medicare generally has a required co-payment of 20% of the Medicare-approved amount for a covered service.

Custodial care: The level of care required to assist an individual in the activities of daily living. This care helps meet personal needs and can be provided by persons without professional licenses or extensive training.

Deductible: The amount of covered expenses which must be incurred and paid by the insured before benefits become payable by the insurer.

Effective date: The date on which insurance coverage goes into effect. (It is not always the same as the date the application is completed.)

Enrollment period: A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Excess charges: The portion of the Medicare provider's charges which exceed Medicare's approved payment amount.

Exclusion or limitation: A specific service, expense, condition, or situation not covered by an insurance plan.

Fee for service: In health care, a payment mechanism in which a provider is paid for each individual service rendered to a patient.

Guaranteed issue: A policy of insurance that will be issued regardless of health condition.

Guaranteed renewable: The policy must be renewed by the company for as long as premiums are paid in a timely manner.

Health maintenance organization (HMO): A type of Medicare Advantage plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your costs may be lower than in the original Medicare plan.

Home health care: A wide variety of skilled nursing care and supportive services for individuals who do not need institutional care. The services are available through intermittent visits and may include nursing care, physical therapy, speech and hearing therapy, occupational therapy, social services, and other support services.

Intermediate care: Less intensive care than skilled nursing care. Its definition may vary from policy to policy. It usually includes assistance with activities of daily living with the availability of any on-duty registered nurse.

Lapse: Termination of a policy due to failure by the policyholder to pay the required premium within the time specified in the policy.

Limiting charge: The highest amount of money you can be charged for a covered service by doctors and other health care providers who do not accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment. (See Approved Amount; Assignment.)

Long-term care: A wide range of routine and complex services designed to provide maintenance, preventive, rehabilitative, and supportive services to those individuals who have conditions that impair their ability to function independently.

Managed care: A system of health care where the goal is a system that delivers quality, cost effective health care through monitoring and recommending utilization of services, and cost of services.

Medically necessary: Reasonable and necessary services for diagnosis or treatment as generally accepted by health care professionals that are clinically appropriate with regard to type, frequency, extent, location and duration; not primarily provided for the convenience of the patient, physician or other provider of healthcare; required to improve a specific health condition of an insured or to preserve his existing state of health; and the most clinically appropriate level of health care that may be safely provided to the insured.

Medicare managed care plans: These are health care choices (like HMOs) in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like preventive care not covered by Medicare. Your costs may be lower than in the original Medicare plan.

Open enrollment: A period when new beneficiaries may elect to enroll in a policy of insurance regardless of health. For a Medicare supplement policy this is the six-month period, when an individual is age 65 or older and enrolled in Part B of Medicare.

Out-of-pocket costs: Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

Point of service: A managed care plan that allows you to use doctors and hospitals outside the plan for an additional cost. (See Medicare managed care plan.)

Pre-existing condition: A physical condition for which medical advice was given or treatment was recommended or received from a doctor within a specified period before the effective date of coverage.

Preferred provider organization (PPO): Health service organization plan with a network of physicians and suppliers who contract to provide services to a health insurance plan on a discounted fee-for-service basis.

Skilled nursing care: Medically necessary care that can only be provided by, or under the supervision of, skilled, licensed, medical professionals such as registered nurses or professional therapists. All skilled services require a physician's order. Medicare's definition is often different from the definitions used in many Medicare supplement and Long-Term Care insurance policies.

Underwriting: The process by which an insurer determines whether or not and on what basis it will accept an application for insurance.

Usual and customary or reasonable charges: The fee most commonly charged by physicians or providers for a particular service, treatment, or supply. This fee may vary from area to area throughout the state.

TWELVE MEDICARE SUPPLEMENT PLANS...A THROUGH L

You can choose from twelve different Medicare supplement policies. No matter what company you buy from, the twelve plans are identical from company to company. Plans H, I and J are no longer sold with prescription coverage to new Medicare eligible enrollees. An insurer may not offer all plans. The plans are described on the chart on page 22, which shows the benefits in each plan. These same charts will be included in every company's sales material. In addition to the twelve plans, insurers may offer two high deductible versions of Plans F and J. These plans include the same coverage as Plans F and J, except the policyholder is responsible for the first \$2,000 of medical expenses each year (adjusted annually). The premiums for these two high deductible plans are significantly less than the premiums for regular plans.

Plans K and L cover 50 percent and 75 percent, respectively, of the co-insurance for basic benefits, skilled nursing, and the Part A deductible. Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100 percent of the Medicare co-payments, co-insurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "excess charges." You are responsible for paying excess charges.

Upcoming Changes

Effective June 1, 2010, the Centers for Medicare and Medicaid Services (CMS) will be revising the Medicare supplement plans by creating new Medicare supplement plans and revising existing plans. Currently there are twelve different standardized Medicare supplement plans in force, plus High Deductible Plan F and High Deductible Plan J. After the modernization revisions are implemented, there will be ten plans available (Plans A-D, Plan F, Plan G, and Plans K-N), plus High Deductible Plan F. The plans are described on the chart on page 23, which shows the benefits in each plan.

As a result, Plan H, Plan I, Plan J, and High-Deductible Plan J are eliminated. Prescription drug benefits were removed from these plans by the Medicare Modernization Act of 2003. Now that Preventive Care and At-Home Recovery benefits are being eliminated, these plans will also become unnecessary and duplicative of other plans. Plan E is also being eliminated. Once other benefit changes are made (in particular the replacement of the 80% Part B Excess Charge benefit with a 100% Part B Excess Charge benefit) this plan became unnecessary and duplicative of another plan. The preventive care and at-home recovery benefits are being eliminated because they are underutilized and outdated benefits which will either be available under Medicare Part B that are not subject to Medicare's deductible and co-payment requirements or they no longer provide a significant benefit.

New Plan M and new Plan N are created. These plans are designed to give beneficiaries new options for higher beneficiary cost-sharing with a lower premium. Plan M includes 50% coverage of the Part A deductible and no coverage of the Part B deductible. Plan N includes full 100% coverage of the Part A deductible but no coverage for the Part B deductible. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new co-pay structure. The co-pay is up to \$20 for office visits and up to \$50 for emergency room visits. The Hospice benefit is also being added as a Basic (core) benefit, which will ensure that hospice coverage is available to all beneficiaries. (Note that Plans K and L already include hospice coverage.) The new Hospice benefit covers cost sharing for all Part A eligible hospice and respite care expenses.

Medicare Parts A and B

The amount of your coverage is also dependent on whether you have coverage under Medicare Part A, Medicare Part B, or both. Medicare Part A typically pays for your inpatient hospital expenses, and Medicare Part B typically covers your outpatient health care expenses including doctor fees.

A benefit is a health care service or supply that is paid for in part or in full by Medicare.

Medicare Advantage plans must cover at least the same benefits covered under Medicare Part A and Part B. However, your costs may be different, and you may have extra benefits, such as coverage for prescription drugs or extra days in the hospital. You should contact your Medicare Advantage plan administrator for specific coverage information for the plan in which you are enrolled.

Medicare Part D

There are two types of Medicare plans that may help lower prescription drug costs and help to protect against higher costs in the future. There is prescription drug coverage that is a part of Medicare Advantage plans and other Medicare health plans. Your Medicare health care is provided through these plans. There is also Medicare prescription drug coverage, called Medicare Part D, that provides additional coverage to the original Medicare plan, and some Medicare cost plans and Medicare private fee-for-service plans. These plans are offered by insurance companies and other private companies approved by Medicare. Both types of plans cover different prescriptions, so you will want to review each carefully. You choose the drug plan and pay a monthly premium. If you decide not to enroll in a drug plan when you are first eligible, you may pay a penalty if you choose to join later.

