

PART
D

UNITEDHEALTH Rx VALUE AND
UNITEDHEALTH Rx BASIC



summary of benefits

JANUARY 1, 2008 - DECEMBER 31, 2008

THIS SUMMARY OF BENEFITS TELLS YOU SOME OF THE
FEATURES OF OUR PLANS.



Section 1

Introduction to summary of benefits — UnitedHealth Rx Value and UnitedHealth Rx Basic

January 1, 2008 – December 31, 2008

Connecticut, Massachusetts, Rhode Island, Vermont

Thank you for your interest in UnitedHealth Rx plans. Our plans are offered by United HealthCare Insurance Company or United HealthCare Insurance Company of New York (for New York residents), Medicare Prescription Drug Plans that contracts with the Federal government. This Summary of Benefits tells you some features of our plans. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call UnitedHealthcare and ask for the "Evidence of Coverage."

You have choices in your Medicare Prescription Drug Coverage.

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like UnitedHealth Rx plans. Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

How can I compare my options?

The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by UnitedHealth Rx plans to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

Where are UnitedHealth Rx plans available?

The service area for these plans include:

Connecticut, Massachusetts, Rhode Island, Vermont

You must live in one of these areas to join the plan.

There are more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

Who is eligible to join?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in the service area. Eligible individuals may only enroll in one Medicare Prescription Drug Plan at a time and may not be enrolled in a Medicare Advantage Plan (HMO, PPO), unless they are a member of a Medicare Private-Fee-For-Services plan or are enrolled in an 1876 Cost Plan. You may join a Medicare Prescription Drug Plan during certain times of the year.

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

UnitedHealth Rx plans do 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?

UnitedHealth Rx plans have 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.

UnitedHealthcare has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower copay or coinsurance. A non-preferred pharmacy is still a network pharmacy, but you may have to pay more for your prescriptions.

The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or call Customer Service for an up-to-date list.

What is a Prescription Drug Formulary?

UnitedHealth Rx plans use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, 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 a formulary to you and you can see our complete formulary on our Web site at www.UnitedHealthRx.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary

with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

What should I do if I have other insurance in addition to Medicare?

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy. This will occur as of the effective date of your coverage in the Medicare Prescription Drug Plan and they will adjust your premium. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join UnitedHealth Rx plans. Get this information before you decide to enroll in this plan.

How can I get help with my drug plan costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join UnitedHealth Rx plans, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help, you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227). TTY/TTD users should call 1-877-486-2048.

What are my protections in this 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 prescription drug 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 UnitedHealth Rx plans, 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 for 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.

What is a Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we may 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.

 **Please contact UnitedHealthcare for more information about this plan.**

Visit www.UnitedHealthRx.com
or, call us:

Customer Service hours:
24 hours a day, 7 days a week

Current members should call:
1-888-867-5562
TTY/TTD **1-877-730-4203**

Prospective members should call:
1-888-867-5561
TTY/TTD **1-877-730-4203**

For more information about Medicare,
call 1-800-MEDICARE (1-800-633-4227)

TTY users should call 1-877-486-2048

You can call 24 hours a day, 7 days a week.


Or, visit www.medicare.gov on the Web.


If you have special needs, this document
may be available in other formats.

If you have any questions about this plan's benefits or costs, please contact UnitedHealthcare for details.

Section 2


summary of benefits


BENEFIT	ORIGINAL MEDICARE	UNITEDHEALTH Rx VALUE	UNITEDHEALTH Rx BASIC
PREMIUM		You pay \$21.20 each month for your Medicare Part D prescription drug benefits.	You pay \$38.50 each month for your Medicare Part D prescription drug benefits.
PRESCRIPTION DRUGS 	Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan).	<p>Drugs covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.UnitedHealthRx.com on the Web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long-term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance, when you travel).</p>	<p>Drugs covered under Medicare Part D</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.UnitedHealthRx.com on the Web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> • have limited incomes, • live in long-term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance, when you travel).</p>

