

**Retiree Benefits Summary Insert**Prepared Exclusively For: **UMC Healthflex**

Group Number 092112 (H0609-804)

*Effective January 1, 2008 to December 31, 2008*

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**BENEFITS AND COVERAGE****YOUR COSTS**

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This is a highlight of benefits only and is not all inclusive of the Plan's benefits, services, limitations or exclusions. Please refer to the enclosed Retiree Benefits Summary booklet and your Evidence of Coverage and Disclosure Information for additional details. Keep this Retiree Benefits Summary Insert, together with your Retiree Benefits Summary, handy for your reference.

**For general questions prior to enrollment** call 1-800-610-2660, or for the hearing impaired (TTY/TDD 1-800-387-1074), 6 a.m. to 7 p.m. PST, Monday through Friday, and 8 a.m. to 12 p.m. PST, Saturday.

**Members** call the number on the back of your membership card, or on the back cover of the Retiree Benefits Summary booklet.

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**Physician Services**

- Primary Care Physician \$10 copayment per office visit
- Specialist \$10 copayment per office visit

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**Emergency Department Services**

- Within the United States \$50 copayment, waived if admitted to the hospital
- Outside of the United States \$50 copayment, waived if admitted to the hospital

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**Urgently Needed Care**

- In-area/in-network provider other than primary care physician \$10 copayment, waived if admitted to the hospital
- In-area/non-network provider or out-of-area provider \$25 copayment, waived if admitted to the hospital

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**Ambulance Services**

\$0 copayment

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**Inpatient Hospital Care**

\$0 copayment for unlimited days\*

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**Inpatient Mental Health Care**

\$0 copayment, 190 day lifetime maximum

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**Skilled Nursing Facility Care**

\$0 copayment per day, days 1-100 up to 100 days per benefit period\*\*, three-day prior hospital stay is not required

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**Home Health Agency Care**

- Home Care Visits \$0 copayment
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**Outpatient Mental Health Care**

\$10 copayment per visit

**Partial Hospitalization Psychiatric Program**

\$50 copayment per day

**Outpatient Substance Abuse Services**

\$10 copayment per visit

**Outpatient Surgery and Services**

\$0 copayment

**Outpatient Hospital Services**

\$0 copayment

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**Medicare-covered Outpatient  
Rehabilitation Services**

- Comprehensive Outpatient Rehabilitation (CORF) \$10 copayment per visit
  - Cardiac and Pulmonary Rehabilitation \$10 copayment per visit
  - Occupational Therapy, Physical Therapy and Speech and Language Pathology Services \$10 copayment per visit
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**Durable Medical Equipment (DME),  
Prosthetics, Orthotics (Corrective Appliances),  
Infusion Equipment and Supplies used in  
conjunction with the above**

\$0 copayment

**Diabetes Self Management Training**

\$0 copayment

**Diabetes Monitoring Supplies**

\$0 copayment per item or up to a 30-day supply

**Medical Nutrition Therapy**

\$0 copayment

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### BENEFITS AND COVERAGE

### YOUR COSTS

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#### Imaging Procedures, X-rays and Portable X-rays Used in the Home

- Medicare-covered Standard X-rays \$0 copayment
- Complex Radiology Services and Imaging Procedures \$0 copayment

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#### Laboratory Services

\$0 copayment

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#### Radiation Therapy

\$0 copayment per visit

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#### Medical Supplies

\$0 copayment

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#### Blood and Its Administration

\$0 copayment

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#### Kidney Dialysis

\$10 copayment at a network facility or at a Medicare-certified facility within the United States

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#### Bone Mass Measurements

\$0 copayment

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#### Colorectal Screening Exams

\$0 copayment

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#### Annual Screening Mammograms

\$0 copayment

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#### Pap Smears and Pelvic Exams

\$0 copayment

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#### Annual Prostate Cancer Screening Exams

\$0 copayment

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#### Cardiovascular Disease Testing

\$0 copayment

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#### Immunizations

- Flu, Pneumococcal Pneumonia, and Hepatitis B Vaccines \$0 copayment

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### BENEFITS AND COVERAGE

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#### Medicare Part B-covered Drugs

Immunosuppressives, Oral Chemotherapy  
Drugs Including Anti-nausea Drugs,  
Inhalation Solutions

\$0 copayment

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#### Outpatient Injectable Medications - Self-Administered

Your MA-PD Plan covers these medications under Medicare Part D. The copayments outlined in the **Outpatient Prescription Drugs** section also apply for these medications.

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#### Outpatient Injectable Medications - Administered in a Physician's Office

\$0 copayment

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#### Outpatient Injectable Medications - Home Health

Your MA-PD Plan covers these medications under Medicare Part D. The copayments outlined in the **Outpatient Prescription Drugs** section also apply for these medications.