Like other insurance, Medicare prescription drug coverage has a yearly deductible (up to \$295). If you have limited income and resources, you may get extra help to cover prescription drugs for little or no cost. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. You must also pay a portion of the cost of your prescriptions. Most Medicare drug plans have a coverage gap. This means that after you and your plan have spent a certain amount of money for covered drugs (\$2,700 in total), you have to pay all costs

out-of-pocket for your drugs up to a limit of \$4,350. Your yearly deductible, your co-insurance or co-payments, and what you pay in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan's premium. After this limit, Medicare pays 95% of the costs for the rest of the year. All drug plans must provide coverage at least as good as the standard coverage set by Medicare. However, some plans might offer more coverage and additional drugs for a higher monthly premium. If your employer or union offers prescription drug coverage, you may not need a Medicare drug plan.

You can join a Medicare prescription drug plan during your initial enrollment period, which is three months before the month you turn age 65 until three months after the month you turn age 65. If you get Medicare due to disability, you can join from three months before to three months after your 25th month of disability.

If you did not join when you were first eligible, you can join during the late enrollment period, which is between November 15 and December 31st of each year, with a 1% penalty for every month you were eligible to join, but did not. If you apply and qualify for extra financial help from CMS, you may enroll one time during the calendar year (without having to wait for the annual open enrollment period).

TIP: If you change your insurance plan, your spouse or dependents may not be able to get healthcare and prescription drug benefits.

On January 1, 2007, Medicare began paying for preventive ultrasound screening for abdominal aortic aneurysms for at-risk beneficiaries as part of the "Welcome to Medicare" physical. The screening is available to men between the ages of 65 and 75 who have smoked at least 100 cigarettes in their lifetime, individuals with a family history of abdominal aortic aneurysm, and any other individuals recommended for screening by the United States Preventive Services Task Force Guidelines. The Medicare initial preventive physical examination form can be found at: <http://www.aafp.org/fpm/20060900/medicarepreventiveexam.pdf> or by calling 1-800-MEDICARE (1-800-633-4227).

Two other changes to Medicare include increasing the number of individuals who qualify for the bone mass measurement benefit due to long-term steroid therapy; and exempting colorectal cancer screening from the Part B deductible, thus eliminating a potential financial barrier to using this benefit.

TIP: You may have to use certain Medicare-contracted suppliers to get certain durable medical equipment in some geographic areas. Call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

MEDICARE SUPPLEMENT INSURANCE SHOPPING TIPS

You May Not Need Medicare Supplement Insurance

If your income is low, you may qualify for a government program which will fill in the gaps in your Medicare coverage. Check with your local Welfare office to find out if you are eligible for **Medicaid** or if you are a **Qualified Medicare Beneficiary (QMB)**, **Specified Low-Income Medicare Beneficiary (SLMB)** or a **Qualified Individual (QI)**.

One Policy is Enough

You do not need more than one policy. If you already have a policy and want better benefits, you can **replace** the policy with a new one. Once you receive the new policy you should drop the old one. **Caution:** Premiums paid in advance are sometimes non-refundable. Example: If you have paid for a one year policy period and decide to cancel in the middle of the policy term, the premium may be earned when paid and there may be no provision for a refund of premium at any time during that policy period. See pages 14-19 and 43.

Right to Coverage

You have the right to buy any Medicare supplement policy on the market **if** you:

- have signed up for Medicare Part B within the past 6 months; **and**
- are 65 years or older.

If you apply for a policy after that six-month period, some companies will reject your application if your health is not good. If you joined Medicare because of a disability before you turned 65, federal law now requires that you be given an open enrollment opportunity when you turn 65.

Shop for Benefits, Service & Price

Check the chart of the twelve plans to see the benefits that are included in each plan. Every company must use the same letters (A through L) to label its policies. Plan A will always be a company's lowest-priced Medicare supplement policy. It covers valuable basic benefits and must be sold by every company. Plans B through L add other benefits to fill different gaps in your Medicare coverage.

Use the Guide

The *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, written by the federal government and the National Association of Insurance Commissioners (NAIC), has excellent information about Medicare as well as health insurance. Any agent or company that offers to sell you Medicare supplement insurance must give you a copy. Upon request, a copy of the Guide is also available from the Division of Insurance, the Division for Aging Services or SHIP.

Read the Outline of Coverage

The outline of coverage for Medicare supplement insurance includes more details about each of the benefits in the policy.

Before buying any new insurance, read your existing policy. Don't switch policies just to get a lower price. Premiums can change, and a new policy may not stay cheaper than the old one. Ask yourself, "**Would a new policy really improve my health coverage?**" Perhaps your old policy can be updated to provide the additional coverage you want.

If you switch policies, remember that your pre-existing conditions are covered immediately when you have been covered for a combined six months period of time under both policies.

More Information is Available

If you have more questions about Medicare supplement insurance, call:

**State of Nevada
Department of Business & Industry
Division of Insurance**

**Carson City Office (775) 687-4270
Las Vegas Office (702) 486-4009
Toll free in Nevada 1-888-872-3234
E-mail: insinfo@doi.state.nv.us**

**ALSO, REFER TO PAGES 42 AND 43 OF THIS GUIDE
FOR FREE COUNSELING AND OTHER RESOURCES**

OTHER TIPS

Ask how an insurance company prices Medigap policies. The manner in which they set the price affects how much you pay now and in the future.

Ask if there are factors other than age that may affect the cost of your Medigap policy. Policies may have discounts based on your sex, if you are a non-smoker, if you are married and/or if you have automatic bank withdrawal.

Ask the reference section of your local public library for financial rating publications that summarize an insurance company's financial position. Some publications rate companies by letter grades, which can be informative.

Be careful to answer all questions accurately. Don't let the agent fill the application out for you. If an agent helps you to complete the application, do not sign it until you are sure that all questions have been completely answered and all requested medical information is included and correct. The omission of information may cause the company to deny your claims or cancel your policy.

Be sure you have the agent's name and address and the address of the company from which you are purchasing the policy. Know how to contact your agent or the company if you need help. It's also a good idea to check the license status of the agent and the insurance company with the Division of Insurance. You may also verify an insurance company at www.nvinsurancealert.com or by calling Toll-Free in Nevada: (888) 467-4195.

Before joining a plan, be sure to carefully read the plan's membership materials and enrollment forms to learn your rights and the nature and extent of your coverage. PPO plans pay less for claims for any non-emergency benefits from providers outside your service area.

Buying locally from an agent with a good reputation is safer than buying from someone you do not know. A traveling agent may never return to your area. You also may want to discuss the policy with a relative, friend or someone else whom you trust before buying. When buying by mail, check whether the company has a local agent or a toll-free number that you can call for answers to your

questions and for help in filing claims. Consider factors other than price when selecting a policy. These include claims handling and a company's reputation for service. Ask friends and family members about their experience with various companies.

Compare before you buy. Shop around and talk to several agents and companies before making a decision. When shopping for a Medigap policy, be sure you are comparing the same policy.

Do not be embarrassed to ask questions. **Do not** buy a policy until you are satisfied with the answers you receive. **Shop around with care** because even the standardized plans may vary widely in cost.

Do not pay cash or make a check out to the agent or in the agent's name. Checks should be made payable **ONLY** to the insurance company. Get a receipt for all payments.

Don't be misled into believing that a Medicare supplement policy is endorsed by or sold by the state or federal government. Although the Division of Insurance reviews Medicare supplement policy forms to make sure they meet Nevada requirements, the Division does not endorse particular companies or policies. It is a violation of federal and state law for insurance companies or agents to suggest they are acting for the government when selling Medicare supplement insurance.

Don't be pressured to buy insurance on the agent's first visit. If you can, invite a trusted friend or relative to be present during the agent's visit. An agent who objects to this may not be the right agent for you.

Don't be stampeded by statements that a certain policy or premium rate will be available only for a limited time. Such statements are seldom true.

Get a copy of the policy.

Group coverage is marketed through employers, labor unions and various private associations. If you have group insurance, ask before retirement if you can continue your employee health insurance or convert it to suitable group Medicare supplement coverage after you turn 65. Group

insurance often costs less and is more comprehensive than individually purchased coverage. Also, if your spouse is included in your group health plan, be sure to check on his or her eligibility.

Make sure you really need Medicare supplement insurance before you buy. People who are eligible for Medicaid don't need Medicare supplement insurance. To find out if you are eligible for Medicaid, contact the State Department of Health and Human Services, Medicaid office at (775) 684-7200 in northern Nevada, (702) 486-1646 in southern Nevada or Toll Free: (800) 992-0900.

