

# **2012 SUMMARY OF BENEFITS**

**School Administrators' and Professional-technical Employees'  
Welfare Trust (HMOPOS) ("Trust")**

## **Classic Retiree Plan**

H2931-801

This document may be available in other formats such as Braille, large print or other alternate formats. This document may be available in a non-English language.

# *Health Plan of Nevada, Inc. (“HPN”)*

## **School Administrators’ and Professional-technical Employees’ Welfare Trust (HMOPOS) (“Trust”) Classic Retiree Plan**

### **Attachment A Summary of Benefits**

#### **HMO – Tier I Benefits**

**HMO – Tier I benefits** apply when you obtain Covered Services or have them arranged by an HPN contracted Primary Care Physician. No claim forms are required, no Deductible applies, and the HMO - Tier I Benefits provide a higher level of coverage with less out-of-pocket expenses than the Expanded Plan Provider - Tier II or Non-Plan Provider - Tier III Benefits.

#### **Expanded Plan Provider - Tier II Benefits**

**Expanded Plan Provider - Tier II Benefits** apply when a Member obtains Covered Services from a Provider who is independently contracted by Health Plan of Nevada, Inc. (“HPN”), to provide services to Members enrolled in HPN. The Member’s out-of-pocket expenses will be higher than HMO - Tier I Benefits because the Member will be responsible for a Calendar Year Deductible (“CYD”), Coinsurance percentages and, in some instances, higher Copayments. All Benefits are subject to a CYD and Coinsurance percentage, up to a Member’s Calendar Year Coinsurance Maximum. Claim forms are not required when using contracted Expanded Plan Providers - Tier II Benefits.

#### **Non-Plan Provider – Tier III Benefits**

**Non-Plan Provider - Tier III Benefits** apply when a Member obtains Covered Services from a Non-Plan Provider - Tier III Benefit. All Benefits are subject to a CYD and Coinsurance percentage, up to a Member’s Calendar Year Coinsurance Maximum. Claim Forms must be submitted for services received

from the Non-Plan Provider – Tier III Benefit.

#### **Emergency Services**

**Emergency Services:** The HMO –Tier I level of benefits will apply to Emergency Services provided at any duly licensed facility. Upon admission to a Non-Plan Hospital and stabilization of the emergency condition and safe for transfer as determined by the attending Physician, the Plan may require transfer to an HMO - Tier I contracted facility in order to pay benefits at the HMO - Tier I level. Benefits for post-stabilization and follow-up care received at an Expanded Plan or Non-Plan Hospital facility are subject to the applicable benefit tier.

#### **Calendar Year Deductible (“CYD”)**

Your CYD is \$75 per Member. The CYD is a combined total of Medicare allowable charges for Expanded Plan Provider - Tier II and Non-Plan Provider - Tier III Covered Services.

#### **Coinsurance**

After meeting your CYD, your Coinsurance for most Expanded Plan Provider - Tier II Covered Services is 20% of Medicare allowable charges. Your Coinsurance for most Non-Plan Provider - Tier III Covered Services is 20% of Medicare allowable charges.

#### **Coinsurance Maximum**

After satisfying your CYD, your Coinsurance (including office visit Copayments) is limited to a maximum of \$1,500 of Medicare allowable charges per Member per Calendar Year if you use Expanded Plan Provider - Tier II Benefits (\$4,500 per family), and \$3,000 of

## *Summary of Benefits*

Medicare allowable charges per Member per Calendar Year if you use Non-Plan Providers - Tier III Benefits (\$9,000 per family). In no event will the total Coinsurance you pay exceed \$3,000 of Medicare allowable charges per Member in any Calendar Year or \$9,000 per family in any Calendar Year.

### **Copayment Maximum**

Copayment Maximum means the maximum amount of Copayments a member is required to pay for covered services in a calendar year in order for full benefits to be payable for covered services obtained after the calendar year Copayment Maximum is met. Your Copayment Maximum is \$2,500 for Tier 1. For the remainder of the calendar year, no further Copayments are required. The calendar year Copayment Maximum does not include charges for services that are not covered services, services that are not Prior Authorized through HPN's Managed Care Program, or charges in excess of the stated covered service benefit maximums as set forth in the Summary of Benefits.

