NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
<u>Deductible</u> • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits • The deductible is never waived. However, some services are not subject to the Deductible as noted in the Schedule of Medical Benefits. • Note: Deductible does not accumulate to the Annual Out-of-Pocket Limit. However, the combined Out-of-Pocket Maximum on cost sharing (deductible and Out-of-Pocket Maximum) complies with the cost sharing limitations of the ACA.		$250 individual $500 Family	Not Applicable	Not Applicable	Not Applicable

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Out-of-Pocket Limit The Out-of-Pocket Limit is the most you pay during a one year period (the calendar year) before your health plan starts to pay 100% for covered health benefits received from Contract providers. The Out-of-Pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's out-of-pocket limit applicable to an individual with self-only coverage.	The Out-of-Pocket Limit for cost sharing includes medical co-payments and coinsurance.	$3,000 Individual $6,000 Family	$2,000 Individual $4,000 Two-Party $6,000 Family	$2,000 Individual $4,000 Family	Individual: $6,000 Family: $12,000 The Out-of-Pocket Maximum does not include: (1) amounts charged for non-Covered services; (2) amounts exceeding applicable Plan benefit maximums or EME payments; or (3) penalties for not obtaining any required Prior Authorization or for the Member otherwise not complying with HPN's Managed Care Program.
Lifetime Maximum The Lifetime Maximum is the most your health plan will pay towards your healthcare costs during your lifetime.		Not Applicable	Not Applicable	Not Applicable	Not Applicable
Hospital Services Inpatient .		90% after deductible	70%	100% after a $500 co-payment per diem Applies to a maximum of 3 days per admission	$300 per admission Physician: $100 co-payment per surgery Anesthesia: $100 co-payment per surgery

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Physician Office Visits and Physician Home Visits		$10 co-payment, deductible does not apply	$40 co-payment	$20 co-payment	Office Visit: $5 co-payment for PCP, PA, PE or Convenient Care and Telemedicine visit Home Visit: $35 co-payment per visit
Allergy Services		Office Visit: $10 co-payment Testing: $10 co-payment Treatment and Serum: 100%	Office Visit: $40 co-payment Testing: No co-payment. Open Access: $60 co-payment Treatment and Serum: 100%	Office Visit: $20 co-payment, $40 co-payment for specialist Testing: $20 co-payment Treatment and Serum: $20 co-payment for treatment, 100% for serum.	Office Visit: $5 co-payment per visit Testing: $5 co-payment per visit Treatment and Serum: $5 co-payment per visit
Ambulance Services (Ground vehicle emergency transportation)		$150 co-payment, deductible does not apply.	$100 co-payment	$50 co-payment	$150 co-payment
Chemotherapy or Radiation		100% after a $10 co-payment, deductible does not apply	No co-payment	No co-payment for standard; 100% after a $50 co-payment for complex	$5 per day in addition to office visit co-payment

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Chiropractic and Acupuncture Services Combined		Chiropractic: Not covered Acupuncture: 100% after a $10 co-payment; covered as an alternative to standard treatment when prescribed by a Plan physician. It is primarily used as a component of a multidisciplinary pain management program for the treatment of chronic pain.	Chiropractic: 100% after a $10 co-payment up to 30 visits per year Acupuncture: Not covered Discounts available through the Health Net Well Rewards Program	Chiropractic: 100% after a $10 co-payment up to 20 visits per year Acupuncture: Not covered	Chiropractic: $5 co-payment; up to 20 visits per member per calendar year. (requires pre-authorization) Acupuncture: Not covered

