Certificate of COVERAGE

UnitedHealthcare® Senior Supplement

Underwritten by UnitedHealthcare Insurance Company

UnitedHealthcare Insurance Company (the "Company") hereby delivers to the Group Policyholder a Policy providing insurance for certain eligible Covered Persons. The Certificate and Schedule of Benefits describe the benefits and provisions of the insurance provided by the Policy.

You may receive the benefits specified in the Certificate and Schedule of Benefits 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.

UnitedHealthcare Insurance Company

Jeffrey D. Alter
President

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Welcome to UNITEDHEALTHCARE

The Company provides health care 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 health care 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 a Dependent, Your Certificate and Schedule of Benefits are key to making the most of Your coverage.

What Else Should I Read To Understand My Benefits?

Along with reading this Certificate and Your Schedule of Benefits, be sure to review any supplemental benefit materials. Your Schedule of Benefits provides the details of Your particular health 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 toll-free: **1-800-851-3802**, TTY **711**, from 8 a.m. to 8 p.m. local time, Monday through Friday.

NOTE: Your Certificate and Your Schedule of Benefits provide the terms and conditions of Your benefits. These forms should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them. You may also correspond with the Company at the following address:

UnitedHealthcare Insurance Company
P.O. Box 30972
Salt Lake City, Utah 84130-0972

Administrators

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

For Eligibility, Benefits Verification, and Payment of Claims:

UnitedHealthcare Insurance Company
P.O. Box 30972
Salt Lake City, Utah 84130-0972

Call Customer Service:

Toll-Free **1-800-851-3802**, TTY **711**
8 a.m. – 8 p.m. local time, Monday through Friday

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 Medical Benefits

- **Inpatient Benefits**
- **Outpatient Benefits**
- **Exclusions and Limitations of Benefits**

This section explains Your medical benefits, including what is and isn't covered by the Company. All Covered Services must be Medically Necessary as determined by the Company. If You have any questions as to whether a service or supply is a Covered Service, please consult this Certificate or contact Us at **1-800-851-3802,** TTY **711,** 8 a.m. to 8 p.m. local time, Monday through Friday. Our Customer Service Department can assist You in determining Your benefits. The Company will evaluate submitted Claims for Medical Necessity, and benefit payments may be adjusted or declined consistent with the evaluation findings. For any Deductibles, Copayments or Coinsurance that may be associated with a benefit, You should refer to Your Schedule of Benefits. Please consult Your Schedule of Benefits and this **Section One** for an explanation of Your Medical Benefits, as well as the Exclusions and Limitations section of this Certificate. You can also find some helpful definitions in **Section Five** at the back of this Certificate.

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

Your Medical Benefits

The benefits of the Policy described in this Certificate are based on the assumption that the Covered Person is enrolled in Medicare Part A and Part B. The Company will pay the following benefits up to the Covered Expense, only to the extent that the Medicare Eligible Expense has not been paid by Medicare and subject to all other limitations and exclusions set forth in the Policy and in the Schedule of Benefits. Covered Persons must use Medicare participating Providers, approved Facilities and approved Hospice agencies.

I. Inpatient Benefits

Please refer to your Schedule of Benefits for further information including, but not limited to, any applicable Copayments, Coinsurance, Deductibles, and limitations for all provisions listed in Section One.

1. **Alcohol, Drug or Other Substance Abuse Treatment and Detoxification.** Inpatient treatment for Alcohol, Drug or Other Substance Abuse is covered. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable.

   For Smoking cessation, please see Section II. Outpatient Benefits.

2. **Blood and Blood Products.** Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.

3. **Clinical Trials.** Clinical Trials, subject to the Company's review and approval based on the criteria below, are covered. If You join a Clinical Trial, the Company will only pay the Coinsurance or Deductible as outlined for Inpatient Benefits in the Schedule of Benefits.

   An approved Clinical Trial shall either:
   (1) involve a Drug that is exempt under federal regulations from a new Drug application; or
   (2) is approved by one of the following:

   - One of the National Institutes of Health
   - The federal Food and Drug Administration, in the form of an Investigational new Drug application
   - The United States Department of Defense
   - The United States Veterans' Administration

   A Clinical Trial with endpoints defined exclusively to test toxicity is not a Covered Expense.

4. **Foreign Country Travel Benefit (Medically Necessary Emergency Services).** Medically Necessary Emergency Hospital, Physician and medical care services received in a foreign country are covered if the Covered Person lost entitlement to Medicare solely because of a temporary absence from the United States. Benefits will be:

   - Limited to charges covered if care had been provided in the United States;
   - Limited to treatment that began during the Covered Person's first six (6) months outside the United States;
   - Limited to Covered Persons whose primary residence is in the United States; and
   - Limited to those charges for which the Covered Person is required to pay.

   Note: Any charges for services incurred while in a foreign country are not covered unless specified in the Schedule of Benefits.

5. **Hospice Services.** Hospice services are covered for Covered Persons with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six (6) months or less, if the Sickness follows its natural course. Hospice services are provided as determined by the plan of care developed by the Covered Person's interdisciplinary team, which includes, but is not limited to, the Covered Person, the Physician, a registered nurse and a social worker.

   Hospice services are provided in an appropriately licensed Medicare-approved Hospice Facility or program when the Covered Person's interdisciplinary team has determined that the Covered Person's care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver, or when it is necessary to relieve the family members or other persons caring for the Covered Person ("Respite Care"). Respite Care is limited to an occasional basis and to no more than five (5) consecutive days at a time.

   Hospice services include: Skilled Nursing Services, certified Home Health Aide Services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; and physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Covered Person to maintain activities of daily living and basic functional skills.

6. **Hospital/Acute Care Services.** Inpatient Hospital Services authorized by the Company are covered, including, but not limited to: semi-private room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory and professional charges by the Hospital-based pathologist, radiologist, or anesthesiologist, emergency room Physician, emergency room and other miscellaneous Hospital charges for care and treatment.

7. **Mastectomy, Breast Reconstruction after Mastectomy and Complications from Mastectomy.** Medically Necessary Mastectomy and lymph node dissection are covered, including prosthetic devices and/or Reconstructive Surgery to restore and achieve symmetry for the Covered Person incident to the mastectomy. The length of a Hospital stay is determined by the attending Physician and surgeon in consultation with the Covered Person, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent Reconstructive Surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

8. **Mental Health Care.** Inpatient psychiatric services in a Medicare-certified Facility are covered.

