

What is the Universal Health Care Insurance Company, Inc. Formulary?

A formulary is a list of covered drugs selected by Universal Health Care Insurance Company, Inc. (UHCIC) in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. UHCIC will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a UHCIC network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary change?

Generally, if you are taking a drug on our 2010 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2010 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, add prior authorization, quantity limits, and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

The enclosed formulary is current as of January 1, 2010. To get updated information about the drugs covered by UHCIC, please visit our website at www.univhc.com or call Member Services at 1-877-204-8149, 24 hours a day, 7 days a week (except Thanksgiving and Christmas). TTY/TDD users should call 1-800-716-3231. Members will receive a written notice 60 days in advance of a formulary change taking place. Members should consult with their physician on the best course of action. Formulary changes are posted on our website and in the Member Portal at www.univhc.com.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 2. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular, Hypertension/Lipids." If you know what your drug is used for, look for the category name in the list that begins on page number 2. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 36. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

UHCIC covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** UHCIC requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from UHCIC before you fill your prescriptions. If you don't get approval, UHCIC may not cover the drug.
- **Quantity Limits:** For certain drugs, UHCIC limits the amount of the drug that UHCIC will cover. For example, UHCIC provides 20 tablets per prescription for KETEK[®]. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, UHCIC requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, UHCIC may not cover Drug B unless you try Drug A first. If Drug A does not work for you, UHCIC will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 2. You can also get more information about the restrictions applied to specific covered drugs by visiting our website at www.univhc.com.

You can ask UHCIC to make an exception to these restrictions or limits. See the section "How do I request an exception to the UHCIC Formulary?" on page iii for information about how to request an exception. UHCIC does not cover over-the-counter drugs.

What if my drug is not on the Formulary?

If your drug is not included in this list of covered drugs, you should first contact Member Services and confirm that your drug is not covered. If you learn that UHCIC does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by UHCIC. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by UHCIC.
- You can ask UHCIC to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the UHCIC Formulary?

You can ask UHCIC to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For certain drugs, UHCIC limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our highest tier subject to the tiering exceptions process tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the lowest tier subject to the tiering exceptions process tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty Drugs tier.

Generally, UHCIC will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drugs, or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering, or utilization restriction exception. **When you are requesting a formulary, tiering, or utilization restriction exception, you should submit a statement from your physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to

72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will cover a temporary 34-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 34-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Transition Policy

New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug.

Please contact Member Services if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 31-day supply (unless the prescription is written for fewer days). After we cover the temporary 31-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 34-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than 90 days and needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Current Members with a change in their level of care

Exceptions are available for beneficiaries who have experienced a change in the level of care they are receiving which requires them to transition from one facility or treatment center to another. Examples of situations in which beneficiaries would be eligible for the one-time temporary fill exception when they are outside of the three month effective date into the Part D program are as follows:

- If a beneficiary was discharged from the hospital and was provided a discharge list of medications based upon the formulary of the hospital.
- Beneficiaries who end their skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who need to revert back to their Part D plan formulary.
- Beneficiaries who give up Hospice status to revert back to standard Medicare Part A and B benefits.
- Beneficiaries who are discharged from Chronic Psychiatric Hospitals with medication regimens that are highly individualized.

All of these situations would warrant a temporary one-time fill exception even if the beneficiary is not in the first 90 days of program enrollment.

Please note that our transition policy applies only to those drugs that are “Part D drugs” and bought at a network pharmacy. The transition policy can’t be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access.

For more information

For more detailed information about UHCIC’s prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you need additional information on network pharmacies, filling prescriptions via mail-order, or any other general questions, please call Member Services at 1-877-204-8149, 24 hours a day, 7 days a week (except Thanksgiving and Christmas). TTY/TDD users should call 1-800-716-3231. Or visit www.univhc.com.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Or visit www.medicare.gov.

UHCIC’s Formulary

The formulary that begins on page 2 provides coverage information about some of the drugs covered by UHCIC. If you have trouble finding your drug in the list, turn to the Index that begins on page 36. The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., NEXIUM®) and generic drugs are listed in lowercase italics (e.g., *omeprazole*).

Following is a list of abbreviations that appear in the Requirement/Limits column. These abbreviations indicate any special requirements for coverage of your drug.