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Prescription Drugs		Retail 30-day Supply Generic Formulary $10 co-payment Formulary Brand Name $30 co-payment Non-Formulary Brand Name or Generic Same as Formulary Mail Order 90-day Supply Generic Formulary $20 co-payment Formulary Brand Name $60 co-payment Non-Formulary Brand Name or Generic Same as Formulary	Retail 30-day Supply Generic Formulary $10 co-payment Formulary Brand Name $20 co-payment Non-Formulary Brand Name or Generic Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. Mail Order 90-day Supply Generic Formulary $20 co-payment Formulary Brand Name $40 co-payment Non-Formulary Brand Name or Generic Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)	Retail 30-day Supply Generic Formulary $10 co-payment Formulary Brand Name $20 co-payment Non-Formulary Brand Name or Generic Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. Mail Order 90-day Supply Generic Formulary $20 co-payment Formulary Brand Name $40 co-payment Non-Formulary Brand Name or Generic Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)	Retail 30-day Supply Tier I: $7 co-payment (Low Cost Option) Tier II: $30 co-payment (Midrange Cost Option) Tier III: $50 co-payment (High Cost Option) Mail Order 90-day Supply Tier I: $17.50 co-payment Tier II: $75 co-payment Tier III: $125 co-payment
Emergency Room and Physician Charges		90% per visit after deductible, waived if admitted	$100 co-payment, waived if admitted	$100 co-payment, waived if admitted	$150 co-payment, waived if admitted

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Family Planning	Reversal of a tubal ligation or vasectomy is not covered.	Infertility: 50% of charges for diagnosis and treatment (does not accumulate toward out-of-pocket maximum) Contraceptive Devices, and Tubal Ligation: 90% after Deductible Vasectomy and Elective Abortions: 90% after Deductible	Infertility: 50% of charges for diagnosis and treatment Contraceptive Devices, and Tubal Ligation: $150 co-payment per procedure Vasectomy: $50 co-payment Elective Abortions: No co-payment	Infertility: Not covered Contraceptive Devices, and Tubal Ligation: $100 co-payment per procedure Vasectomy: $50 co-payment Elective Abortions: Up to 2nd trimester for $125 co-payment. After 20 weeks not covered unless life threatening	Infertility: $10 co-payment / consultation only Contraceptive Devices, and Tubal Ligation: $100 co-payment for inpatient facility Vasectomy: $100 co-payment for inpatient facility Elective Abortions: Not covered
Hearing Care	Coverage is limited to one device per ear, not more often than once every three years from the date of the last purchase. The $2,000 maximum per hearing aid is a combined maximum for all Contract and Non-Contract charges. Alllowed amount does not apply towards your out-of-pocket maximum. Replacement batteries are not covered.	Exams: $10 co-payment Hearing Aids: 100% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	Exams: $40 co-payment. Open Access: $60 co-payment. Hearing Aids: 100% of the lesser of $2,000 per device or the Contract Rate.	Exams: $20 co-payment, $40 co-payment for specialist Hearing Aids: $50 Co-payment. $5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair/replacement) per hearing-impaired ear every three years.	Exams: $5 co-payment Hearing Aids: No charge and limited to a single purchase of a type of hearing aid, including repair and replacement once every three years

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Home Health Care		No co-payment for part time intermittent care when prescribed by a Plan physician	100% after a $40 co-payment The co-payment begins with first visit. Limited to 100 visits per calendar year	100% after a $10 co-payment Limited to 100 visits per calendar year	$35 co-payment for Physician/Nurse (requires pre-authorization)
Hospice		No co-payment	No co-payment	100% after $500 co-payment per day. Co-payment applies to a maximum 3 days per stay. (Prognosis of life expectancy is less than 1 year)	Inpatient: $300 co-payment per admission Outpatient: No charge $10 co-payment for outpatient respite; Inpatient/Outpatient Respite: Benefits are limited to a combined max benefit of five Inpatient days or five Outpatient visits per member, per 90 days of Home Hospice Care.
Laboratory Services (in office or facility other than a Hospital)		$10 per encounter, deductible does not apply	No co-payment	No co-payment	Routine lab: $5 co-payment Routine x-ray: $10 co-payment

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Medical Supplies, Orthopedic Braces, Prosthetic Appliances		Durable Medical Equipment: 80%; deductible does not apply (does not accumulate toward out-of-pocket maximum) Orthopedic & Prosthetic: No co-payment	No co-payment Limited to a benefit maximum of $5,000 per calendar year	100% after a $50 co-payment Limited to a benefit maximum of $5,000 per calendar year	Durable Medical Equipment:: No charge (limited to a single purchase of a type of DME, including repair and replacement once every three years) Orthopedic Devices: $50 co-payment per device Prosthetics Devices: $750 co-payment per device. Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement once every three years. Medical Supplies: No charge

