

Retiree Benefits Summary Insert
Prepared Exclusively For: Fire & Police Pension
 Group Number 092153 (H0609 804)
 Effective January 1, 2010 to December 31, 2010

Insured by: PacifiCare of Colorado, Inc.

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 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 711, 8 a.m. to 8 p.m. local time, 7 days a week.

Members call Customer Service at the phone number listed on the back of your Member ID card, or on the back cover of the Retiree Benefits Summary booklet.

BENEFITS AND COVERAGE	YOUR COSTS
Annual Deductible	None
Physician Services	
• Primary Care Physician	\$10 copayment per office visit
• Specialist	\$10 copayment per office visit
Emergency Department Services	
• Within the United States	\$50 copayment, waived if admitted to the hospital within 24 hours for the same condition
• Outside of the United States	\$50 copayment, waived if admitted to the hospital within 24 hours for the same condition.
Urgently Needed Care	
• In-area/in-network provider other than primary care physician	\$10 copayment, waived if admitted to the hospital within 24 hours for the same condition
• In-area/non-network provider or out-of-area provider	\$25 copayment, waived if admitted to the hospital within 24 hours for the same condition
Ambulance Services	\$0 copayment
Inpatient Hospital Care	\$0 copayment per admission for unlimited days*
Inpatient Mental Health Care	\$0 copayment per admission, 190-day lifetime maximum
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.
Home Health Agency Care	
• Home Care Visits	\$0 copayment per visit

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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 Hospital Services (includes observation, medical and surgical care)	\$0 copayment per surgery
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
Durable Medical Equipment (DME), Prosthetics, Orthotics (Corrective Appliances), Infusion Equipment and Supplies used in conjunction with the above	\$0 copayment for each Medicare-covered item
Diabetes Self-Management Training	\$0 copayment for Medicare-covered diabetes self-management training
Diabetes Monitoring Supplies	\$0 copayment per item or up to a 30-day supply
Medical Nutrition Therapy	\$0 copayment

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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
• Diagnostic Procedure/Test (non-radiological) Pulmonary and Cardiac Testing	\$0 copayment
Laboratory Services	\$0 copayment
Radiation Therapy	\$0 copayment per visit
Medical Supplies	\$0 copayment per item
Blood and Its Administration	\$0 copayment
Kidney Dialysis	\$10 copayment at a network facility or at a Medicare-certified facility within the United States
Bone Mass Measurements	\$0 copayment
Colorectal Screening Exams	\$0 copayment
Annual Screening Mammograms	\$0 copayment
Pap Smears and Pelvic Exams	\$0 copayment
Annual Prostate Cancer Screening Exams	\$0 copayment
Cardiovascular Disease Testing	\$0 copayment
Abdominal Aortic Aneurysm Screening	\$0 copayment for a Medicare-covered screening
Medicare-covered Physical Exams	\$0 copayment
Please note: Due to new Medicare guidelines, this benefit is amended. The Retiree Benefits Summary booklet should read, "If your coverage for Medicare Part B begins on or after January 1, 2005, you may receive a one-time physical exam within the first twelve months of your new Part B coverage."	
Immunizations	
• Flu, Pneumococcal Pneumonia, and Hepatitis B Vaccines	\$0 copayment

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Medicare Part B-covered Drugs (Immunosuppressives, Oral Chemotherapy Drugs Including Anti-nausea Drugs, Inhalation Solutions)	\$0 copayment
Outpatient Injectable Medications — Self-Administered	\$0 copayment
Outpatient Injectable Medications — Administered in a Physician’s Office	\$0 copayment
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.
Hemophilia Clotting Factors — (Self-Administered, Administered in a Physician’s Office, Home Health)	\$0 copayment
Antigens	\$0 copayment
Chiropractic Services	
• Medicare-covered	\$10 copayment per visit
• Routine (non-Medicare covered)	\$10 copayment per visit/limit of 12 visits per year
Dental Services	
• Medicare-covered	\$10 copayment for each Medicare-covered dental service
• Preventive (non-Medicare covered)	Not Covered
Foot Care	
• Medicare-covered	\$10 copayment per visit