   Services must be for "active treatment," which is defined by the following criteria:

- Services are provided under an individualized treatment or diagnostic plan;
- Services are reasonably expected to improve the Covered Person's condition or for the purpose of diagnosis; and
- Services must be supervised and evaluated by a Physician.

9. **Organ Transplant and Transplant Services.** Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Covered Person and the transplant is performed at a Medicare participating Facility. Food and housing is not covered.

   Autologous and allogeneic bone marrow and stem cell transplants are covered. The testing of blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Covered Person is the intended recipient.

10. **Physician Services.** Services from Physicians, including specialists and other licensed health professionals are covered while the Covered Person is Hospitalized as an Inpatient.

11. **Rehabilitation Services.** Rehabilitation Services that must be provided in an Inpatient rehabilitation Facility are covered. Rehabilitation Services are the individual or combined and coordinated use of medical, physical, occupational and speech-language pathology services for training and retraining individuals disabled by Sickness or Injury. A rehabilitation Facility provides comprehensive Rehabilitation Services under the supervision of a Physician to Inpatients with physical disabilities.

12. **Reconstructive Surgery.** Reconstructive Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or Sickness is covered. The primary purposes of Reconstructive Surgery are to correct abnormal structures of the body to either (a) improve function, or (b) create a normal appearance, to the extent possible.

13. **Skilled Nursing Services/Subacute and Transitional Care.** Medically Necessary Inpatient Skilled Nursing Services in a Medicare-certified Skilled Nursing Facility are covered. Skilled Nursing Services are covered if the insured requires Skilled Nursing Services or skilled Rehabilitation Services on a daily basis and these skilled services can be provided only on an Inpatient basis in a Skilled Nursing Facility. Inpatient stays solely to provide Custodial Care are not covered.

    Covered Services include, but are not limited to, the following: Semi-private room (private room if Medically Necessary); meals, including special diets; regular nursing services; physical therapy, occupational therapy, and speech-language pathology services; Drugs (this includes substances that are naturally present in the body, such as blood clotting factors); blood; medical and surgical supplies; laboratory tests; X-rays and other radiology services; use of appliances such as wheelchairs; and Physician services.

II. Outpatient Benefits

Please refer to your Schedule of Benefits for further information including, but not limited to, any applicable Copayments, Coinsurance, Deductibles, and limitations for all provisions listed in Section One.

1. **Alcohol, Drug or Other Substance Abuse Treatment and Detoxification.** Outpatient treatment for Alcohol, Drug or Other Substance Abuse is covered. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable.

   Smoking cessation counseling sessions are covered for an enrollee with a disease aggravated by tobacco; performed by a health

care professional within the scope of his or her licensure; up to 12 sessions in a 24-month period. **Definition:** A session is 10 minutes or more of face-to-face counseling by a health care professional within the scope of his or her licensure, e.g., social worker, psychologist, Physician Assistant, MD/DO, or Nurse Practitioner or Clinical Nurse Specialist.

2. **Allergy Serum.** Allergy serum, as well as needles, syringes, and other supplies for the administration of the serum are covered for the treatment of allergies.

3. **Ambulance.** The use of an ambulance (land or air) is covered when the Covered Person, as a prudent layperson, reasonably believes that the medical or psychiatric condition requires services, and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the "911" emergency response system. Ambulance transportation is limited to the nearest available emergency Facility having the expertise to stabilize the Covered Person's Emergency Medical Condition. Use of an ambulance for non-Emergency Services is limited to inter-Facility transfers between two Hospitals, between a Hospital and a non-custodial Skilled Nursing Facility, or between a non-custodial Skilled Nursing Facility and dialysis or radiation therapy Facility are covered when Medical Necessity criteria for an ambulance is met.

4. **Blood and Blood Products.** Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.

5. **Clinical Trials.** If you join a Clinical Trial, the Company will only pay the Coinsurance or Deductible as outlined for Outpatient Benefits in the Schedule of Benefits.

6. **Contraceptives.** Federal Legend contraceptives (which means those that bear the legend "Caution: Federal law prohibits dispensing without a prescription") and prescription diaphragms are covered if prescribed by a licensed Provider and dispensed by a pharmacy.

7. **Dental Treatment Anesthesia.** See "Oral Surgery and Dental Services" and "Oral Surgery and Dental Services: Dental Treatment Anesthesia" provisions below.

8. **Diabetic Management and Treatment.** Coverage includes Outpatient self-management training, education and medical nutrition therapy services. The diabetes Outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and be prescribed by a Provider acting within the scope of his or her licensure.

9. **Diabetic Self-Management Items.** Equipment and supplies for the management and treatment of diabetes are covered, based upon the medical needs of the Covered Person, including but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; insulin pumps and all related necessary supplies; ketone urine testing strips; podiatry services and devices to prevent or treat diabetes related complications; pen delivery systems for the administration of insulin; insulin syringes; and visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

   Covered benefits include the following prescription items if determined to be Medically Necessary:

   - Insulin
   - Prescriptive medications for the treatment of diabetes
   - Glucagon

10. **Dialysis.** Acute and chronic dialysis services and supplies are covered.

11. **Drugs and Prescription Medication Covered by Medicare.**

    - **Outpatient Prescription Drugs.** The following Outpatient Prescription Drugs are covered when approved by Medicare: Osteoporosis Drugs; Erythropoietin (Epogen) or Epoetin Alfa; Hemophilia Clotting Factors; Immunosuppresive Drugs; Oral Cancer Drugs; and Oral Anti-Nausea Drugs.

- **Infusion Therapy.** Infusion therapy means the therapeutic use of Drugs or other substances, prepared or compounded, and administered by a Provider and given to a Covered Person through a needle or catheter. Services must be provided in the Covered Person's home or an institution that is not a Hospital or is not primarily engaged in providing skilled nursing or Rehabilitation Services. (For example, board and care, custodial care Facility and assisted living Facility.) Infusion therapy is only covered as part of a treatment plan prescribed by a Physician.
- **Outpatient Injectable Medications.** Outpatient injectable medications include those Drugs or preparations that are not usually self-administered, and which are given by the Intramuscular or Subcutaneous route. Outpatient injectable medications are covered when administered as a customary component of a Physician's office visit and when not otherwise limited or excluded (e.g., infertility Drugs, birth control, or off-label use of covered injectable medications).

