Certificate of Coverage 2027

UnitedHealthcare® RxSupplement™

Group Name (Plan Sponsor): CITY OF ALEXANDRIA
Group Number: 12229





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8 a.m.-8 p.m. CT, Monday-Friday



GRPRETRX-0112-VA

Underwritten by UnitedHealthcare® Insurance Company
Hartford, Connecticut

Group Outpatient Prescription Drug Insurance Certificate

UnitedHealthcare® Insurance Company (the "Company") hereby delivers to the Group Policyholder a Policy providing outpatient Prescription Drug insurance for certain eligible Covered Persons who are covered by Medicare Part D Drug coverage. The Certificate describes the benefits and provisions of the insurance provided by the Policy.

You may receive the benefits specified in the Certificate if You are eligible for insurance under the provisions of the Policy.

The Certificate is not a contract of insurance and only summarizes the primary provisions of the Policy. The Certificate supersedes and replaces any similar Certificate that the Company previously issued to You.

The Certificate is valid only if it includes Your Schedule of Benefits.

Please Read The Following Information so you will know from whom or what group of providers prescription benefits may be obtained.

UnitedHealthcare® Insurance Company



Robert Hunter,
President

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Welcome to UnitedHealthcare

The Company provides outpatient Prescription Drug benefits to Covered Persons who have properly enrolled and meet the Employer's eligibility requirements. To learn more about these requirements, see **Section Three: Covered Person Eligibility.**

What is this Publication?

This publication is called a Certificate of Coverage (Certificate). It is a legal document that explains Your outpatient Prescription Drug plan and should answer many important questions about Your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section Five: Definitions**.

Whether You are the Insured Person for this coverage or enrolled as an eligible Dependent, Your Certificate and Schedule of Benefits (**Section Seven**) are key to making the most of Your coverage.

What Else Should I Read to Understand My Benefits?

Along with reading this Certificate, which includes Your Schedule of Benefits in **Section Seven**, be sure to review any supplemental benefit materials. Your Schedule of Benefits provides the details of Your particular outpatient Prescription Drug plan, including any Deductibles, Copayments or Coinsurance that You may have to pay when receiving a health care service. Together, these documents explain Your coverage.

What if I Still Need Help?

After You become familiar with Your benefits, You may still need assistance. Please don't hesitate to contact Our Customer Service Department as shown below:

- By calling **1-800-457-8506** from **8 a.m.-8 p.m. CT, Monday-Friday**
- By accessing Our Customer Service Web site at **retiree.uhc.com**

NOTE: Your Certificate, which includes Your Schedule of Benefits, provides the terms and conditions of Your benefits. These forms should be read completely and carefully. You also may correspond with the Company at the following address:



UnitedHealthcare
P.O. Box 30770 Salt Lake City, UT 84130-0770



1-800-457-8506



retiree.uhc.com

Administrators

Certain provisions of the Certificate are administered by one or more of the Company's Administrators. They are as follows:

FOR ELIGIBILITY AND BENEFITS VERIFICATION:

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770
1-800-457-8506

FOR PAYMENT OF CLAIMS:

OptumRx
P.O. Box 650287
Dallas, TX 75265-0287

All inquiries and notifications required by the terms and conditions of the Policy or Certificate are to be mailed or phoned to the Company's Administrator. Notification requirements to the Company are fulfilled by contacting the Company's Administrator in this manner.

Section One - Your Outpatient Prescription Drug Benefits

- Outpatient Prescription Drug Benefits
- Limitations and Exclusions

This section explains Your outpatient Prescription Drug benefits, including what is and isn't covered by the Company. All Covered Services must be Medically Necessary. If You have any questions as to whether an outpatient Prescription Drug is a Covered Service, please consult this Certificate or contact Us at 1-800-457-8506. Our Customer Service Department can assist You in determining Your benefits. For any Deductibles, Copayments and/or Coinsurance that may be associated with a benefit, You should refer to Your Schedule of Benefits. Some Drugs require Prior Authorization by Your Part D coverage, have limitations, or are excluded from Coverage. Please consult Your Part D coverage, Your Schedule of Benefits in this Certificate, and this **Section One** for an explanation of Your outpatient Prescription Drug benefits, as well as the Limitations and Exclusions Section of this Certificate. You can also find some helpful definitions in **Section Five** at the back of this Certificate.

The benefits of the Policy described in this Certificate are based on the assumption that the Covered Person is enrolled in Medicare Part D coverage issued by the Company. The Company will pay the following benefits up to the Covered Expense, only to the extent that the Covered Expense has not been paid by the Part D plan, and subject to all other limitations and exclusions set forth in this Policy and in the Schedule of Benefits in Section Seven of this Certificate.

If a specific service or supply is not included in this **Section One: Your Outpatient Prescription Drug Benefits** purchased by the Covered Person's Employer, it is not a Covered Service and no benefits will be provided under the Policy.

I. Outpatient Prescription Drug Benefits

You or Your Physician may contact the Company at 1-800-457-8506, or Our Web site retiree.uhc.com, to determine if a particular Drug is covered under this plan or to obtain a list of covered Drugs. Your Physician is not obligated to prescribe a covered Drug and may prescribe any FDA approved Drug he or she feels is appropriate for Your treatment. **However, prescriptions for medications not on the list of covered Drugs which have not received Prior Authorization from Your Part D coverage will not be a Covered Expense under this Policy.**

Covered Expense. Covered Expense includes expenses that are incurred for a Covered Service and provided to a Covered Person in accordance with the provisions of this Certificate. The Covered Expense will not exceed the negotiated or contract cost for prescriptions filled at a Participating Pharmacy, and will not exceed the submitted or billed charges for medications filled at a Non-Participating Pharmacy. Covered Expenses include the Unit supply usually prescribed by a provider or a 30-day supply.

Covered Services. Covered Services include outpatient Prescription Drugs prescribed by a licensed provider and dispensed by a pharmacy for the treatment of an injury or sickness as outlined in Your Certificate or Drug List. Covered Services consist only of Medically Necessary Drugs and medications which, in accordance with federal or state laws, may not be dispensed without the written prescription of a provider, and which are dispensed by a provider who dispenses outpatient Prescription Drugs to patients when required to do so in the course of his or her regular practice. The outpatient Prescription Drug benefit will be provided for the following medications when ordered by a provider:

1. Drugs approved by the FDA that are prescribed in excess of the recommended dosage for use in the treatment of intractable cancer pain, if such excess dosage is prescribed, dispensed, or administered in good faith for recognized medicinal or therapeutic purposes.

