

Effective January 1, 2010 – December 31, 2010

Your monthly plan premium.

Your premium payment is determined by your plan sponsor (former employer, union group or trust administrator). Please contact your plan sponsor if you have questions about your premium.

If you get extra help from Medicare to pay for your premiums or copays, the amounts you pay may be different than shown in this document. These amounts are listed in the "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs." You will get this document when you enroll and again each fall if you qualify for extra help. Your employer will apply the extra help amount to any premium you may owe.

You can find more information about paying your premium and qualifying for extra help in Section 1 of the Evidence of Coverage. You can also get this information by calling UnitedHealthcare® MedicareRx for Groups (PDP) (the plan) Customer Service.

Your annual deductible.

\$0.

Your plan has no annual deductible. Your coverage starts with your first prescription on or after January 1, 2010.

Prescription drug costs.

When you fill a prescription for a covered drug, you may pay part of the costs for your drug, and the plan will pay the rest. The amount you pay is called the copay or coinsurance.

The amount you pay for your prescription depends on:

- The coverage period you are in when you get your prescription.
- The type of drug it is.
- Whether you are filling your prescription at an in-network or out-of-network pharmacy.

Medicare has increased the 2010 threshold amounts that mark the beginning and the end of coverage periods. At each of these thresholds, your payment responsibilities change.

Initial coverage period.

The initial coverage period for your plan is when your yearly true out-of-pocket costs,¹ excluding premium payments, are between \$0 and \$4,550.

During the initial coverage period — you pay:

	THRESHOLD	YOU PAY
INITIAL COVERAGE ²	\$0–\$4,550 ³	<p>Retail Pharmacy⁴</p> <p>Tier 1 Drugs</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (31-day) supply of drugs • \$30 copay for a three-month (90-day) supply of drugs <p>Tier 2 Drugs</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (31-day) supply of drugs • \$75 copay for a three-month (90-day) supply of drugs <p>Tier 3 and Specialty Tier Drugs</p> <ul style="list-style-type: none"> • \$75 copay for a one-month (31-day) supply of drugs • \$225 copay for a three-month (90-day) supply of drugs <p>Long-Term Care Pharmacy</p> <p>Tier 1 Drugs</p> <ul style="list-style-type: none"> • \$10 copay for a one-month (31-day) supply of drugs <p>Tier 2 Drugs</p> <ul style="list-style-type: none"> • \$25 copay for a one-month (31-day) supply of drugs <p>Tier 3 and Specialty Tier Drugs</p> <ul style="list-style-type: none"> • \$75 copay for a one-month (31-day) supply of drugs

	THRESHOLD	YOU PAY
INITIAL COVERAGE ²	\$0–\$4,550 ³	<p>Mail Service</p> <p>Tier 1 Drugs</p> <ul style="list-style-type: none"> • \$20 copay for a three-month (90-day) supply of drugs <p>Tier 2 Drugs</p> <ul style="list-style-type: none"> • \$50 copay for a three-month (90-day) supply of drugs <p>Tier 3 and Specialty Tier Drugs</p> <ul style="list-style-type: none"> • \$150 copay for a three-month (90-day) supply of drugs

¹ True out-of-pocket costs is the total amount you and/or others have spent on prescription drugs that count toward qualifying you for catastrophic coverage. This total includes the amounts spent for your copays/coinsurance on covered drugs. This amount doesn't include payments made by a government-funded health program or other excluded parties.

² Initial Coverage, Out-of-Pocket and Catastrophic Coverage dollar amounts are set by the Centers for Medicare & Medicaid Services (CMS) on a calendar year basis and may change as of January 1, 2011.

³ Threshold has increased from \$4,350 in 2009 to \$4,550 in 2010, and refers to the amount of money you or others on your behalf pay out of pocket for covered drugs.

⁴ At in-network and out-of-network retail pharmacies. For out-of-network pharmacies, you will also be 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 charged for your prescriptions.

Catastrophic coverage.

All Medicare Prescription Drug Plans include catastrophic coverage. When your yearly true out-of-pocket costs (excluding premium) reach \$4,550, you will qualify for catastrophic coverage.