Never sign a blank application form.

Read what you are being asked to sign. If the agent tries to rush you, be suspicious.

Remember, if you are replacing policies, you should have full coverage for all pre-existing conditions when you have been covered for six months under the old policy, the new policy or both. This should be explained to you in a Replacement Notice provided by the new insurance company or its agent. If you return the policy to the company, be sure to send it by certified mail with a return receipt requested. This will give you a record of the date it was returned in case there is a dispute.

Remember, the outline of coverage only describes the policy in general terms. You need to read the actual policy for the details of your coverage. When reviewing the policy, spend extra time studying the provisions about pre-existing conditions.

Take full advantage of your "free look" period by carefully reviewing your new policy. You have 30 days from the date you receive the policy to return and cancel it for a full refund. Read the policy when it arrives. Don't wait until the last minute. If you find it difficult to understand, get help from a friend, relative or someone else you trust. Some senior citizen organizations have volunteer insurance advisors. See page 41 for information regarding SHIP.

You, or your spouse may be eligible for TRICARE for Life if either has retired from the United States military service. The benefits covered by TRICARE for Life supplement Medicare coverage eliminate the need for a Medicare supplement policy. In addition, TRICARE for Life benefits include coverage for outpatient prescription drugs not covered by Medicare. Unlike Medicare supplement policies, there is no enrollment fee to belong to TRICARE for Life. If you believe that you are eligible for this program you can contact the Defense Manpower Data Center Support Office (DSO) at (800) 538-9552.

COST COMPARISON AND GUIDE TO PREMIUM CHART

This section of the booklet has a graph outlining the twelve standard plans and offers a comparison of premiums by plan and company. Companies are listed in alphabetical order.

NOTICE

The policy comparison section summarizes material submitted by the insurers. The figures are theirs, not those of the Division of Insurance. Some information may not be current at the time you read this publication. The policy itself becomes the contract between the insurance company and you and will be the basis of final determinations. Only policies that meet the requirements of Nevada laws and regulations at time of publication are included.

Publication of this comparison is for informational purposes only. Inclusion of information about a policy in this brochure does not in any way constitute endorsement of a policy or company by the Division of Insurance.

GUIDE TO THE PREMIUM COMPARISON CHART

Annual Premiums

The premiums shown are only a sampling of the 2008 annual rates. Additional information regarding the rates can be obtained from the insurance company. The rates may change every year as companies file new rates with the Division of Insurance. Some companies expect you to pay every month, others bill every 2 to 3 months, and some bill annually. While rates can change because of an insurance company's increased claims for all similar policyholders, your premiums cannot increase based on your individual claims.

Age Groups

Premiums are based on your age when you buy the policy. Although companies may have a different premium for each year's difference in age, this comparison shows premiums at 5-year intervals (Age 65 and 70). It's important to remember that premiums will probably increase every year to keep up with changes in Medicare. Companies may also increase premiums if claim expenses are higher than anticipated.

Premium Type

Companies have two different methods of pricing policies based on your age. These are shown in the “Prem Type” column.

- **Issue Age (I):** These policies are priced at the age when you initially purchase the policy. Your future rates will **not** increase because of age as you become older. If you buy the policy at age 65 you will always pay the premium that the company charges 65-year old customers. However, your premiums can increase because of an insurance company’s overall claims experience. While the initial rate for an **Issue Age (I)** policy may be greater than a similar **Attained Age (A)** policy, it could be less expensive over the life of the policy.
- **Attained Age (A):** In addition to the annual rate increases for changes in Medicare and overall claims experience, the premium will increase as you become older. If you buy a policy at 65, when you are 70 you will pay whatever the company is then charging individuals who are 70 years old.
- **No Age Rating (N):** The premium is the same for all customers who buy this policy, regardless of age.

Area

Some companies charge different premiums based on where you live. Some companies may charge different premiums for non-smokers and smokers. If this column has a **Y**, the company has two or more sets of prices. You should check with the company to find out if your premium would be higher or lower.

Sex

Premiums are shown for women. A company with an **N** in this column uses the same rates for both male and female. A company with a **Y** in this column has different (usually higher) premiums for men.

Health Screening / Underwriting

Although most companies underwrite, some offer policies regardless of any health problems you may now have.

2009 POLICY BENEFIT CHART

Medicare supplement insurance can be sold in only ten standard plans and two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in Nevada.

Basic Benefits: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).

Blood: First three pints of blood each year.

A	B	C	D	E	High Deductible			I	J	High Deductible			L**
					F	F*	G			H	J*	K**	
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits**	Basic Benefits**	Basic Benefits**
	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance(50%)	Skilled Nursing Facility Coinsurance(75%)	Skilled Nursing Facility Coinsurance(75%)									
	Part A Deductible	Part A Deductible(50%)	Part A Deductible(75%)	Part A Deductible(75%)									
	Part B Deductible												
					Part B Excess 100%								
	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency										
			At-Home Recovery			At-Home Recovery							
				Preventive Care				Preventive Care	Preventive Care	Preventive Care			
											\$[4,440] OOP***	\$[2,220] OOP***	\$[2,220] OOP***

* These high deductible plans pay the same benefits as Plans F and J after a calendar year deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses equal to the annual deductible have been satisfied. Out-of-pocket expenses for this deductible are expenses that would ordinarily have been paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does not include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

2008 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT (AGE 65)

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	Benefit Plans A - J													
						A	B	C	D	E	F	G	H	I	J	HDF	K	L	
AARP United HealthCare Insurance Company	1-800-523-5800	A	Y	N	3	811	1,062	1,207	1,121	1,125	1,215	1,129	1,246	1,254	1,330			575	789
American Family Mutual Insurance Company	1-800-692-6326	A	Y	Y	0	874		1,650			1,731							798	1,162
American Republic Corp Insurance Company	1-888-755-3065	A	Y	Y	0	961									1,202				
Bankers Life and Casualty Company	1-800-621-3724	A	Y	N	0	1,787	1,735	2,500	1,546	2,222	2,344	2,224			2,010				
Combined Insurance Company of America	1-800-544-5531	I	N	N	0	1,542		2,160			2,315								
Conseco Health Insurance Company	1-800-888-4918	A	Y	Y	0	2,254	2,311	2,330	1,570	1,340	1,833	1,537							
Continental Life Insurance Co. of Brentwood, TN	1-800-264-4000	A	Y	Y	3	1,270	1,504	1,849	1,587	1,583	1,914	1,617							
Genworth Life Insurance Company	1-877-825-9337	A	Y	Y	0	1,397	1,681	2,025	1,685		2,087						821		
Globe Life & Accident Insurance Company	1-800-801-6831	A	N	N	2	953	1,406	1,571			1,588								
Great American Life Insurance Company	1-800-880-2745	A	Y	Y	6	905			1,112		1,360	1,136							
Humana Insurance Company	1-800-872-7294	A	Y	Y	3	1,092	1,152	1,332			1,344						528	636	924
Mutual of Omaha Insurance Company	1-800-693-6093	A	Y	Y	0	1,080		1,430	1,292		1,736								
National States Insurance Company	1-800-868-6788	A/I	Y	Y	0	1,249	2,305		1,283		2,701								
PacificCare Life Assurance Company	1-800-768-1479	A	Y	N	0	1,335		1,834			1,849	1,582		1,903			624		

NOTE: Rates shown are based on the Las Vegas area. Other rates are available if there is a "y" in either the Area Column or the Sex Column.

