

2020 Certificate of Coverage



Specifics about your extra prescription drug coverage

UnitedHealthcare® RxSupplement™

Group Name (Plan Sponsor): North Carolina State Health Plan for Teachers and State Employees
Enhanced Plan

Group Numbers: 12330, 12331, 12332, 12333



Toll-Free 1-866-747-1014, TTY 711
8 a.m. – 8 p.m. ET, Monday – Friday



www.UHCRetiree.com/ncshp



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 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.

Important Cancellation Information – Please Read The Provision Entitled, “Termination of Benefits” Found on Page 17.

Please Read This Certificate Carefully. This Certificate is part of a legal contract between the Company and the Group Policyholder.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

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

UnitedHealthcare Insurance Company



William J. Golden, President

GRPRTX-0112-NC

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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 and/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 1-866-747-1014 from 8 a.m. – 8 p.m. ET, Monday – Friday
- By accessing Our Customer Service Web site at www.UHCRetiree.com/ncshp

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

PO Box 29675, Hot Springs, AR 71903-9675



1-866-747-1014



www.UHCRetiree.com/ncshp

Administrators

Certain provisions of the Certificate are administered by the following:

FOR ELIGIBILITY AND BENEFITS VERIFICATION:

UnitedHealthcare
PO Box 29675
Hot Springs, AR 71903-9675
1-866-747-1014

FOR PAYMENT OF CLAIMS:

OptumRx
PO Box 29045
Hot Springs, AR 71903

All inquiries and notifications required by the terms and conditions of the Policy or Certificate are to be mailed or phoned to the Company.

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 1-866-747-1014. 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 available only when 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 1-866-747-1014, or Our Web site www.UHCRetiree.com/ncshp, 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.

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. Covered Expenses include the Unit supply usually prescribed by a provider or a 31-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.

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 a Participating 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 the Participating 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.

Exception to Prior Authorization for Restricted Access Drugs or Devices.

Prior approval is not required for a Restricted Access Drug or Device if Your Physician certifies, in writing, that You have previously used an alternative non-Restricted Access Drug or Device and such Drug or Device has been harmful to Your health or has been ineffective in treating the same condition. And, the treating Physician states, in writing, that in his/her opinion, the non-Restricted Access Drug or Device is still likely to be harmful to Your health or ineffective in treating the condition again.

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. 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.
6. Medications which may be properly received without charge under local, state or federal programs or which is reimbursable under other insurance programs, Medicare, or medications furnished by any other Drug or medical service for which no charge is made to the Covered Person.
7. 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.

Exception for Cancer Drugs. This exclusion does not include a Drug that has been prescribed for the treatment of a type of cancer for which the Drug has not specifically been approved by the federal Food and Drug Administration. The Drug must have been approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the Drug has been prescribed in any of the following established reference compendia: (a) The National Comprehensive Cancer Network Drugs & Biologics Compendium; (b) The ThomsonMicromedex DrugDex; (c) The Elsevier Gold Standard's Clinical Pharmacology; or (d) any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services. Such Drugs will not be covered for any experimental or investigational Drug or any Drug that the federal Food and Drug Administration has determined to be contra-indicated for treatment of the specific type of cancer for which the Drug has been prescribed.

8. Patent Drugs for which there is a non-prescription equivalent available, even if ordered by a Physician.

9. Drugs or medicines used or taken primarily to improve or otherwise modify the Covered Person's external appearance.
10. 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.
11. Administration or injection of any Drug.
12. Drugs purchased outside the United States and its territories.
13. Off-Label Drugs. There are certain exceptions. Please see the definition of "Off-Label Drug" in the Definitions section of this Certificate.
14. Drugs used to promote fertility, including injectable infertility Drugs.
15. Drugs used to promote hair growth.
16. Drugs when used for the treatment of sexual or erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
17. 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.
18. 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.
19. Barbiturates and Benzodiazepines.
20. Immunizing agents and injectables, biological sera, blood plasma or medications prescribed for parenteral use.
21. Federal Legend oral contraceptives and prescription diaphragms.
22. Elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to: athletic performance, cosmetic purposes, anti-aging and mental performance.
23. New prescription medications or supplies until they are reviewed for safety, efficacy and cost effectiveness.
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.
31. Services or supplies for the treatment of an occupational injury or sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the Covered Person, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act

