

Summary of Benefits Report

State of Nevada (PEBP) Value Group (HMO) Plan

If you have any questions about this plan's benefits or costs, please contact Senior Care Plus.

Benefit Category	Original Medicare	State of Nevada (PEBP) Value Group (HMO) Plan
<p>1 – Premium and Other Important Information</p>	<p>In 2010 the monthly Part B Premium is \$96.40 and the yearly Part B deductible amount is \$155.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p><u>General</u> See your State Retiree Open Enrollment booklet or the State PEBP Representative for specific plan premiums.</p> <p><u>In-Network</u> \$3,000 out-of-pocket limit.</p> <p>All plan services included.</p> <p>See page 53 for additional information on out-of-pocket limit and plan services.</p>
<p>2 – Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p><u>In-Network</u> NO referral required for network doctors, specialist, and hospitals.</p> <p>You must go to network doctors, specialist, and hospitals.</p>

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SUMMARY OF BENEFITS		
INPATIENT CARE		
<p>3 – Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2010 the amounts for each benefit period are:</p> <p>Days 1-60: \$1,100 deductible</p> <p>Days 61-90: \$275 per day</p> <p>Days 91-150: \$550 per lifetime reserve day</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><u>In-Network</u></p> <p>For Medicare-covered hospital stays:</p> <p>Days 1-4: \$150 copay per day</p> <p>Days 5-90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>See page 53 for more additional information about inpatient and inpatient mental health.</p>
<p>4 – Inpatient Mental Health Care</p>	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p><u>In-Network</u></p> <p>For Medicare-covered hospital stays:</p> <p>Days 1-4: \$150 copay per day</p> <p>Days 5-90: \$0 copay per day</p> <p>Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:</p> <p>Days 1-4: \$150 copay per day</p> <p>Days 5-90: \$0 copay per day</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

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5 – Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	<p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <p>Days 1-20: \$0 per day</p> <p>Days 21- 100: \$137.50 per day</p> <p>100 days for each benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> For SNF stays: Days 1-15: \$0 copay per day Days 16-100: \$50 copay per day Plan covers up to 100 days each benefit period</p> <p>No Prior hospital stay is required.</p>
6 – Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay	<p><u>General</u> Authorization rules may apply</p> <p><u>In-Network</u> \$0 copay for each Medicare-covered home health visits. \$150 copay for Respite care. \$150 copay for Custodial Care See page 53 for more additional information about respite and Custodial Care</p>
7 – Hospice	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must receive care from a Medicare-certified hospice.</p>	<p><u>General</u> You must receive care from a Medicare-certified hospice.</p>

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OUTPATIENT CARE		
8 – Doctor Office Visits	20% coinsurance	<p><u>General</u> See “Physical Exams” for more information.</p> <p><u>In-Network</u> \$15 copay for each primary care doctor visit for Medicare-covered benefits. \$40 copay for each specialist visit for Medicare-covered benefits. \$20 copay for each in-area network urgent care Medicare-covered visit.</p>
9 – Chiropractic Services	Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a Chiropractor or other qualified provider.	<p><u>In-Network</u> \$40 copay for each Medicare-covered visit. Medicare-covered Chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a Chiropractor or other qualified provider.</p>
10 – Podiatry Services	Routine care not covered 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	<p><u>In-Network</u> \$40 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
11 – Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	<p><u>In-Network</u> \$40 copay for Medicare-covered individual or group therapy visit.</p>
12 – Outpatient Substance Abuse Care	20% coinsurance	<p><u>In-Network</u> \$40 copay for each Medicare-covered individual or group therapy visit.</p>

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13 – Outpatient Services / Surgery	20% coinsurance for the doctor 20% of outpatient facility charges	<u>General</u> Authorization rules may apply <u>In-Network</u> \$150 copay for each Medicare-covered ambulatory surgical center visit. \$0 to \$150 copay for each Medicare-covered outpatient hospital facility visit.
14 – Ambulance Services (medically necessary ambulance services)	20% coinsurance	<u>In-Network</u> \$150 copay for each Medicare-covered ambulance benefits.
15 – Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.	<u>In-Network</u> \$50 copay for Medicare-covered emergency room visits Worldwide coverage If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.
16 – Urgently Needed Care (This is NOT emergency care, and in most cases is out of the service area.)	20% coinsurance, or set copay NOT covered outside the U.S. except under limited circumstances.	<u>General</u> \$20 copay for Medicare-covered urgently needed care visits. If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit. See page 53 for additional information about Urgently Needed Care.
17 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	<u>In-Network</u> \$20 copay for Medicare-covered Occupational Therapy, Physical and/or Speech/Language Therapy visit. See page 54 for additional information about Outpatient Services.