2008 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT (AGE 65)

Company	Company Phone Numbers	Prem Type	Area	Sex	Pre-ex Wait Months	Benefit Plans A - J												
						A	B	C	D	E	F	G	H	I	J	K	L	
Physicians Life Insurance Company	1-800-228-9100	A/I	Y	N	0	1,396	1,591					2,293	1,878					
Provident American Life & Health Insurance Co.	1-866-459-4272	A	Y	Y	6	1,682		1,837				2,041	1,562	1,359	1,627	1,704	543	
Reserve National Insurance Company	1-800-654-9106	A	N	N	6	746	1,210	1,435	1,311			1,394						
Standard Life and Accident Insurance Company	1-888-350-1488	A	Y	Y	0	1,337	1,677	1,930	2,157	1,904	1,823	2,025					238	
State Farm Mutual Automobile Insurance Co.	Contact Local Agent	A	Y	N	0	1,322		1,994			2,014							
Sterling Investors Life Insurance Company	1-800-321-0102	A	Y	Y	0	1,437	1,568	1,881	1,347	1,579	1,936	1,384					791	
Sterling Life Insurance Company	1-888-858-8544	A	Y	Y	0	1,952	2,250	2,460			2,462							901
Thrivent Financial for Lutherans	1-800-847-4836	A	Y	N	0	950	1,123	1,455	1,217		1,462							898
United American Insurance Company	1-800-331-2512	A/I	N	N	2	1,316	1,918	2,777	2,638		2,167	2,654					668	1,150
United of Omaha Life Insurance Company	1-800-865-2674	A	Y	Y	0	859					1,245	1,058						
United Teacher Associates Insurance Co.	1-800-880-8824	A	Y	Y	6	1,767	1,967	1,940	1,836		1,949	1,828						
United World Life Insurance Company	1-800-366-3298	A	Y	Y	0	1,153	1,414	1,414	1,285		1,583	1,508						
USAA Life Insurance Company	1-800-531-8722	A	N	N	0	1,030			1,271		1,465	1,452						
Western Mutual Insurance Company	1-888-748-5340	I	N	N	6	828		2,004								2,280		

NOTE: Rates shown are based on the Las Vegas area. Other rates are available if there is a "y" in either the Area Column or the Sex Column.

2008 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT (AGE 70)

Company	Company Phone Numbers	Prem Type	Area	Sex	Wait Months	Pre-ex													
						A	B	C	D	E	F	G	H	I	J	HDF	K	L	
AARP United HealthCare Insurance Company	1-800-523-5800	A	Y	N	3	1,266	1,653	1,875	1,743	1,749	1,887	1,755	1,935	1,947	2,064			903	1,233
American Family Mutual Insurance Company	1-800-692-6326	A	Y	Y	0	970	1,837				1,927							889	1,293
American Republic Corp Insurance Company	1-888-755-3065	A	Y	Y	0	1,153									1,442				
Bankers Life and Casualty Company	1-800-621-3724	A	Y	N	0	2,030	2,050	2,953	1,854	2,641	2,847	2,738			2,480			944	1,256
Combined Insurance Company of America	1-800-544-5531	I	N	N	0	1,628		2,273			2,469								
Conseco Health Insurance Company	1-800-888-4918	A	Y	Y	0	2,627	2,736	2,694	1,882	1,605	2,132	1,854							
Continental Life Insurance Co. of Brentwood, TN	1-800-264-4000	A	Y	Y	3	1,428	1,715	2,074	1,805	1,794	2,146	1,834							
Genworth Life Insurance Company	1-877-825-9337	A	Y	Y	0	1,647	1,999	2,370	2,004		2,443						960		
Globe Life & Accident Insurance Company	1-800-801-6831	A	N	N	2	1,270	1,737	1,901			1,919								
Great American Life Insurance Company	1-800-880-2745	A	Y	Y	6	1,286			1,581		1,912	1,615							
Humana Insurance Company	1-800-872-7294	A	Y	Y	3	1,368	1,440	1,668			1,680						660	804	1,164
Mutual of Omaha Insurance Company	1-800-693-6093	A	Y	Y	0	1,281		1,696	1,531		2,058								
National States Insurance Company	1-800-868-6788	A/I	Y	Y	0	1,391	2,566	2,791	1,538		3,008								

NOTE: Rates shown are based on the Las Vegas area. Other rates are available if there is a "y" in either the Area Column or the Sex Column.

2008 ANNUAL PREMIUM COMPARISON WHEN PURCHASED AT (AGE 70)

Company	Company Phone Numbers	Prem Type Area	Sex	Months	Pre-ex Wait																	
					A	B	C	D	E	F	G	H	I	J	HDF	K	L					
PacifiCare Life Assurance Company	1-800-768-1479	A	Y	N	0	1,632	2,177					2,192	1,879				2,256		828			
Physicians Life Insurance Company	1-800-228-9100	A/I	Y	N	0	1,606	1,892					2,745	2,248									
Provident American Life & Health Insurance Co.	1-866-459-4272	A	Y	Y	6	2,035		2,225				2,471	1,748	1,518	1,821	1,907			657			
Reserve National Insurance Company	1-800-654-9106	A	N	N	6	865	1,387	1,695	1,599			1,639										
Standard Life and Accident Insurance Company	1-888-350-1488	A	Y	Y	0	1,369	1,716	1,974	2,207	1,949		1,865	2,072						243			
State Farm Mutual Automobile Insurance Co.	Contact Local Agent	A	Y	N	0	1,653	2,493					2,517										
Sterling Investors Life Insurance Company	1-800-321-0102	A	Y	Y	0	1,610	1,758	2,086	1,531	1,774	1,554								878			
Sterling Life Insurance Company	1-888-858-8544	A	Y	Y	0	2,271	2,644	2,902				2,902									1,036	
Thrivent Financial for Lutherans	1-800-847-4836	A	Y	N	0	1,087	1,285	1,665	1,391			1,671										1,027
United American Insurance Company	1-800-331-2512	A/I	N	N	2	1,441	2,233	3,229	3,088			2,421	3,113						879	1,533	2,161	
United of Omaha Life Insurance Company	1-800-865-2674	A	Y	Y	0	999						1,449	1,275									
United Teacher Associates Insurance Co.	1-800-880-8824	A	Y	Y	6	2,005	2,239	2,213	2,096			2,225	2,087									
United World Life Insurance Company	1-800-366-3298	A	Y	Y	0	1,311	1,607	1,608				1,800	1,714									
USAA Life Insurance Company	1-800-531-8722	A	N	N	0	1,206		1,487				1,714	1,699									

NOTE: Rates shown are based on the Las Vegas area. Other rates are available if there is a "Y" in either the Area Column or the Sex Column.

MEDICARE ADVANTAGE

Original fee-for-service Medicare and original Medicare with a Medicare supplement policy are available to all Nevada beneficiaries who are age 65 or older, under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease (Note that very few insurers offer Medicare supplement policies to beneficiaries under age 65). Under managed care plans, Medicare HMOs are currently available in six Nevada counties (Clark, Esmeralda, Lyon, Mineral, Nye and Washoe). The options available in the Medicare Advantage program are described below and include:

Advantra Freedom Private Fee-for-Service Plan (PFFS) – Churchill, Elko, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Storey and Washoe Counties

Advantra Savings Medicare Savings Account (MSA) – Churchill, Elko, Eureka, Humboldt, Lander, Lincoln, Lyon, Storey and Washoe Counties

Aetna Medicare PFFS – Churchill and Clark County

Aetna Medicare HMO – Clark County

Anthem Blue Cross and Blue Shield PFFS – Carson City, Clark, Douglas, Lincoln, Lyon, Mineral, Nye, Pershing, Storey and White Pine Counties

Anthem Blue Cross and Blue Shield PPO – Clark and Washoe County

Health Plan of Nevada, Inc. HMO – Lyon and Mineral County

Health Plan of Nevada, Inc. HMO with POS option – Clark, Esmeralda, Nye and Washoe Counties

Health Plan of Nevada Inc. SNP – Nye and Washoe County

Humana Insurance Company PFFS – all counties

Humana Insurance Company PPO – Clark and Nye County

Humana Health Plan, Inc. HMO – Clark and Nye County

Molina Healthcare of Nevada Medicare Special Needs Plan (SNP) – Clark and Washoe County

Molina Healthcare of Nevada HMO – Clark and Washoe County

SecureHorizons MedicareDirect PFFS – Churchill, Lander and Washoe Counties

Senior Care Plus HMO – Washoe County

Senior Care Plus PPO – Washoe County

Sierra Health and Life Insurance Company, Inc. PFFS/PPO – all counties

Sterling Life Insurance Company PFFS – all counties

Unicare Life & Health Insurance Company PFFS – Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander and Washoe Counties

Universal American PFFS – all counties

Universal Health Care Insurance Company, Inc. PFFS – all counties

WellCare PFFS – Churchill, Clark, Elko, Esmeralda, Eureka, Humboldt, Lander, Lyon, Mineral and Washoe Counties

Original Medicare is the traditional fee-for-service Medicare and is available to all Medicare beneficiaries. Medicare Part A (hospital insurance) is available to all eligible Medicare beneficiaries without a monthly premium. You have the option to pay a premium for Medicare Part B (medical insurance) to receive those benefits. For 2008, the Medicare Part B premium is \$96.40 per month. Under traditional Medicare, you can choose any health care provider who accepts Medicare. Medicare pays the provider each time you incur an expense. While Medicare pays its portion, you are responsible for paying the balance including deductibles, co-payments, co-insurance and the cost of services not covered by Medicare.