Procedure for Obtaining Drugs not Included in or Subsequently Removed From the Company's Drug List. You may receive a Drug that is not included in or has been subsequently removed from the Drug List covered under this Policy if, in the judgment of the Company and the authorized prescriber:

1. there is no equivalent Drug included in the Company's Drug List; or
2. an equivalent Drug included in the Company's Drug List:
    a. has been ineffective in treating Your disease or condition; or
    b. has caused or is likely to cause an adverse reaction or other harm to You.

To request an exception for a non-covered Drug, Your provider must submit the request to the Company.

Your provider will be required to submit pertinent medical/drug history, prior treatment history, and any other necessary supporting clinical information with the request.

For Drugs that have been removed from the Drug List, You must have been receiving this specific drug for at least six months prior to the revision of the Drug List.

Standard requests will be reviewed and determinations will be made within one business day of receipt of the request. Expedited or urgent requests will be reviewed and determinations will be made in 24 hours. A request is considered urgent if Your provider believes that applying the standard process may seriously jeopardize Your life, health, or ability to regain maximum function. Providers will be notified by fax or in writing of the determination.

You will pay the same share of the cost for Drugs obtained under this provision as Drugs that are included in the Drug List.
Providers may request authorization by phone, fax or online:
Toll-free phone number: **(800) 791-7658**
Written request via fax: **(800) 527-0531** for oral medications and **(800) 853-3844** for injectable/specialty medications
Online at **OptumRx.com**

Mail Service Pharmacy Program. The Company offers a Mail Service Pharmacy Program. The Mail Service Pharmacy Program provides convenient service on medications that You may take on a regular basis by allowing You to purchase certain Drugs for receipt by mail. You get high quality medications mailed directly to Your home or address of Your choice within the United States. Shipping and handling is at no additional charge. Prescription maintenance Drugs may be dispensed for up to three Prescription Units or up to a 90-day supply. The Copayment and/or Coinsurance amount is specified in the Schedule of Benefits.

If You use Our Mail Service Pharmacy Program, You will generally get Your medication within seven (7) to fourteen (14) working days after receipt of Your order. All orders are shipped in discreetly labeled envelopes for privacy and safety.

When You receive Your prescription, You will get detailed instructions that tell You how to take the medication, possible side effects and any other important information about the medication. If You have questions, registered pharmacists are available to help You by calling 1-888-279-1828 or for the hearing impaired at 711.

If You are starting a new medication, please request two prescriptions from Your provider. Have one filled immediately at Your pharmacy while mailing the second prescription to UnitedHealthcare's Mail Service Pharmacy. Once You receive Your medication through the mail service, You should stop filling the prescription at Your pharmacy.

Prior Authorization For Selected Drugs. This Policy does not require Prior Authorization; however, coverage provided under Your Medicare Part D plan issued by the Company might require Prior Authorization for selected Drugs. You must satisfy any Prior Authorization requirements under Your Part D coverage in order to be eligible to receive a benefit under this Policy. Please check Your Part D coverage for any Prior Authorization requirements.

Quantity Limits for Selected Drugs. A “quantity limit” is a management tool that is designed to limit the use of selected Drugs for quality, safety, or utilization purposes. Limits may be included on the amount of the Drug that We cover per prescription or for a defined period of time. Please check Your Part D coverage to determine if any quantity limits apply.

II. Limitations and Exclusions of Benefits

No benefits are payable for any of the following:

1. Drugs or medicines purchased and received prior to the Covered Person’s Effective Date or subsequent to the Covered Person’s termination.
2. Prescriptions or devices that are covered under Medicare Part B benefits. Therapeutic devices or appliances, even though they may require a prescription. This includes: hypodermic needles; syringes (except insulin syringes when provided for use with covered Self-Injectable medications); support garments; and other non-medical substances.
3. All non-prescription contraceptive jellies, ointments, foams or devices.

4. Drugs dispensed by a Hospital, rest home, sanitarium, skilled nursing facility, convalescent care facility, nursing home or similar institution while confined as a patient or when covered under Medicare Part A.
5. Self-Injectable Drugs.
6. Dietary supplements, including vitamins, mineral products, and fluoride supplements; health or beauty aids and diet pills, herbal supplements and/or alternative medicine; and dental related products, such as topical fluoride, medicated dental rinses and children's fluoride vitamins.
7. Medications which may be properly received without charge under local, state or federal programs or which is 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.
8. Medications prescribed for experimental or non-FDA approved indications, unless prescribed in a manner consistent with a specific indication in Drug Information for the Health Care Professional, published by the United States Pharmacopoeial Convention or in the American Hospital Formulary Services edition of Drug Information; medications limited to investigational use by law; or medications that are determined not to be effective for the specific diagnosis or that do not follow community practice standards unless prior authorized under Your Part D plan.
9. Patent Drugs for which there is a non-prescription equivalent available, even if ordered by a Physician.
10. Drugs or medicines used or taken primarily to improve or otherwise modify the Covered Person's external appearance.
11. Over-the-Counter smoking cessation products including, but not limited to, nicotine gum, nicotine patches, nicotine nasal spray or any other Drug containing nicotine or other smoking deterrent medications.
12. Administration or injection of any Drug.
13. Drugs purchased outside the United States and its territories.
14. Off-Label Drugs. There are certain exceptions. Please see the definition of "Off-Label Drug" in the **Definitions** section of this Certificate.
15. Drugs used to promote fertility, including injectable infertility Drugs.
16. Drugs used to promote hair growth.
17. Drugs when used for the treatment of sexual or erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
18. Drugs when used for treatment of anorexia, weight loss, or weight gain, including, but not limited to, prescription or non-prescription weight loss medications, weight control programs, supplies or supplements.
19. 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.
20. Barbiturates and Benzodiazepines.
21. Immunizing agents and injectables, biological sera, blood plasma or medications prescribed for parenteral use.
22. Federal Legend oral contraceptives and prescription diaphragms.

23. Elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to: athletic performance, cosmetic purposes, anti-aging and mental performance.
24. Compound Medication: any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount, unless prior authorized by Your Part D coverage.
25. Drugs used for diagnostic purposes.
26. Saline and irrigation solutions.
27. Replacement of lost, stolen or destroyed medications.
28. Unit dose/convenience dosage forms: Unit dose, pre-packaged medications, individual packets, etc.
29. Medications that are prescribed by Physicians or other providers who are excluded from Medicare program participation.
30. Drugs used for the symptomatic relief of cough and colds.

Please note: Your Group Policyholder **may** have elected to offer some of the Drugs listed above to You as an additional benefit. If so, You will receive additional information about the Drugs they have chosen to offer to You separately in Your Plan materials.

Early Refills

Early refills for lost, stolen or destroyed Drugs are not covered except during a declared "National Emergency."

Early refills for vacation supplies are limited to a one-time fill of up to 90 days per calendar year.

You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days supply. This limit is set at seventy percent (70%) for prescription eye drops.

