

2011 summary of benefits Prescription Drug Plan

UnitedHealthcare® MedicareRx for Groups (PDP)

Effective January 1, 2011



Effective January 1, 2011 – December 31, 2011

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 copayments (copays) and/or coinsurance, the amounts you pay may be different than those shown in this document. Extra help 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 Chapter 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, 2011.

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 and/or coinsurance.

The amount you pay for your prescription depends on:

- The coverage stage 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 makes changes to the amounts that mark the Initial Coverage Limit and the end of the Catastrophic Out-of-Pocket threshold. At each of these thresholds, your payment responsibilities could change. These thresholds and rules for counting costs toward these amounts have been set by Medicare.

Initial coverage stage.

The initial coverage stage for your Plan is when your yearly true out-of-pocket costs,¹ excluding premium payments, are between \$0 and \$4,550. However, when your total drug costs fall between \$2,840 and \$4,550, if you fill a prescription for a brand-name drug, then the discount applies to your share of the cost.

Beginning in 2011, the Medicare Coverage Gap Discount Program will provide manufacturer discounts on brand-name drugs to Part D enrollees who have reached the coverage gap stage and are not already receiving “Extra Help.” About a 50% discount on the negotiated price (excluding the dispensing fee) will be available for those brand-name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits will show any discount provided. The amount discounted by the manufacturer would count toward your out-of-pocket costs as if you had paid this amount and moves you through the coverage gap stage.

During the initial coverage stage — you pay:

	THRESHOLD	YOU PAY
INITIAL COVERAGE STAGE ²	\$0–\$4,550 ³	<p>Retail Pharmacy⁴</p> <p>Tier 1 Drugs</p> <ul style="list-style-type: none"> • \$5 copay for a one-month (31-day) supply of drugs • \$15 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 Drugs</p> <ul style="list-style-type: none"> • \$60 copay for a one-month (31-day) supply of drugs • \$180 copay for a three-month (90-day) supply of drugs <p>Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs • 33% coinsurance for a three-month (90-day) supply of drugs

INITIAL COVERAGE STAGE ²	THRESHOLD	YOU PAY
	\$0–\$4,550 ³	<p>Long-Term Care Pharmacy</p> <p>Tier 1 Drugs</p> <ul style="list-style-type: none"> • \$5 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 Drugs</p> <ul style="list-style-type: none"> • \$60 copay for a one-month (31-day) supply of drugs <p>Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance for a one-month (31-day) supply of drugs <p>Mail Service</p> <p>Tier 1 Drugs</p> <ul style="list-style-type: none"> • \$10 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 Drugs</p> <ul style="list-style-type: none"> • \$120 copay for a three-month (90-day) supply of drugs <p>Specialty Tier Drugs</p> <ul style="list-style-type: none"> • 33% coinsurance 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 and/or coinsurance on covered drugs. (This amount does not 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 For 2011 the threshold will remain \$4,550, 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 stage.

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 STAGE	AFTER \$4,550 ⁵ 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

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 copay 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.

⁵ For 2011 the threshold will remain \$4,550, and refers to the amount of money you or others on your behalf pay out-of-pocket for covered drugs.

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 and/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 and/or coinsurance for the vaccine (including administration), less any difference between the amount the doctor charges and what the Plan normally pays.⁶</p>
The pharmacy	Your doctor	You pay your normal copay and/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. ⁶

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:⁷

- Your copay and/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.

⁶ 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.

⁷ 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 does not 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
- Prescription drug manufacturers
- Indian Health Service and AIDS Drug Assistance Programs
- 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 do not 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 and the VA)
- 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.

Does my Plan cover Medicare Part B or Part D drugs?

Our Plan does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

Where can I get my prescriptions?

UnitedHealthcare MedicareRx for Groups (PDP) has formed a network of pharmacies. You must use a network pharmacy to receive Plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or visit our Plan website. Our Customer Service number is listed at the bottom of the page.

What is a Prescription Drug Formulary?