Please read your Trust's Evidence of Coverage to determine the governing contractual provisions for this Plan and to understand how Medicare allowable charges payments to Providers are determined.

## *Summary of Benefits*

Covered Services and Limitations	*P A R	HMO – Tier I Benefits  Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<b>Physician Services/ Consultations</b> <ul style="list-style-type: none"> <li>● <b>Non-Specialist Office Visit</b></li>   <li>● <b>Specialist Office Visit</b></li>   <li>● <b>Inpatient Visit</b> <ul style="list-style-type: none"> <li>○ Non-Specialist</li> <li>○ Specialist</li> </ul> </li> </ul>	No	\$5 per visit	No	\$10 per visit	Member pays 20% of Medicare allowable charges. Not subject to CYD
	Yes	\$10 per visit	No	\$20 per visit	Member pays 20% of Medicare allowable charges. Not subject to CYD
	No No	No Charge No Charge	No No	No Charge No Charge	No Charge No Charge
<b>Preventive Healthcare Services (Includes Medicare- covered Preventive Healthcare Services)</b> <ul style="list-style-type: none"> <li>● Bone Mass Measurement</li> <li>● Colorectal Screening</li> <li>● Immunizations (flu, pneumonia, Hepatitis B)</li> <li>● Mammogram screening</li> <li>● Pap smears/pelvic exams</li> <li>● Prostate cancer screening</li> <li>● Abdominal Aortic Aneurysm Screening</li> </ul>	No	No Charge	No	Member pays 20% of Medicare allowable charges. Not subject to CYD	Member pays 20% of Medicare allowable charges. Not subject to CYD

## *Summary of Benefits*

Covered Services and Limitations	*P A R	HMO – Tier I Benefits  Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
(ultrasound) <ul style="list-style-type: none"> <li>● Cardiovascular screening (lab)</li> <li>● Diabetes screening</li> <li>● Diabetes self-monitoring training</li> <li>● EKG screening (diagnostic test)</li> <li>● Glaucoma test (vision benefit)</li> <li>● HIV screening (lab)</li> <li>● Smoking Cessation counseling</li> </ul>					
<b>Self-Management and Treatment of Diabetes</b> <ul style="list-style-type: none"> <li>● Education and Training</li> <li>● Supplies</li> <li>● Insulin Pump Supplies</li> <li>● Insulin Pump/Equipment</li> <li>● Glucometer</li> </ul> <p><b>*No Copayment applies to Part B Diabetic Supplies obtained through the Mail Order Plan</b></p>	No  No  No  Yes  No	\$0 per visit  \$5 per Therapeutic Supply  \$5 per Therapeutic Supply  \$20 per unit  No Charge	No  No  No  Yes  No	\$10 per visit  \$5 per Therapeutic Supply  \$5 per Therapeutic Supply  \$20 per unit  No Charge	After CYD, Member pays 20% of Medicare allowable charges

## *Summary of Benefits*

Covered Services and Limitations	*P A R	HMO – Tier I Benefits  Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<b>Provider</b>					
<b>Inpatient Hospital Services, including emergency post-stabilization care</b>	Yes	No Charge	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<b>Outpatient Hospital Facility</b>	Yes	\$50 per admission	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<b>Ambulatory Surgical Facility Services</b>	Yes	\$25 per admission	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<b>Skilled Nursing Facility Services</b> <i>Subject to a combined HMO - Tier I; Expanded Plan Provider - Tier II; Non-Plan Provider - Tier III maximum benefit of 100 days per Benefit Period.</i>	Yes	No Charge Maximum benefit applies.	Yes	After CYD, Member pays 20% of Medicare allowable charges. Maximum benefit applies	After CYD, Member pays 20% of Medicare allowable charges. Maximum benefit applies
<b>Hospice Care Services</b> You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.  Original Medicare (rather than our plan)	No	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are	No	Hospice Care Services are covered under the HMO-Tier I Benefit	Hospice Care Services are covered under the HMO-Tier I Benefit