All newly enrolled Medicare beneficiaries are covered for an initial physical examination and cardiovascular screening blood tests. Persons that are considered at risk are covered for a diabetes screening test for early detection and treatment of this life-threatening condition.

Original Medicare with a Supplement Policy

You can purchase a private Medicare supplement insurance plan (also referred to as “Medigap insurance”) to cover some of your obligations after traditional Medicare has paid its portion. You may purchase one of twelve standard Medicare supplemental insurance policies (Medigap or Medicare SELECT described below). The benefits provided by these plans are summarized on the policy benefit chart found on page 22. (Note: 2010 policy benefits are summarized on the chart found on page 23.) Most policies pay Medicare co-insurance amounts while others pay Medicare deductibles. Some beneficiaries may already have supplemental coverage from other sources such as a former employer or Medicaid.

- **Medigap:** You can go to any doctor or hospital.
- **Medicare SELECT:** They're almost identical to standard Medigap insurance. When you purchase one of Medicare's SELECT policies, you're buying a standard Medigap plan. The only difference is that they operate like managed care plans. You **must** use plan hospitals and, in some cases, plan doctors in order to be eligible for full Medigap benefits.

Managed Care

Under a managed care plan, a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) offer comprehensive, coordinated medical services on a pre-paid basis. You pay the Part B monthly premium of \$96.40 and Medicare makes a monthly payment to the plan. Some plans charge you an extra monthly premium. You may also be required to pay a co-payment per visit or service. The monthly premiums and co-payments will vary depending on the plan you choose and the county in which you live. A supplemental insurance policy is not necessary if you join a managed care plan.

- **HMO:** In a Health Maintenance Organization, you **must** use the plan's providers (doctors, hospitals, skilled nursing facilities and ancillary providers). These providers are paid directly by the HMO and you are only required to make small co-payments (\$5 to \$10 per visit). These plans offer services that are not covered by traditional fee-for-service Medicare.
- **HMO with POS option:** Less restrictive than HMOs. When combined with a basic HMO package, the POS (point-of-service) option allows you to use doctors and hospitals outside of the plan for an additional cost.
- **PSO:** In a Provider Sponsored Organization you **must** use the plan's providers. These plans operate like an HMO; however, the plan is sponsored by the providers (doctors and/or hospitals).
- **PPO:** The in-network benefits are provided by the plan's providers (preferred providers). However, you can use doctors and hospitals outside of the plan for an additional cost.

Private Fee-for-Service Plan

In a private fee-for-service plan, you select a private insurance plan which accepts Medicare beneficiaries. You pay the Part B premium, any other monthly premium the private fee-for-service plan charges, and an amount per visit or service. While the plan determines how much to

allow for the service (rather than Medicare), the provider is allowed to charge more than the allowed amount and bill you for the difference. The plan may provide extra benefits that traditional Medicare does not cover.

Health Savings Account (HSA)

Health Saving Accounts (HSAs) are tax-advantaged savings accounts that can be used to pay for medical and retiree health expenses incurred by individuals and their families; and are open to anyone who enrolls in a high-deductible health insurance plan. However, if you are on Medicare or if you receive benefits from the Department of Veterans Affairs, you cannot set up an HSA. For 2009, the high-deductible plan must have an annual deductible of at least \$1,150 for individual coverage and at least \$2,300 for family coverage, with a maximum out-of-pocket of \$5,800 and \$11,600, respectively. Total yearly contributions to an HSA can be up to the lesser of deductible or \$3,000 for individual coverage and up to the lesser of deductible or \$5,950 for family coverage.

HSAs fall under the jurisdiction of the United States Department of Treasury. If an individual ceases to be an eligible individual or makes an ineligible withdrawal, penalties and taxes may apply. For assistance with HSAs, please contact your HSA trustee or visit the Treasury's Web site at www.treas.gov and click on Health Savings Accounts.

MEDICARE HMOs

An **HMO** that has a contract with Medicare must provide or arrange for the full range of Part A and B services if you are covered under both parts of Medicare. HMOs can also provide benefits beyond what Medicare allows, such as preventive care, prescription drugs (limited amount), dental care, hearing aids and eyeglasses.

Before joining a plan, be sure to read the plan's membership materials and enrollment forms carefully to learn your rights and the nature and extent of your coverage. If you belong to an HMO plan, the plan will not pay claims for any non-emergency benefits you receive from providers outside of the HMO. Below is a list of Medicare HMOs offered in Nevada.

Clark County:

Aetna Medicare (Aetna Golden Medicare Plan)	(800) 455-1560
Health Plan of Nevada, Inc. (HPN) (Senior Dimensions)	(800) 274-6648
Humana Health Plan, Inc. (Humana Gold Plus HMO)	(800) 833-0632
Molina Healthcare of Nevada (Molina Medicare Options)	(800) 403-8293

Esmeralda County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions)	(800) 274-6648
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Lyon County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions)	(800) 274-6648
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Mineral County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions)	(800) 274-6648
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Nye County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions)	(800) 274-6648
Humana Health Plan, Inc. (Humana Gold Plus HMO)	(800) 547-5514

Washoe County:

Health Plan of Nevada, Inc. HPN (Senior Dimensions)	(800) 274-6648
Hometown Health Plan (Senior Care Plus)	(800) 336-0123
Molina Healthcare of Nevada (Molina Medicare Options)	(800) 403-8293

2009 MEDICARE ADVANTAGE BENEFITS COMPARISON CHART
 (For use in the 2009 Medicare Supplement and Premium Comparison Guide)