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Mental Health Treatment		Inpatient: 90% after deductible Outpatient: Individual: 100% after a $10 co-payment; Group: 100% after a $5 co-payment	Inpatient: 80% per admit Maximum benefit of 30 days per calendar year * Outpatient: Individual: 100% after $30 co-payment (non-severe) and 100% after $15 co-payment (severe) Group: 100% after $15 co-payment (non-severe) and 100% after $7.50 co-payment (severe) Maximum benefit of 20 outpatient visits per calendar year *Specific Mental Illness Diagnoses are covered with no day or visit limitations	Inpatient: 100% after a $250 co-payment per day up to a maximum of 3 days per stay per calendar year* Inpatient: 100% after a $40 co-payment* *Specific Mental Illness Diagnoses are covered with no day or visit limitations	Inpatient: $300 co-payment per admission Outpatient: $5 co-payment
Outpatient Surgery		90% after deductible	70%	$250 co-payment	$50 co-payment per surgery for Ambulatory facility $200 co-payment per surgery for Hospital facility

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Physical Therapy and Respiratory Therapy, Combined		$10 co-payment	$40 co-payment, limitations apply. Open Access: $60 co-payment limited to $1,500 per calendar year	$40 co-payment, limitations apply.	$5 co-payment; Limitations apply All inpatient and outpatient short term rehab is subject to a combined maximum benefit of 120 days / visits per member per calendar year
Podiatry Exam		Office Visits: 100% after a $10 co-payment; if medically necessary. Deductible does not apply. Orthotic appliances: No co-payment.	Office Visits: 100% after a $40 co-payment; if medically necessary Orthotic appliances: Covered only if incorporated into a cast, splint, brace or strapping of foot	Office Visits: 100% after a $30 co-payment; if medically necessary Orthotic appliances: Covered only if incorporated into a cast, splint, brace or strapping of foot	Office Visits: $10 co-payment Orthotic appliances: $50 co-payment per device. Limited to a single purchase of a type of orthotic device, including repair and replacement, once every three years.
Radiology, X-ray (Complex Services) including but not limited to MRI, PET and CAT scans		$50 co-payment	$100 co-payment	$50 co-payment	$100 co-payment per test
Radiology, X-ray (Non-Complex Services) in office or facilities other than Hospital		$10 co-payment	100%	100%	Routine lab: $5 co-payment Routine x-ray: $10 co-payment

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Skilled Nursing Facility (SNF)	• Participant payments for SNF do not accumulate to the annual Out-of-Pocket maximum	90%, deductible does not apply. Limited to a maximum benefit of 100-days per calendar period	Days 1-10: No co-payment Days 11-100: $25 per day	100% after a $200 co-payment per day Apply to a maximum of 3 days per stay. Limited to 100-consecutive calendar days from the first treatment per disability.	$300 co-payment per admission and up to 100 days per member per calendar year; co-payment waived if admitted from an acute care facility.
Speech Therapy and Occupational Therapy combined		100% after a $10 co-payment. Limitations apply.	100% after a $40 co-payment. Limitations apply.	100% after a $40 co-payment. Limitations apply.	$5 co-payment; Limitations apply All inpatient and outpatient short term rehab is subject to a combined maximum benefit of 120 days / visits per member per calendar year.

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Substance Abuse Treatment		Inpatient: 90%; deductible applies to Detoxification Only Transitional Recovery Services: 100% after a $100 per admission co-payment up to a maximum calendar year benefit of 60-days and no more than 120-days in a consecutive 5 year period in an approved non-residential facility Outpatient: 100% after a $10 co-payment Individual / $5 co-payment Group	Inpatient: 80% per admit; maximum benefit of 30 days per calendar year Outpatient: 100% after a $30 co-payment Individual / 100% after a $15 co-payment Group; Maximum benefits of 20 visits per calendar year	Inpatient: 100% after a $500 per day co-payment; Applied to a maximum of 3 days per stay Transitional Recovery Services: Prior Authorization Required (800) 999-9585 Outpatient: 100% after a $40 co-payment No Dependent Coverage	Inpatient: $300 co-payment per admission Outpatient: $5 co-payment per visit
Urgent Care		100% after a $10 co-payment, deductible does not apply	100% after a $40 co-payment, waived if admitted	Participating Provider: 100% after a $20 co-payment Non-Participating Provider: 100% after a $100 co-payment Waived if admitted. If you receive services in addition to urgent care, additional co-payments or co-insurance may apply.	$20 co-payment per visit

