



Teachers Health Trust

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September 14, 2007

Dear Participant:

The Trust would like to take this opportunity to inform you of the health benefits available to you upon your retirement.

Currently, a retiree health plan for Clark County School District (CCSD) licensed employees is available through the Public Employee's Benefit Program (PEBP). This plan is not associated with the Trust; instead, it is maintained by the state of Nevada. In July 2007, the Nevada legislature voted to discontinue this plan for many public employees, including CCSD employees, who are not enrolled in the state's active plan on the date of their retirement. This change applies to all teachers who retire after September 2008. This decision certainly resulted in concerns regarding retiree benefits from many Trust participants, specifically those planning to retire after the September 2008 termination date. Media reports have created further fears, indicating that CCSD employees will have no options when the state plan terminates.

Contrary to these reports, the Trust does have a relationship with PacifiCare/Secure Horizons through which an unsubsidized retiree plan is currently available. Further, the Trust is currently in negotiations with the CCSD and the Clark County Education Association (CCEA) to obtain funding to assist you in paying the premiums of the Trust retiree plan.

Please find included a summary of the comprehensive retiree plans offered by the Trust. The Trust will notify you when the 2008 rates have been finalized with PacifiCare. Further, the Trust will send additional communication regarding the results of the negotiations with CCSD and CCEA as soon as they are complete.

If you have any questions or require additional information, please contact the Service Department at 702-794-0272 or 800-432-5859 between 7 a.m. and 5:45 p.m., Monday through Thursday, and between 8 a.m. and 11:45 a.m. Friday. You may also e-mail your questions to the Service Team at serviceteam@teachershealthtrust.org.

Sincerely,
Teachers Health Trust



Teachers Health Trust

Medicare Advantage through Secure Horizons

Effective January 1, 2007



Benefits	Member Responsibility
Physician Services Primary Care Office Visit Specialist Office Visit	\$10 co-pay \$15 co-pay
Medicare Required (Part B) Drugs	20% coinsurance
Inpatient Hospital Stay	\$50 per admit
Inpatient Skilled Nursing Facility	\$0 for first 20 days \$25 per day for days 21 – 100
Outpatient Co-pays Lab Services Standard Film X-rays Surgery & Observation All Other Procedures	\$0 \$0 \$25 co-pay \$ co-pay
Outpatient Occupational, Physical, or Speech Therapy	\$0 co-pay
Outpatient Rehabilitation Facility	\$0 co-pay
Inpatient Mental Health /Substance Abuse	\$50 per admit
Partial Hospitalization	\$60 per day
Outpatient Mental Health: Group Visits	\$10 co-pay
Outpatient Mental Health: Individual Visits	\$15 co-pay
Home Health Services	\$0
Durable Medical Equipment	20% coinsurance
Transplants	\$1,500 co-pay
Renal Dialysis	20% coinsurance
Podiatry: 6 routine visits per year	\$15 co-pay
Routine Eye Exam (Annual)	\$15 co-pay
Medicare Required Dental	\$15 co-pay
Medicare Required Chiropractic	\$15 co-pay
Emergency Room	\$50 co-pay
Urgent Care Centers	\$35 co-pay
Ambulance	\$50 co-pay
Annual Global Out of Pocket Maximum ⁽¹⁾	\$1,500
Prescription Benefits	
Retail Generic Preferred Brand Non-Preferred Brand Preferred Specialty	\$4 co-pay \$20 co-pay \$40 co-pay \$40 co-pay
Mail Order Generic Preferred Brand Non-Preferred Brand Preferred Specialty	\$8 co-pay \$50 co-pay \$110 co-pay \$120 co-pay
Premium Rate	
\$76.19 per person*	

*These rates are effective until 12/31/2007.

(1) Annual Global Out-of-Pocket Maximums will apply to most medical benefits except office visit co-pays.



Teachers Health Trust Retiree Point of Service (POS) Plan

Open Access POS Plan

Plan #42A47



Tier 1: HMO
\$10/\$25/\$0
You must use HMO contracted
Physicians listed in the
Tier 1: *HMO Provider Directory*

Tier 2: PPO
\$250/\$20/\$30/20%
You must use PPO contracted
Physicians found in the Tier 2:
PPO NPP/UHN Provider Directory

**Tier 3: Non-Contracted
Providers \$750/40%**
You may use any licensed Provider
providing services within the scope
of their license

Deductible, Copayment, and Coinsurance Maximum

Individual Deductible	N/A	\$250	\$750
Family Deductible	N/A	\$500	\$1,500
Individual Copayment and Coinsurance Maximum	\$2,000 per Benefit Year	\$3,000 per Benefit Year	\$5,000 per Benefit Year
Family Copayment and Coinsurance Maximum	\$6,000 per Benefit Year	\$9,000 per Benefit Year	\$15,000 per Benefit Year
Maximum While Insured	N/A	\$2,000,000	