or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

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 in an emergency area in which the President has declared a major disaster or the Secretary of the Department of Health and Human Services has declared a public health emergency. Early refills would also be covered when: (a) the North Carolina Commissioner of Insurance issues a Bulletin Advisory notifying all insurance carriers licensed in North Carolina of a declared state of disaster or state of emergency in North Carolina; or (b) the Covered Person lives in a county for which a proclamation of disaster is issued by the Governor or by a resolution of the General Assembly. The "refill too soon" edits will be removed for Prescription Drugs covered by this Policy for the duration of the emergency or, if no timeframe is provided, for an initial period of ninety (90) days. If the emergency is long-term, the Mail Service Pharmacy Program will be notified to call the Covered Persons to determine if shipment should occur.

Early refills for vacation supplies are limited to a one-time fill of up to 31 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

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. Participating pharmacies are available nationwide. 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 www.UHCRetiree.com/ncshp, or contact Our Customer Service Department at 1-866-747-1014 or for the hearing impaired TTY 711, to locate a Participating Pharmacy near You.

If a UnitedHealthcare Participating Pharmacy is Not Available. If a Participating Pharmacy is not available, 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.

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 1-866-747-1014 or for the hearing impaired TTY 711, or visit UnitedHealthcare’s Web site at www.UHCRetiree.com/ncshp 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
PO Box 29045
Hot Springs, AR 71903

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. Written proof of loss must be furnished to the Company at its office within one hundred eighty (180) days after the date of the loss. 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, 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.

In no event will the Company be obligated to pay benefits for any Claim if the proof of loss for such Claim is submitted to the Company more than one hundred eighty (180) days plus one year after the date of loss, except in the case of legal incapacity of the Covered Person.

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.

Notice given by or on behalf of the Covered Person or the beneficiary to the Company at UnitedHealthcare, PO Box 30995, Salt Lake City, UT 84130-0995, or to an authorized agent of the Company, with information sufficient to identify the Covered Person, shall be deemed notice to the Company.

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 one hundred eighty (180) 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 after the one hundred eighty (180) day proof of loss period.

Time of Payment of Claims. Benefits for incurred outpatient Prescription Drug expenses that are covered under the Policy will be paid upon 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. In the event of the Covered Person's death or incapacity and in the absence of 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.

Right to Receive and Release Information. 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 provided under the Policy, the Company may recover such excess payments.

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 and or Your eligible Dependents 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. 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 or a Dependent child of the Insured Person enrolled under the Policy if such Spouse or Child (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.

NOTE: After this Policy has been in force for a period of two (2) years during the lifetime of the Covered Person, it shall become incontestable as to the statements contained in the application. If misstatements of age, occupation, or other insurance are discovered prior to the Policy having been in force for two (2) years during the lifetime of the Covered Person, the Company may, at its discretion, terminate or rescind a Covered Person's coverage. In such instance, the Company shall send a written notice of termination or rescission to the Covered 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 has 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 or a relative or other representative of 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
 PO Box 6106, MS CA124-0197
 Cypress, CA 90630-9948
 1-866-747-1014

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.

The Covered Person may obtain, upon request and free of charge, copies of all documents, records and other information relevant to the appeal.

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.

31-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 31-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.

Deductible means the amount of Covered Expense a Covered Person must pay before benefits become payable under the Policy. Until You satisfy the Deductible, You will pay 100% of the Company's contracted rate with the pharmacy for the medication and that amount will be applied toward Your Deductible.

Dependent means a person who is the Insured Person's Spouse who is not legally separated from the Insured Person, or the Insured Person's Dependent child, 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.

“Hospital” also means a duly licensed state tax-supported institution, including community mental health centers, and other health clinics which are certified as Medicaid providers.