UnitedHealthcare MedicareRx for Groups (PDP) uses a formulary. A formulary is a list of drugs covered by your Plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send an abridged formulary to you and you can request a copy of our complete formulary by calling Customer Service.

What are my protections in the Plan?

All Medicare Prescription Drug Plans agree to stay in the program for a full year at a time. Each year, the Plans decide whether to continue for another year. Even if a Medicare Prescription Drug Plan leaves the program, you will not lose Medicare coverage. If a Plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

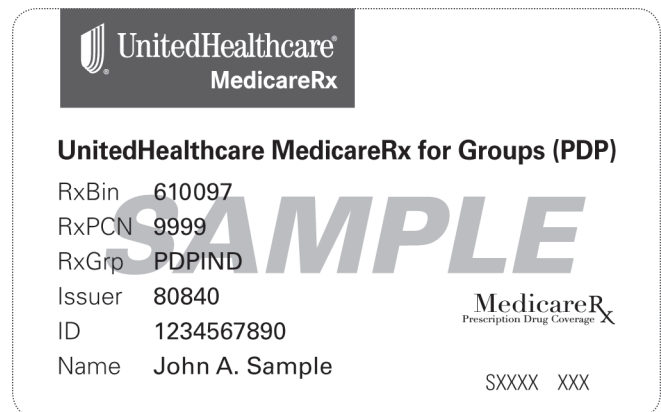
As a member of this Plan, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact the Plan for more details.

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 are not 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 cannot cover a drug that is covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan cannot 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,⁸ citations. Congress specifically listed the three compendia that list whether the off-label use would be permitted. 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

⁸ 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.

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 your Plan in other cases. In general, your pharmacist or provider will determine whether to bill Medicare Part B or the Plan for the drug in question.

Medicare prescription drug limitations.

This section 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.⁸

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.

⁸ 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). Note, you may be eligible to receive some of these excluded drugs through this Plan. 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.⁸
5. Administration or injection of any drug except covered vaccines.
6. Immunizing agents, injectables (except as shown in "Covered Services"), biological sera, blood plasma or medications prescribed for parenteral use.
7. Any applicable sales tax or surcharge.
8. New prescription medications or supplies until they are reviewed for safety, efficacy and cost effectiveness, and approved by the Plan.
9. Drugs used for diagnostic purposes.
10. Saline and irrigation solutions.
11. Unit dose/convenience dosage forms: unit dose, pre-packaged medications, individual packets, etc.

⁸ 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.

Formulary (Drug List).

Your formulary is the list of drugs covered by UnitedHealthcare MedicareRx for Groups (PDP). The Plan 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, however your Plan may have the same copay and/or coinsurance for one or more tiers.

Tier 1: Lowest Copay and/or Coinsurance

Includes most generic drugs. For the lowest out-of-pocket cost, you and your doctor should decide if Tier 1 medications are right for your treatment.

Tier 2: Medium Copay and/or Coinsurance

Includes many common brand-name drugs, called preferred brands, and some higher-cost generic prescription drugs. Some Tier 2 drugs have lower-cost options that you may consider with your doctor.

Tier 3: Highest Copay and/or Coinsurance

Includes non-preferred generic and non-preferred brand-name drugs. Drugs in Tier 3 usually have lower-cost treatment options in Tier 1 or Tier 2. 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.

Tier 4 (Specialty Tier): Copay and/or Coinsurance

Includes unique and/or very high-cost drugs. You pay a portion of the total drug cost, called a copay and/or coinsurance.

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 the Plan for certain prescription drugs. Please contact UnitedHealthcare MedicareRx for Groups (PDP) for details.

For more information on your Plan, please call Customer Service at 1-888-556-6648, TTY call 711, 8 a.m. – 8 p.m. local time, 7 days a week.

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. The Plan 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 the Plan 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 the Plan 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 the Plan 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 Medicare-approved Part D sponsor. All decisions about prescription drugs are between you and your physician or other health care provider.

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A UnitedHealthcare® Medicare Solution

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