12. **Durable Medical Equipment (Rental, Purchase or Repair).** Durable Medical Equipment is covered when it is designed to assist in the treatment of an Injury or Sickness of the Covered Person, and the equipment is for use in the home. Durable Medical Equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered Durable Medical Equipment include wheelchairs, Hospital beds and standard oxygen delivery systems. Replacements, repairs and adjustments to Durable Medical Equipment are limited to normal wear and tear or because of a significant change in the Covered Person's physical condition.
13. **Eye Exams.** Some preventive eye tests and screenings are covered. Coverage includes a yearly eye exam for diabetic retinopathy, and a glaucoma screening every 12 months for people with diabetes or a family history of glaucoma, or for African Americans age 50 and older. Ocular photodynamic therapy with verteporfin, a treatment for patients with age-related macular degeneration, is also covered.
14. **Eyewear.** Eyewear and corrective lenses are covered following cataract surgery with an intraocular lens (IOL) and when the Covered Person is missing an intraocular lens without a replacement either after cataract surgery or naturally. If an IOL is placed, the Covered Person is entitled to one pair of frames and lenses after each cataract surgery. If the Covered Person does not have an IOL, then the Covered Person is covered for ongoing contacts and glasses through the prosthetic benefit.
15. **Foreign Country Travel Benefit (Medically Necessary Emergency Services).** Medically Necessary Emergency Hospital, Physician and medical care services received in a foreign country are covered if the Covered Person lost entitlement to Medicare solely because of a temporary absence from the United States. Benefits will be: (1) limited to charges covered if care had been provided in the United States; (2) limited to treatment that began during the Covered Person's first six (6) months outside the United States; (3) limited to Covered Persons whose primary residence is in the United States; and (4) limited to those charges for which the Covered Person is required to pay.

    Note: Any charges for services incurred while in a foreign country are not covered unless specified in the Schedule of Benefits.
16. **Hearing Exams.** Diagnostic hearing exams are covered.
17. **Home Health Care.** Home Health Services for a homebound Covered Person include: part-time or intermittent skilled nursing and Home Health Aide Services; physical and occupational therapy and speech pathology services; medical social services; medical supplies and Durable Medical Equipment (such as wheelchairs, Hospital beds, oxygen, walkers).

    The Plan covers either part-time or intermittent skilled nursing and Home Health Aide Services in accordance with Medicare guidelines. Part-time or intermittent means any number of days per week up to 48 hours per week of skilled nursing and Home Health Aide Services combined for less than 12 hours per day, based upon the reasonable need for such

care. The Plan may cover, subject to review on a case-by-case basis depending on the need for such care, 35 or fewer hours per week of skilled nursing and Home Health Aide Services combined for less than 12 hours per day.

A homebound Covered Person has restricted ability, due to an illness or Injury, to leave home without assistance of another person or aid of a supportive device (such as crutches, a cane, a wheelchair or a walker), or if leaving the home is contraindicated. You do not have to be bedridden in order to be considered confined to the home. However, Your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If You leave the home, You may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment, including regular absences for the purpose of participating in therapeutic, psychosocial or medical treatment in an adult day-care program that is licensed or certified by the state, or to attend religious services. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

18. **Hospice Services.** Hospice Services are covered for Covered Persons with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of six (6) months or less, if the Sickness follows its natural course. Hospice services are provided pursuant to the plan of care developed by the Covered Person's interdisciplinary team, which includes, but is not limited to, the Covered Person, the Covered Person's Physician, a registered nurse, a social worker and a spiritual caregiver.

    Covered Hospice services are available in the home on a 24-hour basis during periods of crisis, when a Covered Person requires continuous care to achieve palliation or management of acute medical symptoms.

19. **Laboratory and Diagnostic Services.** Medically Necessary diagnostic and therapeutic laboratory services and other Medically Necessary diagnostic services are covered.

20. **Maternity Care, Tests and Procedures.** Physician visits, laboratory services and radiology services are covered for prenatal and postpartum Maternity care.

    Nurse midwife services are covered by midwives practicing within the scope of their license.

    Genetic testing and counseling are covered as part of an amniocentesis or chorionic villus sampling procedure.

21. **Medical Supplies and Materials.** Medical supplies and materials necessary to treat a Sickness or Injury are covered when used or furnished while the Covered Person is being treated in the Provider's office or in the home by a licensed health care professional, or used in conjunction with Durable Medical Equipment for proper functioning of the Durable Medical Equipment.

22. **Mental Health Care.** Outpatient psychiatric services must meet the following criteria to be covered:

    - Services are provided by a licensed Provider;
    - Services for the purpose of diagnostic study or would reasonably be expected to improve the Covered Person's condition;
    - The treatment must be designed to reduce or control the Covered Person's psychiatric symptoms so as to prevent relapse or Hospitalization and improve or maintain the patient's level of functioning;
    - Services must be prescribed by a Physician and provided under an individualized written plan of treatment established by a Physician;
    - Services must be supervised and evaluated by a Physician to determine the extent to which treatment goals are being realized;
    - Partial Hospitalization services when the Covered Person is discharged from an Inpatient Hospital treatment program, and the partial Hospitalization program is in lieu of continued Inpatient treatment;
    - Partial Hospitalization services for Covered Persons who, in the absence of partial

Hospitalization, would be at reasonable risk of requiring Hospitalization.

23. **Neuromuscular Skeletal Disorder Services.** Treatment by means of manual manipulation of the spine to correct a subluxation, provided by a licensed chiropractor (DC), doctor of medicine (MD) or doctor of osteopathy (DO) are covered.

24. **Oral Surgery and Dental Services.** Emergency Services for stabilization of an acute Injury to sound natural teeth, the jawbone or surrounding structures are covered.

    Other covered Oral Surgery and Dental Services include:

    - Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease and treatment of temporomandibular joint ("TMJ") syndrome;
    - Preventive fluoride treatment prior to a chemotherapeutic or radiation therapy protocol; and
    - Tooth extraction prior to a major organ transplant or radiation therapy to the head or neck.

25. **Oral Surgery and Dental Services: Dental Treatment Anesthesia.** Anesthesia and associated Facility charges for dental procedures provided in a Hospital or Outpatient surgery center are covered when the Covered Person's clinical status or underlying medical condition requires use of an Outpatient surgery center or Inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a Hospital or Outpatient surgery center setting. Charges are also covered for: (a) a Covered Person who is under 7 years of age; and (b) a Covered Person who is developmentally disabled, regardless of age.