## *Summary of Benefits*

Covered Services and Limitations	*P A R	HMO – Tier I Benefits Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				<b>(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit</b>	
<p>will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Drugs for symptom control and pain relief</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <p>You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p> <ul style="list-style-type: none"> <li>• You can obtain your non-hospice care from plan</li> </ul>		<p>paid for by Original Medicare, not our Plan.</p>			

## Summary of Benefits

Covered Services and Limitations	*P A R	HMO – Tier I Benefits  Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<p>providers. In this case, you only pay plan allowed cost sharing</p> <ul style="list-style-type: none"> <li>--or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare.</li> </ul> <p><b>Note:</b> If you need non-hospice care (care that is not related to your</p>					

## *Summary of Benefits*

Covered Services and Limitations	*P A R	HMO – Tier I Benefits Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<p>terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>					
<p><b>Physician Surgical Services</b></p> <ul style="list-style-type: none"> <li>● Inpatient Hospital</li> <li>● Outpatient Facility</li> <li>● Physician's Office</li> <li>● Sterilizations in Physician's office</li> </ul>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No Charge</p> <p>No Charge</p> <p>\$5 per visit</p> <p>\$5 per visit</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No Charge</p> <p>\$50 per surgery</p> <p>\$10 per visit</p> <p>\$10 per visit</p>	<p>No Charge</p> <p>After CYD, Member pays 20% of Medicare allowable charges</p> <p>After CYD, Member pays 20% of Medicare allowable charges</p> <p>After CYD, Member pays 20% of Medicare allowable charges</p>
<p><b>Mastectomy Reconstructive Surgery</b></p> <ul style="list-style-type: none"> <li>● Physician Surgical Services</li> </ul>	<p>Yes</p>	<p>No Charge</p>	<p>N/A</p>	<p>Mastectomy Reconstructive</p>	<p>Mastectomy Reconstructive Surgery is</p>

## Summary of Benefits

Covered Services and Limitations	*P A R	HMO – Tier I Benefits Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<ul style="list-style-type: none"> <li>Prosthetic Device for Mastectomy Reconstruction <i>Unlimited</i></li> </ul>	Yes	\$200 or 20% of the cost per device, whichever is less	N/A	Surgery is covered under the HMO – Tier I Benefit  Prosthetic Device for Mastectomy Reconstructive Surgery is covered under the HMO – Tier I Benefit	covered under the HMO – Tier I Benefit  Prosthetic Device for Mastectomy Reconstructive Surgery is covered under the HMO – Tier I Benefit
<b>Gastric Restrictive Surgical Services</b> <ul style="list-style-type: none"> <li>Physician Surgical Services</li> <li>Inpatient Hospital Facility</li> <li>Outpatient Hospital Facility</li> </ul>	Yes	No charge  No charge  No charge	Yes	No charge  \$100 per surgery  \$50 per surgery	After CYD, Member pays 30% of EME.
<b>Infertility Office Visit Evaluation</b> Please refer to the applicable surgical procedure Copayment and/or Coinsurance amount herein for any surgical infertility procedures performed.	Yes	\$10 per visit	Yes	After CYD, Member pays 20% of EME.	After CYD, Member pays 30% of EME.
<b>Oral Surgical Physician Services</b> <ul style="list-style-type: none"> <li>Office Visit</li> <li>Physician Surgical and Diagnostic Services</li> </ul>	Yes	\$5 per visit	Yes	\$10 per visit	After CYD, Member pays 20% of Medicare allowable charges

## *Summary of Benefits*

Covered Services and Limitations	*P A R	HMO – Tier I Benefits Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				<b>(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit</b>	
- Inpatient Hospital Facility	Yes	No Charge	Yes	No Charge	No Charge
- Outpatient Hospital Facility	Yes	No Charge	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<b>Temporomandibular Joint Treatment (TMJ)</b> <i>Dental-related treatment is limited to \$2,500 per Member per Calendar Year and \$4,000 maximum lifetime benefit per Member.</i>	Yes	Member pays 50% of Medicare allowable charges. Maximum benefit applies.	N/A	TMJ Treatment is covered under the HMO – Tier I Benefit	TMJ Treatment is covered under the HMO – Tier I Benefit
<b>Surgical Assistant Services</b>	Yes	No Charge	Yes	No Charge	No Charge
<b>Anesthesia Services</b>	Yes	\$50 per surgery	Yes	After CYD, member pays 20% of Medicare allowable charges.	After CYD, member pays 20% of Medicare allowable charges.
<b>Emergency Services Within the Service Area</b>					
• Physician's Services	No	\$25 per visit	No	Emergency Services are covered under the HMO - Tier I Benefit	Emergency Services are covered under the HMO - Tier I Benefit
• Emergency Room	No	\$50 per visit, waived if admitted	No	Emergency Services are covered under the HMO - Tier I	Emergency Services are covered under the HMO - Tier I Benefit