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OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	<p><u>General</u> Authorization rules may apply</p> <p><u>In-Network</u> 20% of the cost for Medicare-covered items.</p>
19 – Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	<p><u>General</u> Authorization rules may apply</p> <p><u>In-Network</u> 20% of the cost for Medicare-covered item.</p>
20 – Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	<p>20% coinsurance</p> <p>Nutrition Therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietician or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><u>In-Network</u> \$0 copay for Diabetes self-monitoring training.</p> <p>\$40 copay for Nutrition Therapy for Diabetes.</p> <p>0% to 20% of the cost for Diabetes supplies.</p> <p>Separate Office Visit cost sharing of \$15 copay may apply.</p>
21 – Diagnostic Tests, X-Rays, and Lab Services	<p>20% coinsurance for diagnostic tests and x-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvements Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p><u>In-Network</u> \$0 to \$50 copay for Medicare-covered lab services.</p> <p>\$0 copay for Medicare-covered Routine Lab.</p> <p>\$0 to \$50 copay for Medicare-covered diagnostic procedures and tests.</p> <p>\$50 copay for Medicare-covered X-rays.</p> <p>\$0 to \$50 copay for Medicare-covered diagnostic radiology services.</p> <p>\$0 to \$50 copay for Medicare-covered therapeutic radiology services.</p> <p>See page 54 for additional information about x-ray and lab services.</p>

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PREVENTIVE SERVICES		
22 – Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<u>In-Network</u> \$0 copay for Medicare-covered bone mass measurement. Separate Office Visit cost sharing of \$15 copay may apply.
23 – Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	<u>In-Network</u> \$50 copay for Medicare-covered Colorectal Screening. \$50 copay up to 1 additional screening(s) every two years.
24 – Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccines. You may only need the Pneumonia vaccines once in your lifetime. Call your doctor for more information.	<u>In-Network</u> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccines. No referral needed for Medicare-covered Flu and Pneumonia vaccines.
25 – Mammograms (Annual Screening - for women with Medicare age 40 and older)	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	<u>In-Network</u> \$0 copay for Medicare-covered Mammograms, and additional screening Mammograms - additional screening mammograms Separate Office Visit cost sharing of \$15 copay may apply. No limit on the number of covered screening mammograms.
26 – Pap Smears and Pelvic Exams (for women with Medicare)	\$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams	<u>In-Network</u> \$0 copay for Medicare-covered pap smears and Pelvic exams - additional pap smears and pelvic exams Separate Office Visit cost sharing of \$15 copay may apply. No limit on the number of Medicare-covered Pap Smears and Pelvic exams.

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27 – Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	<p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p><u>In-Network</u></p> <p>\$0 copay for Medicare-covered Prostate Cancer screening - additional screening</p> <p>Separate Office Visit cost sharing of \$15 copay may apply.</p> <p>No limit on the number of Prostate Cancer screening.</p>
28 – End Stage Renal Disease (ESRD)	<p>20% coinsurance for dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but are not on dialysis or have not had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><u>In-Network</u></p> <p>20% of the cost for renal dialysis.</p> <p>\$40 copay for Nutrition Therapy for End-Stage Renal Disease.</p>
29 – Prescription Drugs	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p><u>DRUGS COVERED UNDER MEDICARE PART B</u></p> <p><u>General</u></p> <p>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>See page 54 for additional information about Part B drugs.</p> <p><u>DRUGS COVERED UNDER MEDICARE PART D</u></p> <p><u>General</u></p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.hometownhealth.com/SCPlus/scp_m_prescriptions.asp on the web.</p>