26. **Outpatient Surgery.** Short stay, same day or other similar Outpatient surgery services (of less than twenty-four (24) hours) are covered when provided as a substitute for Inpatient care at a Hospital or licensed free-standing Outpatient surgical center.

27. **Periodic Health Screenings.** Periodic Health Screenings are covered and shall not exceed the limits shown below. This benefit includes the following health screenings:

    a. Diagnostic Hearing Screening. Hearing examination to evaluate hearing loss. Further diagnostic testing by an Audiologist, including hearing and balance assessment services, when the Covered Person's Physician orders the testing as part of a diagnostic evaluation, or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. These services are not covered when the diagnostic information required to determine the appropriate medical or surgical treatment is already known to the Physician, or the diagnostic services are performed only to determine the need for the appropriate type of hearing aid.

    b. Immunizations for adults are covered consistent with the most current recommendations of the Centers for Disease Control and Prevention (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices. Covered immunizations include vaccines for acquired immune deficiency syndrome (AIDS) that are approved for marketing by the federal Food and Drug Administration (FDA) and recommended by the Unites States Public Health Service.

    c. Immunizations for Dependent children through age 18 are covered consistent with the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

    d. Diagnostic laboratory services (age and gender appropriate) in conjunction with an office visit.

    e. Breast and Pelvic Cancer Screening and Diagnosis. Services for the screening and diagnosis of breast cancer, including a clinical breast exam, and an annual cervical

cancer screening test once every twelve (12) months, regardless of the risk status or age of the Covered Person.

An annual cervical cancer screening test will include:

- The conventional Pap test;
- A human papillomavirus screening test that is approved by the federal Food and Drug Administration; and
- The option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the Covered Person's Provider.

Mammography for screening or diagnostic purposes is covered as follows:

- A mammogram for women age 40 and over every twelve (12) months; and
- One baseline mammogram between the ages of 35 and 39.

f. Colorectal Cancer Screening includes an examination for Covered Persons age 50 and over, and who have an **average** risk of developing colon cancer as determined by a Physician. This screening may include the following:

- A fecal occult blood test performed once every twelve (12) months;
- A flexible sigmoidoscopy performed every five (5) years or a colonoscopy for initial screening only and performed every ten (10) years. (If additional therapeutic or surgical services are required during the screening as a result of screening findings, the Outpatient surgery Coinsurance and the Deductible will apply);
- A colonoscopy performed once every twenty-four (24) months, if you are at high risk for colon cancer. If you are not at high risk for colon cancer, once every ten (10) years, but not within forty-eight (48) months of a screening sigmoidoscopy; and
- A barium enema can be performed instead of a flexible sigmoidoscopy or colonoscopy.

g. Osteoporosis screening using bone mass measurement for the detection of low bone mass and for the determination of the Covered Person's risk of osteoporosis and fractures associated with osteoporosis. Services will include all Food and Drug Administration approved technologies as deemed medically appropriate.

h. Bone mass measurements if the following conditions are met:

- The test must be ordered by a doctor or qualified practitioner who is treating You; and
- Measurements may be taken every two (2) years or more frequently if Medically Necessary.

i. Diagnostic laboratory services are limited to the following tests (as defined in Current Procedural Terminology (CPT) from the American Medical Association): complete blood count (CBC), urinalysis, thyroid stimulating hormone (TSH), prothrombin time/international normalized ratio (PT/INR), partial thromboplastin time (PTT), or panels for the diagnosis or treatment of disease or organ abnormalities. Components of the above tests are also covered if ordered individually.

j. Standard X-Rays. Standard X-rays are covered for the diagnosis of a Sickness or Injury, or to screen for certain defined diseases. Standard X-rays are defined to include conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas, and oral cholecystograms), mammograms, obstetrical ultrasounds, and bone mineral density studies (including ultrasounds and DEXA scans).

k. Prostate Screening. Evaluations for the screening and diagnosis of prostate cancer are covered for men when Medically Necessary and consistent with good professional practice. This screening may include, but is not limited to, the following:

- Prostate-specific antigen testing
- Digital rectal examination

l. Glaucoma screening once every twelve (12) months for people at high risk for glaucoma. This includes people with diabetes, a family history of glaucoma, or African Americans who are age 50 and older.

m. Flu shot once a year in the fall or winter.

n. Pneumococcal pneumonia shot (vaccine).

o. Hepatitis B shot (vaccine) if there is medium to high risk for Hepatitis B.

p. A foot exam is covered every six (6) months. Coverage is for individuals with diabetic peripheral neuropathy and loss of protective sensations, as long as there are no other visits to a foot care professional for another reason.

28. **Phenylketonuria ("PKU") Testing and Treatment.** Testing for Phenylketonuria ("PKU") is covered to prevent the development of serious physical or mental disabilities, or to promote normal development or function as a consequence of PKU enzyme deficiency. PKU treatment includes those formulas and special food products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease.

29. **Physician Office Visits.** Services for the detection and treatment of an Injury or Sickness during or associated with a Physician's office visit are covered. Medically Necessary Covered Services include:

- Antigens
- Breast and Pelvic Cancer Screening, including Mammography screening
- Colorectal Cancer Screenings
- Detection of Osteoporosis
- Diabetes Self-Monitoring and Training Supplies
- Immunizations
- Immunosuppressives
- Inhalation Solutions
- Nutrition Therapy
- Oral Chemotherapy
- Outpatient Injectables (Home-based, Self-Administered, Home Health)
- Pain Management
- Pap Smear
- Pelvic Exam
- Prostate Cancer Screening
- Periodic health evaluations for children (through age 18) including age appropriate immunizations, laboratory services in connection with the periodic health evaluations, screening for blood lead levels, height and weight evaluation, vision screening
- Smoking cessation counseling

30. **Podiatry Services.** Services of a podiatrist for Medically Necessary treatment of injuries or diseases of the foot, such as hammer toe or bunion deformities and heel spurs are covered. A foot exam is covered every six (6) months for people with diabetic peripheral neuropathy and loss of protective sensations as long as there has been no other covered visit to a foot care professional for another reason between visits.

31. **Routine Podiatry Services.** Medically Necessary podiatry, including, but not limited to, a routine exam is covered.