Outpatient Care

Physician's Office Visit	You pay \$10 per visit	You pay \$20 per visit, no BYD	You pay 40% of Limited Fee Schedule per visit after BYD
Specialist Office Visit <i>(no referral required except ancillary services, including but not limited to, physical therapy, lab, x-ray, outpatient surgery and DME)</i>	You pay \$25 per visit	You pay \$30 per visit, no BYD	You pay 40% of Limited Fee Schedule per visit after BYD
Routine Physicals <i>(limited to a maximum of \$500 per Benefit Year, Tiers 2 and 3 combined)</i>	You pay \$10 per visit	You pay \$20 per visit, no BYD	You pay 40% of Limited Fee Schedule per visit after BYD
Periodic Health Exams and Well-Child Care <i>(limited to a maximum of \$500 per Benefit Year, Tiers 2 and 3 combined)</i>	You pay \$10 per visit	You pay \$20 per visit, no BYD	You pay 40% of Limited Fee Schedule per visit after BYD
Vision Exams <i>(limit one per Benefit Year)</i>	You pay \$25 per visit	You pay \$30 per visit, no BYD	You pay 40% of Limited Fee Schedule per visit after BYD
Hearing Exams <i>(limit one per Benefit Year)</i>	You pay \$25 per visit	You pay \$30 per visit, no BYD	You pay 40% of Limited Fee Schedule per visit after BYD
Physical Occupational, and Speech Therapy* <i>(limited to 30 visits per Benefit Year, all tiers combined)</i>	You pay \$25 per visit	Tier 1: HMO Facilities/Providers only when in the HMO service area; outside of HMO service area, you pay 20% per visit after BYD	Tier 1: HMO Facilities/Providers only when in the HMO service area; outside of HMO service area, you pay 40% of Limited Fee Schedule per visit after BYD

BYD=Benefit Year Deductible

*Prior Authorization required. Failure to obtain a prior authorization will result in a 50% reduction of Covered Expense, not to exceed \$500 maximum per occurrence.

**Please note: Some services are only covered under Tier 1 HMO and are not Covered Services under Tiers 2 and 3. Those services restricted to Tier 1 HMO are described on this and the following pages.

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Physicians found in the Tier 2:
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Providers \$750/40%**

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of their license

Outpatient Care (Continued)

Lab Services (<i>includes cytologic screening</i>)	You pay \$10 per visit	You pay 20% after BYD. If services are accessed from a Tier 1: HMO provider, Tier 1 copayment applies.	You pay 40% of Limited Fee Schedule after BYD. If services are accessed from a Tier 1: HMO provider, Tier 1 copayment applies.
X-Ray Services (<i>includes mammograms</i>)	You pay \$10 per visit	You pay 20% after BYD. If services are accessed from a Tier 1: HMO provider, Tier 1 copayment applies.	You pay 40% of Limited Fee Schedule after BYD. If services are accessed from a Tier 1: HMO provider, Tier 1 copayment applies.
Specialized Scanning and Imaging* (<i>including but not limited to MRIs, MRAs, CTs, PETs</i>)	You pay \$100 per visit	You pay 20% after BYD. If services are accessed from a Tier 1: HMO provider, Tier 1 copayment applies.	You pay 40% of Limited Fee Schedule after BYD. If services are accessed from a Tier 1: HMO provider, Tier 1 copayment applies.

Hospital Services

Inpatient Hospitalization* (<i>anesthesia, physician services, surgeon, assistant surgeon</i>)	You pay \$0 per Inpatient admit	You pay 20% per Inpatient admit, after BYD	You pay 40% of Limited Fee Schedule per Inpatient admit, after BYD
Acute Inpatient Rehabilitation* (<i>limited to 30 days per Benefit Year, all tiers combined</i>)	You pay \$0 per Inpatient admit	You pay 20% per Inpatient admit, after BYD	You pay 40% of Limited Fee Schedule per Inpatient admit, after BYD
Transplants*	You pay \$0 per Inpatient admit	Covered on Tier 1: HMO only	Covered on Tier 1: HMO only
Skilled Nursing Facility* (<i>limited to 30 days per Benefit Year, all tiers combined</i>)	You pay \$0 per Inpatient admit	Tier 1: HMO Facilities/Providers only when in the HMO service area; outside of HMO service area, you pay 20% per Inpatient admit after BYD	Tier 1 HMO Facilities/Providers only when in the HMO service area; outside of HMO service area, you pay 40% of Limited Fee Schedule per Inpatient admit, after BYD
Outpatient Surgery*	You pay \$0 per Outpatient visit	You pay 20% per Outpatient visit, after BYD	You pay 40% of Limited Fee Schedule per Outpatient visit, after BYD

Emergency Services

Emergency Room (<i>not waived if admitted</i>)	You pay \$100 per visit <i>Inpatient hospitalization benefits apply if admitted</i>	Covered under Tier 1: HMO regardless of Provider	Covered under Tier 1: HMO regardless of Provider
Ambulance (<i>medically necessary</i>)	You pay \$30 per trip	Covered under Tier 1: HMO regardless of Provider	Covered under Tier 1: HMO regardless of Provider
Urgent Care	You pay \$35 per visit	You pay \$50 per visit, no BYD	You pay 40% of Limited Fee Schedule per visit, after BYD