Section Two - Payment Responsibility

- Claims Policies and Procedures
- Coordination of Benefits

This section explains Claims payment procedures and related Claims matters. It also explains when the Company needs to coordinate Your benefits with another plan.

I. Claims Policies and Procedures

Participating Pharmacy Reimbursement. You should present Your UnitedHealthcare identification card at any Participating Pharmacy. At Participating Pharmacies, outpatient Prescription Drug Claims will be processed electronically online at point-of-sale, in accordance with the National Council for Prescription Drug Program ("NCPDP") guidelines and standards and guidelines established by the Company. UnitedHealthcare's Participating Pharmacies include most major pharmacy and supermarket chains, as well as many independent pharmacies. For an up-to-date listing of Participating Pharmacies, visit Our Web site at retiree.uhc.com, or contact Our Customer Service Department at 1-800-457-8506 or for the hearing impaired TTY 711, to locate a Participating Pharmacy near You.

If a UnitedHealthcare Participating Pharmacy is Not Used. If a Participating Pharmacy is not used, the Covered Person must pay the Non-Participating Pharmacy the retail price for the Prescription Drug and then file a Claim for direct reimbursement, in accordance with the instructions in the Non-Participating Pharmacy Reimbursement or Direct Reimbursement section below.

Exception: Claims for Covered Services provided by a Non-Participating Pharmacy will be processed the same as for a Participating Pharmacy if such Non-Participating Pharmacy notifies the Company in writing of their agreement to accept, as payment in full, reimbursement for their Covered Services at the negotiated costs applicable to Participating Pharmacies. In such event, the Covered Person will not be responsible for any amounts that may be charged by the Non-Participating Pharmacy in excess of any Copayment and/or Coinsurance applicable to prescriptions filled at a Participating Pharmacy.

Non-Participating Pharmacy Reimbursement or Direct Reimbursement. For prescriptions obtained at a Non-Participating Pharmacy or when submitting a Claim for direct reimbursement for Drugs, the Covered Person must complete a Claim form and submit a receipt from the pharmacist. The receipt must specify: the prescription number, name of Drug, date filled, name of pharmacy, name of patient, and proof of payment. Call the Customer Service Department at 1-800-457-8506 or for the hearing impaired TTY 711, or visit UnitedHealthcare's Web site at retiree.uhc.com to obtain the direct reimbursement form. The Company will reimburse the Covered Person for those Covered Services shown in the Schedule of Benefits and Covered Services section of this Certificate. Claims should be submitted to:
OptumRx

P.O. Box 650287
Dallas, TX 75265-0287

Payment of Benefits. The Company will pay a benefit under the Policy for the Covered Expenses. Benefits will be paid as set forth in the Schedule of Benefits. Benefits will not exceed any maximums or limits set forth in the Policy. Benefits are subject to the Exclusions and Limitations specified in the Policy. The Definitions and all other terms and conditions of the Policy that may limit or exclude benefits also apply in determining the payment of the benefits.

Non-Duplication of Benefits. Benefits provided under the Policy will not duplicate any benefits paid by a Medicare Part D plan. The combined benefits provided under the Policy and Medicare or other coverage will never exceed one hundred percent (100%) of the charges incurred for outpatient Prescription Drug services and supplies. Additionally, if a service is covered under more than one provision of the Policy, benefits will be provided under the provision that provides the greatest benefit, but not under both provisions.

Limitation of Liability. Except in the case of legal incapacity of the Covered Person, the Company shall not be obligated to pay any benefits under the Policy for any Claims if the proof of loss for such Claim was not submitted within the period provided under the Proof of Loss provision below, unless it is shown that: (1) it was not reasonably possible to have submitted the proof of loss within such period; and (2) the proof of loss was submitted as soon as it was reasonably possible.

Notice of Claim. A written notice of Claim must be furnished to the Company within twenty (20) days after a covered loss occurs or begins, or as soon thereafter as reasonably possible.

Claim Forms. The Company will, upon receipt of notice of Claim, furnish to the Covered Person such forms as are usually furnished for filing proof of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements of the Policy as to the proof of loss upon submitting within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, and the character and the extent of the loss for which a Claim is made.

Proof of Loss. Written proof of loss must be furnished to the Company at its office within ninety (90) days after the date of the loss. The Company will not reduce or deny a Claim for failure to furnish such proof within the time required, provided such proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, the Company will not accept proof more than one (1) year from the time proof is otherwise required.

Time of Payment of Claims. Benefits for incurred outpatient Prescription Drug expenses that are covered under the Policy will be paid within sixty (60) days of receipt of a proper Claim by the Company.

Payment of Benefits to Covered Person. All benefits, unless assigned under the Policy, are payable to the Covered Person.

Death or Incapacity of Covered Person. Any benefits payable for loss of the Covered Person's life will be paid to the beneficiary designated by the Covered Person to receive such benefits. Any other benefits that have not been paid when the Covered Person dies may be paid either to the designated beneficiary or the Covered Person's estate. All other amounts will be paid to the Covered Person. In the event no such designated or specified beneficiary is living at the death of the Covered Person, payment of any benefits is subject to the provisions of the Policy.

In the event of the Covered Person's death or incapacity, if any benefit is payable to the Covered Person's estate, or to a person who is a minor or otherwise not competent to give a valid release, and there is no written evidence to the Company of the qualification of a guardian for the Covered Person's estate, the Company may, in its sole discretion, make any and all payments of benefits under the Policy to the individual or institution that, in the opinion of the Company, is or was providing the Covered Person's care and support.

Assignments. Benefits for Covered Expenses may be assigned by the Covered Person to the person or institution providing the outpatient Prescription Drug. No such assignment will bind the Company prior to the payment of the benefits assigned. The Company will not be responsible for determining an assignment's validity. Payment of assigned benefits will be made directly to the assignee, unless a written request not to honor the assignment, signed by the Covered Person and the assignee, is received prior to payment.

Legal Actions. Any Person may not bring legal action for benefits against the Company:

1. Until at least sixty (60) days after proof of loss is sent to the Company as required; or
2. More than three (3) years after the time for submitting proof has ended.

II. Coordination Of Benefits

Coordination of Benefits. The Company will coordinate benefits with benefits available under other similar insurance policies. Coordination of Benefits between policies may result in a reduction in the amount of benefits ordinarily payable, so that the Covered Person never receives a total, from all Plans, of more than one hundred percent (100%) of Covered Expense incurred. All benefits provided under the Policy are subject to this coordination provision.

What is a Plan?