32. **Preventive Care Services.** Preventive Care Services are limited to Periodic Health Screenings, as shown in this section, including: Physician, lab, radiology or other tests; preventive measures or related services considered Medically Necessary and appropriate for age and gender to determine a Covered Person's health status.

    Benefits will be based on the actual charges made by the Provider up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service, as identified in the American Medical Association Current Procedural Terminology (AMA CPT) codes (where applicable or based on Usual and Customary Charges). This benefit will not include payment for any procedure covered by Medicare.

33. **Prosthetics and Corrective Appliances.** Prosthetics are covered. Bionic and microprocessors covered only when approved by Medicare. Custom-made or custom-fitted corrective appliances are covered. Replacements, repairs and adjustments to corrective appliances

and prosthetics are limited to normal wear and tear or because of a significant change in the Covered Person's physical condition.

34. **Radiation Therapy.** Services for radiation therapy are covered.
35. **Reconstructive Surgery.** Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or Sickness is covered. The purposes of reconstructive surgery are to correct abnormal structures of the body to either (a) improve function, or (b) create a normal appearance, to the extent possible.
36. **Rehabilitation Services and Therapy.** Covered Outpatient services include physical therapy, speech therapy and occupational therapy for the treatment of a Sickness or Injury, provided by a licensed health care professional or under the direct supervision of a licensed health care professional.
37. **Specialized Footwear.** Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes, is covered for a Covered Person with diabetic foot disease, disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability.
38. **Specialized Scanning and Imaging Procedures.** Specialized scanning and imaging procedures are covered for the diagnosis of a Sickness or Injury. Specialized procedures are defined to include those which, unless specifically classified as standard X-rays, are digitally-processed, or computer-generated, or which require contrast administered by injection or infusion. Examples of specialized scanning and imaging procedures include, but are not limited to, the following scanning and imaging procedures: CT, PET, SPECT, MRI, MRA, EKG, EEG, EMG and nuclear scans, angiograms (includes heart catheterization), arthrograms, and myelograms.
39. **Sterilization.** Benefits include sterilization procedures including, but not limited to, tubal ligations and vasectomies.
40. **Urgent Care Services.** Benefits include Covered Services from an Urgent Care Facility.

III. Exclusions and Limitations of Benefits

The following treatments, services or supplies are either limited or not covered, as follows:

1. Any expense or service that is not a Medicare Eligible Expense is not covered, unless coverage for the expense or service is specifically provided by this Certificate or Rider to the Policy.
2. Any treatment, service or supply that is not Medically Necessary is not covered. Payment for these services will be the Covered Person's financial responsibility.
3. Any service or supply determined by Medicare to not be necessary for the treatment of an illness or Injury is not covered.
4. Services not specifically included in **Section One: Your Medical Benefits,** or any supplemental Benefit Rider purchased by the Covered Person's Employer, are not covered. Payment for these services will be the Covered Person's financial responsibility.
5. Services rendered prior to the Covered Person's Effective Date of enrollment or after the Effective Date of disenrollment are not covered.
6. The Company does not cover the services or costs associated with a service that is not a Covered Service under the Covered Person's Policy including, but not limited to, cosmetic surgery, bariatric surgery, and Experimental and Investigational procedures. This means that the Company will not cover follow-up care or complications associated with or arising from a non-Covered Service when:
   a. The services or expenses are incurred in preparation for a non-Covered Service;
   b. The complications or services are associated with non-Covered Services provided by another health plan or insurance company even if the service was covered under the prior plan;
   c. The complications or services are associated with non-Covered Services the Covered Person paid for out-of-pocket (e.g., cosmetic surgery, bariatric surgery, Experimental and Investigational procedures).

7. **Active Military Duty.** Services incurred as a result of active military duty are not covered.

8. **Acupuncture and Acupressure.** Acupuncture and Acupressure are not covered.

9. **Air Conditioners, Air Purifiers and Other Environmental Equipment.** Air conditioners, air purifiers and other environmental equipment are not covered.

10. **Ambulance.** Ambulance services are not covered if they are not Medically Necessary or if used as a convenience for the Covered Person or his or her family. Wheelchair transportation services (e.g., a specially designed van or taxi) and personal transportation costs, such as gasoline costs for a private vehicle or taxi fare, are also not covered.

11. **Bariatric Surgical Procedures.** Bariatric surgical procedures are not covered.

12. **Behavior Modification and Non-Crisis Mental Health Counseling and Treatment.** Behavior modification and non-crisis mental health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.

13. **Blood and Blood Products.** The costs of:
    - Transportation and processing for autologous, donor-directed or donor-designated blood are not covered in excess of the cost of a unit of blood from a recognized blood bank organization.
    - A platelet derived wound-healing formula such as Procuren or other similar blood products used in the repair of chronic, non-healing, cutaneous ulcers or wounds are not covered.
    - Blood charges incurred by Covered Persons for services/supplies in conjunction with donating blood for another individual are not covered.
    - Blood charges associated with non-covered procedures are not covered.

14. **Bone Marrow and Stem Cell Transplants.** Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel. Unrelated donor computer searches for Covered Persons who require a bone marrow or stem cell transplant are limited to the donor maximum for the Covered Person's transplant benefit.

15. **Complementary and Alternative Medicine.** Complementary and alternative medicine are not covered.

16. **Cosmetic Services and Surgery.** Cosmetic services and cosmetic surgery are not covered. Cosmetic services and cosmetic surgery are services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic services or cosmetic surgery are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Covered Person's dissatisfaction with his/her appearance, as influenced by that Covered Person's underlying psychological makeup or psychiatric condition.

17. **Custodial Care.** Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed Hospice Facility incident to a Covered Person's terminal illness as described in the explanation of Hospice Services in the Medical Benefits section of this Certificate.

18. **Dental Care, Dental Services, Dental Appliances and Orthodontics.** Except as otherwise provided under the Outpatient benefit captioned "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental Care refers to all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces, and orthodontic procedures.

19. **Dental Treatment Anesthesia.** Dental treatment anesthesia provided or administered in a dentist's office is not covered unless provided by a supplemental Benefit Rider.

20. **Diagnostic Admissions.** Services in connection with a Hospital stay primarily for diagnostic tests which could have been performed on an Outpatient basis are not covered.

21. **Disabilities Connected to Military Services.** Treatment in a government Facility for a Sickness or Injury connected to military service that the Covered Person is legally entitled to receive through a federal governmental agency, and to which the Covered Person has reasonable access, is not covered.