During catastrophic coverage — you pay:

	THRESHOLD	YOU PAY
CATASTROPHIC COVERAGE	After \$4,550, ¹ NO LIMIT	<p>Generic drugs (including brand-name drugs treated as generic)</p> <ul style="list-style-type: none"> • Greater of \$2.50 or 5% coinsurance <p>All other covered drugs</p> <ul style="list-style-type: none"> • Greater of \$6.30 or 5% coinsurance

¹ Threshold has increased from \$4,350 in 2009 to \$4,550 in 2010, and refers to the amount of money you or others on your behalf pay out of pocket for covered drugs.

Vaccine coverage (including administration).

Our plan's prescription drug benefit covers a number of vaccines, including vaccine administration. The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network, and that you may have to pay for the entire cost of the vaccine and its administration in advance.

You will need to mail the plan the receipts, following our out-of-network paper claims policy (see Chapter 2 in the Evidence of Coverage), and then you will be reimbursed up to our normal coinsurance or copayment for that vaccine. In some cases, you will be responsible for the difference between what the plan pays and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed):
The pharmacy	The pharmacy (not possible in all states)	You pay your normal copay or coinsurance for the vaccine.
Your doctor	Your doctor	<p>You pay up front for the entire cost of the vaccine and its administration.</p> <p>You are reimbursed this amount less your normal copay or coinsurance for the vaccine (including administration), less any difference between the amount the doctor charges and what the plan normally pays.¹</p>
The pharmacy	Your doctor	You pay your normal copay or coinsurance for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less any applicable in-network charge for administering the vaccine, less any difference between what the doctor charges for administering the vaccine and what the plan normally pays. ¹

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage:²

- Your copay or coinsurance up to the initial coverage limit.

- Payments you made this year under another Medicare Prescription Drug Plan prior to your enrollment in our plan.

¹ If you receive extra help, the plan will reimburse you for this difference. Our Customer Service Associates can help you understand the costs associated with vaccines (including administration) available under our plan before you go to your doctor. For more information, please contact Customer Service.

² As long as the drug you are paying for is a Part D drug or transition drug, it is on the formulary (or if you get a favorable decision on a coverage determination request, exception request or appeal), it is obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy) and otherwise meets our coverage requirements.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories.
- Prescription drugs not covered by the plan.
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for Part D drugs covered by the plan count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:

- Family members or other individuals;
- Medicare programs that provide extra help with prescription drug coverage; and

- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following don't count toward your out-of-pocket costs:

- Group Health Plans (those sponsored by a former employer, union or trust);
- Insurance plans and government-funded health programs (e.g., TRICARE, the VA, the Indian Health Service and AIDS Drug Assistance Programs); and
- Third-party arrangements with a legal obligation to pay for prescription costs (e.g., Workers' Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must let the plan know.

The plan will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. In addition, for every month in which you purchase covered prescription drugs through the plan, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

UnitedHealthcare MedicareRx for Groups (PDP) member identification (ID) card.

You must use your UnitedHealthcare MedicareRx for Groups (PDP) member ID card instead of your red, white and blue Medicare card when accessing covered services at network pharmacies. Please carry your ID card with you at all times. You will need to show this card in order to get your prescription drugs paid for. If your ID card is damaged, lost or stolen, call Customer Service and we will send you a new card.



Medicare Part D drug exclusions.

This section talks about drugs that are “excluded,” meaning they aren’t normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself, unless they are found upon appeal to be drugs that the plan should have paid for or covered.

- A Medicare Prescription Drug Plan can’t cover a drug that is 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 FDA) of a prescription drug only in cases in which the use is supported by certain reference books, known as compendia, citations. Congress specifically listed the three compendia that list whether the off-label use would be permitted.¹ If the use is not supported by one of these compendia, then the drug is considered a non-Part D drug and cannot be covered by our plan.

In addition, 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 used for treatment of anorexia, weight loss or weight gain.
3. Drugs used to promote fertility.
4. Drugs used for cosmetic purposes or to promote hair growth.
5. Drugs used for the symptomatic relief of cough or colds.
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
7. 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.
8. Barbiturates and Benzodiazepines.
9. Erectile dysfunction medications such as Viagra, Cialis, Levitra and Caverject.