A "Plan," as used in this Coordination of Benefits provision, means any of the following policies that provide benefits or services for outpatient Prescription Drug benefits:

1. group, or blanket insurance coverage;
2. prepaid coverage under service Plan contracts, or under group or individual practice;
3. any coverage under labor-management trusteed plans, union welfare plans, Employer organization Plans, or employee benefit organizations Plans;

4. Medicare or other governmental benefits, not including a state plan under Medicaid, and not including a Plan when, by law, its benefits are in excess to those of any private insurance Plan or other non-governmental Plan; or
5. any coverage under group-type contracts that is not available to the public and can only be obtained and maintained because of membership in or association with a particular organization or group.

Each Plan, or other arrangement for coverage described above, is a separate Plan. If a Plan has two parts and the Coordination of Benefits provisions only apply to one part, each part is a separate Plan. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no Coordination of Benefits between those separate contracts.

What is a Covered Expense?

A Covered Expense, as used in this Coordination of Benefits provision, means any expense that is covered by at least one Plan during a Claim Determination Period; however, any expense that is not payable by the primary Plan because of the claimant's failure to comply with cost containment requirements will not be considered a Covered Expense by the secondary Plan.

Order of Benefit Determination Rules. The following rules determine the order of benefit payment:

1. A Plan without a Coordination of Benefits provision pays before one with such a provision;
2. A Plan that covers a person other than as a Dependent pays before a Plan that covers a person as a Dependent;
3. When rules 1. and 2. do not establish the order of benefit determination, the Plan covering the Person for a longer period pays first; however:
    a. the Plan covering the person as a retired employee, or as a Dependent of a retired employee, will pay after any other Plan covering that person as a full-time employee, or Dependent of a full-time employee; and
    b. if the other Plan does not have an Order of Benefit Determination Rule regarding retired employees, then the provisions of rule 3.a. will not apply.

Effect on Benefits. Benefits will be reduced when the Policy is secondary to one or more other Plans. Benefits will be reduced when the sum of:

1. the benefits payable for the Covered Expense under this Plan without this provision; and
2. the benefits payable for the Covered Expense under the other Plans, without this provision, whether or not a Claim is made, exceed the Covered Expense in a Plan Year. Thereafter, benefits will be reduced so that coordination with benefits payable under the other Plans do not total more than the Covered Expense.

Right to Receive and Release Information. For determining the applicability and implementing the terms of this Coordination of Benefits provision or any provision of similar purpose of any other Plan, the Company may release or obtain from any insurance company or

other organization or person any information, with respect to any Covered Person, which the Plan deems to be necessary for such purposes. Any Covered Person claiming benefits must furnish information necessary to implement this provision.

Reimbursement of Payment. Payments made by any organization may be reimbursed by the Company subject to Policy limitations. Such reimbursements will fully discharge the Company's liability under the Policy.

Right of Recovery. Whenever payments for Covered Expenses exceed the maximum payment necessary to satisfy the Coordination of Benefits provisions, the Company may recover such excess payments. The term "payments for Covered Expenses" includes the reasonable cash value of any benefits provided in the form of services.

Third Party Liability and Non-Duplication of Benefits

1. Non-Duplication of Benefits

a. Workers' Compensation. The Company shall not furnish benefits under the Policy to any Covered Person which duplicate benefits the Covered Person is entitled to under any Workers' Compensation law.
In the event of a dispute regarding the Covered Person's receipt of benefits under Workers' Compensation laws, the Company will provide the benefits described in the Policy until resolution of the dispute.

In the event the Company provides benefits which duplicate the benefits the Covered Person is entitled to under Workers' Compensation law, the Covered Person agrees to reimburse the Company, for all such benefits provided by the Company, immediately upon obtaining any monetary recovery. The Covered Person shall hold any sum collected as the result of a Workers' Compensation action in trust for the Company. Such sum shall equal the lesser of the amount of the recovery obtained by the Covered Person or the benefits furnished to the Covered Person by the Company on account of each incident.

The Covered Person agrees to cooperate in protecting the interests of the Company under this provision. The Covered Person must execute and deliver to the Company any and all liens, assignments or other documents necessary to fully protect the right of the Company, including, but not limited to, the granting of a lien right in any Claim or action made or filed on behalf of the Covered Person.

b. Medicare Benefits. The Company shall not furnish benefits under the Policy which duplicate the benefits the Covered Person is entitled to as a Medicare beneficiary.

c. TRICARE Benefits. The Company shall not furnish benefits under the Policy which duplicate the benefits to which the Covered Person is entitled under TRICARE. If payment

is made by the Company in duplication of the benefits available under TRICARE, the Company may seek reimbursement up to the amount of benefits which duplicate such benefits under TRICARE.

Section Three - Covered Person Eligibility

- Who is a Covered Person?
- Termination of Benefits

I. Who is a Covered Person?

There are two kinds of Covered Persons: the Insured Person who enrolls under the Policy through his or her former Employer and the Insured Person's eligible Dependents.

The coverage provided under the Policy is made available to You because of Your retirement from Your Employer or former Employer. In order for You to participate in the Employer's Retiree welfare benefit plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods. The specific time periods and other standards for participation in the Employer's Retiree welfare benefit plan are determined by the Employer, or state and/or federal law. Eligibility requirements are described in general terms below. For more specific eligibility information You should contact the Human Resources or benefits department of Your former Employer.

The Insured Person must be a former employee of the Employer who: (1) has met all the eligibility requirements established by the Employer for participation in the Employer's Retiree welfare benefit plan (including, but not limited to, having attained retirement eligibility under the Employer's Retiree welfare benefit plan); and (2) is eligible for, and enrolled in, a Medicare Part D plan issued by the Company.

Eligible Dependents include a Spouse of the Insured Person enrolled under the Policy if such Spouse (1) is eligible for coverage under the Employer's Retiree welfare benefit plan; and (2) is eligible for, and enrolled in, a Medicare Part D plan issued by the Company.

Notification of Eligibility Change. Any Covered Person who no longer satisfies the eligibility requirements is not covered by the Policy and has no right to any of the benefits described in the Certificate. The Company must be notified within thirty-one (31) days of any condition that may affect eligibility.

II. Termination of Benefits

Individual Terminations. A Covered Person's coverage will terminate on the earliest of the following:

1. the date the Policy terminates;
2. the last day of the Insurance Month in which the Covered Person requests termination;
3. the last day of the last Insurance Month for which premium payment is made on behalf of the Covered Person;
4. the date the Covered Person ceases to be eligible for coverage under the Policy; or
5. with respect to any particular insurance benefit, the date that benefit terminates.

Fraud or Deception. At its discretion, the Company may terminate or rescind the Policy or a Covered Person's coverage thereunder, if the following are true:

1. such Covered Person knowingly provides the Company with fraudulent information upon which the Company relies; and
2. such information materially affects the Covered Person's eligibility for enrollment or benefits under the Policy. In such instance, the Company shall send a written notice of termination or rescission to the Insured Person. It shall also refund any unearned premium which applies after the date of termination or rescission.

