2016 Summary of BENEFITS

Classic Retiree Plan (HMO-POS)

Your Medicare coverage as a Member of Administrators' and Professional-technical Employees' Welfare Trust ("Trust")

Plan Year 2016

H2931-801

Y0066_150915_443355

SECTION 1 – INTRODUCTION TO SUMMARY OF BENEFITS

Your Health Care Coverage

This plan is offered through your Plan Sponsor.

You may be able to join or leave a plan only at certain times designated by your Plan Sponsor. If you choose to enroll in a Medicare health plan or Medicare Prescription Drug plan that is not offered by your Plan Sponsor, you may lose the option to enroll in a plan offered by your Plan Sponsor in the future. You could also lose coverage for other Plan Sponsor retirement benefits you may currently have. Once enrolled in our plan, if you choose to end your membership outside of your Plan Sponsor's open enrollment period, re-enrollment in any plan your Plan Sponsor offers may not be permitted, or you may have to wait until their next open enrollment period.

It is important to understand your Plan Sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other benefits before submitting a request to enroll in a plan not offered by your Plan Sponsor, or a request to end your membership in our plan.

For more information please call Classic Retiree Plan (HMO–POS) at the number listed below.

If you want information about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About Classic Retiree Plan (HMO–POS)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at **1-800-279-4863**.

THINGS TO KNOW ABOUT CLASSIC RETIREE PLAN (HMO–POS)

Hours of Operation

You can call us October 1 through February 14: 8 a.m. to 8 p.m. local time, 7 days a week.
Between February 15 through September 30: 8 a.m. to 8 p.m. local time, Monday – Friday.

Classic Retiree Plan (HMO–POS) Phone Numbers and Website

- Call toll-free at **1-800-279-4863**.
- Our website: www.SeniorDimensions.com

Who can join?

To join Classic Retiree Plan (HMO–POS) you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area and you meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the following counties in Nevada: Clark, Esmeralda, Lyon, Mineral, Nye.

The service area for this plan includes these parts of counties in Nevada: Washoe the following zip codes only:

89431, 89432, 89433, 89434, 89435, 89436, 89441, 89442, 89501, 89502, 89503, 89504, 89505, 89506, 89507, 89508, 89509, 89510, 89511, 89512, 89513, 89515, 89519, 89520, 89521, 89523, 89533, 89555, 89557, 89570, 89595, 89599.

Which doctors, hospitals and pharmacies can I use?

Classic Retiree Plan (HMO–POS) has a network of doctors, hospitals, pharmacies and other providers. For some services you can use providers that are not in our network. If you use the providers that are not in our network, you may pay more for your covered services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website www.SeniorDimensions.com. Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers — and more.

- **Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.SeniorDimensions.com
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of two "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If the actual cost for 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.

SECTION 2 – SUMMARY OF BENEFITS

If you have any questions about this plan's benefits or costs, please contact Classic Retiree Plan (HMO–POS) for details.

<table>
<tr><th colspan="2">MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES</th></tr>
<tr><td>How much is the monthly premium?</td><td>Contact your group plan benefit administrator to determine your actual premium amount, if applicable.</td></tr>
<tr><td>How much is the deductible?</td><td>$75 annual deductible for Tier II expanded network and Tier III out-of-network Medicare-covered services.</td></tr>
<tr><td>Is there any limit on how much I will pay for my covered services?</td><td>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

Your yearly limit in this plan:
$2,500 when using Tier I providers
$1,500 per individual/$4,500 per family when using Tier II providers
$3,000 per individual/$9,000 per family when using Tier III providers
If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the plan year.

Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs, if applicable.</td></tr>
<tr><td>Is there a limit on how much the plan will pay?</td><td>No. There are no limits on how much our plan will pay.</td></tr>
<tr><th colspan="2">COVERED MEDICAL AND HOSPITAL BENEFITS</th></tr>
<tr><th colspan="2">OUTPATIENT CARE AND SERVICES</th></tr>
<tr><td>Ambulance</td><td>In-network Tier I: $0 copay
Expanded network Tier II: $0 copay
Out-of-network Tier III: $0 copay</td></tr>
</table>

Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network Tier I: $10 copay • Expanded network Tier II: $20 copay • Out-of-network: 20% of the cost
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network Tier I: $5 copay • Expanded network Tier II: $10 copay • Out-of-network Tier III: 20% of the cost
Diabetes Supplies and Services	Diabetes monitoring supplies: • In-network Tier I: $0 to $5 copay • Expanded network Tier II: $0 to $5 copay • Out-of-network Tier III: 20% of the cost Diabetes self-management training: • In-network Tier I: $0 copay • Expanded network Tier II: $10 copay • Out-of-network Tier III: 20% of the cost Therapeutic shoes or inserts: • In-network Tier I: $200 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost

Service	Costs
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for services may be different if received in an outpatient surgery setting)	Diagnostic radiology services (such as MRIs, CT scans): • In-network Tier I: $0 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost Diagnostic tests and procedures: • In-network Tier I: $0 copay • Expanded network Tier II: $0 copay • Out-of-network Tier III: 20% of the cost Lab services: • In-network Tier I: 0% to 25% of the cost • Expanded network Tier II: $0 copay • Out-of-network Tier III: 20% of the cost Outpatient x-rays: • In-network Tier I: $0 copay • Expanded network Tier II: $0 copay • Out-of-network Tier III: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network Tier I: $10 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost
Doctor's Office Visits	Primary care provider visit: • In-network Tier I: $5 copay • Expanded network Tier II: $10 copay • Out-of-network Tier III: 20% of the cost Specialist visit: • In-network Tier I: $10 copay • Expanded network Tier II: $20 copay • Out-of-network Tier III: 20% of the cost
Durable Medical Equipment (wheelchairs, oxygen, etc.)	• In-network Tier I: $0 to $20 copay • Expanded network Tier II: $0 to $20 copay • Out-of-network Tier III: 20% of the cost
Emergency Care	• $50 copay

Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network Tier I: $10 copay • Expanded network Tier II: $20 copay • Out-of-network Tier III: 20% of the cost **Additional benefit not covered by Original Medicare** Routine foot care (for up to 4 visits every plan year): • In-network Tier I: $20 copay for each visit • Expanded network Tier II: $20 copay for each visit • Out-of-network Tier III: 20% of the cost for each visit
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network Tier I: $10 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost **Additional benefit not covered by Original Medicare** Hearing aids are limited to a combined maximum benefit of $5,000 per member per calendar year and further limited to a single purchase: • In-network Tier I: $0 copay • Expanded network Tier II: $0 copay • Out-of-network Tier III: 30% coinsurance
Home Health Care	• In-network Tier I: $0 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost

Mental Health Care	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay: • In-network Tier I: $0 copay per stay • Expanded network Tier II: $0 copay per stay • Out-of-network Tier III: $0 copay per stay Outpatient group therapy visit: • In-network Tier I: $5 copay • Expanded network Tier II: $10 copay • Out-of-network Tier III: 20% of the cost Outpatient individual therapy visit: • In-network Tier I: $10 copay • Expanded network Tier II: $10 copay • Out-of-network Tier III: 20% of the cost
Outpatient Rehabilitation	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network Tier I: $3 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost Occupational therapy visit: • In-network Tier I: $3 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost Physical therapy and speech and language therapy visit: • In-network Tier I: $3 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost
Outpatient Substance Abuse	Group therapy visit: • In-network Tier I: $5 copay • Expanded network Tier II: $10 copay • Out-of-network Tier III: 20% of the cost Individual therapy visit: • In-network Tier I: $5 copay • Expanded network Tier II: $10 copay • Out-of-network Tier III: 20% of the cost