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29 - Prescription Drugs continued		<p>Different out-of-pocket costs may apply for people who:</p> <ul style="list-style-type: none"> - have limited incomes - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Services). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quality limits.</p> <p>Your provider must get prior authorization from Senior Care Plus: for certain drugs.</p> <p>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.</p> <p>If you request a formulary exception in this plan, you will pay Non-Preferred Brand cost-sharing.</p> <p><u>In-Network</u></p> <p>\$0 deductible</p> <p>Some covered drugs don't count toward your out-of-pocket drug costs.</p>

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29 - Prescription Drugs continued		<p><u>INITIAL COVERAGE</u> You pay the following until total yearly drug costs reach \$4,550:</p> <p><u>RETAIL PHARMACY</u></p> <p><u>Preferred Generic</u> \$2 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>\$5 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Generic</u> \$6 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>\$15 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Preferred Brand Name</u> \$35 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>\$87.50 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Brand Name</u> \$70 copay for a one-month (30-day) supply of drugs in this tier.</p> <p>\$175 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Special Pharmaceutical</u> 33% coinsurance for a one-month (30-day) supply of drugs in this tier.</p> <p>33% coinsurance for a three-month (90-day) supply of drugs in this tier.</p> <p><u>LONG TERM CARE PHARMACY</u></p> <p><u>Preferred Generic</u> \$2 copay for a one-month (31-day) supply of drugs in this tier.</p>

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29 - Prescription Drugs continued		<p><u>Non-Preferred Generic</u> \$6 copay for a one-month (31-day) supply of drugs in this tier.</p> <p><u>Preferred Brand Name</u> \$35 copay for a one-month (31-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Brand Name</u> \$70 copay for a one-month (31-day) supply of drugs in this tier.</p> <p><u>Special Pharmaceutical</u> 33% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p><u>MAIL ORDER</u></p> <p><u>Preferred Generic</u> \$6 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Generic</u> \$15 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Preferred Brand Name</u> \$87.50 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Brand Name</u> \$175 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Special Pharmaceutical</u> 33% coinsurance for a three-month (90-day) supply of drugs in this tier.</p> <p><u>COVERAGE GAP</u> The Plan covers all drugs through the coverage gap. You pay the following:</p>

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29 - Prescription Drugs continued		<p><u>RETAIL PHARMACY</u></p> <p><u>Preferred Generic</u> \$2 copay for a one-month (30-day) supply of drugs in this tier. \$5 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Generic</u> \$6 copay for a one-month (30-day) supply of drugs in this tier. \$15 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Preferred Brand</u> \$35 copay for a one-month (30-day) supply of drugs in this tier. \$87.50 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Brand</u> \$70 copay for a one-month (30-day) supply of drugs in this tier. \$175 copay for a three-month (90-day) supply of drugs in this tier.</p> <p><u>Special Pharmaceutical</u> 33% coinsurance for a one-month (30-day) supply of drugs in this tier. 33% coinsurance for a three-month (90-day) supply of drugs in this tier.</p> <p><u>LONG TERM CARE PHARMACY</u></p> <p><u>Preferred Generic</u> \$2 copay for a one-month (31-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Generic</u> \$6 copay for a one-month (31-day) supply of drugs in this tier.</p>

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29 - Prescription Drugs Continued		<p><u>OUT-OF-NETWORK</u></p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Senior Care Plus: Value Rx Enhanced Plan (HMO).</p> <p><u>OUT-OF-NETWORK INITIAL COVERAGE</u></p> <p>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$4,550:</p> <p><u>Preferred Generic</u> \$2 copay for a one-month (30-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Generic</u> \$6 copay for a one-month (30-day) supply of drugs in this tier.</p> <p><u>Preferred Brand Name</u> \$35 copay for a one-month (30-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Brand Name</u> \$70 copay for a one-month (30-day) supply of drugs in this tier.</p> <p><u>Special Pharmaceutical</u> 33% coinsurance for a one-month (30-day) supply of drugs in this tier.</p>

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29 - Prescription Drugs Continued		<p><u>OUT-OF-NETWORK COVERAGE GAP</u></p> <p>You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p><u>Preferred Generic</u> \$2 copay for a one-month (30-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Generic</u> \$6 copay for a one-month (30-day) supply of drugs in this tier.</p> <p><u>Preferred Brand</u> \$35 copay for a one-month (30-day) supply of drugs in this tier.</p> <p><u>Non-Preferred Brand</u> \$70 copay for a one-month (30-day) supply of drugs in this tier.</p> <p><u>Special Pharmaceutical</u> 33% coinsurance for a one-month (30-day) supply of drugs in this tier.</p> <p><u>OUT-OF-NETWORK CATASTROPHIC COVERAGE</u></p> <p>After your yearly out-of-pocket drug cost reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance.