		SENIOR DIMENSIONS Northern Nevada SHMO (Washoe County)	SENIOR DIMENSIONS Northern Nevada (HMO) Medicare Advantage (portions of Washoe County)	SENIOR DIMENSIONS Greater Nevada (HMO) Medicare Advantage (Lyons & Mineral Counties)
		1/1/09 - 12/31/009	1/1/09 - 12/31/09	1/1/09 - 12/31/09
		YOU PAY:	YOU PAY:	YOU PAY:
		\$0 plus \$96.40 Part B Premium (No Premium Credit in 2009)	\$0 plus \$96.40 Part B Premium (No Premium Credit in 2009)	\$0 for Plan Premiums for Parts A & B + \$96.40 Medicare Part B Premium
Premium	Hospital Care	1 to 60 days \$1,024 61 to 90 \$256 a day 91 to 150 \$512 a day Beyond 150 All costs	\$200 per stay \$0 \$0 \$0	\$800 per stay \$0 \$0
	Doctors Visits	Per Visit 20%, plus* Deductible \$135		
	Primary Care/Specialist		\$10PCP/\$20Mental Health/\$40Specialist OutPt; 20% Inpat.	10 to \$10 PCP/\$20Mental Health/\$40Specialist OutPt; 20% Inpat.
Prescription Copayment	Pharmacy - 30 days	\$3 Generic/\$30 Preferred Brand/33% Specialty Drug \$85 Non-Formulary Generic & Brand	\$3 Generic/\$30 Preferred Brand/33% Specialty Drug \$85 Non-Formulary Generic & Brand	\$10 Generic/\$47 Preferred Brand/33% Specialty Drug \$95 Non-Formulary Generic & Brand
	Mail Order - 90 days	90 day supply from plan mail order vendor \$6 Generic/\$60 Preferred Brand/ 33%Specialty Drug 90 day supply at retail pharmacy for \$9Generic/\$90Preferred Brand/33% Specialty Drug	90 day supply from plan mail order vendor \$6 Generic/\$60Preferred Brand/ 33%Specialty Drug 90 day supply at retail pharmacy for \$9Generic/\$90Preferred Brand/33% Specialty Drug	90 day supply from plan mail order vendor \$9 Generic/\$59Preferred Brand/ 25%Specialty Drug 90 day supply at retail pharmacy for \$20Generic/\$100Preferred Brand/33% Specialty Drug
Coverage Gap		(No coverage gap)	(No coverage gap)	(No coverage gap)
Annual Limit		After your yearly total drug costs reach \$6,153.75 you pay the greater of: \$2.40 for Generic or a Preferred Brand drug that is a multi-source drug, \$6.00 for all other drugs, or 5% coinsurance	After your yearly total drug costs reach \$6,153.75 you pay the greater of: \$2.40 for Generic or a Preferred Brand drug that is a multi-source drug, \$6.00 for all other drugs, or 5% coinsurance	After your yearly total drug costs reach \$4,350 you pay the greater of: \$2.40 for Generic or a Preferred Brand drug that is a multi-source drug, \$6.00 for all other drugs, or 5% coinsurance
Out of Plan Svcs.	Urgent Care	\$10 to \$25 plan facility; \$50 non-plan	\$10 to \$25	\$50
	Emergency Care	\$50	\$50	\$50
Phone Number:		Existing Members: 702-242-7301 or 800-650-6232 (TTY 702-242-9214 or 800-349-3538) Prospective members: 775-824-9700 or 800-753-0669 (TTY 702-242-9214 or 800-349-3538)	Existing Members: 702-242-7301 or 800-650-6232 (TTY 702-242-9214 or 800-349-3538) Prospective members: 775-824-9700 or 800-753-0669 (TTY 702-242-9214 or 800-349-3538)	Existing Members: 702-242-7301 or 800-650-6232 (TTY 702-242-9214 or 800-349-3538) Prospective members: 775-824-9700 or 800-753-0669 (TTY 702-242-9214 or 800-349-3538)

* You pay 20% of the Medicare approved fee plus additional charges if the provider does not accept the Medicare approved fee in full.

2009 MEDICARE ADVANTAGE BENEFITS COMPARISON CHART
 (For use in the 2009 Medicare Supplement and Premium Comparison Guide)

		Traditional Medicare	Humana, Inc. (LPPO) Clark & Nye Counties
Premium	YOU PAY:		HumanaChoice PPO H9503-001
			In 2009 YOU PAY:
		\$96.40 Part B	\$88 plus Part B Premium
		\$1,068	\$550/admit IN; \$750/admit OON
		\$267 a day	\$0
Hospital Care	1 to 60 days	\$534 a day	\$0
	61 to 90 days	All costs	\$0
	91 to 150 days**	20% plus*	\$0
	Beyond 150 days	\$135	\$10 PCP/ \$25 Spec IN; 30% OON
Doctor Visits (Primary Care & Specialists)	Per Visit	N/A	\$0
	Deductible	N/A	\$0
Prescription Copayment (Generic & Brand)	Deductible	N/A	\$0
	Retail Pharmacy (30 days)	N/A	Tier 1- Preferred Generic - \$8
		N/A	Tier 2- Preferred Brand - \$35
		N/A	Tier 3- Non-preferred brand/generic - \$60
		N/A	Tier 4- Specialty - 33%
Annual Prescription Coverage Limit	Preferred	N/A	Tier 1- Preferred Generic - \$0
	Mail Order (90 Days)	N/A	Tier 2- Preferred Brand - \$87.50
		N/A	Tier 3- Non-preferred brand/generic - \$150
Catastrophic Rx Coverage			Coverage Limit at \$2,700 total drug expenditure
			After \$4,350 member's out-of-pocket copayments would be greater of \$2.40 (for generic & preferred multi-source brand drugs)/\$6.00 (for all other tier drugs) or 5% of drug cost
Out of Plan Services	Urgent Care	N/A	\$25
	Emergency Care	N/A	\$50
Phone Numbers	Members (800) 457- 4708 or (800) 633 - 4227		

* You pay 20% of the Medicare-approved fee plus additional charges if the provider does not accept the Medicare-approved fee in full.
 ** Coverage from days 91-150 available only if you have not yet used your Lifetime reserve Days.

2009 MEDICARE ADVANTAGE BENEFITS COMPARISON CHART
(For use in the 2009 Medicare Supplement and Premium Comparison Guide)

		Humana, Inc. (HMO)	
Traditional Medicare		Clark County	Clark County
YOU PAY:		Humana Gold Plus HMO H2949-002	Humana Gold Plus HMO H2949-0012
		Clark County	Clark County
		Humana Gold Plus HMO H2949-002	Humana Gold Plus HMO H2949-0012
		In 2009 YOU PAY:	
Premium		\$0 plus Part B Premium	\$0 plus Part B Premium
Hospital Care	1 to 60 days	\$195/day - Days 1-5	\$50/day - Days 1-5
	61 to 90 days	\$0	\$0
	91 to 150 days**	\$0	\$0
	Beyond 150 days	\$0	\$0
Doctor Visits (Primary Care & Specialists)	Per Visit	\$0 PCP / \$30 Spec	\$0 PCP / \$30 Spec
	Deductible	\$0	\$0
Prescription Copayment (Generic & Brand)	Deductible	\$0	\$0
	Retail Pharmacy (30 days)	Tier 1- Preferred Generic - \$5 Tier 2- Preferred Brand - \$30 Tier 3- Non-preferred brand/generic - \$60 Tier 4- Speciality - 33%	Tier 1- Preferred Generic - \$5 Tier 2- Preferred Brand - \$30 Tier 3- Non-preferred brand/generic - \$60 Tier 4- Speciality - 33%
	Preferred Mail Order (90 Days)	Tier 1- Preferred Generic - \$0 Tier 2- Preferred Brand - \$75 Tier 3- Non-preferred brand/generic - \$150 Coverage Limit at \$2,700 total drug expenditure	Tier 1- Preferred Generic - \$0 Tier 2- Preferred Brand - \$75 Tier 3- Non-preferred brand/generic - \$150 Coverage Limit at \$2,700 total drug expenditure
		After \$4,350 member's out-of-pocket copayments would be greater of \$2.40 (for generic & preferred multi-source brand drugs) or 5% of drug cost	After \$4,350 member's out-of-pocket copayments would be greater of \$2.40 (for generic & preferred multi-source brand drugs) or 5% of drug cost
Annual Prescription			
Catastrophic Rx Coverage			
Out of Plan Services	Urgent Care	\$30	\$30
	Emergency Care	\$50	\$50
Phone Numbers			
		Members (800) 457- 4708 or (800) 633- 4227	

* You pay 20% of the Medicare-approved fee plus additional charges if the provider does not accept the Medicare-approved fee in full.