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) means, for Covered Services eligible for payment under **Section One**, those Covered Services or supplies that are:

1. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease, and, except as allowed under NCGS 58-3-255 for services or supplies provided for clinical trials, are not for experimental, investigational, or cosmetic purposes;
2. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
3. Within generally accepted standards of medical care in the community; and
4. Not solely for the convenience of the Covered Person, the Covered Person’s family or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

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 Physician for the treatment of certain types of cancer for which the Drug may not have originally been approved and has not been determined by the federal Food and Drug Administration to be contraindicated for treatment of the specific type of cancer for which the Drug has been prescribed;
- The Drug has been proven effective and accepted for the treatment of the specific type of cancer for which the Drug has been prescribed in any one of the following established reference compendia: (a) The National Comprehensive Cancer Network Drugs & Biologics Compendium; (b) The ThomsonMicromedex DrugDex; (c) The Elsevier Gold Standard's Clinical Pharmacology; or (d) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

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 Deductible means the amount of Covered Expense shown on the Schedule of Benefits that a Covered Person is responsible for paying each Plan Year before benefits are payable under the Policy.

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 31-day supply or a 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.

Reasonable and Customary Charge means the lesser of:

- A pharmacy’s usual charge for a specific medication or supply; or
- The charge the Company determines to be the general rate charged by others who dispense the specific medication or supply to persons who reside in the same area.

Restricted Access Drug or Device means those covered Prescription Drugs or devices for which payment by the Company is conditioned on the Company’s prior approval to prescribe the Drug or Device, or on the Physician prescribing one or more alternative Drugs or Devices before prescribing the Drug or Device in question.

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, 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 individual Certificates. These Certificates summarize 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.

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

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.

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 – includes most generic drugs

Tier 2 – includes many common brand name drugs, called preferred brands

Tier 3 – includes non-preferred generic and non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in tier 3.

Tier 4 – includes unique and/or very high-cost brand or 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 www.UHCRetiree.com/ncshp or request a paper copy by calling Customer Service Department at 1-866-747-1014.

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.

The Plan's Pharmacy Directory. In most situations You should use a Participating Pharmacy to get Your covered Drugs. 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 www.UHCRetiree.com/ncshp or request a paper copy by calling Customer Service at 1-866-747-1014.

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. Coverage for charges incurred at a Non-Participating Pharmacy will be based upon the Reasonable and Customary Charge for Prescription Drugs that are purchased in the area in which the pharmacy is located. Your Coinsurance amounts will never be greater than thirty (30) percent of what would be required for non-Part D Drugs purchased at a Participating Pharmacy. However, You may also be responsible for paying the difference between what We will pay to a Non-Participating Pharmacy, based upon Reasonable and Customary Charges, and what the Non-Participating Pharmacy charges for the Drug or supply.

Here are the circumstances when We would always cover prescriptions filled at a Non-Participating Pharmacy in the same manner in which prescriptions are covered that are filled at a Participating Pharmacy:

- **Prescriptions for a medical emergency.** We will cover prescriptions that are filled at a Non-Participating Pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in the Drug List without restrictions, and are not excluded from Medicare Part D coverage.
- **Coverage when traveling.** If You take a Prescription Drug on a regular basis and You are going on a trip, be sure to check Your supply of the Drug before You leave. When possible, take along all the medication You will need. You may be able to order Your Prescription Drugs ahead of time through Our Mail Service Pharmacy program or through other Participating Pharmacies. If You are traveling within the U.S. and become ill or run out of or lose Your Prescription Drugs, We will cover prescriptions that are filled at a Non-Participating Pharmacy if You follow all other coverage rules. **In this situation, please check first with Customer Service to see if there is a Participating Pharmacy nearby.**

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

Out-of-Pocket Expense Maximum \$2,500

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 31-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 Level Stage of coverage is:

For Part D Drugs

Participating Pharmacy		Participating Pharmacy and the Plan's Participating Pharmacy Mail Service Pharmacy Program
	(when You get a 31-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	\$20 Copayment
Tier 2	\$35 Copayment	\$70 Copayment
Tier 3	\$50 Copayment	\$100 Copayment
Tier 4	25% Coinsurance but Your cost share will not be more than \$100	25% Coinsurance but Your cost share will not be more than \$200

If You choose to use a Non-Participating Pharmacy, Your Coinsurance amounts for Drugs purchased at a Non-Participating Pharmacy will never be greater than thirty (30) percent of what would be required Drugs purchased at a Participating Pharmacy.

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 (\$6,350). 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.

You have full coverage under this Policy for the Coverage Gap Stage.

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.

You have full coverage under this Policy for the Catastrophic Coverage Stage.

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 or, in New York, UnitedHealthcare Insurance Company of New York. 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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