22. **Drugs and Prescription Medication (Outpatient).** Outpatient Drugs and prescription medications are not covered unless provided by a supplemental Benefit Rider. Refer to the Drugs and Prescription Medication Covered by Medicare provision of Outpatient Benefits for benefit coverage.

23. **Durable Medical Equipment.** Replacement of lost or stolen Durable Medical Equipment is not covered. The following equipment and accessories are not covered: non-Medically Necessary optional attachments and modifications to Durable Medical Equipment for the comfort or convenience of the Covered Person; accessories for portability or travel; a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment; home and/or vehicle modifications to accommodate the Covered Person's physical condition.

24. **Educational Services for Developmental Delays and Learning Disabilities.** Educational services to treat developmental delays or learning disabilities are not covered. A Learning Disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading, psychological and visual integration training.

25. **Elective Enhancements.** Elective or voluntary enhancement services, procedures, treatments, supplies and medications, including but not limited to, services related to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance are not covered.

26. **Exercise Equipment and Services.** Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs, gyms, home exercise equipment or swimming pools, even if ordered by a health care professional.

27. **Experimental and/or Investigational Procedures, Items and Treatments.** Experimental and/or Investigational Procedures, items and treatments are not covered unless otherwise required by federal or state law. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit, are determined by a Company Medical Director, or his or her designee. Procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

    - It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
    - It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
    - It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
    - It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
    - It has not been proven to have shown a demonstrable benefit for diagnosing or treating a particular illness or disease for

which its use has been proposed in prevailing peer-reviewed literature.

- It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).

The sources of information to be relied upon by the Company in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this plan include, but are not limited to, the following:

- The Covered Person's medical records;
- The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
- Any informed consent document the Covered Person, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- The published authoritative medical and scientific literature regarding the drug, device, treatment, or procedure;
- Expert medical opinion;
- Opinions of other agencies or review organizations, e.g., ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries or MCMC Medical Ombudsman;
- Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Health Care Policy and Research ("AHCPR").

A Covered Person with a life threatening or seriously debilitating condition may be entitled to an expedited external, independent review of the Company's coverage determination regarding Experimental or Investigational therapies.

Note: These exclusions do **not** apply to a Covered Person who has been diagnosed with cancer and accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer when the Covered Person's treating Physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Covered Person.

28. **Eyewear and Corrective Refractive Procedures.** Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered unless provided by an attached supplemental Benefit Rider. Surgical and laser procedures to correct or improve refractive error are not covered unless provided by an attached supplemental Benefit Rider. This exclusion does not apply following cataract surgery with an intraocular lens (IOL) and when the Covered Person is missing an intraocular lens without a replacement either after cataract surgery or naturally. If an IOL is placed, the Covered Person is entitled to one pair of frames and lenses after each cataract surgery. If the Covered Person does not have an IOL, then the Covered Person is covered for ongoing contacts and glasses through the prosthetic benefit.

29. **Family Planning.** Family planning is not covered. Family planning is defined as services and supplies related to a surgical or medical voluntary termination of pregnancy. This exclusion does not apply to therapeutic abortions where the mother's life is in danger or the fetus is not viable.

30. **Foot Care.** Routine foot care, including, but not limited to, removal or reduction of corns and calluses, and clipping of toenails, is not covered.

31. **Foreign Country Travel.** Any charges for services incurred while in a foreign country are not covered unless specified in the Schedule of Benefits.

32. **Genetic Testing and Counseling.** Genetic testing and counseling are excluded for all of the following:
    - Non-Covered Person.
    - Solely to determine the gender of a fetus.
    - Non-medical reasons (e.g., court-ordered tests, work-related tests, paternity tests).
    - Screening of newborns, children or adolescents to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to initiate medical interventions during childhood.
    - Covered Persons who have no clinical evidence or family history of a genetic abnormality.
    - Covered Persons who do not meet the Company's Medical Necessity criteria for genetic testing and counseling.

33. **Government Services and Treatment.** Any services that the Covered Person receives from a local, state or federal governmental agency are not covered.

34. **Hearing Aids and Hearing Devices.** Hearing aids and non-implantable hearing devices are not covered unless provided by a supplemental Benefit Rider. Hearing aid supplies are not covered.

35. **Hearing Examinations.** Audiology services performed only to determine the need for, or the appropriate type of, hearing aid are not covered unless provided by a supplemental Benefit Rider.

36. **Immunizations.** Travel and/or required work-related immunizations are not covered.

37. **Implants.** The following implants and services are not covered:
    - Removal and/or replacement of breast implants for non-medical reasons.
    - Replacement of breast prosthesis and the prosthesis itself following cosmetic breast augmentation mammoplasty.

38. **Infertility Services.** Infertility services are not covered.

39. **Institutional Services and Supplies.** Except for Skilled Nursing Services provided in a Skilled Nursing Facility, any services or supplies furnished by a Facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered.

40. **Maternity Services and Education.** Educational courses on lactation, childcare and/or prepared childbirth classes are not covered.

41. **Neuromuscular Skeletal Disorder Services.** Services are limited to Neuromuscular Skeletal Disorder Services as described in the Outpatient Benefits section of this Certificate and as provided by a supplemental Benefit Rider, if any.

42. **Nurse Midwife Services.** Elective home deliveries are not covered.

43. **Nursing, Private Duty.** Private Duty Nursing is not covered.

44. **Nutritional Supplements or Formulas.** Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the Outpatient description of "Phenylketonuria (PKU) Testing and Treatment."

45. **Off-Label Drug Use.** Off-Label Drug Use, which means the use of a Drug for a purpose that is different from the use for which the Drug has been approved by the FDA, including off label self-injectable Drugs or infusion therapy, is not covered except as indicated below.

    If a Drug is prescribed for Off-Label Drug 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;
- The Drug is Medically Necessary to treat the condition;
- The Drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: The American Hospital Formulary Service Drug Information; The United States Pharmacopoeia Dispensing Information, Volume 1; or in two articles 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 provision shall prohibit the Company from use of a formulary, Copayment, or Coinsurance.