Fraudulent Use of Identification Card. A Covered Person's eligibility for coverage under the Policy shall immediately terminate if such Covered Person permits the use of his or her insurance identification card by any other person. In such instance, the Company shall mail a written notice of termination to the Covered Person. It shall also refund any unearned premium which applies after the date of termination.

Please Note: No coverage shall be in force and no benefit shall be payable for charges which are incurred after the date a Covered Person's coverage terminates for any reason under this Certificate, except as provided by any applicable continuation coverage which the Covered Person elects and submits premium in a timely manner.

Coverage Options Following Termination of Individual Coverage. Following termination of coverage, a Covered Person may be entitled to coverage under the employer group's primary Part D plan or an individual Medicare Part D plan.

Section Four - Decisions Regarding Benefits

- Appealing a Decision Relating to Benefits
- The Appeals Process
- Statement of ERISA Rights

I. Appealing a Decision Relating to Benefits

A Covered Person and the Company may not always agree that a Claim or request for Covered Services had been reviewed properly. When this happens, the Covered Person‘s first step should be to call the Company’s Customer Service Department. The Company’s Customer Service Department coordinator will assist the Covered Person and attempt to find a solution to the Covered Person’s problem or grievance.

If the Covered Person feels that his or her problem or grievance requires additional action, the Covered Person may also request a formal Appeal.

The Company’s appeals review procedures are designed to deliver a timely response and resolution to a Covered Person’s problem or grievance. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the problem or grievance. The Covered Person may submit a formal appeal within 180 days of the receipt of an initial determination through the Company's Appeals Department. To initiate an appeal, call the Company’s Customer Service Department or write the Appeals Department at the address below:

UnitedHealthcare® Insurance Company
Appeals Department
P.O. Box 6103, MS CA120-0368
Cypress, CA 90630-0023
1-800-457-8506

This written request will initiate the following Appeals Process, except in the case of “Urgent Requests” as discussed below. A Covered Person, or a representative appointed by a Covered Person including an Attorney, may submit written comments, documents, records and any other information relating to Your appeal regardless of whether this information was submitted or considered in the initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to Your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

The Company will review Your appeal and if the appeal involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or utilized, the determination will be made by a medical reviewer who has the education, training and relevant expertise in the field of medicine necessary to evaluate the specific clinical issues that serve as the basis of Your appeal.

II. The Appeals Process

The Company will review Your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination not later than thirty (30) days of the Company's receipt of the appeal. For appeals involving the delay, denial or modification of health care services, the Company's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the Certificate that exclude that coverage.

Urgent Requests. Appeals involving an imminent and serious threat to Your health including, but not limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to the Company's clinical review personnel. If Your case does not meet the criteria for an Urgent Request, it will be reviewed under the appeal process. If Your appeal requires urgent review, the Company will immediately inform You in writing of Your review status.

III. Statement of ERISA Rights

Contact Your Employer's Benefit Administrator to learn whether Your plan is an employee welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA). If You participate in an ERISA employee welfare benefit plan, ERISA provides You with certain rights and protections.

1. All benefit determination or Claim procedures are described for You in Your summary plan description.
2. If You receive an adverse benefit determination, a determination notice will be forwarded to You, electronically or in writing, within a reasonable time not to exceed ninety (90) days of the date the Claim is submitted.
3. You may appeal any adverse benefit determination. ERISA provides You with at least one hundred eighty (180) days from the day You receive notice of an adverse benefit determination to appeal it. You will be provided an opportunity to submit relevant information in support of Your appeal.
4. ERISA provides for up to two (2) mandatory appeal levels for any adverse determination. You have a right to bring a civil action on any adverse determination that You believe, after participating in the mandatory appeal process, was incorrectly made under Your plan.
5. ERISA provides that, in connection with any appeal of an adverse benefit determination, You have the right to request access to and receive a free copy of any and all documents, records, and other information, as follows:
    a. Relied on in making Your benefit determination;
    b. Submitted, considered, or generated in the course of making Your benefit determination;
    c. Which demonstrates compliance with administrative safeguards concerning consistent application of the plan document among similar claims, and
    d. Any plan Policy statement or guidance regarding Your diagnosis.
6. ERISA provides that most benefit appeal determination notices will be forwarded to You, in writing, within a reasonable period not to exceed sixty (60) days from the date of the plan's receipt of the benefit appeal request.

7. Your participation in a voluntary appeal level does not affect Your legal review rights, or any rights You have under Your plan. Any statute of limitations will be tolled during the time You participate in a voluntary review level.
8. You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor office and Your state insurance regulatory agency.

Section Five - Definitions

The Company is dedicated to making its services easily accessible and understandable. To help You understand the precise meanings of many terms used to explain Your benefits, We have provided the following definitions. These definitions apply to the capitalized terms used in Your Certificate, as well as the Schedule of Benefits.

30-Day Supply means, for most oral medication, the maximum amount (quantity) of medication that may be dispensed per single Copayment and/or Coinsurance amount at any one time during a 30-day period.

90-Day Supply means, for most oral medication, the maximum amount (quantity) of medication that may be dispensed per single mail service Copayment and/or Coinsurance amount at any one time during a 90-day period.

Administrator means an appropriately licensed organization with whom the Company has contracted to perform administration services. Applicable Administrators are identified under the Administrators section of the Certificate.

Brand Name Drug means a pharmaceutical product protected by a patent issued to the original innovator or marketer. The patent prohibits the manufacture of the Drug by other companies without consent of the innovator, as long as the patent remains in effect.

Certificate means this summary of the terms of Your Benefits. The Certificate is attached to and is part of the Policy issued to the Group Policyholder and is subject to the terms of the Policy.

Claim means notification in a form acceptable to the Company that a Covered Service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such Covered Service as required by the Company.

COBRA means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as amended) that regulate the conditions and manner in which an Employer must offer continuation of group health insurance to Covered Persons whose coverage would otherwise terminate under the terms of the Policy.

Coinsurance means that portion of the Covered Expense, which is not payable as a benefit due to the Percentage Payable being less than one hundred (100%). Coinsurance does not include any Deductibles or Copayments. Coinsurance does not include any amounts payable by the Covered Person because Prior Authorization was not obtained. Coinsurance does not include any amounts payable by the Covered Person, which are not considered as Covered Expense under the Policy.

Copayment means that portion of Covered Expenses which are the responsibility of the Covered Person and which are shown as Copayments on the Schedule of Benefits.

Covered Expense means an expense that:
1. is incurred for a Covered Service provided to a Covered Person; and
2. does not exceed the smallest of any Policy maximum that may apply to the Covered Expense.