BENEFIT	ORIGINAL MEDICARE	UNITEDHEALTH Rx VALUE	UNITEDHEALTH Rx BASIC
PRESCRIPTION DRUGS (continued)		<p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from UnitedHealth Rx Value for certain drugs.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p>	<p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from UnitedHealth Rx Basic for certain drugs.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p>
<p>In-Network \$275.00 yearly deductible.</p>		<p>In-Network \$0.00 deductible.</p>	
<p>Some covered drugs don't count toward your out-of-pocket drug costs.</p>			
<p>Initial Coverage</p> <p>After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,510:</p>		<p>Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2,510:</p>	
<p>Retail Pharmacy</p> <p>Tier 1 – Preferred Generic \$6.00 copay for a one-month (31-day) supply of drugs.</p> <p>\$18.00 copay for a three-month (90-day) supply of drugs.</p> <p>Tier 2 – Preferred Brand \$27.75 copay for a one-month (31-day) supply of drugs.</p> <p>\$83.25 copay for a three-month (90-day) supply of drugs.</p>		<p>Retail Pharmacy</p> <p>Tier 1 – Preferred Generic \$7.00 copay for a one-month (31-day) supply of drugs.</p> <p>\$21.00 copay for a three-month (90-day) supply of drugs.</p> <p>Tier 2 – Preferred Brand \$28.00 copay for a one-month (31-day) supply of drugs.</p> <p>\$84.00 copay for a three-month (90-day) supply of drugs.</p>	

BENEFIT	ORIGINAL MEDICARE	UNITEDHEALTH Rx VALUE	UNITEDHEALTH Rx BASIC
PRESCRIPTION DRUGS (continued)		<p>Tier 3 – Other Non-Preferred (Generic, Brand) 25% coinsurance for a one-month (31-day) supply of drugs.</p> <p>25% coinsurance for a three-month (90-day) supply of drugs.</p> <p>Tier 4 – Specialty (Generic, Brand) 25% coinsurance for a one-month (31-day) supply of drugs.</p> <p>25% coinsurance for a three-month (90-day) supply of drugs.</p> <p>Long-Term Care Pharmacy</p> <p>Tier 1 – Preferred Generic \$6.00 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 2 – Preferred Brand \$27.75 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 3 – Other Non-Preferred (Generic, Brand) 25% coinsurance for a one-month (31-day) supply of drugs.</p> <p>Tier 4 – Specialty (Generic, Brand) 25% coinsurance for a one-month (31-day) supply of drugs.</p>	<p>Tier 3 – Other Non-Preferred (Generic, Brand) \$65.70 copay for a one-month (31-day) supply of drugs.</p> <p>\$197.10 copay for a three-month (90-day) supply of drugs.</p> <p>Tier 4 – Specialty (Generic, Brand) 33% coinsurance for a one-month (31-day) supply of drugs.</p> <p>33% coinsurance for a three-month (90-day) supply of drugs.</p> <p>Long-Term Care Pharmacy</p> <p>Tier 1 – Preferred Generic \$7.00 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 2 – Preferred Brand \$28.00 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 3 – Other Non-Preferred (Generic, Brand) \$65.70 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 4 – Specialty (Generic, Brand) 33% coinsurance for a one-month (31-day) supply of drugs.</p>