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30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p><u>In-Network</u> \$40 copay for Medicare-covered dental benefits.</p> <p>Routine Dental Contact your State PEBP representative.</p>
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 copay for hearing aids. \$0 to \$40 copay for Medicare-covered diagnostic hearing exams \$0 to \$40 copay for up to 1 routine hearing test(s) every three years \$0 to \$40 copay for up to 1 hearing aid fitting evaluation(s) every three years \$300 limit for hearing aids every three year. See page 55 for additional information on hearing aids through TurHearing.</p>
32 - Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><u>In-Network</u> 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery. \$20 copay for exams to diagnose and treat diseases and conditions of the eye. \$20 copay for up to 1 routine eye exam(s) every year 0% of the cost for up to 1 pair(s) of contacts every two years 0% of the cost for up to 1 pair(s) of lenses every two years 0% of the cost for up to 1 frame(s) every two years</p>

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32 - Vision Services continued		<p>\$125 limit for contact lenses every two years.</p> <p>\$125 limit for eye glass frames every two years.</p> <p>See page 55 for additional information on routine vision through Vision Service Plan (VSP).</p>
33 - Physical Exams	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p><u>In-Network</u></p> <p>\$0 copay for routine exams.</p> <p>Limited to 1 exam every year.</p> <p>Separate Office visit cost-sharing of \$15 copay may apply.</p>
Health/Wellness Education	<p>Smoking Cessation:</p> <p>Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p>	<p><u>General</u></p> <p>Please visit our plan Web site to see our list of covered Over-the-Counter items. OTC items may be purchased only for the enrollee.</p> <p>Please contact the plan for specific instructions for using this benefit.</p> <p><u>In-Network</u></p> <p>This plan covers the following: health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials - Newsletter - Nutrition Training - Nutrition benefit - Additional Smoking Cessation - Health Club – Membership/Fitness Classes - Nursing Hotline - \$0 copay for each Medicare-covered smoking cessation counseling session.

Summary of Benefits Report

State of Nevada (PEBP) Value Group (HMO) Plan

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Benefit Category	Original Medicare	State of Nevada (PEBP) Value Group (HMO) Plan
Transportation (Routine)	Not Covered	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 copay for each round trip to plan-approved location.</p>
Acupuncture	Not Covered	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$40 copay per visit up to 2 visit(s) every year.</p>
ADDITIONAL INFORMATION FOR THE VALUE Rx ENHANCED PLAN (HMO)		
<p><u>Out-of-Pocket Limit</u></p> <ul style="list-style-type: none"> Only medical benefits count towards your \$3,000 out-of-pocket limit. 		
<p><u>Inpatient Hospital & Inpatient Mental Health Care</u></p> <ul style="list-style-type: none"> \$150 each day for 4 days for Inpatient using in-network hospital(s) each service period. \$150 each day for 4 days for Inpatient Mental Health using in-network hospital(s) limited to 190-days Lifetime for inpatient mental health services in a psychiatric hospital. “Service Period” There is no additional copayments for Inpatient Hospital – Acute Services when re-admitted to a contracted facility during a “service” period or within 30 days of last discharge. A “service” period starts the day you go into a hospital and ends when you go for 30 days without hospital care. If you go into the hospital after one “service” period has ended, a new “service” period begins. You may pay up to the “maximum” inpatient hospital copayment(s) for each “service” period. There is no limit to the number of “service” periods you can have in one year. 		
<p><u>Home Health Care</u></p> <p style="margin-left: 20px;"><u>Custodial Care</u></p> <ul style="list-style-type: none"> \$150 copay for in-network custodial care. Custodial care is limited to 5 days per calendar year and may be provided either in a Skilled Nursing Facility (SNF) or at home (up to 8 hours per day). <p style="margin-left: 20px;"><u>Respite Care</u></p> <ul style="list-style-type: none"> \$150 copay per visit for in-network respite care for temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program so that the usual caregiver can rest or take some time off. 		
<p><u>Urgently Needed Care</u></p> <ul style="list-style-type: none"> \$20 copay for services rendered at an Urgent Care Facility in-network (preferred). 		