NON-MEDICARE RETIREE MEDICAL BENEFITS					
Benefit Description	Explanations and Limitations	Non-Medicare Retirees Residing in California Kaiser Permanente HMO	Non-Medicare Retirees Residing in California Health Net HMO	Non-Medicare Retirees Residing in California UnitedHealthCare HMO	Non-Medicare Retirees Residing in Nevada Health Plan of Nevada HMO
Routine Health Exams Preventative Health Care		100% after a $10 co-payment, deductible does not apply	100% after a $40 co-payment Open Access: $60 co-payment	100% after $20 co-payment 100% after $40 co-payment for Specialist Office Visit	No co-payment (Preventive Care Services)
Vision Service Plan (VSP)	• VSP Customer Service: (800) 877-7195	Exam: $10 co-payment Glasses/Contact Lenses: Not covered Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount.	Exam: $40 co-payment, Open Access: $60 co-payment Glasses/Contact Lenses: Not covered Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount.	Exam: $40 co-payment Glasses/Contact Lenses: Not covered Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount.	Exam: $5 co-payment Glasses/Contact Lenses: Not covered Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount.
Spectera/UnitedHealthcare Vision	• Spectera Customer Service: (800) 638-3120				

MEDICARE RETIREE MEDICAL BENEFITS				
Benefit Description	Explanations and Limitations	Medicare Retirees Residing in California Kaiser Permanente Senior Advantage HMO	Medicare Retirees Residing in California Health Net Seniority Plus HMO	Medicare Retirees Residing in Arizona, California or Nevada UnitedHealthCare Secure Horizons HMO
<u>Deductible</u> • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits		Not Applicable	Not Applicable	Not Applicable
<u>Out-of-Pocket Limit</u> The Out-of-Pocket Limit is the most you pay during a one year period (the calendar year) before your health plan starts to pay 100% for covered health benefits received from Contract providers. The Out-of-Pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's out-of-pocket limit applicable to an individual with self-only coverage.	The Out-of-Pocket Limit for cost sharing includes medical co-payments and coinsurance.	Individual: $1,500 Family: $3,000	$3,400 per person	$1,800 per person

MEDICARE RETIREE MEDICAL BENEFITS				
Benefit Description	Explanations and Limitations	Medicare Retirees Residing in California Kaiser Permanente Senior Advantage HMO	Medicare Retirees Residing in California Health Net Seniority Plus HMO	Medicare Retirees Residing in Arizona, California or Nevada UnitedHealthCare Secure Horizons HMO
Lifetime Maximum The Lifetime Maximum is the most your health plan will pay towards your healthcare costs during your lifetime.		Not Applicable	Not Applicable	Not Applicable
Hospital Services Inpatient		No co-payment	No co-payment	$100 co-payment per admit
Physician Office Visits and Physician Home Visits		Office: $10 co-payment Home: No co-payment	$10 co-payment	Primary Care: $5 co-payment Specialist: $20 co-payment
Allergy Services		Office Visits/Testing: $10 co-payment for office visits, no co-payment for testing Treatment and Serum: $3 co-payment per injection	Office Visits/Testing: $10 co-payment for office visits, no co-payment for testing Treatment and Serum: No co-payment	Office Visits/Testing: $5 co-payment for office visits, no co-payment for testing Treatment and Serum: No co-payment
Ambulance Services (Ground vehicle emergency transportation)		No co-payment if medically necessary	No co-payment	$50 co-payment