Outpatient Surgery	Ambulatory surgical center: • In-network Tier I: $25 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost Outpatient hospital: • In-network Tier I: $50 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost
Prosthetic Devices (braces, artificial limbs, etc.)	Prosthetic devices: • In-network Tier I: $200 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost Related medical supplies: • In-network Tier I: $0 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost
Renal Dialysis	• In-network Tier I: $10 copay • Expanded network Tier II: $10 copay • Out-of-network Tier III: $10 copay
Urgently Needed Services	• In-network Tier I: $20 copay • Expanded network Tier II: $20 copay • Out-of-network Tier III: $25 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye: • In-network Tier I: $10 copay • Expanded network Tier II: $20 copay • Out-of-network Tier III: 20% of the cost Yearly glaucoma screening: • In-network Tier I: $0 copay • Expanded network Tier II: $20 copay • Out-of-network Tier III: 20% of the cost Eyeglasses or contact lenses after cataract surgery: • In-network Tier I: $10 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost

Preventive Care	
	• In-network Tier I: You pay nothing • Expanded network Tier II: Please see the Evidence of Coverage • Out-of-network Tier III: Please see the Evidence of Coverage Our plan covers many preventive services, including but not limited to: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colonoscopy, Colorectal cancer screenings, Fecal occult blood test, Flexible sigmoidoscopy • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, • Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.

Preventive Care (continued)	**Additional benefit not covered by Original Medicare**
	Fitness program:
	• $0 membership fee.
	• There is no visit or use fee for basic membership when you use network service providers.
	Nursing Hotline:
	• Nursing Hotline services available, 24 hours a day, 7 days a week. Speak to a registered nurse (RN) about your medical concerns and questions.
	  • 1-702-242-7330
	  • 1-800-288-2264
	  • TTY 1-800-326-6888

Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
INPATIENT CARE	
Inpatient Hospital Care	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network Tier I: $0 copay per stay • Expanded network Tier II: 20% of the cost per stay • Out-of-network Tier III: 20% of the cost per stay
Inpatient Mental Health Care	For inpatient mental health care, see the “Mental Health Care” section of this booklet.
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. • In-network Tier I: $0 copay per stay • Expanded network Tier II: 20% of the cost per stay • Out-of-network Tier III: 20% of the cost per stay
PRESCRIPTION DRUG BENEFITS	
How much do I pay?	For Part B drugs such as chemotherapy drugs: • In-network Tier I: $10 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost Other Part B drugs: • In-network Tier I: $10 copay • Expanded network Tier II: 20% of the cost • Out-of-network Tier III: 20% of the cost Our plan covers Part D prescription drugs and the following charts below further explain your cost sharing.

<table>
<tr><td>Initial Coverage</td><td>You pay the following until total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Retail cost shares

For a one month (30-day) supply

Tier 1: Generic
$5 copay
Tier 2: Brand
$10 copay
Mail Order Pharmacy

For a three month (100-day) supply

Tier 1: Generic
$5 copay
Tier 2: Brand
$10 copay
You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</td></tr>
<tr><td>Coverage Gap</td><td>After you enter the coverage gap, we will continue to pay our share of the cost of your drugs and you pay your share of the cost.</td></tr>
<tr><td>Catastrophic Coverage</td><td>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850 you pay the greater of:

5% of the costs, or $2.95 copay for generic (including brand drugs treated as generic) and $7.40 copay for all other drugs</td></tr>
</table>

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-279-4863. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-279-4863 . Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-279-4863 。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-279-4863 。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-279-4863 . Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-279-4863 . Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-279-4863 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-279-4863. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-279-4863 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-279-4863 . Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه . سيقوم شخص ما يتحدث العربية 1-800-279-4863 ترجم فوري، ليس عليك سوى الاتصال بنا على خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-279-4863 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-279-4863 . Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-279-4863 . Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal wa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-279-4863. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-279-4863. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-279-4863 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

For more information, please contact Customer Service at:

Toll-Free **1-800-279-4863**, TTY **711**

October 1 through February 14: 8 a.m. to 8 p.m. local time, 7 days a week.
Between February 15 through September 30: 8 a.m. to 8 p.m. local time, Monday – Friday

A UnitedHealthcare® Medicare Solution

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. This information is not a complete description of benefits. Contact the plan for information. Limitations, co-payments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.

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