Covered Person means the Insured Person or the eligible Dependent(s) of the Insured Person who are insured under the Policy.

Dependent means a person who is the Insured Person's Spouse who is not legally separated from the Insured Person and who is covered under a Medicare Part D plan issued by the Company.

Dependent Insurance means the group health insurance provided by the Policy for Dependent(s) of the Insured Person.

Drugs or Prescription Drugs mean those pharmaceutical substances required by law to be dispensed by prescription.

Effective Date means, with respect to any Covered Person, the date such Covered Person is first insured under the Policy.

Employer means the Group Policyholder approved by the Company for participation in the coverage provided by the Policy.

Generic Drug means a Drug that is designated as a Generic Drug according to Medispan, inclusive of single-source and multi-source generics.

Group Policyholder means the person, partnership, corporation or trust as shown on the Policy Information Page of the Policy.

Hospital means an acute care Facility operated pursuant to state laws and:
1. is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or by the Medicare program;
2. is primarily engaged in providing, for compensation from its patients, diagnostic and surgical facilities for the care and treatment of injured or sick individuals by or under the supervision of a staff of Physicians;
3. has 24-hour nursing services by registered nurses; and
4. is not primarily a place for rest or custodial care, or a nursing home, convalescent home or similar institution.

Insurance Month means that period of time:
1. beginning at 12:00 a.m. Standard Time at the Group Policyholder's principal location on the first day of any calendar month; and
2. ending at 11:59 p.m. on the last day of the same calendar month.

Insured Person means the Retiree for whom coverage is in effect as provided by the Policy.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the Treating Physician and by the Company's medical director to be all of the following:

1. A Health Intervention for the purpose of treating a medical condition;
2. The most appropriate supply or level of service, considering potential benefits and harms to the Covered Person;
3. Known to be Effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
4. If more than one Health Intervention meets the requirements of (1) through (3) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Covered Person.

A service or item will be covered under the Company health plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated, yet not be a covered benefit or meet the definition of Medical Necessity.

In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

- "Treating Physician" means the Physician who has personally evaluated the Covered Person.
- A "Health Intervention" is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat, or palliate) a medical condition or to maintain or restore functional ability. A "medical condition" is a disease, sickness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and the Covered Person's indications for which it is being applied.
- "Effective" means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- "Health outcomes" are outcomes that affect health status as measured by the length or quality (primary as perceived by the patient) of a person's life.
- "Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and the health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of

conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

- A "new intervention" is one that is not yet in widespread use for the medical condition and Covered Person's indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

Medicare means Hospital Insurance Plan (Part A), Medical Insurance (Part B), and the supplementary Outpatient Prescription Drug Insurance Plan (Part D) provided under Title XVIII of the Social Security Act, as amended.

Non-Participating Pharmacy means a pharmacy that has not contracted with the Company.

Off-Label Drug means a Drug that is used for a purpose that is different from the use for which the Drug has been approved by the FDA. The Company excludes coverage for Off-Label Drugs, including Off-Label self-injectable Drugs, except as described in this Certificate. If an Off-Label Drug is prescribed for use, the Drug and its administration will be covered only if it satisfies the following criteria:

- The Drug is approved by the FDA;
- The Drug is prescribed by a provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition, including cancer;
- The Drug is Medically Necessary to treat the condition;
- The Covered Person has failed, is intolerant of, or has contraindications to standard therapies;
- The Drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition, including cancer, in any of the standard reference compendia or in substantially accepted peer-reviewed medical literature by one of the following: The American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network's Drugs and Biologics Compendium, the Elsevier Gold Standard's Clinical Pharmacology, or from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug use or uses as generally safe and effective.

Nothing in this section shall prohibit the Company from use of a formulary, or Copayment and/or Coinsurance.

Out-of-Pocket Expense Maximum means the maximum out-of-pocket expense shown in the Schedule of Benefits. When a Covered Person has paid an amount during the Plan Year equal to the Out-of-Pocket Expense Maximum including Pharmacy Copayment and/or Coinsurance, then the Percentage Payable will be one hundred percent (100%) for all additional Covered Expenses the Covered Person incurs during the rest of that Calendar Year.

Participating Pharmacy means a pharmacy that has contracted with the Company to provide outpatient Prescription Drugs to a Covered Person at negotiated costs.

Plan Year means any consecutive twelve-month period beginning on the Effective Date shown in the Policy.

Percentage Payable means the benefits payable under the Policy which are a percentage of the Covered Expense in excess of all Deductibles and Copayments. The Percentage Payable for each type of Covered Service is set forth in the Schedule of Benefits.

Personal Insurance means the group Prescription Drug insurance provided by the Policy on Insured Persons.

Physician means a licensed doctor of allopathy or osteopathy who is practicing within the scope of his or her licensure, and any other practitioner of the healing arts who renders services within the scope of his or her licensure.

Policy means the Group Health Insurance Policy issued by the Company to the Group Policyholder.

Policy Anniversary means the annual date stated as the "Policy Anniversary" on the Policy Information Page of the Policy.

Policy Effective Date means the date stated as the "Policy Effective Date" on the Policy Information Page of the Policy.

Prescription Unit means the maximum amount (quantity) of medication that may be dispensed per single Copayment. For most oral medications, a Unit represents a 30-day supply or 90-day supply (through the mail service benefit) of medication. For other medications, a Unit represents a single container, inhaler unit, vial, package or course of therapy. The Unit will be tripled, e.g., 3 containers, 3 inhaler units, etc., if the medication is dispensed through the mail service benefit for a 90-day supply. For Drugs that could be habit-forming, a Unit may be set at a smaller quantity for the Covered Person's protection and safety.

Prior Authorization means getting approval in advance to obtain certain Drugs that may or may not be on the Company's formulary. Some Drugs are covered only if the Covered Person's Physician or other provider gets Prior Authorization from the Company. Covered Drugs that require Prior Authorization are marked in the formulary. If Prior Authorization is required, it must be obtained or the Drug might not be covered under the Policy.

Retiree means a former employee of the Employer who: (1) has met all the eligibility requirements established by the Employer for participation in the Employer's Retiree welfare benefit plan; (2) is eligible for, and enrolled in, a Medicare Part D plan issued by the Company; and (3) is entitled to benefits under the Policy.

Self-Injectable means those Drugs which are either generally self-administered by Intramuscular injection at a frequency of one or more times per week, or which are generally self-administered by the subcutaneous route.

Spouse means a legally married spouse as recognized under federal law.

We, Our, Us and Company mean UnitedHealthcare® Insurance Company.

You and Your mean the Insured Person.