## Summary of Benefits

Covered Services and Limitations	*P A R	HMO – Tier I Benefits  Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<ul style="list-style-type: none"> <li>Hospital Admission Emergency Stabilization <i>Applies until stabilization and safe for transfer as determined by the attending physician.</i></li> <li>Urgent Office Visit to Non-Plan Physician</li> <li>Urgent Care Facility <i>Copayment waived if admitted to the Hospital within 24 hours for the same condition.</i></li> </ul>	No	No Charge	No	Benefit  Emergency Services are covered under the HMO - Tier I Benefit	Emergency Services are covered under the HMO - Tier I Benefit
<ul style="list-style-type: none"> <li>Urgent Office Visit to Non-Plan Physician</li> <li>Urgent Care Facility <i>Copayment waived if admitted to the Hospital within 24 hours for the same condition.</i></li> </ul>	No	\$25 per visit	No	Urgent Care Facility Services are covered under the HMO – Tier I Benefit	Urgent Care Facility Services are covered under the HMO – Tier I Benefit
<ul style="list-style-type: none"> <li>Urgent Care Facility <i>Copayment waived if admitted to the Hospital within 24 hours for the same condition.</i></li> </ul>	No	\$20 per visit	No	Urgent Care Facility Services are covered under the HMO – Tier I Benefit	Urgent Care Facility Services are covered under the HMO – Tier I Benefit
<b>Emergency Services Outside the Service Area</b> <ul style="list-style-type: none"> <li>Physician's Services</li> </ul>	No	\$50 per visit	No	Emergency Services are only covered under the HMO – Tier I Benefit	Emergency Services are only covered under the HMO – Tier I Benefit

## Summary of Benefits

Covered Services and Limitations	*P A R	HMO – Tier I Benefits Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<ul style="list-style-type: none"> <li>Emergency Room</li> </ul>	No	\$50 per visit, waived if admitted	No	Emergency Services are only covered under the HMO – Tier I Benefit	Emergency Services are only covered under the HMO – Tier I Benefit
<ul style="list-style-type: none"> <li>Hospital Admission Emergency Stabilization <i>Applies until stabilization and safe for transfer as determined by the attending Physician.</i></li> </ul>	No	No Charge	No	Emergency Services are only covered under the HMO – Tier I Benefit	Emergency Services are only covered under the HMO – Tier I Benefit
<ul style="list-style-type: none"> <li>Urgent Office Visit to Non-Plan Physician</li> </ul>	No	\$25 per visit	No	Urgent Care Facility Services are covered under the HMO – Tier I Benefit	Urgent Care Facility Services are covered under the HMO – Tier I Benefit
<ul style="list-style-type: none"> <li>Non-Plan Urgent Care Facility <i>Copayment waived if admitted to the Hospital within 24 hours for the same condition.</i></li> </ul>	No	\$25 per visit	No	Urgent Care Facility Services are covered under the HMO – Tier I Benefit	Urgent Care Facility Services are covered under the HMO – Tier I Benefit
<b>Ambulance Services</b> <ul style="list-style-type: none"> <li>Emergency</li> <li>Non-Emergency</li> </ul>	No Yes	No Charge No Charge	No Yes	No Charge No Charge	No Charge No Charge
<b>Short-Term Inpatient and Outpatient Rehabilitation Services</b> <ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul>	Yes Yes	No Charge \$3 per visit	No No	No Charge After CYD,	No Charge After CYD, Member pays