** Coverage from days 91-150 available only if you have not yet used your Lifetime reserve Days.

2009 MEDICARE ADVANTAGE BENEFITS COMPARISON CHART
(For use in the 2009 Medicare Supplement and Premium Comparison Guide)

		Traditional Medicare	Humana, Inc. (HMO) Nye County	
		YOU PAY:	Nye County	Nye County
Premium		\$96.40 Part B	\$0 plus Part B Premium	\$0 plus Part B Premium
Hospital Care	1 to 60 days	\$1,068	\$100/day - Days 1-5	\$50/day - Days 1-5
	61 to 90 days	\$267 a day	\$0	\$0
	91 to 150 days**	\$534 a day	\$0	\$0
	Beyond 150 days	All costs	\$0	\$0
Doctor Visits (Primary Care & Specialists)	Per Visit	20% plus*	\$0 PCP / \$30 Spec	\$0 PCP / \$30 Spec
	Deductible	\$135	\$0	\$0
Prescription Copayment (Generic & Brand)	Deductible	N/A	\$0	N/A
	Retail Pharmacy (30 days)	N/A	Tier 1- Preferred Generic - \$5 Tier 2- Preferred Brand - \$30 Tier 3- Non-preferred brand/generic - \$60 Tier 4- Specialty - 33%	No drug coverage
	Preferred Mail Order (90 Days)	N/A	Tier 1- Preferred Generic - \$0 Tier 2- Preferred Brand - \$75 Tier 3- Non-preferred brand/generic - \$150	No drug coverage
			Coverage Limit at \$2,700 total drug expenditure	N/A
Annual Prescription Coverage Limit			After \$4,350 member's out-of-pocket copayments would be greater of \$2.40 (for generic & preferred multi-source brand drugs)/\$6.00 (for all other tier drugs) or 5% of drug cost	N/A
Catastrophic Rx Coverage	Urgent Care	N/A	\$30	\$30
	Emergency Care	N/A	\$50	\$50
Out of Plan Services			Members (800) 457- 4708 or (800) 633 - 4227	
Phone Numbers				

* You pay 20% of the Medicare-approved fee plus additional charges if the provider does not accept the Medicare-approved fee in full.

** Coverage from days 91-150 available only if you have not yet used your Lifetime reserve Days.

2009 MEDICARE ADVANTAGE* BENEFITS COMPARISON CHART
(For use in the 2009 Medicare Supplement and Premium Comparison Guide)

		SENIOR CARE PLUS Value Basic Plan (HMO) (Hometown Health Plan) Washoe County	SENIOR CARE PLUS Value Rx Plan (HMO) (Hometown Health Plan) Washoe County
Premium		YOU PAY: \$96.40 Part B	YOU PAY: \$0 plus \$96.40 Part B Premium= \$96.40
Hospital Care	1 to 60 days	\$1,068	\$250 per day for 1-4 days (unlimited days)***
	61 to 90	\$267 a day	\$0
	91 to 150	\$534 a day	\$0
	Beyond 150	All costs	\$0
Doctors Visits	Per Visit	20% plus**	\$10/\$40
Primary Care/Specialist	Deductible	\$135	\$0
Prescription Copayment	Pharmacy - 30 days	Full	Formulary \$2/\$6/\$40/\$70
	Mail Order - 90 days	Amount	Formulary \$5/\$15/\$100/\$175
Generic/Preferred Brand/ Non-Preferred Brand Name	Annual Limit		generic coverage in the gap
Out of	Urgent Care	NA	\$25/\$50 (anywhere in United States)
Plan Svs.	Emergency Care	NA	\$50 (worldwide)
Other	Vision	NA	\$20 Exam / 100% Lenses / \$100 Frames
Other	Dental	NA	No Coverage
Other	Fitness Benefit	NA	No Coverage
Other	Silver&Fit	NA	No Coverage
Phone Number:			(775) 982-3158

		SENIOR CARE PLUS Value Rx Enhanced Plan (HMO) (Hometown Health Plan) Washoe County	SENIOR CARE PLUS Value Rx Premier Plan (HMO) (Hometown Health Plan) Washoe County
Premium		YOU PAY: \$96.40 Part B	YOU PAY: \$100 plus \$96.40 Part B Premium= \$196.40
Hospital Care	1 to 60 days	\$1,068	\$150 per day for 1-3 days (unlimited days)***
	61 to 90	\$267 a day	\$0
	91 to 150	\$534 a day	\$0
	Beyond 150	All costs	\$0
Doctors Visits	Per Visit	20% plus**	\$10/\$40
Primary Care/Specialist	Deductible	\$135	\$0
Prescription Copayment	Pharmacy - 30 days	Full	Formulary \$2/\$6/\$40/\$70
	Mail Order - 90 days	Amount	Formulary \$5/\$15/\$100/\$175
Generic/Preferred Brand/ Non-Preferred Brand Name	Annual Limit		generic coverage in the gap
Out of	Urgent Care	NA	generic and brand coverage in the gap
Plan Svs.	Emergency Care	NA	\$20/\$40 (anywhere in United States)
Other	Vision	NA	\$50 (worldwide)
Other	Dental	NA	\$15 Exam / 100% Lenses / \$125 Frames
Other	Fitness Benefit	NA	Preventive Dental Included
Other	Silver&Fit	NA	Fitness Club Membership Included
Phone Number:			(775) 982-3158

		SENIOR CARE PLUS Freedom Rx Premier Plan (PPO) (Hometown Health Plan) Washoe County
Premium		YOU PAY: \$96.40 Part B
Hospital Care	1 to 60 days	\$1,068
	61 to 90	\$267 a day
	91 to 150	\$534 a day
	Beyond 150	All costs
Doctors Visits	Per Visit	20% plus**
Primary Care/Specialist	Deductible	\$135
Prescription Copayment	Pharmacy - 30 days	Full
	Mail Order - 90 days	Amount
Generic/Preferred Brand/ Non-Preferred Brand Name	Annual Limit	
Out of	Urgent Care	NA
Plan Svs.	Emergency Care	NA
Other	Vision	NA
Other	Dental	NA
Other	Fitness Benefit	NA
Other	Silver&Fit	NA
Phone Number:		(775) 982-3158

* Medicare + Choice has changed its name to Medicare Advantage

** You pay 20% of the Medicare approved fee plus additional charges if the provider does not accept the Medicare approved fee in full.

*** Service Period - There are no additional copayments for Inpatient Hospital-Acute Services when readmitted to a contracted facility during a "service period" or within 30 days of last discharge.

MEDICARE PPOs

A Medicare PPO Plan has a list (called a “network”) of primary care doctors, specialists, and hospitals that you may go to. You can go to any doctor, specialist, or hospital not on the plan’s list, but it will usually cost more. Some Medicare PPO plans offer prescription drug coverage. Some plans also offer additional benefits, such as vision and hearing screenings, disease management, and other services not covered under the original Medicare plan. Monthly premiums and how much you pay for services vary depending on the plan. There is an annual limit on your out-of-pocket costs. This limit varies depending on the plan.

The new regional PPOs serve 26 regions across the United States, which include all rural areas. Nevada is in region 22. All regional PPO plans must offer the same benefits as traditional fee-for-service Medicare with simplified cost-sharing and new protections against catastrophic costs.

HIGH DEDUCTIBLE PLANS

The annual deductible for high deductible plans is \$2,000¹. Other than the deductible amount, these plans have the same coverage as a regular Plan F and Plan J. Benefits under these plans will not begin until the out-of-pocket expenses have reached \$2,000. The expenses not paid are the amounts the policy would have paid including the Medicare deductibles for Part A and Part B, but not the separate deductible for prescription drugs in Plan J, or the separate deductibles for emergency foreign travel in plans F & J. The premiums for these plans are significantly less than the regular Plans F & J. At this time there are eight insurers offering high deductible plans. The following are the names and telephones for these insurers:

<u>Company</u>	<u>Telephone Number</u>	<u>High Deductible Plan</u>
Bankers Life and Casualty Company	1-800-621-3724	Plan F
Genworth Life Insurance Company	1-877-825-9337	Plan F
Humana Insurance Company	1-800-872-7294	Plan F
PacifiCare Life Assurance Company	1-888-768-1479	Plan F

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The high deductible amount of \$1,500 was initially established in 1999. This amount is adjusted annually by the United States Department of Health and Human Services.

Provident American Life & Health Ins. Company	1-800-459-4272	Plan F
Standard Life and Accident Insurance Company	1-888-350-1488	Plan F
Sterling Investors Life Insurance Company	1-800-321-0102	Plan F
United American Insurance Company	1-800-331-2512	Plan F

Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan pays 100% of the Medicare co-payments, co-insurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does not include charges from your provider that exceed Medicare-approved amounts, called “excess charges.” You are responsible for paying excess charges.