Summary of Benefits Report

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Benefit Category	Original Medicare	State of Nevada (PEBP) Value Group (HMO) Plan
<u>Outpatient Services</u>		
<ul style="list-style-type: none"> \$15 copay for Cardiac Rehabilitation per visit in-network. \$50 copay for Comprehensive Outpatient Rehabilitation Facility Services (CORF). \$50 copay for Colorectal Screening exam in-network. Colonoscopy, flexible sigmoidoscopy and endoscopy procedures covered when preformed during a colorectal screening. 		
<u>Diagnostic Tests – X-rays and Lab Services</u>		
<ul style="list-style-type: none"> \$0 copay for Routine Lab in-network \$50 copay per visit for diagnostic X-ray(s) or lab services in-network \$50 copay per visit for CT Scan(s) in-network \$50 copay per visit for MRI/PET Scan(s)/Nuclear Medicine in-network 		
<u>Medicare Part B Drugs</u>		
<ul style="list-style-type: none"> Medicare Part B Drugs are covered at 20% coinsurance. Separate Office Visit cost sharing of \$15 copay may apply. Original Medicare covers a limited number of prescription drugs and self-administered drugs. Refer to your Evidence of Coverage (EOC) booklet for listing. 		
<u>Medicare Part D Prescription Drugs</u>		
<p>After you reach a yearly out-of-pocket drug cost of \$4,550 then you pay the greater of: \$2.50 for generic (including brand name drugs treated as generic) and \$6.30 for all other drugs, or 5% coinsurance.</p>		
<u>Over-the-Counter (OTC) Medication</u>		
<p>\$5 Generic copay per one-month supply.</p> <ul style="list-style-type: none"> Omeprazole (QLL#42) (Generic for Prilosec) Loratadine (QLL#30) (Generic for Claritin) Cetirizine (QLL#30) (Generic for Zyrtec) Lansoprazole (QLL#30) (Generic for Prevacid) 		
<u>Diabetic Supplies</u>		
<ul style="list-style-type: none"> \$0 copay or coinsurance for blood glucose monitors in-network (SCP has limited supplies) 20% of the cost for in-network supplies 		
<u>Visitor/Travel Program</u>		
<ul style="list-style-type: none"> Emergency care, including ambulance services, is covered World-wide. Copay for emergency room and ambulance services are the same as if the services were provided by in-network providers. 		
<u>Silver&Fit Club Membership</u>		
<ul style="list-style-type: none"> Get your exercise, in the privacy of your home or as a Club Member at convenient locations in your area through Silver&Fit. Please call Silver&Fit to enroll at: 1-877-427-4788. 		
<u>Health/Wellness Education</u>		
<ul style="list-style-type: none"> Congestive Heart Program and Disease Management is covered, refer to your EOC booklet for additional listing. 		

Summary of Benefits Report

State of Nevada (PEBP) Value Group (HMO) Plan

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Benefit Category	Original Medicare	State of Nevada (PEBP) Value Group (HMO) Plan
<u>Smart Health Connection (formerly called Senior Options)</u> <ul style="list-style-type: none">• You automatically become a member when you enroll in Senior Care Plus and receive the following services and more;• Discounts throughout the community on Hardware, Building supplies, Dining, Elder Care Assistance and more. Please ask for the Smart Health Connection booklet.• Health Screenings• Newsletter		
<u>Vision Service Plan (VSP) 800-877-7195</u> <ul style="list-style-type: none">• \$20 routine exam (VSP provider) every year. Senior Care Plus will pay up to \$125 limit for contact (every year) lenses or frames (every two years).		
<u>Hearing Aid Benefit (TruHearing) 877-343-0742 (TTY users call: 800-975-2674)</u> <ul style="list-style-type: none">• Discounts are offered through TruHearing, as well as \$300 maximum every 36 months hearing aids. To receive reimbursement from Senior Care Plus for your services, you must send in your receipts of confirmation of services and payments to Senior Care Plus, 830 Harvard Way, Reno, NV 89502, please include your member number.• Free hearing screening• 45-day money-back guarantee• 3-year warranty• Free one-year supply of batteries• 12 months, no interest financing available upon approved credit		