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#### Hemophilia Clotting Factors - Self Administered, Administered in a Physician's Office, Home Health

\$0 copayment

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#### Antigens

\$0 copayment

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#### Chiropractic Services

- Medicare-covered
- Routine (non-Medicare covered)

\$10 copayment per visit

\$10 copayment per visit/12 visits per year

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#### Dental Services

- Medicare-covered

\$10 copayment per visit

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#### Foot Care

- Medicare-covered

\$10 copayment per visit

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### BENEFITS AND COVERAGE

### YOUR COSTS

#### Hearing Services

- Medicare-covered diagnostic hearing exam \$10 copayment per visit
- Routine tests for hearing aids (non-Medicare covered) \$0 copayment/one exam per year
- Hearing Aids \$300 hearing aid allowance every 24 months

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#### Vision Services

Eye care – medical need

- Medicare-covered eye exam \$10 copayment per visit
  - Medicare-covered eyewear \$0 copayment after cataract surgery
- Routine Vision Services (non-Medicare covered)
- Routine eye exam (refraction) \$10 copayment/one exam per year
  - Routine eyewear \$75 eyewear allowance every 24 months. Contact lenses not covered.

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#### Annual Routine Physical Examination (non-Medicare covered)

Medicare initial preventive physical exam covered in full, \$10 copayment for annual routine physical examination

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#### Optum<sup>®</sup> NurseLine

You pay \$0 for calls to the NurseLine, available 24 hours a day, every day to help you with health and medical questions. Simply call 1-877-365-7949, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for 1-877-365-7951.

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\*Inpatient Hospital Copayments are charged on a per admission or daily basis. **Original Medicare hospital benefit periods do not apply.** For Inpatient Hospital, you are covered for an unlimited number of days as long as the hospital stay is medically necessary and authorized by United Healthcare or contracting providers.

\*\*A benefit period begins the day you go to a hospital. The benefit period ends when you haven't received hospital or skilled care (in a SNF) for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the skilled nursing facility care copayment, if applicable, for each benefit period. There is no limit to the number of benefit periods you can have.



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## BENEFITS AND COVERAGE

## YOUR COSTS

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*MedicareComplete® Retiree Plans and MedicareComplete® Retiree Prescription Drug (MA-PD) Plans are SecureHorizons® Medicare Advantage plans insured or covered by an affiliate of UnitedHealthcare, PacifiCare Health Plans or Oxford Health Plans, Medicare Advantage Organizations with a Medicare contract. This document is available in alternative formats. Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party. You must have both Medicare Part A and B, and must reside in the service area of the plan. Your ability to enroll may be limited to certain times of the year. Members must use network providers to receive plan benefits except under emergent or urgent care situations or for out-of-area renal dialysis. If you are already enrolled in a Medicare Advantage Prescription Drug Plan you must receive your Medicare Prescription Drug Benefit through that Plan. PacifiCare's contract with CMS is renewed annually. Availability of coverage beyond the end of the current contract year is not guaranteed. Benefits may vary by employer group.*

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### BENEFITS AND COVERAGE

### YOUR COSTS

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#### Outpatient Prescription Drugs

Your Medicare Advantage plan includes a Medicare-approved Part D drug benefit. You automatically receive Medicare Part D prescription drug coverage as a part of your benefit plan.

#### **\$0 – \$4,050 Out of Pocket Costs**

##### **Retail:**

You pay a **\$10** Tier 1 preferred generic drug copayment/**\$20** Tier 2 preferred brand name drug copayment/**\$20** Tier 3 non-preferred drug copayment/**\$20** copayment for Tier 4 specialty drugs per Prescription Unit or up to a 30-day supply

##### **Mail Service:**

You pay a **\$20** Tier 1 preferred generic drug copayment/**\$40** Tier 2 preferred brand name drug copayment/**\$40** Tier 3 non-preferred drug copayment/**\$40** copayment for Tier 4 specialty drugs up to a 90-day supply through our contracted Mail Service Pharmacy

#### **After your yearly Out-of-Pocket Costs reach \$4,050**

You pay the greater of \$2.25 for generic or a preferred brand drug that is a multi-source drug, and \$5.60 for all other drugs, or 5% coinsurance once your total out-of-pocket costs reach \$4,050.

**The SecureHorizons MedicareComplete<sup>®</sup> Standard Retiree Formulary applies for both retail and mail service prescriptions. Bonus Drugs included.**

#### Limitations and Exclusions

(Please note that these Limitations and Exclusions apply to Part D covered drugs only. Your Plan Sponsor may have elected to offer additional coverage for some prescription drugs that are normally excluded from your Part D coverage. Please refer to your formulary and/or formulary addendum to determine if your Plan Sponsor offers you additional drug coverage beyond the Medicare Part D coverage.)