46. **Organ Donor Evaluation and Services.** Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Covered Person. Covered Services for living donors are limited to transplant-related clinical services once a donor is identified. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children.
47. **Physical or Psychological Examinations.** Physical or psychological examinations for court hearings, travel, premarital, pre-adoption, employment or other non-preventive health reasons are not covered.
48. **Private Rooms and Comfort Items.** Personal or comfort items, and non-Medically Necessary private rooms during Inpatient Hospitalization, are not covered.
49. **Reconstructive Surgery.** Reconstructive surgeries are not covered when another more appropriate surgical procedure will be approved for the Covered Person, or if, in accordance with the standard of care as practiced by Physicians specializing in reconstructive surgery, the surgery offers only a minimal improvement in the appearance of the Covered Person. Please refer to the Reconstructive Surgery benefit in the Inpatient Benefits section of this Certificate for a description of Covered Services related to reconstructive surgery.
50. **Recreational, Lifestyle, Educational or Hypnotic Therapy.** Recreational, lifestyle, educational or hypnotic therapy, and any related diagnostic testing, are not covered except for diabetic self-management training.
51. **Rehabilitation Services and Therapy.** Rehabilitation services and therapy are either limited or not covered, as follows:
    - Speech, occupational or physical therapy are not covered when medical documentation does not support the Medical Necessity because of the Covered Person's inability to progress toward the treatment plan goals or when a Covered Person has already met the treatment goals.
    - Speech therapy is limited to Medically Necessary therapy to treat speech disorders caused by a defined Sickness, Injury or surgery (for example, cleft palate repair). Speech therapy for stuttering, lisping or delayed speech is not covered.
    - Cognitive Rehabilitation Therapy is limited to initial neuropsychological testing by a treating Physician or licensed Provider and the Medically Necessary treatment of functional deficits as a result of traumatic brain injury or cerebral vascular insult. This benefit is subject to the applicable Coinsurance and Deductibles.
    - Exercise programs are only covered when they require the direct supervision of a licensed physical therapist and are part of a Physician's treatment plan.
    - Aquatic/pool therapy is not covered unless conducted by a licensed physical therapist and part of a Physician's treatment plan.
    - Massage therapy is not covered.
    - Activities that are motivational in nature or that are primarily recreational, social or for general fitness are not covered.

- Developmental and neuroeducational testing beyond initial diagnosis is not covered.
- Developmental and neuroeducational treatment is not covered.
- Hypnotherapy is not covered.
- Psychological testing is not covered.
- Vocational rehabilitation is not covered.

Rehabilitation Services and therapies for the following conditions are not covered:

- Learning Disability.
- Mental Retardation as defined in the Certificate.

52. **Respite Care.** Respite Care is not covered, unless part of an authorized Hospice plan and is necessary to relieve the primary caregiver in a Covered Person's residence. Respite Care is covered only on an occasional basis, not to exceed five (5) consecutive days at a time.
53. **Reversal of Sterilization Procedures.** Reversal of sterilization procedures; sex change operations; conception by artificial means, which includes, but is not limited to, insemination procedures, in-vitro fertilization, zygote intrafallopian transfers and gamete intrafallopian transfers; and non-prescription contraceptive supplies and devices are not covered.
54. **Self-Injectable Medications.** Self-injectable medications are defined as those Drugs that 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. Self-injectable medications are not covered except for the following:
    - Blood clotting factors.
    - Drugs used in immunosuppressive therapy.
    - Erythropoietin for dialysis patients.
55. **Services Provided at No Charge to the Covered Person.** Services and supplies that are provided free of charge if the Covered Person did not have coverage under this Policy or for which the Covered Person will not be held financially responsible are not covered, unless the Company has agreed to payment arrangements prior to the provision of the services or supplies to the Covered Person.
56. **Services While Incarcerated or Confined.** Services required for Injuries or Sicknesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered. However, the Company will reimburse Covered Persons their out-of-pocket expenses for services received while confined/ incarcerated or, if a juvenile, while detained in any facility, if the services were provided or authorized by the Company in accordance with the terms of this Certificate.
57. **Sex Transformations.** Procedures, services, medications and supplies related to sex transformations are not covered.
58. **Sexual Dysfunction or Inadequacy Medications.** Sexual dysfunction or inadequacy medications/drugs, procedures, services and supplies, including penile implants/prosthesis except testosterone injections for the documented low testosterone levels are not covered.
59. **Skin Reduction Surgery.** Surgical removal of excessive skin following massive weight loss associated with bariatric surgery or other weight loss programs is not covered.
60. **Surrogacy.** Infertility and Maternity services for non-Covered Persons are not covered.
61. **Telehealth.** Telehealth services are not covered except as provided by state law or unless determined to be Medically Necessary by the Company Medical Director.
62. **Transplant Services.** Transplant services are not covered when the transplant is not performed at a Medicare-certified Transplant Center. Non-human organs and artificial hearts are not covered.
63. **Transportation.** Transportation is not a covered benefit except as covered under the Ambulance and Organ Transplant Services benefits in this Certificate.

64. **Veterans' Administration Services.** Veterans' Administration (VA) services are not covered.

65. **Vision Training.** Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.

66. **Weight Alteration Programs.** Weight loss or weight gain programs are not covered.

67. **Workers' Compensation.** Services payable under Workers' Compensation are not covered.

68. **War.** Services incurred as a result of declared or undeclared war are not covered.

Payment Responsibility

- **Claims Policies and Procedures**
- **Coordination of Benefits**

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

I. Claims Policies and Procedures

The benefits of the Policy are based on the assumption that the Covered Person is enrolled in Medicare Part A and Part B. The Company may pay the benefits directly to You, to the Physician, or to the Hospital.

You should present Your UnitedHealthcare identification card along with Your Social Security Medicare identification on Your first visit to the Physician or Hospital. Most Providers bill both Medicare and the Company for You. However, You may request that the Provider contact the Company for billing authorization and procedure.

Payment of Claims. The Company will pay a benefit under the Policy for the Covered Expense that a Covered Person incurs due to Sickness or Injury when the Covered Expense exceeds the Calendar Year Deductible and any other Deductible that may apply. Benefits will be paid as set forth in the Schedule of Benefits. 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.

- **Payment of Benefits to Insured Person.** All benefits, unless assigned under the Policy, are payable to the Insured Person whose Injury or Sickness, or whose covered Dependent's Injury or Sickness, is the basis of a Claim.
- **Death or Incapacity of Insured Person.** In the event of the Insured Person's death or incapacity and in the absence of written evidence to the Company of the qualification of a guardian for the Insured 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 Insured Person's care and support.
- **Assignments.** Benefits for Covered Expenses may be assigned by the Covered Person to the person or Provider rendering the services. 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.