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Covered Services and Limitations	*P A R	HMO – Tier I Benefits Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
				Member pays 20% of Medicare allowable charges	20% of Medicare allowable charges
<b>Laboratory Services</b> In addition to office visit Copayment.	Yes	No Charge	Yes	No Charge	After CYD, Member pays 20% of Medicare allowable charges
<b>Routine Radiological and Non-Radiological Diagnostic Imaging Services-Outpatient</b> In addition to office visit Copayment.	Yes	No Charge	Yes	No Charge	After CYD, Member pays 20% of Medicare allowable charges
<b>Other Diagnostic and Therapeutic Services</b>					
<ul style="list-style-type: none"> <li>● Anti-Cancer Drug Therapy</li> </ul>	Yes	\$10 per day	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<ul style="list-style-type: none"> <li>● ESRD Dialysis</li> </ul>	Yes	\$10 per day	Yes	Covered under the HMO – Tier I Benefit	Covered under the HMO – Tier I Benefit
<ul style="list-style-type: none"> <li>● Therapeutic Radiology</li> </ul>	Yes	\$10 per day	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<ul style="list-style-type: none"> <li>● Allergy Testing and Serum Injections</li> </ul>	Yes	\$3 per visit	Yes	\$50 Copayment Maximum per Calendar Year	After CYD, Member pays 20% of Medicare allowable charges
<ul style="list-style-type: none"> <li>● Otologic Evaluations</li> </ul>	Yes	\$10 per visit	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges

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<b>Covered Services and Limitations</b>	<b>*P A R</b>	<b>HMO – Tier I Benefits Copayments</b>	<b>*P A R</b>	<b>Expanded Plan Provider - Tier II Benefits (1)</b>	<b>Non-Plan Provider - Tier III Benefits (1)</b>
				<b>(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit</b>	
<ul style="list-style-type: none"> <li>• Other services such as complex diagnostic imaging (for example, PET scans, CT scans and MRIs); vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.</li> </ul>	Yes	No Charge	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<b>Home Health Care Services</b> <ul style="list-style-type: none"> <li>• Physician House Calls</li> <li>• Home Care Services</li> <li>• Private Duty Nursing</li> </ul>	Yes	\$20 per visit	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<b>Hearing Aids</b> <i>Limited to a combined maximum benefit of \$5,000 per member per calendar year and further limited to a single purchase. Repairs and replacement are</i>	Yes	No Charge Subject to maximum benefit.	Yes	No Charge Subject to maximum benefit.	After CYD, member pays 30% of EME. Subject to maximum benefit.

## Summary of Benefits

Covered Services and Limitations	*P A R	HMO – Tier I Benefits  Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<i>limited to once every three (3) years.</i>					
<b>Podiatry Services</b> <i>Limited to four (4) routine foot care visits per Calendar Year.</i>	No	\$20 per visit	No	\$20 per visit	After CYD, Member pays 20% of Medicare allowable charges
<b>Manual Manipulation</b>	No	\$10 per visit	No	\$20 per visit	After CYD, Member pays 20% of Medicare allowable charges
<b>Medical Supplies</b>	No	No Charge	No	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<b>Prosthetic Devices and Orthotic Devices</b>	Yes	\$200 per device	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
<b>Durable Medical Equipment</b>	Yes	No Charge	Yes	No Charge	After CYD, Member pays 20% of Medicare allowable charges
<b>Organ and Tissue Transplants</b>					
• Inpatient Hospital Services	Yes	No Charge	N/A	Organ Transplants and Retransplantations are covered under the HMO - Tier I Benefit	Organ Transplants and Retransplantations are covered under the HMO - Tier I Benefit
• Physician Surgical Services	Yes	No Charge	N/A		
• Transportation, Lodging and Meals	Yes	No Charge	N/A	Organ Transplants and	Organ Transplants and Retransplantations are