The amount you pay when you fill a prescription for these drugs does not count toward qualifying you for catastrophic coverage. In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary or call Customer Service for more information.

If you receive extra help, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

See your “Medicare & You Handbook” for more information about drugs that are covered by Medicare Part A and Part B. Some drugs are covered under Medicare Part B in certain cases and under UnitedHealthcare MedicareRx for Groups (PDP) in other cases. In general, your pharmacist or provider will determine whether to bill Medicare Part B or UnitedHealthcare MedicareRx for Groups (PDP) for the drug in question.

Medicare prescription drug limitations.

This sections talks about limitations of all Medicare prescription drug plans.

1. A prescription drug is a Part D drug only if it is for a medically accepted indication as defined in the Medicare statute. This definition includes prescribed uses supported by a citation included, or approved for inclusion, in one of the three compendia.¹

Based on this statutory definition, indications are not “medically accepted” if they are supported in peer-reviewed medical literature, but not yet included or approved for inclusion in one of the compendia. Therefore, the use of a drug for such indications would not meet the definition of a Part D drug, and the drug would not be covered under the plan, even if your doctor states that the drug is medically necessary.

2. The plan reserves the right to require prior authorization for certain drugs on the UnitedHealthcare MedicareRx for Groups (PDP) formulary prior to dispensing.
3. Drugs dispensed by non-network pharmacies are not covered except under limited circumstances. These circumstances include:
 - If you need a prescription while a patient in an emergency department, provider-based clinic, outpatient surgery or other outpatient setting.
 - If you need a prescription while traveling within the United States because you become ill or run out of your prescription drugs.

- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy is not within reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or mail order pharmacy (including high-cost and unique drugs).

4. Early refills for lost, stolen or destroyed drugs are not covered except during a declared “national emergency.”
5. Early refills for vacation supplies are limited to a one-time fill of up to 31 days per calendar year.
6. Medications will not be covered if prescribed by physicians or other providers who are excluded from Medicare program participation.
7. You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days supply.

¹ Reference books (compendia) referenced in this document include: *American Hospital Formulary Service Drug Information*, the DRUGDEX[®] Information System and United States Pharmacopeia-Drug Information (USPDI) or its successor.

UnitedHealthcare MedicareRx for Groups (PDP) exclusions and limitations.

This section talks about exclusions and limitations set by UnitedHealthcare MedicareRx for Groups (PDP). You may be eligible to receive some of these excluded drugs through UnitedHealthcare MedicareRx for Groups (PDP). See the Evidence of Coverage for information on exceptions.

1. Drugs or medicines purchased and received prior to, or following, the covered person's eligibility.
2. Therapeutic devices or appliances, even though they may require a prescription. This includes: hypodermic needles, syringes (except insulin syringes when provided by a participating pharmacy for use with approved self-injectable medications), support garments and other nonmedical substances.
3. Medications which may be properly received without charge under local, state or federal programs or that are reimbursable under other insurance programs, including Workers' Compensation and Medicare, or medications furnished by any other drug or medical service for which no charge is made to the covered person.
4. Medications prescribed for experimental or non-FDA-approved indications unless prescribed in a manner consistent with a special indication in the compendia.¹
5. Immunizing agents, injectables (except as shown in "Covered Services"), biological sera, blood plasma or medications prescribed for parenteral use.
6. Any applicable sales tax or surcharge.
7. New prescription medications or supplies until they are reviewed for safety, efficacy and cost effectiveness, and approved by UnitedHealthcare MedicareRx for Groups (PDP).
8. Drugs used for diagnostic purposes.
9. Saline and irrigation solutions.
10. Unit dose/convenience dosage forms: unit dose, pre-packaged medications, individual packets, etc.

¹Reference books (compendia) referenced in this document include: *American Hospital Formulary Service Drug Information*, the DRUGDEX[®] Information System and United States Pharmacopeia-Drug Information (USPDI) or its successor.

