

# Benefit Highlights



**SecureHorizons<sup>®</sup> MedicareComplete<sup>®</sup> Retiree Plan (HMO)**

**Columbia University**

CU2143NY (H3307 802)

Benefits effective January 01, 2011 to December 31, 2011

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<b>Annual Out-of-Pocket Maximum</b>	<b>\$6,700</b>
<b>Physician Services</b>	
Primary Care Physician office visit	\$20 copayment
Specialist office visit	\$20 copayment
<b>Inpatient Care</b>	
Inpatient Hospital Care	\$200 copayment per admission
<b>Outpatient Services</b>	
X-rays	\$0 copayment
Radiation therapy	\$25 copayment
Diagnostic Radiology Services	\$25 copayment
Outpatient Diagnostic Tests	\$25 copayment
Laboratory tests	\$0 copayment
Outpatient surgery, observation and medical services, or outpatient hospital services provided at an outpatient facility	\$100 copayment
Ambulance Services	\$50 copayment
Emergency Care (waived if admitted to the hospital)	\$50 copayment
Urgently Needed Care (waived if admitted to the hospital)	\$35 copayment
<b>Additional Benefits</b>	
Preventive Dental Services	Included. See the chapter of the Evidence of Coverage titled: Additional benefits (not covered under Original Medicare) for more details
Routine Podiatry (Up to 6 visits per plan year)	\$20 copayment
Hearing Services - Routine hearing exams (1 exam every 12 months)	\$0 copayment
- Hearing aids (every 3 years)	Plan pays up to \$500 per ear
Vision Services - Routine eye exam (refraction) (1 exam every 12 months)	\$0 copayment
- Routine eyewear or contact lenses	\$0 eyewear copayment every 2 years through Davis. Plan pays up to \$70 eyewear allowance every 2 years at other network locations.
<p>Membership in a senior fitness program at no additional cost to you</p> <p>Health and well-being programs provided through OptumHealth<sup>SM</sup></p> <p>Evercare<sup>TM</sup> Solutions for Caregivers</p>	

## Prescription Drug Benefits

### Network Pharmacy (for up to a 31-day supply)

Tier 1 - Preferred Generic	\$10 copayment
Tier 2 - Preferred Brand	\$25 copayment
Tier 3 - Non-preferred	\$50 copayment
Tier 4 - Specialty Drug	\$50 copayment
Coverage in the Gap*	Yes

### Mail Service Pharmacy (up to a 90-day supply)

Tier 1 - Preferred Generic	\$20 copayment
Tier 2 - Preferred Brand	\$50 copayment
Tier 3 - Non-preferred	\$100 copayment
Tier 4 - Specialty Drug	\$100 copayment

\*For more information about Coverage in the Gap and what this means for you please see the chapter in the Evidence of Coverage (EOC) titled *What you pay for your Part D prescription drugs*. The EOC is included in the Welcome Kit you receive when you become a member.

This is a highlight of benefits only and is not all-inclusive of the plan benefits, services, limitations or exclusions. For a complete description of plan benefits, please call customer service, or refer to the Evidence of Coverage (EOC) Chapter 3: *Medical benefits chart (what is covered and what you pay)*. The EOC is included in the Welcome Kit you receive when you become a member.

# Questions?

Call UnitedHealthcare® Customer Service about your plan:



**1-800-610-2660** TTY **711**<sup>1</sup>

8 a.m. - 8 p.m. local time, 7 days a week.



## A UnitedHealthcare® Medicare Solution

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<sup>1</sup> Already a member? Call the customer service number on the back of your member ID card.

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan.

Plans are insured or covered by an affiliate of UnitedHealthcare Insurance Company, a Medicare Advantage Organization with a Medicare contract and a Medicare-approved Part D sponsor. This document is available in alternative formats. Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. You must have both Medicare Part A and B, and must reside in the service area of the plan. You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party. Your ability to enroll may be limited to certain times of the year. For more information contact your Plan Sponsor. HMO members must use network providers to receive plan benefits except in emergency or urgent care situations or for out-of-area renal dialysis. If you obtain routine care from out-of-network providers neither Medicare nor the Medicare Advantage plan will be responsible for the costs. You may be able to get Extra Help to pay for your prescription drug premiums 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; 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. The plan's prescription drug benefit is only available to members of the Medicare Advantage Prescription Drug (MA-PD) plan. If you are already enrolled in an MA-PD plan you must receive your Medicare Prescription Drug benefit through that plan. To receive the highest level of benefit you must use contracted network pharmacies to access your prescription drug benefit except in the case of emergency. The pharmacy network includes retail, mail order, long-term care, home infusion and I/T/U (Indian Health Service, Tribes or Urban Indian) pharmacy services. You may obtain your prescriptions from pharmacies outside the contracted network at a reduced benefit. Quantity limitations and restrictions may apply. For information about mail order, names and addresses of network pharmacies or for more information call us or go to our Plan's website. The plan's contract with the Centers for Medicare & Medicaid Services is renewed annually. Availability of coverage beyond the end of the current contract year is not guaranteed. Limitations, copayments, and coinsurance may apply. Benefits may vary by employer group.