## Summary of Benefits

Covered Services and Limitations	*P A R	HMO – Tier I Benefits Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<p><i>The maximum benefit per Transplant Benefit Period for transportation, lodging and meals is \$10,000. The maximum daily limit for lodging and meals is \$200.</i></p> <ul style="list-style-type: none"> <li>• Procurement</li> <li>• Retransplantation Services</li> </ul>	<p>Yes</p> <p>Yes</p>	<p>No Charge</p> <p>No Charge</p>	<p>N/A</p> <p>N/A</p>	<p>Retransplantations are covered under the HMO - Tier I Benefit</p>	<p>covered under the HMO - Tier I Benefit</p>
<p><b>Severe Mental Illness Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	<p>Yes</p> <p>Yes</p>	<p>No Charge</p> <p>\$5 per visit</p>	<p>Yes</p> <p>Yes</p>	<p>No Charge</p> <p>\$10 per visit</p>	<p>No Charge</p> <p>After CYD, Member pays 20% of EME.</p>
<p><b>Enteral Formulas Special Food Products</b></p>	<p>Yes</p>	<p>No Charge</p>	<p>Yes</p>	<p>After CYD, Member pays 20% of Medicare allowable charges</p>	<p>After CYD, Member pays 20% of Medicare allowable charges</p>
<p><b>Mental Health Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient <i>(unlimited days)</i></li> <li>• Outpatient Group Therapy <i>(unlimited visit)</i></li> <li>• Outpatient Therapy - Individual, Marital, Family and Partial Care</li> </ul>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No Charge</p> <p>\$5 per visit</p> <p>\$10 per visit</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No Charge</p> <p>\$10 per visit</p> <p>\$10 per visit</p>	<p>No Charge</p> <p>After CYD, Member pays 20% of Medicare allowable charges</p> <p>After CYD, Member pays 20% of Medicare allowable charges</p>

## Summary of Benefits

Covered Services and Limitations	*P A R	HMO – Tier I Benefits  Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<b>Substance Abuse Services</b> <ul style="list-style-type: none"> <li>● Inpatient Detoxification/ Rehabilitation</li> <li>● Outpatient Detoxification</li> <li>● Outpatient Rehabilitation Group Therapy</li> <li>● Individual, Marital, Family and Partial Care.</li> </ul>	Yes	No Charge	Yes	No Charge	No Charge
	Yes	\$5 per visit	Yes	\$10 per visit	After CYD, Member pays 20% of Medicare allowable charges
	Yes	\$5 per visit	Yes	\$10 per visit	After CYD, Member pays 20% of Medicare allowable charges
	Yes	1st visit-No Charge; subsequent visits-\$10 per visit	Yes	\$10 per visit	After CYD, Member pays 20% of Medicare allowable charges
<b>Genetic Disease Testing Services</b> <ul style="list-style-type: none"> <li>● Comprehensive Breast Cancer Genetic Disease Testing Services</li> <li>● Partial Breast Cancer Genetic Disease Testing Services</li> <li>● All other covered Genetic Disease Testing Services</li> </ul>	Yes	Member pays 25% of EME per test	N/A	Genetic Disease Testing Services are covered under the HMO – Tier I Benefit	Genetic Disease Testing Services are covered under the HMO – Tier I Benefit
	Yes	Member pays 25% of EME per test	N/A		
	Yes	Member pays 25% of EME per test	N/A		

## *Summary of Benefits*

Covered Services and Limitations	*P A R	HMO – Tier I Benefits Copayments	*P A R	Expanded Plan Provider - Tier II Benefits <sup>(1)</sup>	Non-Plan Provider - Tier III Benefits <sup>(1)</sup>
				(CYD, Coinsurance and/or Copayments) HPN pays the remainder of the Medicare allowable charges balance up to the applicable maximum benefit	
<b>Post-Cataract Surgical Services</b> <ul style="list-style-type: none"> <li>● Frames and Lenses <i>Maximum frame allowance of \$100.</i></li> <li>● Contact Lenses <i>Maximum contact lenses allowance of \$100.</i></li> </ul> <p><i>Benefit limited to one (1) pair of glasses or set of contact lenses as applicable per Member per surgery.</i></p>	Yes	\$10 per pair of glasses	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges
	Yes	\$10 per set of contact lenses	Yes	After CYD, Member pays 20% of Medicare allowable charges	After CYD, Member pays 20% of Medicare allowable charges

\*Prior Authorization Required – Except as otherwise noted, All Covered Services not provided by the Member’s Primary Care Physician require Prior Authorization in the form of a written referral authorization from HPN. Please refer to your Trust’s Classic Retiree Evidence of Coverage for additional information.