Medicare beneficiaries can enroll in Part D of Medicare to obtain coverage of outpatient prescription drugs from approved Prescription Drug Plans (PDP) or Medicare Advantage plans. Any beneficiary enrolled in a Medicare supplement plan with drug coverage who chose not to enroll in Part D continued to receive drug coverage through her or his existing Medicare supplement plan. Such beneficiaries were required to forego the new federal subsidies available for drug coverage under Part D. If beneficiaries decide to enroll in Part D after the initial enrollment period, and their current drug coverage is not determined to be equal in value to Medicare Part D coverage, they will face a late enrollment penalty. Prior to Part D enrollment period, Medicare supplement insurers are required to provide a written notice to their subscribers who have drug coverage explaining what their options will be. For more information contact the CMS Web site www.cms.hhs.gov or call (410) 786-3000 or Toll-Free: (877) 267-2323.

GUARANTEED ISSUE

Certain people will have a right to **guaranteed issue of a Medicare supplement plan**. The conditions for guaranteed issue are as follows:

1. When an employer terminates a group plan or eliminates substantially all supplemental benefits, an individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L**.
2. When a group plan is primary to Medicare and either the plan terminates or an individual leaves the plan, the individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L**.
3. An individual who has a Medicare SELECT supplemental policy or is enrolled in a Medicare Advantage plan under Medicare (managed care or private fee-for-service, see pages 28 - 30), and discontinues the coverage because:
 - a. The plan terminates or no longer provides service in the individual's area of residence;
 - b. The individual is no longer eligible for the plan due to a change in residence; or
 - c. The individual can show that the plan:
 - 1) Violated a material provision of the contract; or
 - 2) The agent for the plan materially misrepresented the plan.The individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L**.
4. An individual who is enrolled in a Medicare supplement plan and the coverage ceases because:
 - a. The insurer becomes insolvent;
 - b. Other involuntary terminations occur;
 - c. The insurer violated a material provision of the contract, or;
 - d. The insurer or agent materially misrepresented the plan.The individual is eligible for **Plans A, B, C, F (including F with a high deductible), K or L**.
5. An individual who terminates a Medicare supplement plan in order to sign up for a Medicare SELECT supplemental policy or a plan under Medicare Advantage (managed care or private fee-for-service, see pages 28 - 30), and then terminates the new coverage within 12 months, is **eligible for the same plan** the individual had prior to the change.
6. An individual who becomes eligible for the first time and signs up for Medicare Advantage and terminates this coverage within 12 months is **eligible for any plan**.

In order to be eligible for guaranteed issue under any of these six circumstances mentioned above, you must apply within 63 days after losing your other health plan coverage.

MEDICARE SHIP PROGRAM

The **STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP)** is funded by a grant from the federal government and administered by the Nevada Department of Health and Human Services, Division for Aging Services.

The Program meets one of the most universal and critical needs of seniors and Medicare beneficiaries today: **FREE** one-on-one assistance and counseling for questions and problems regarding Medicare and supplemental health insurance. SHIP provides the following services:

- Pre-Medicare Counseling;
- Information and eligibility on Medicare entitlements, benefits, limitations, Medicaid (Qualified Medicare Beneficiaries & Specified Low Income Medicare Beneficiaries), and Managed Care Plans through Health Maintenance Organizations (HMOs);
- Assistance with claims, requests for reconsideration and appeals processes under Medicare and supplemental insurance;
- Unbiased information that will assist the consumer in determining supplemental insurance and long-term care insurance needs;
- Outreach information and materials for seniors and families through meetings, seminars, classes, health fairs, senior fairs, and the media (**SPEAKERS AVAILABLE**); and
- Referrals for coordination with federal and other state and community services.

Arrangements may be made for homebound seniors who need personal counseling assistance.

The services offered by the Program are **FREE OF CHARGE AND CONFIDENTIAL** and senior citizens are assured there will be no selling or soliciting for insurance. For additional information on SHIP or for individual counseling, please call:

(702) 486-3478 in Las Vegas; and

for STATEWIDE COUNSELING call TOLL FREE at 1-800-307-4444

MEDICARE COUNSELING PROGRAM

The following is a list of Senior Centers and/or local numbers to contact for counseling with the Nevada State Health Insurance Assistance Program (SHIP):

PLEASE CONTACT THE CENTER FOR COUNSELING TIMES AND ADDITIONAL INFORMATION

Austin	(775) 964-2338	Hawthorne	(775) 945-5519
Battle Mountain	(775) 635-5311	Henderson	(702) 565-6990
Beatty	(775) 553-2954	Laughlin	(702) 298-2592
Boulder City	(702) 293-3320	Lovelock	(775) 273-2291
Caliente	(775) 726-3740	Overton	(702) 397-8002
Carlin	(775) 754-6465	Pahrump	(775) 727-5008
Carson City	(775) 883-0703	Reno	(775) 328-2575
Crescent Valley	(775) 468-0466	Silver Springs	(775) 577-5014
Dayton	(775) 246-6210	Sparks	(775) 353-3110
Elko	(775) 738-5911	Tonopah	(775) 482-6450
Eureka	(775) 237-5597	Wells	(775) 752-3280
Fallon	(775) 423-7096	Winnemucca	(775) 623-6211
Fernley	(775) 575-3370	Yerington	(775) 463-6550
Gardnerville	(775) 783-6455	Zephyr Cove	(775) 588-5140

**Las Vegas: For counseling sites in the Las Vegas area, please call
the SHIP program at (702) 486-3478**

THE SERVICE OFFERED BY THE MEDICARE SHIP PROGRAM
IS PROVIDED BY TRAINED VOLUNTEERS/ADVISORS
AND IS **FREE OF CHARGE**

OTHER RESOURCES

Division of Insurance
(702) 486-4009 or (775) 687-4270 or Toll-Free: (888) 872-3234
www.doi.state.nv.us

Centers for Medicare & Medicaid Services (CMS)
(410) 786-3000 or Toll-Free: (877) 267-2323
www.cms.hhs.gov

Social Security Administration (SSA)
(800) 772-1213
www.ssa.gov

National Association of Insurance Commissioners (NAIC)
(816) 842-3600
www.naic.org

Public Employees' Retirement System of Nevada (PERS)
(775) 687-4200 or Toll-Free: (866) 473-7768
www.nvpers.org

Nevada Division for Aging Services
(702) 486-3545 or (775) 687-4210
www.aging.state.nv.us

Governor's Office of Consumer Health Assistance (OCHA)
(702) 486-3587 or Toll-Free (888) 333-1597
www.govcha.state.nv.us

Public Employees' Benefits Program
(775) 684-7000 or Toll-Free (800) 326-5496
www.pebp.state.nv.us

As of January 2009

HOW TO FILE AN INQUIRY OR COMPLAINT

If you have an insurance question or problem, you should first contact your agent or company to get the matter resolved.

If you cannot get the matter resolved, contact the **Nevada Division of Insurance** for assistance. Inquiries or questions may be directed to either of the Insurance Division offices, located at:

2501 East Sahara Avenue #302, Las Vegas
(702) 486-4009

or

788 Fairview, #300, Carson City
(775) 687-4270

Or, call **toll-free** anywhere in Nevada at

1-888-872-3234

www.doi.state.nv.us

The Division of Insurance cannot recommend an insurance company or tell you which policy to buy. Our staff, however, will explain the insurance terminology in your policy to you. The Division of Insurance will also contact the company on your behalf in an attempt to help resolve problems you may be having.

POLICY CHECKLIST

You may find this checklist useful in assessing the benefits provided by a Medicare supplement policy or in comparing policies.

	Policy 1		Policy 2		Policy 3	
	Yes	No	Yes	No	Yes	No
DOES THE POLICY COVER:						
Medicare Part A hospital deductible?						
Medicare Part A hospital daily coinsurance?						
Hospital care beyond Medicare's 150-day limit?						
Skilled nursing facility daily coinsurance?						
Skilled nursing beyond Medicare's limits?						
Medicare Part B annual deductible?						
Medicare Part B coinsurance?						
Physician and supplier charges in excess of Medicare's approved amounts?						
OTHER POLICY CONSIDERATIONS:						
Can the company cancel or refuse to renew the policy?						
What are the policy limits for covered services?						
How much is the annual premium?						
How long before existing health problems are covered?						