MEDICARE RETIREE MEDICAL BENEFITS				
Benefit Description	Explanations and Limitations	Medicare Retirees Residing in California Kaiser Permanente Senior Advantage HMO	Medicare Retirees Residing in California Health Net Seniority Plus HMO	Medicare Retirees Residing in Arizona, California or Nevada UnitedHealthCare Secure Horizons HMO
Chiropractic and Acupuncture Services Combined		Chiropractic: Not covered Acupuncture: $10 co-payment ; covered as an alternative to standard treatment when prescribed by a Plan physician; primarily used as a component of a multidisciplinary pain management program	Chiropractic: $5 co-payment, limited to 20 visits per calendar year Acupuncture: Not covered	Chiropractic: 50%, limited to 12 visits per calendar year Acupuncture: Not covered
Prescription Drugs		Retail 30-day Supply Generic Formulary $10 co-payment Formulary Brand Name $20 co-payment Non-Formulary Brand Name or Generic Not Applicable Mail Order 90-day Supply Generic Formulary $20 co-payment Formulary Brand Name $40 co-payment Non-Formulary Brand Name or Generic Not Applicable	Retail 30-day Supply Generic Formulary $10 co-payment Formulary Brand Name $20 co-payment Non-Formulary Brand Name or Generic $40 co-payment Mail Order 90-day Supply Generic Formulary $20 co-payment Formulary Brand Name $40 co-payment Non-Formulary Brand Name or Generic $80 co-payment Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)	Retail 30-day Supply Generic Formulary $10 co-payment Formulary Brand Name $20 co-payment Non-Formulary Brand Name or Generic $40 co-payment Mail Order 90-day Supply Generic Formulary $20 co-payment Formulary Brand Name $40 co-payment Non-Formulary Brand Name or Generic $80 co-payment Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)

MEDICARE RETIREE MEDICAL BENEFITS				
Benefit Description	Explanations and Limitations	Medicare Retirees Residing in California Kaiser Permanente Senior Advantage HMO	Medicare Retirees Residing in California Health Net Seniority Plus HMO	Medicare Retirees Residing in Arizona, California or Nevada UnitedHealthCare Secure Horizons HMO
Emergency Room and Physician Charges		Northern California: $35 co-payment Southern California: $20 co-payment	$20 co-payment	$50 co-payment
Hearing Care	• Coverage is limited to one device per ear, not more often than once every three years from the date of the last purchase. • The $2,000 maximum per hearing aid is a combined maximum for all Contract and Non-Contract charges. • Alllowed amount does not apply towards your out-of-pocket maximum. • Replacement batteries are not covered.	Exam: $10 co-payment Hearing Aids: 100% of the lesser of $2,000 per device or the Contract Rate.	Exam: $10 co-payment Hearing Aids: 100% of the lesser of $2,000 per device or the Contract Rate.	Exam: No co-payment Hearing Aids: $500 allowance every 36 months. As an additional benefit, 100% of the lesser of $2,000 per device or the Contract Rate.
Home Health Care		No co-payment for part time intermittent care when prescribed by a Plan physician	No co-payment	No co-payment per Medicare guidelines
Hospice		No co-payment	Covered under Medicare	Covered under Medicare

MEDICARE RETIREE MEDICAL BENEFITS				
Benefit Description	Explanations and Limitations	Medicare Retirees Residing in California Kaiser Permanente Senior Advantage HMO	Medicare Retirees Residing in California Health Net Seniority Plus HMO	Medicare Retirees Residing in Arizona, California or Nevada UnitedHealthCare Secure Horizons HMO
Medical Supplies, Orthopedic Braces, Prosthetic Appliances		No co-payment	No co-payment	80%
Mental Health Treatment		Inpatient: No co-payment Outpatient: $10 co-payment	Inpatient: No co-payment and no lifetime maximum Outpatient: $10 co-payment, unlimited visits per calendar year	Inpatient: $100 co-payment per admit limited to 190-days per lifetime Outpatient: Individual: $20 co-payment; Group: $5 co-payment
Outpatient Surgery		$10 co-payment	No co-payment	$50 co-payment
Physical Therapy and Respiratory Therapy, Combined		$10 co-payment, limitations apply.	No co-payment, limitations apply.	No co-payment
Podiatry Exam		Office Visits: $10 co-payment, must be medically necessary Orthotic appliances: Per Medicare guidelines	Office Visits: $10 co-payment, must be medically necessary Orthotic appliances: Covered only if incorporated into a cast, splint, brace or strapping of foot	Office Visits: $20 co-payment. Orthotic appliances: Per Medicare guidelines
X-Ray and Lab		No co-payment	No co-payment	No co-payment
Skilled Nursing Facility (SNF)	• Participant payments for SNF do not accumulate to the annual Out-of-Pocket maximum	No co-payment, limited to 100 days per benefit period	No co-payment, limited to 100 days per benefit period (duration of illness) in a Medicare certified bed	Days 1-20: No co-payment Date 21-100: $25 co-payment