(1) Expanded Plan Provider - Tier II and Non-Plan Provider - Tier III Benefits are underwritten by HPN. If Medically Necessary Covered Services are provided without the required Prior Authorization, benefits are reduced to 50% of what the Member would have received with Prior Authorization. The Medicare program will not be responsible for charges that are not paid by Health Plan.

## *Summary of Benefits*

<b>Prescription Drug Benefit Program</b>			
<b>If the actual cost of a drug is less than the normal cost sharing amount for that drug, you will pay the actual cost, not the higher cost sharing amount.</b>			
	<b>Tier I</b>	<b>Tier II</b>	<b>Tier III</b>
	<b>Retail Plan Pharmacy</b>	<b>Retail Plan Pharmacy</b>	<b>Retail Plan Pharmacy</b>
No Benefit Maximum applies.  For a one-month supply at a retail plan pharmacy.  For a 90-day supply at a retail plan pharmacy.	<b>Generic</b>  \$5 per 31-day Therapeutic Supply  \$15 per 90-day Supply	<b>Preferred Brand Name</b>  \$10 per 31-day Therapeutic Supply  \$30 per 90-day Supply	<b>Non-Preferred Brand Name Covered Drug</b>  \$20 per 31-day Therapeutic Supply  \$60 per 90-day Supply
	<b>Mail Order Plan Pharmacy</b>	<b>Mail Order Plan Pharmacy</b>	<b>Mail Order Plan Pharmacy</b>
No Benefit Maximum applies.	<b>Generic</b>  \$5 per 90-day Maintenance Supply	<b>Preferred Brand Name</b>  \$10 per 90-day Maintenance Supply	<b>Non-Preferred Brand Name Covered Drug</b>  \$20 per 90-day Maintenance Supply
	<b>Non-Plan Pharmacy</b>	<b>Non-Plan Pharmacy</b>	<b>Non-Plan Pharmacy</b>
No Benefit Maximum applies.	Member pays 30% of EME per 31-day Therapeutic Supply <b>plus</b> \$5 Copayment.	Member pays 30% of EME per 31-day Therapeutic Supply <b>plus</b> \$10 Copayment.	Member pays 30% of EME per 31-day Therapeutic Supply <b>plus</b> \$20 Copayment.

Si usted habla Español y necesita asistencia con esta forma o tiene alguna pregunta acerca de su cobertura con Trust's Classic Retiree Plan tenemos representantes disponibles para asistirle. Puede llamarnos al servicio del cliente de Trust's Classic Retiree Plan al 702-562-8077 or 800-279-4863 (TTY 711):

- De octubre 15, 2011 hasta de febrero 14, 2012 - 7 días de la semana de 8:00 a.m.-8:00 p.m.
- Comenzando de febrero 15, 2012 hasta octubre 14, 2012 - lunes a viernes de 8:00 a.m.-8:00 p.m. Llamadas recibidas los sábados, domingos y los días festivos serán contestadas por nuestro sistema de teléfono automatizado (donde usted podrá dejar un mensaje detallado, y un representante le regresará su llamada lo más pronto posible.)

## *Summary of Benefits*

If you speak Spanish and need assistance with this summary or have questions about your coverage with the Trust's Classic Retiree Plan, we have representatives who can help you. Please call Customer Service at 702-562-8077 or 800-279-4863 (TTY 711):

- From October 15, 2011 through February 14, 2012 7 days per week from 8:00 a.m. – 8:00 p.m.
- Beginning February 15, 2012 through October 14, 2012 Monday - Friday from 8:00 a.m. to 8:00 p.m. Calls on Saturday, Sunday and holidays will be received by our automated phone system (where you can leave a detailed message, and a representative will return your call as soon as possible).

The Trust's Classic Retiree Plan is insured through Health Plan of Nevada, Inc., a UnitedHealthcare Insurance Company and Medicare Advantage organization with a Medicare contract. Anyone with Medicare Parts A & B may apply. You must continue to pay your Medicare premiums. Prescription coverage subject only to quantity limitations.