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Hearing Services	
• Medicare-covered diagnostic hearing exam	\$10 copayment per visit
• Routine hearing tests for hearing aids (non-Medicare covered)	\$0 copayment for routine hearing tests, up to 1 test every 12 months
• Hearing Aids	Up to a \$500 hearing aid allowance every 36 months
Vision Services	
Eye care — medical need	
• Medicare-covered eye exam	\$10 copayment for each Medicare-covered vision service
• Medicare-covered eyewear	Up to a \$75 allowance for one pair of Medicare-Covered eyeglasses or contact lenses after cataract surgery
Routine Vision Services (non-Medicare covered)	
• Routine eye exam (refraction)	\$0 copayment for each refractive eye exam with a network provider, limited to 1 exam every year
• Routine eyewear or contact lenses	Not Covered
Annual Routine Physical Examination (non-Medicare covered)	Medicare initial preventive physical exam covered in full, \$0 copayment for annual routine physical examination
SilverSneakers[®] Fitness Program	You pay a \$0 monthly membership fee for a Fitness Program through Contracted fitness centers. There is no visit or use fee when you use Contracted service providers. Call us to find a program near you. (All fitness programs may not be available in all areas. We may offer other fitness programs in your area.)
Optum[®] NurseLineSM	You pay \$0 for calls to the NurseLine, available 24 hours a day, every day, to help you with health and medical questions, or to find quality providers or assist you in scheduling appointments. Simply call 1-877-365-7949, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for the phone number above, 1-877-365-7949.

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Wellness Advising	<p>You pay \$0 for this program designed to help you address certain particular conditions (for example weight management or fall risk issues) associated with defined medical conditions or criteria.</p> <p>The program provides you with access to advisors who assist you in making lifestyle behavior changes, as well as understanding risk factors associated with your health issues. The advisors provide you either printed materials or telephonic support to achieve your goal.</p>
Treatment Decision Support	<p>You pay \$0 for calls to the NurseLine to help you make effective treatment decisions, find a quality doctor, schedule appointments, work more effectively with your doctor, find a resource for a second opinion or answer questions about a number of medical conditions and treatment options (back pain, knee or hip replacements, benign prostate problems, prostate cancer, breast cancer, benign uterine conditions (fibroids, endometriosis, uterine bleeding), coronary disease, obesity (bariatric surgery)). Simply call 1-866-247-8292, 9 a.m. to 7 p.m. (Central Time), Monday through Friday, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for 1-866-247-8292.</p>
Access Support	<p>You pay \$0 for calls to the NurseLine to help you find a quality doctor and schedule appointments. Simply call 1-877-365-7949, 9 a.m. to 7 p.m. (Central Time), Monday through Friday, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for 1-877-365-7949.</p>
Out-of-Pocket Maximum (annual)	None

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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 UnitedHealthcare or contracting providers. When you are admitted to an Inpatient Hospital and then subsequently transferred to another Inpatient Hospital, you pay the copayment charged for the first hospital admission. You do not pay a copayment for the second hospital admission; the copayment is waived.
- ** A benefit period begins the first day of a Medicare-covered inpatient hospital or Skilled Nursing Facility (SNF) stay and ends with the close of a period of 60 consecutive days during which you were neither an inpatient of a hospital nor a SNF. 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**

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–\$4,550 Covered Drug Costs**Retail:**

You pay a **\$10 copayment** Tier 1 preferred generic drug copayment/**\$25 copayment** Tier 2 preferred brand name drug copayment/**\$50 copayment** Tier 3 non-preferred drug copayment/**\$50 copayment** for Tier 4 specialty drugs per Prescription Unit or up to a 31-day supply

Mail Service:

You pay a **\$20 copayment** Tier 1 preferred generic drug copayment/**\$50 copayment** Tier 2 preferred brand name drug copayment/**\$100 copayment** Tier 3 non-preferred drug copayment/**\$100 copayment** for Tier 4 specialty drugs up to a 90-day supply through our network Mail Service Pharmacy

After your yearly Out-of-Pocket Costs reach \$4,550

You pay the greater of \$2.50 for generic or a preferred brand name drug that is a multi-source drug, and \$6.30 for all other drugs, or 5% coinsurance once your total out-of-pocket costs reach \$4,550.

The MedicareComplete[®] Formulary 1
Retiree Formulary applies for both retail and
mail service prescriptions. Bonus Drugs included.

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Excluded Drugs

This section talks about drugs that are “excluded,” meaning they aren’t normally covered by a Medicare Prescription Drug Plan. If you get drugs that are excluded, you must pay for them yourself. We won’t pay for the exclusions that are listed in this section, and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered.

- A Medicare Prescription Drug Plan can’t cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can’t cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug’s label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

By law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs.” These drugs include:

1. Non-prescription drugs (or over-the-counter drugs).
2. Drugs when used to promote fertility.
3. Drugs when used for the symptomatic relief of cough or colds.
4. 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.
5. Drugs, such as Viagra, Cialis, Levitra and Caverject, when used for the treatment of sexual or erectile dysfunction.
6. Drugs when used for treatment of anorexia, weight loss, or weight gain.
7. Drugs when used for cosmetic purposes or to promote hair growth.
8. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
9. Barbiturates and Benzodiazepines.

Your Plan Sponsor may have elected to offer any combination of the above “non-Part D drugs” to you as an additional benefit. If so, you will receive information about the additional “non-Part D drugs” your Plan Sponsor has chosen to offer to you in your Plan materials.

Members 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.