MEDICARE RETIREE MEDICAL BENEFITS				
Benefit Description	Explanations and Limitations	Medicare Retirees Residing in California Kaiser Permanente Senior Advantage HMO	Medicare Retirees Residing in California Health Net Seniority Plus HMO	Medicare Retirees Residing in Arizona, California or Nevada UnitedHealthCare Secure Horizons HMO
Speech Therapy and Occupational Therapy combined		$10 co-payment, limitations apply.	No co-payment, limitations apply.	No co-payment
Substance Abuse Treatment		Inpatient: No co-payment, detoxification only Transitional Recovery Services: No co-payment up to a maximum of 60-days per calendar year and no more than 120 days in any 5 consecutive years in an approved non-residential facility Outpatient: Individual: $10 co-payment; Group: $5 co-payment	Inpatient: No co-payment, acute medical conditions only Outpatient: $10 co-payment, unlimited visits per calendar year	Inpatient: $100 co-payment per admit Outpatient: Individual: $20 co-payment; Group: $5 co-payment
Urgent Care		$10 co-payment	$20 co-payment	$35 co-payment
Routine Health Exams Preventative Health Care		No co-payment	No co-payment $10 co-payment for annual routine physical exam	No co-payment

MEDICARE RETIREE MEDICAL BENEFITS				
Benefit Description	Explanations and Limitations	Medicare Retirees Residing in California Kaiser Permanente Senior Advantage HMO	Medicare Retirees Residing in California Health Net Seniority Plus HMO	Medicare Retirees Residing in Arizona, California or Nevada UnitedHealthCare Secure Horizons HMO
Vision Service Plan (VSP)	• VSP Customer Service: (800) 877-7195	Exam: $10 co-payment Glasses/Contact Lenses: $175 allowance Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount.	Exam: $10 co-payment Glasses/Contact Lenses: $100 allowance Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount.	Exam: $20 co-payment (includes glaucoma testing) Glasses: $75 allowance (No co-payment for one pair of Medicare covered standard glasses or contact lenses after a cataract surgery) Contact Lenses: Covered in lieu of glasses Additional benefits available through either Vision Service Plan or Spectera Vision for an additional premium amount.
Spectera/UnitedHealthcare Vision	• Spectera Customer Service: (800) 638-3120			

DENTAL BENEFITS FOR NON-MEDICARE AND MEDICARE RETIREES RESIDING IN CALIFORNIA				
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Health Net HMO Dental Plan**	**United Concordia HMO Dental Plan**
Choice of Providers	Participants can visit any licensed dentist, however costs are lowest when visiting a Delta Dental PPO Dentist. If participants do not use a Delta Dental PPO Dentist, they still have access to a Delta Dental Premier Dentist. You may pay more when seeing a Premier dentist than a PPO dentist, but you still have cost protections that are not available when visiting a non-Delta Dental dentist. Delta Dental Customer Service (800) 765-6003	Participants must use an authorized DeltaCare USA HMO Dental Provider DeltaCare USA Customer Service (800) 422-4234 *Note: DeltaCare USA* *HMO Dental Plan dentists are not the same as Delta Dental PPO Dentist or a Delta Premier PPO Dentist.*	Participants must use an authorized Health Net HMO Dental Provider. Health Net Dental Customer Service (800) 880-8113	Participants must use an authorized United Concordia HMO Dental Provider. UCCI HMO Customer Service: (866) 357-3304
Deductible • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits	$50 per person $150 per family	Not Applicable	Not Applicable	Not Applicable
Maximum Calendar Year Benefit • The Maximum Calendar Year Benefit is the most the Plan will pay during a calendar year for your covered dental benefits.	PPO network: $3,000 per person Premier network: $2,000 per person Out-of-network: $1,500 per person Limits do not apply to pediatric dental services to age 19 when obtained at a PPO or Premier provider.	No Maximum	No Maximum	No Maximum