BENEFIT	ORIGINAL MEDICARE	UNITEDHEALTH Rx VALUE	UNITEDHEALTH Rx BASIC
<p data-bbox="127 245 304 357">PRESCRIPTION DRUGS (continued)</p> <div data-bbox="245 396 317 454" style="border: 1px solid black; padding: 2px; display: inline-block;">  </div>		<p data-bbox="574 245 724 278">Mail Order</p> <p data-bbox="574 310 987 470">Tier 1 – Preferred Generic \$0.00 copay for a three-month (90-day) supply of drugs from a preferred mail order pharmacy.</p> <p data-bbox="574 498 1014 614"> \$18.00 copay for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</p> <p data-bbox="574 642 1028 944">Tier 2 – Preferred Brand \$68.25 copay for a three-month (90-day) supply of drugs from a preferred mail order pharmacy. \$83.25 copay for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</p> <p data-bbox="574 972 1028 1310">Tier 3 – Other Non-Preferred (Generic, Brand) 25% coinsurance for a three-month (90-day) supply of drugs from a preferred mail order pharmacy. 25% coinsurance for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</p> <p data-bbox="574 1338 1028 1640">Tier 4 – Specialty (Generic, Brand) 25% coinsurance for a three-month (90-day) supply of drugs from a preferred mail order pharmacy. 25% coinsurance for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</p>	<p data-bbox="1061 245 1211 278">Mail Order</p> <p data-bbox="1061 310 1475 470">Tier 1 – Preferred Generic \$0.00 copay for a three-month (90-day) supply of drugs from a preferred mail order pharmacy.</p> <p data-bbox="1061 498 1508 614"> \$21.00 copay for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</p> <p data-bbox="1061 642 1515 944">Tier 2 – Preferred Brand \$69.00 copay for a three-month (90-day) supply of drugs from a preferred mail order pharmacy. \$84.00 copay for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</p> <p data-bbox="1061 972 1515 1310">Tier 3 – Other Non-Preferred (Generic, Brand) \$182.10 copay for a three-month (90-day) supply of drugs from a preferred mail order pharmacy. \$197.10 copay for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</p> <p data-bbox="1061 1338 1515 1640">Tier 4 – Specialty (Generic, Brand) 33% coinsurance for a three-month (90-day) supply of drugs from a preferred mail order pharmacy. 33% coinsurance for a three-month (90-day) supply of drugs from a non-preferred mail order pharmacy.</p>

BENEFIT	ORIGINAL MEDICARE	UNITEDHEALTH Rx VALUE	UNITEDHEALTH Rx BASIC
PRESCRIPTION DRUGS (continued)		<p>Coverage Gap</p> <p>After your total yearly drug costs reach \$2,510, you pay 100% until your yearly out-of-pocket drug costs reach \$4,050.</p>	<p>Coverage Gap</p> <p>After your total yearly drug costs reach \$2,510, you pay 100% until your yearly out-of-pocket drug costs reach \$4,050.</p>
<p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> • \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or • 5% coinsurance. 		<p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> • \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or • 5% coinsurance. 	
<p>Out-of-Network</p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy.</p> <p>You may pay more than the copay if you get your drugs at an out-of-network pharmacy.</p>		<p>Out-of-Network</p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy.</p> <p>You may pay more than the copay if you get your drugs at an out-of-network pharmacy.</p>	

BENEFIT	ORIGINAL MEDICARE	UNITEDHEALTH Rx VALUE	UNITEDHEALTH Rx BASIC
PRESCRIPTION DRUGS (continued)		<p>Out-of-Network Initial Coverage</p> <p>After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,510:</p> <p>Tier 1 – Preferred Generic \$6.00 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 2 – Preferred Brand \$27.75 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 3 – Other Non-Preferred (Generic, Brand) 25% coinsurance for a one-month (31-day) supply of drugs.</p> <p>Tier 4 – Specialty (Generic, Brand) 25% coinsurance for a one-month (31-day) supply of drugs.</p>	<p>Out-of-Network Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2,510:</p> <p>Tier 1 – Preferred Generic \$7.00 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 2 – Preferred Brand \$28.00 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 3 – Other Non-Preferred (Generic, Brand) \$65.70 copay for a one-month (31-day) supply of drugs.</p> <p>Tier 4 – Specialty (Generic, Brand) 33% coinsurance for a one-month (31-day) supply of drugs.</p>



BENEFIT	ORIGINAL MEDICARE	UNITEDHEALTH Rx VALUE	UNITEDHEALTH Rx BASIC
PRESCRIPTION DRUGS (continued)		<p>Out-of-Network Coverage Gap</p> <p>After your total yearly drug costs reach \$2,510, you pay 100% until your yearly out-of-pocket drug costs reach \$4,050.</p>	
		<p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> • \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or • 5% coinsurance. 	<p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> • \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or • 5% coinsurance.