Section Six - General Provisions

Certificate. Each Covered Person will receive an individual Certificate. The Certificate, which is part of the Policy, summarizes the benefits provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

Clerical Error. Clerical error does not invalidate insurance otherwise validly in force, nor continue insurance otherwise validly terminated. Neither the passage of time nor the payment of premiums for a person who is not eligible for insurance under the terms of the Policy makes this insurance valid for such person. In this event, the Company's only liability is the proper refund of unearned premiums. If a premium adjustment requires the refund of unearned premium, the maximum refund is the six- (6) month period preceding the date the Company receives proof of the adjustment. The Company can request such information while the Policy is in force and for one (1) year after the Policy ends.

Conformity to State and Federal Law. The Company amends any provision of the Policy that conflicts with state or federal law on the Policy Effective Date to the minimum requirements of the law.

Entire Contract. The Policy, the Certificate, the Group Application which is attached to the Policy, and any individual applications constitute the entire contract between the parties. All statements made by the Group Policyholder and by Insured Persons shall be deemed representations not warranties. A statement from the Insured Person will only support a contest of the coverage provided by the Policy when the Company provides a copy of the statement to the Insured Person or the Insured Person's beneficiary or authorized representative.

Group Policyholder Not Our Agent. The Group Policyholder is not an agent of the Company.

Incontestablity. The validity of the Policy shall not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue. No statement made by a Covered Person relating to the insurability of such Covered Person shall be used in contesting the validity of the insurance, with respect to which such statement was made: (a) after the insurance has been in force for two (2) years during the Covered Person's lifetime; and (b) unless it is in writing and signed by the Covered Person.

Provider As Independent Agent. The Company does not undertake to directly furnish any health care service under the Policy. The obligations of the Company under the Policy are limited to the payment for health care service provided to Covered Persons by providers who are independent agents.

Outpatient Prescription Drug Records. The Company shall have access to outpatient Prescription Drug and treatment records of Covered Persons to determine benefits, process Claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably

related to the Policy benefits. Each Covered Person shall complete and submit to the Company such additional consents, releases and other documents as may be requested by the Company in order to determine or provide benefits under the Policy. The Company reserves the right to reject or suspend a Claim based on lack of supporting outpatient Prescription Drug information or records.

Recovery of Payments. The Company reserves the right to deduct from any benefits properly payable under the Policy the amount of any payment which has been made:

1. in error;
2. pursuant to a misstatement contained in a Claim;
3. pursuant to a misstatement made to obtain coverage under the Policy within two (2) years after the date such coverage commences;
4. with respect to an ineligible person; or
5. pursuant to a Claim for which benefits are recoverable under any Policy or act of law provided for coverage for occupational injury or disease to the extent that such benefits are recoverable. This provision shall not be deemed to require the Company to pay benefits under the Policy in any such instance.

Such deduction may be made against any Claim for benefits under the Policy by a Covered Person if such payment is made with respect to such Covered Person.

Discharge of Liability. Any payment made in accordance with the provisions of the Policy shall fully discharge the liability of the Company to the extent of such payment.

Right to Receive Information. The Group Policyholder shall provide the Company with the information necessary to administer coverage under the Policy. Payroll and any other records of an Insured Person relating to coverage under the Policy shall be open for review by the Company at any reasonable time. The Company may request that information needed to compute the premium be furnished at least once each year.

Upon request, the Company shall provide the Group Policyholder with a complete record of the Group Policyholder's claim experience incurred under the Policy for the period of time since the Policy was issued or since it was last renewed, whichever is less. Such record shall be made available promptly, provided the request is made not less than 30 days prior to the date the premiums or contractual terms of the Policy may be amended.

Time Effective. Whenever an Effective Date of coverage or termination date of coverage is specified by the Policy, such commencement of coverage will be effective as of 12:00 a.m. of that date.

Waiver of Rights. The Company's failure to enforce any provision of the Policy does not affect Our right to enforce any provision at a later date, and does not affect the Company's right to enforce any other provision of the Policy.

Section Seven - Schedule of Benefits

Outpatient Prescription Drug Benefit

The Company will pay an outpatient Prescription Drug Benefit for Covered Expense incurred by a Covered Person for Covered Services described in this Certificate. The benefit will be subject to the Copayments and/or Coinsurance and Exclusions and Limitations described in this Certificate, and will not exceed any applicable maximum shown in this Schedule of Benefits.

This Schedule of Benefits focuses on what You pay for Your outpatient Prescription Drugs under this Policy. To keep things simple, We use the term "Drug" to mean any Prescription Drug, item or medication that is included under this Policy.

To understand the payment information We give You in this section, You need to know the basics of what Drugs are covered. Your Medicare Part D plan materials issued by the Company will provide You with information for prescription coverage under Your Part D plan. This Schedule of Benefits provides information for obtaining benefits under this outpatient Prescription Drug Policy.

This Policy covers amounts that are payable after the Medicare Part D plan issued by the Company has paid, and/or after any applicable discounts have been applied. This Policy may also cover selected Drugs that are not covered by Your Part D plan. Benefits will be paid as set forth below.

Drug Tiers

Every Drug on the Drug List is included in a tier as defined below. In general, the higher the tier number, the higher Your cost for the Drug. **Please refer to the cost share charts under the Drug Payment Stages in this Schedule of Benefits section to determine what Your out-of-pocket costs may be under this Policy.**

Tier 1 – Preferred Generic – includes most covered generic drugs
Tier 2 – Preferred Brand – includes many common brand name drugs, called preferred brands and some higher-cost generic drugs
Tier 3 – Non-preferred Drug – includes non-preferred brand name drugs and non-preferred generic drugs. In addition Part D eligible compound medications are covered in Tier 3.
Tier 4 – Specialty Tier – includes unique and/or very high-cost brand and generic drugs

For the Catastrophic Coverage Stage, Tier 1 will include only Generic Drugs and Tier 2 will include only Brand Name Drugs.

Drug List

To find out which tier Your Drug is in, look it up in the Drug List. If You need a copy of the Drug List, You may access it by going online at retiree.uhc.com or request a paper copy by calling Customer Service Department at 1-800-457-8506.

We will generally cover a Drug on the Drug List as long as You follow the other coverage rules explained in this Schedule of Benefits and the Drug is Medically Necessary, meaning reasonable and necessary, for treatment of Your illness or injury. It also needs to be an accepted treatment for Your medical condition.

The Drug List can change during the year

Most of the changes in Drug coverage happen at the beginning of each Plan Year. However, during the year, many kinds of changes may be made to the Drug List. For example:

- **Addition or removal of Drugs from the Drug List.** New Drugs become available, including new Generic Drugs. Perhaps the government has given approval to a new use for an existing Drug. Sometimes, a Drug gets recalled and We decide not to cover it, or We might remove a Drug from the list because it has been found to be ineffective.
- **A Drug is moved to a higher or lower tier.**
- **A Brand Name Drug is replaced with a Generic Drug.**

Do changes to Your Drug coverage affect You right away?