DENTAL BENEFITS FOR NON-MEDICARE AND MEDICARE RETIREES RESIDING IN CALIFORNIA				
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**	**Health Net HMO Dental Plan**	**United Concordia HMO Dental Plan**
Diagnostic, Preventative, Basic, and Majored Covered Services	PPO Network: 100% for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. Premier Network: 100% for Diagnostic & Preventative; 80% for Basic and Major services based on Delta Dental Premier contracted fees. Out-of-Network: 80% of Allowed Amount for Diagnostic & Preventative; 50% of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates for non-Delta Dental dentists.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information. Members must receive all services from their assigned DeltaCare USA provider.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information.
Orthodontia	Plan pays 50% of Delta Dental PPO contracted fees up to a lifetime maximum of $1,000 for dependent children only.	Ortho Extractions: No co-payment Enrollee Cost (Comprehensive Adult or Child Treatment): $1,000 co-payment Orthodontic Takeover - is covered	$1,450 co-payment for participants, plus $250 co-payment for retention phase	$1,500 co-payment for children, $2,000 co-payment for adults; plus an additional $240 co-payment for retention phase

DENTAL BENEFITS FOR NON-MEDICARE AND MEDICARE RETIREES RESIDING IN NEVADA		
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**
Choice of Providers	Participants can visit any licensed dentist, however costs are lowest when visiting a Delta Dental PPO Dentist. If participants do not use a Delta Dental PPO Dentist, they still have access to a Delta Dental Premier Dentist. You may pay more when seeing a Premier dentist than a PPO dentist, but you still have cost protections that are not available when visiting a non-Delta Dental dentist. Delta Dental Customer Service: (800) 765-6003	Participants must use an authorized DeltaCare USA HMO Dental Provider DeltaCare USA Customer Service: (800) 422-4234 *Note: DeltaCare USA HMO Dental Plan dentists are not the same as Delta Dental PPO Dentist or a Delta Premier PPO Dentist.*
Deductible • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits	$50 per person $150 per family	Not Applicable

DENTAL BENEFITS FOR NON-MEDICARE AND MEDICARE RETIREES RESIDING IN NEVADA		
Benefit Description	**Fee-For-Service Dental Plan Contract Provider Benefits**	**DeltaCare USA HMO Dental Plan**
Maximum Calendar Year Benefit • The Maximum Calendar Year Benefit is the most the Plan will pay during a calendar year for your covered dental benefits.	PPO network: $3,000 per person Premier network: $2,000 per person Out-of-network: $1,500 per person Limits do not apply to pediatric dental services to age 19 when obtained at a PPO or Premier provider.	No Maximum
Diagnostic, Preventative, Basic, and Majored Covered Services	PPO Network: 100% for Diagnostic & Preventative, Basic and Major services based on Delta Dental PPO contracted fees. Premier Network: 100% for Diagnostic & Preventative; 80% for Basic and Major services based on Delta Dental Premier contracted fees. Out-of-Network: 80% of Allowed Amount for Diagnostic & Preventative; 50% of Allowed Amount for Basic and Major services; Allowed Amount based on Delta standard reimbursement rates for non-Delta dentists.	All services must be pre-authorized and referrals are necessary for specialized treatments. Please refer to the enrollment packet for specific co-payment information. Members must receive all services from their assigned DeltaCare USA provider.
Orthodontia	Plan pays 50% of Delta Dental PPO contracted fees up to a lifetime maximum of $1,000 for dependent children only.	Ortho Extractions: $0-$90 co-payment Enrollee co-payment: • Comprehensive Adult Treatment: $1,900 • Comprehensive Child Treatment: $1,700 Orthodontic Takeover: Covered