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**BENEFITS AND COVERAGE**

**YOUR COSTS**

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**Limitations**

1. Drugs prescribed for non-FDA approved indications are excluded, unless prescribed in a manner consistent with a specific indication in one of the following compendia: *Drug Information for the Health Care Professional*, published by the United States Pharmacopeial Convention; DRUGDEX information system, American Medical Association Drug Evaluations, or the American Hospital Formulary Services edition of *Drug Information*.
2. UnitedHealthcare reserves the right to require Prior Authorization for certain drugs on the Formulary prior to dispensing.
3. Drugs prescribed by non-contracting doctors and/or drugs dispensed by non-contracting pharmacies are not covered (except for covered prescriptions required as a result of an emergency or urgently needed service for an acute condition).
4. Smoking cessation products and treatments are covered in accordance with Medicare guidelines.
5. Medicare Part A and Part B drugs are not covered under your Part D prescription drug coverage and are limited to those drugs available through your medical benefit.
6. Compounded drugs are limited to those drugs that are Prior Authorized and that have been determined by United Healthcare to be medically necessary.
7. Drugs that apply to your annual Deductible (if applicable), your Covered Drug costs or your Out-of-Pocket costs are limited to drugs included on the Formulary and drugs that have been determined by United Healthcare to be medically necessary.
8. Drugs not included on the Formulary and/or drugs that have not been determined by United Healthcare to be medically necessary are limited to those drugs approved through United Healthcare's exception policy process.

**Exclusions**

1. Drugs purchased before you started or after you terminated your MedicareComplete<sup>®</sup> Plan membership.
2. Elective or voluntary enhancement services procedures, treatments, supplies and drugs including, but not limited to:
  - Drugs used for anorexia, weight loss or weight gain. Examples of these drugs include, but are not limited to: Xenical<sup>®</sup> and Meridia<sup>®</sup>.
  - Drugs used for sexual dysfunction, hair growth, athletic performance, cosmetic purposes and anti-aging. Examples of these drugs include, but are not limited to: Cialis<sup>®</sup>, Viagra<sup>®</sup>, Levitra<sup>®</sup>,

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Caverject<sup>®</sup>, Penlac<sup>®</sup>, Retin-A<sup>®</sup>, Renova<sup>®</sup>, Vaniqa<sup>®</sup>, Propecia<sup>®</sup> and Lustra<sup>®</sup>, unless specifically listed on the Formulary.

- Drugs used to promote fertility.

(Your Plan Sponsor may have elected Bonus/Buy-Up prescription drugs as a supplemental benefit. Refer to your Prescription Drug Formulary Addendum.)

3. Drugs used for the symptomatic relief of coughs or colds.
4. Dietary supplements, including prescription vitamin and mineral products (except prenatal vitamins and fluoride), and health or beauty aids, herbal supplements and/or alternative medicine, except as covered by Medicare Part D.
5. Barbiturates  
(Your Plan Sponsor may have elected Bonus/Buy-Up prescription drugs as a supplemental benefit. Refer to your Prescription Drug Formulary Addendum.)
6. Benzodiazepines  
(Your Plan Sponsor may have elected Bonus/Buy-Up prescription drugs as a supplemental benefit. Refer to your Prescription Drug Formulary Addendum.)
7. Drugs for which the cost is recovered under any Workers' Compensation, Occupational Disease Law or from any state or government agency, or drug furnished by any other drug or medical services for which there is no charge to the member.
8. Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.
9. Non-prescription drugs, unless they are part of a Step Therapy protocol.

*Only members or enrollees of a MedicareComplete<sup>®</sup> Medicare Advantage Prescription Drug (MA-PD) Plan may access the Medicare-approved Part D prescription drug benefit offered through UnitedHealthcare. Members or enrollees enrolled in a MA-PD Plan may not enroll in any other Medicare Part D prescription drug plan (including an individual or group Prescription Drug Plan (PDP)). If you are enrolling or are enrolled in any other Medicare Part D prescription drug plan (including an individual or group Prescription Drug Plan (PDP)), you will be disenrolled from this MA-PD benefit plan.*

*You must use network pharmacies. UnitedHealthcare contracts with many of the largest retail pharmacy chains nationwide, as well as many local independent pharmacies. You can have your prescription filled at any of UnitedHealthcare's network pharmacies nationwide. Also included in the UnitedHealthcare network of*

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*contracted pharmacies are long-term care pharmacies, Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies and home infusion pharmacies. Sometimes a particular pharmacy may leave the United Healthcare contracting network. In that situation, have your prescriptions filled at another network pharmacy. Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. In addition to paying the copayments/coinsurance listed above, you are required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charges for your prescription. Please contact Customer Service for details.*

*You may be able to get extra help to pay for your prescription drug premiums (if applicable) and costs. To see if you qualify for getting extra help, call:*

- *1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week); or*
- *The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call, 1-800-325-0778; or*
- *Your State Medicaid Office.*

*If you have been identified as a member or enrollee with a limited income and limited resources, you will receive extra help with your Medicare Part D prescription drug costs. You do not pay the deductibles (if applicable), copayments and coinsurance amounts listed in this section. Please contact Customer Service for details.*