Mental Health

Outpatient Office Visits (<i>limited to 20 visits per Benefit Year, all tiers combined</i>)	You pay \$25 per visit	Covered under Tier 1: HMO only	Covered under Tier 1: HMO only
Inpatient* (<i>limited to 20 days per Benefit Year, all tiers combined</i>)	You pay \$0 per Inpatient admit	Covered under Tier 1: HMO only	Covered under Tier 1: HMO only

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\$10/\$25/\$0**

You must use HMO contracted
Physicians listed in the
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\$250/\$20/\$30/20%**

You must use PPO contracted
Physicians found in the Tier 2:
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Providers \$750/40%**

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Substance Abuse**

Outpatient Office Visits <i>(limited to \$2,500 per Benefit Year, all tiers combined)</i>	You pay \$25 per visit	Covered under Tier 1: HMO only	Covered under Tier 1: HMO only
Inpatient Detox* <i>(limited to \$1,500 per Benefit Year, all tiers combined)</i>	You pay \$0 per Inpatient admit	Covered under Tier 1: HMO only	Covered under Tier 1: HMO
Inpatient Treatment* <i>(limited to \$9,000 per Benefit Year, all tiers combined)</i>	You pay \$0 per Inpatient admit	Covered under Tier 1: HMO only	Covered under Tier 1: HMO

**Substance Abuse subject to annual limitations.

Durable Medical Equipment (DME)

Standard* <i>(limited to \$5,000 per Benefit Year, combined with Specialty/Custom DME, all tiers combined)</i>	Covered 100%	You pay 20% per item, after BYD	You pay 40% of Limited Fee Schedule per item, after BYD
Specialty/Custom* <i>(limited to \$5,000 per Benefit Year, combined with Standard DME, all tiers combined)</i>	You pay \$50 per item	You pay 20% per item, after BYD	You pay 40% of Limited Fee Schedule per item, after BYD
Prosthetics* <i>(limited to \$10,000 per Benefit Year, all tiers combined)</i>	You pay \$100 per item	You pay 20% per item, after BYD	You pay 40% of Limited Fee Schedule per item, after BYD
Corrective Appliances*	Covered 100%	You pay 20% per item, after BYD	You pay 40% of Limited Fee Schedule per item, after BYD

Specialty Services

Home Health Care* <i>(limited to 100 days per Benefit Year, all tiers combined)</i>	Covered 100%	Tier 1: HMO Facilities/Providers only when in the HMO service area; outside of HMO service area, you pay 20% per day, after BYD	Tier 1 HMO Facilities/Providers only when in the HMO service area; outside of HMO service area, you pay 40% of Limited Fee Schedule per day, after BYD
Dialysis	You pay \$10 per visit	You pay 20% per visit, after BYD after BYD	You pay 40% of Limited Fee Schedule per visit, after BYD
Hospice* <i>(terminally ill care) (respite care limited to \$1,500• all tiers combined)</i>	You pay \$0 per Inpatient admit	Tier 1: HMO Facilities/Providers only when in the HMO service area; outside of HMO service area, you pay 20%, after BYD	Tier 1 HMO Facilities/Providers only when in the HMO service area; outside of HMO service area, you pay 40% of Limited Fee Schedule, after BYD
Temporomandibular (TMJ) <i>(limited to \$1,000 per lifetime, all tiers combined)</i>	You pay 50%	Covered on Tier 1: HMO only	Covered on Tier 1: HMO only

BYD=Benefit Year Deductible

*Prior Authorization required. Failure to obtain a prior authorization will result in a 50% reduction of Covered Expense, not to exceed \$500 maximum per occurrence.

THT Retiree Plan does not require a referral to see a Tier 1: HMO specialist; many ancillary services will still require a physician order to access. These services include, but are not limited to, laboratory and x-ray services; physical therapy; occupational therapy; speech therapy; DME; prosthetics; corrective appliances; home health; all inpatient services; chemotherapy; radiation therapy; dialysis; and outpatient surgery.

Prescription Drug Benefit	Generic Formulary	Brand Formulary	Non-Formulary
Retail Pharmacy Copayment <i>(per Prescription Unit or up to 30 days)</i>	\$10	\$30	\$50
Mail Service Pharmacy Copayment <i>(Three Prescription Units or up to a 90-day supply)</i>	\$20	\$75	\$135

2007 Premium Rates

Coverage	Participant Premium
Retiree	\$541.85
Retiree + 1 Dependent	\$948.43
Retiree + Family	\$1426.99

The Trust will provide the 2008 Premium Rates when they become available.

For a complete plan description, including exclusions and limitations, please contact the Trust Service Team at 702-794-0272 or via email at serviceteam@teachershealthtrust.org between the hours of 7 a.m. and 5:45 p.m. Monday through Thursday and 8 a.m. to 11:45 a.m. Friday. You can also visit the Trust offices at 2950 E. Rochelle Avenue, Las Vegas, NV 89121.

