2018
SUMMARY OF BENEFITS

Overview of your plan

UnitedHealthcare® MedicareRx℠ for Groups (PDP)

Group Name (Plan Sponsor): ARLINGTON PUBLIC SCHOOLS
Group Number: 23707

S5820-803

Look inside to learn more about the drug coverages the plan provides.
Call Customer Service or go online for more information about the plan.

Toll-Free **1-877-558-4749**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

www.UHCRetiree.com

UnitedHealthcare®

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Our service area includes the 50 United States, the District of Columbia and all US territories.

Summary of Benefits

January 1, 2018 - December 31, 2018

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.UHCRetiree.com or you can call Customer Service with questions you may have. You get an EOC when you enroll in the plan.

About this plan.

UnitedHealthcare® MedicareRx℠ for Groups (PDP) is a Medicare Prescription Drug Plan plan with a Medicare contract.

To join UnitedHealthcare® MedicareRx℠ for Groups (PDP), you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, live in our service area as listed on the cover be a United States citizen or lawfully present in the United States and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Use network pharmacies.

UnitedHealthcare® MedicareRx℠ for Groups (PDP) has a network of pharmacies. If you use out-of-network pharmacies, the plan may not pay for those drugs or you may pay more than you pay at an in-network pharmacy.

You can go to www.UHCRetiree.com to search for a network pharmacy using the online directory. You can also view the plan formulary (drug list) to see what drugs are covered, and if there are any restrictions.

UnitedHealthcare® MedicareRx℠ for Groups (PDP)

Premiums and Benefits	Cost-Share
Monthly Plan Premium	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Annual Prescription Drug Deductible	This plan does not have a deductible.

Prescription Drugs

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor has chosen to make supplemental drug coverage available to you. This coverage is in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D prescription drug benefit and your supplemental drug coverage. Once you are enrolled in this plan, you will receive a separate document called the "Certificate of Coverage" with more information about this supplemental drug coverage.

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see your Additional Drug Coverage list for more information.

If you reside in a long-term care facility, you will pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

Stage 1: Annual Prescription Deductible	Since you have no deductible, this payment stage doesn't apply.	
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	**Retail Cost-Sharing**	**Mail Order Cost-Sharing**
	One-month supply	**Three-month supply**
Tier 1: Preferred Generic	$10 copay	$20 copay
Tier 2: Preferred Brand, (Includes some Generics)	$25 copay	$50 copay
Tier 3: Non-Preferred Drugs, (Includes some Generics)	$40 copay	$80 copay
Tier 4: Specialty Tier	$40 copay	$80 copay
Stage 3: Coverage Gap Stage	After your total drug costs reach $3,750, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.	

Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,000, you pay the greater of: • 5% coinsurance, or • $3.35 copay for generic (including brand drugs treated as generic) and a $8.35 copay for all other drugs.

Required Information

This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply.

The Formulary and/or pharmacy networkmay change at any time. You will receive notice when necessary.

Premium and/or co-payments/co-insurance may change at the beginning of each plan year.

You must continue to pay your Medicare Part B premium.

OptumRx is an affiliate of UnitedHealthcare Insurance Company. You are not required to use OptumRx home delivery for a 90 day supply of your maintenance medication.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.