If any of the following types of changes affect a Drug You are taking, the change will not affect You until the next Plan Year if You stay in the Plan:

- If We move Your Drug into a higher tier.
- If We remove Your Drug from the Drug List, but not because of a sudden recall or because a new Generic Drug has replaced it.

If any of these changes happens for a Drug You are taking, then the change won't affect Your use or what You pay as Your share of the cost until the next Plan Year. Until that date, You won't see any increase in Your payments or any added restriction to Your use of the Drug. However, on the first day of the next Plan Year, the changes will affect You.

In some cases, You will be affected by the coverage change before the next Plan Year. In this case, You should work with Your doctor to switch to the Generic Drug or to a different Drug that We cover.

If a Drug is suddenly recalled because it's been found to be unsafe or for other reasons, the Drug will immediately be removed from the Drug List. Your doctor will know about this change, and can work with You to find another Drug for Your condition.

If Your Drug is not included in or has been subsequently removed from the Drug List. Please see the Covered Services provision in the Outpatient Prescription Drug Benefits section for additional information regarding Drugs not included in or removed from the Drug List.

The Plan's Participating Pharmacy Directory. A Participating Pharmacy is a pharmacy that has a contract with the Company to provide Your covered Drugs. The term "covered Drugs" means all of the Drugs that are covered by this Policy. The **Pharmacy Directory** has a list of Participating Pharmacies and it explains how You can use the mail order service. It also explains

how You can get a long-term supply of a Drug (such as filling a prescription for a three month's supply). You can access the Pharmacy Directory online at retiree.uhc.com or request a paper copy by calling Customer Service at 1-800-457-8506.

Using Non-Participating Pharmacies. If You choose to use a Non-Participating Pharmacy, Your out-of-pocket costs may be greater than if You use a Participating Pharmacy. Your Coinsurance or Copayment amounts will be the same for Drugs purchased at either a Participating Pharmacy or a Non-Participating Pharmacy. **HOWEVER,** a Non-Participating Pharmacy may also require You to pay the difference between what the Company pays for a Drug and what the Non-Participating Pharmacy charges for a Drug. See the Claims Policies and Procedures in Section Two for more information on using Non-Participating Pharmacies.

What is Your share of cost for Drugs covered under this plan?

The Copayment and/or Coinsurance for a covered Drug depends on:

1. Which Medicare Part D Drug Payment Stage You are in;
2. The tier for the Drug; and
3. Where You fill Your prescription; and
4. The "daily cost sharing rate" if You received less than a one month supply.

The "daily cost sharing rate" means the Copayment and/or Coinsurance amount applied to certain prescriptions filled under Your Part D coverage for less than a one month supply. This provides You, in consultation with Your Physician, the option of a shorter day supply of a new prescription without having to pay a full month's Copayment and/or Coinsurance.

Drug Payment Stages

As shown below, there are various "Drug Payment Stages" for Your Prescription Drug coverage under Your Medicare Part D coverage. How much You pay under this Prescription Drug Policy for a Drug also may depend on which of these stages You are in at the time You get a prescription filled or refilled under Your Part D coverage.

We keep track of the costs of Your Prescription Drugs and the payments You have made when You get Your prescriptions filled or refilled at the pharmacy. This way, We can tell You when You have moved from one Drug Payment Stage to the next. For each month in which You fill a prescription, You will receive an Explanation of Benefits in the mail indicating what Drug Payment Stage You are in.

For some Drugs, You can get a longer-term supply (also called an "extended supply") when You fill Your prescription. This can be up to a 90-day supply. The tables below show what You pay when You get a 30-day supply and a longer-term up to 90-day supply of a Drug.

Initial Coverage Level Stage (ICL): During the Initial Coverage Level Stage, Your Part D coverage plan pays its share of the cost of Your covered Prescription Drugs, and You pay Your share. Your share of the cost will vary depending on the Drug and where You fill Your prescription. You stay in

this stage until Your Part D Drug payments for the year total the Medicare ICL for the Plan Year. At that time You enter the Coverage Gap Stage.

Your cost share during the Initial Coverage Stage is:

For Part D Drugs

	Participating and Non-Participating Pharmacy	Mail Service Pharmacy Program
	(when You get a 30-day supply (or less) of a covered Drug)	(when You get a longer-term supply up to 90 days of a covered Drug)
Tier 1	$10 Copayment	$10 Copayment
Tier 2	$25 copayment	$10 Copayment
Tier 3	$25 Copayment	$10 Copayment
Tier 4	$25 Copayment	$10 Copayment

Coverage Gap Stage: You stay in this stage until Your Part D payments for the year total the Medicare True Out of Pocket (TrOOP) amount for the current Plan Year. Refer to your Medicare Part D plan materials for information about the TrOOP amounts and requirements.

When You enter the Medicare Part D Coverage Gap, this Prescription Drug Policy will cover certain Drugs that are not being covered by Your Part D coverage, or a portion of the cost of certain Drugs that Your Part D coverage does still cover.

Catastrophic Coverage Stage: Once You are in the Part D Catastrophic Coverage Stage, You will stay in this stage for the rest of the year. Once You have paid enough for Your Part D Drugs to move on to this last payment stage, **Your Part D plan will pay most of the cost** of Your Part D Drugs for the rest of the year.

Your cost share during the Catastrophic Coverage Stage is:

For Part D Drugs

	Participating and Non-Participating Pharmacy	Mail Service Pharmacy Program
	(when You get a 30-day supply (or less) of a covered Drug)	(when You get a longer-term supply up to 90 days of a covered Drug)
Tier 1	$0 Copayment	$0 Copayment
Tier 2	$0 Copayment	$0 Copayment

NOTE: THIS CERTIFICATE CONSTITUTES ONLY A SUMMARY OF THE BENEFITS AVAILABLE UNDER THE EMPLOYER'S PLAN. THE POLICY BETWEEN THE COMPANY AND THE GROUP POLICYHOLDER MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE POLICY WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT UNITEDHEALTHCARE® INSURANCE COMPANY AND YOUR EMPLOYER'S PERSONNEL OFFICE.

UnitedHealthcare® RxSupplement™ is not a Medicare Part D prescription drug plan. This is an employer group retiree prescription drug plan. UnitedHealthcare® RxSupplement™ group retiree prescription drug plans are underwritten by UnitedHealthcare® Insurance Company. These are private insurance companies not connected with or endorsed by the U.S. Government or the federal Medicare program. RxSupplement™ plans may not be available in all states. UnitedHealthcare® is part of the UnitedHealth Group family of companies.

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