Formulary (Drug List).

Your formulary is the list of drugs covered by UnitedHealthcare MedicareRx for Groups (PDP). UnitedHealthcare MedicareRx for Groups (PDP) selected the drugs in consultation with a team of health care providers with expertise in the prescription drug needs of people with Medicare. New plan members receive a formulary (partial list of drugs) in the welcome kit.

Your formulary has 4 tiers. A tier is a classification used by many formularies to divide drugs into preferred and standard categories. Each tier typically has a different cost-share amount, but your plan has the same copay/coinsurance for multiple tiers.

Tier 1: Most generic drugs

Most generic prescription drugs are included in this tier. For the lowest out-of-pocket expense, you and your doctor should decide if Tier 1 medications are right for your treatment.

Tier 2: Most preferred brand-name drugs

This tier includes many common brand-name and some higher-cost generic prescription drugs. Drugs are included in Tier 2 because they offer clinical advantages and/or lower prices than Tier 3 drugs. Some Tier 2 drugs have lower-cost Tier 1 options that you may consider with your doctor.

Tier 3: Most non-preferred brand-name drugs

Drugs are included in Tier 3 because they may have clinical disadvantages over other drug therapies and/or higher prices than Tier 1 and/or Tier 2 drugs. If you are taking a Tier 3 drug, ask your doctor if you could use a Tier 1 or Tier 2 drug instead, to lower your out-of-pocket expenses.

Specialty Tier (SP): unique or high-cost specialty drugs

Unique or very high-cost drugs are included in this tier.

Summary of prescription drug benefits.

Call Customer Service if you want a complete formulary listing. If the formulary changes, you will be notified in writing before the change. Only Medicare Part D covered drugs will affect your Medicare prescription drug plan annual out-of-pocket spending. Certain prescription drugs will have maximum quantity limits. Your provider must get prior authorization from UnitedHealthcare MedicareRx for Groups (PDP) for certain prescription drugs. Please contact UnitedHealthcare MedicareRx for Groups (PDP) for details.

For more information on your plan, please call 1-888-556-6648, 24 hours a day, 7 days a week. TTY, call 711.

UnitedHealthcare MedicareRx for Groups (PDP) provides coverage for outpatient prescription drugs only. You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party. Members may be enrolled in only one Part D plan at a time. Members must reside in the service area to be eligible to enroll. UnitedHealthcare MedicareRx for Groups (PDP) covers both brand-name drugs and generic drugs. Generic drugs have the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. Contact UnitedHealthcare MedicareRx for Groups (PDP) for more information.

Enrollees must use network pharmacies to receive plan benefits except under emergency circumstances. Our network includes retail, mail service, long-term care, I/T/U and home infusion pharmacies. If you would like additional information about our mail service, please contact UnitedHealthcare MedicareRx for Groups (PDP) at the number below.

People who have low incomes, who live in long-term care facilities or who have access to Indian/Tribal/Urban (I/T/U) facilities may have different out-of-pocket drug costs. Please contact UnitedHealthcare MedicareRx for Groups (PDP) for more details. If members have qualified for additional assistance for Medicare Prescription Drug Plan costs, the amount of your premium and cost at the pharmacy will be less. Once you have enrolled in UnitedHealthcare MedicareRx for Groups (PDP), Medicare will tell the plan how much assistance you are receiving, and the plan will send you information on the amount you will pay.

If you are not receiving this additional assistance, you should call 1-800-MEDICARE (1-800-633-4227) (TTY users should call 1-877-486-2048), 24 hours a day, 7 days a week; the Social Security Administration at 1-800-772-1213 or the toll-free TTY number 1-800-325-0778, between 7 a.m. and 7 p.m., Monday through Friday; or your State Medicaid office.

This Medicare Prescription Drug Plan (PDP) is insured by UnitedHealthcare Insurance Company or UnitedHealthcare Insurance Company of New York for New York residents (together called "UnitedHealthcare"). UnitedHealthcare contracts with the Federal government as a PDP sponsor. All decisions about prescription drugs are between you and your physician or other health care provider.

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