Non-Duplication of Benefits. Benefits provided under the Policy will not duplicate any benefits paid by Medicare. The combined benefits provided under the Policy and Medicare or other coverage will never exceed one hundred percent (100%) of the charges incurred for medical 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.

Medicare Assignment. If a Provider of services accepts Medicare assignment, the Company's payment will be limited to the difference between the amount paid by Medicare and the approved amount under Medicare, subject to any benefit limitations, Deductibles, Copayments and Coinsurance set forth in the Schedule of Benefits.

Limitation of Liability. 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 not submitted to the Company within one (1) year after the date of loss, except in the case of legal incapacity of the Covered Person.

Claims Processing. The Company reviews and evaluates all service benefit payment submissions for Medical Necessity and the possibility of billing irregularities. The review relies on and complies with the American Medical Association guidelines and the Current Procedural Terminology system coding standards. The Company may adjust or decline benefit payments consistent with the evaluation findings.

Notice of Claim. A written notice of Claim must be furnished to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible.

Claim Forms. The Company, upon written notice of Claim, will furnish to the Covered Person such forms as are usually furnished by the Company for filing proofs 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, 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 within ninety (90) days after the termination of the period for which the Company is liable, and in case of Claim for any other loss, within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any Claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Time of Payment of Claims. Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid as they accrue and any balance remaining unpaid at termination of the period of liability will be paid immediately upon receipt of due written proof.

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.

Physical Examinations. The Company, at its expense, may:

1. Have a Covered Person examined, as often as reasonably necessary, while any Claim is pending; and
2. In the case of death of a Covered Person, have an autopsy made, where allowed by law, if a Claim for benefits is made.

II. Coordination of Benefits

The Company may coordinate benefits with benefits available under other similar health 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 100% of Allowable 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 medical or surgical treatment:

1. Group, blanket or franchise 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. Any coverage in group, group-type and individual automobile "no-fault" and traditional automobile "fault" type plans;
5. 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

6. 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 applies 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 an Allowable Expense?

Allowable Expense means the usual, customary and reasonable charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the Covered Person's stay in a private hospital room is considered Medically Necessary under at least one of the plans involved.

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 which covers a person other than as a Dependent pays before a Plan which covers a person as a Dependent;
3. When rules 1 through 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 laid-off or retired employee, or as a Dependent of a laid-off or 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 laid-off or 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 Allowable Expense under this Plan without this provision; and
2. The benefits payable for the Allowable Expense under the other Plans, without this provision, whether or not a Claim is made, exceed the Allowable Expense in a Calendar Year. Thereafter, benefits will be reduced so that coordination with benefits payable under the other Plans does not total more than 100% of the Allowable 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. **Third Party Liability.** Expenses incurred due to liable third parties are not covered.

   Health care expenses incurred by a Covered Person for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act, or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Certificate. However, in all cases, the Company will pay for the arrangement or provision of health care services for a Covered Person that would have been Covered Services except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the section of this Certificate captioned "The Company's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Covered Person's Health Care Expenses."

   The Company's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Covered Person's Health Care Expenses. Expenses incurred by a Covered Person for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act, or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Certificate. However, in all cases, the Company will pay for the arrangement or provision of health care services for a Covered Person that would have been Covered Services except that they were required due to a liable third party, in exchange for the following agreement:

   If a Covered Person is injured by a liable third party, the Covered Person agrees to give the Company, or its representative, agent or delegate, a security interest in any money the Covered Person actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

   If the Covered Person does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Covered Person will have no obligation to repay the Covered Person's debt to the Company, which debt shall include the cost of arranging or providing otherwise covered health care services to the Covered Person for the care and treatment that was necessary because of a liable third party.

2. **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. **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.

c. **Automobile, Accident or Liability Coverage.** The Company shall not furnish benefits which duplicate benefits the Covered Person is entitled to under any automobile, Accident or liability coverage. The Covered Person is responsible for taking whatever action necessary to obtain the available benefits of such coverage, and will notify the Company of receipt of such available benefits. If payment is provided by the Company in duplication of the benefits under other automobile, Accident or liability coverage, the Company may seek reimbursement for the duplicate benefits. Should the cost of Covered Services exceed the benefits under any other liability coverage pursuant to this section, the Policy benefits will be provided over and above such liability coverage.

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 Employer or 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 Employer or former Employer.

Eligibility Requirements

The Insured Person must be a former employee of the Employer: (1) who 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); (2) who is age 65 or older and (3) who is eligible for, and enrolled in, Medicare Part A and Part B. Eligible Dependents of the Insured Person may be enrolled under the Policy if such Dependent is: (1) eligible for coverage under the Employer's Retiree welfare benefit plan; and (2) is eligible for, and enrolled in, Medicare Part A and Part B.

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.

Effective Date. An Insured Person or his or her Dependent(s) may be enrolled for coverage under the Policy in one of the four ways described below. Subject to payment of the applicable premium and the Company's receipt of the appropriate enrollment forms, and in accordance with the provision below, Personal or Dependent Insurance becomes effective as indicated in this section.

1. **Open Enrollment.** If a Retiree or a Dependent enrolls during an Open Enrollment Period, coverage will become effective on the first day of the Insurance Month following the end of the Open Enrollment Period.
2. **Within 90 Days of an Eligibility Date.** If a Retiree or eligible Dependent enrolls within ninety (90) days after first becoming eligible for coverage under the Policy, Personal Insurance or Dependent Insurance will become effective on the first day of the Insurance Month following the date of enrollment.
3. **Late Enrollment.** In the event a Retiree or eligible Dependent who is eligible for coverage under the Policy declines enrollment for such coverage within ninety (90) days of becoming eligible, and subsequently requests enrollment, such Retiree or Dependent will not be eligible for coverage under the Policy unless the Retiree or Dependent is eligible for Special Enrollment as described below.

4. **Special Enrollment.** A Special Enrollment Period of 90 days is provided for Retirees or eligible Dependents eligible to enroll for coverage under the Policy if the Retiree or eligible Dependent:

   a. Had other group health insurance coverage at the time he or she was eligible to enroll under the Policy;

   b. Was given the opportunity to enroll;

   c. Certified in writing that having such other coverage was the reason for declining enrollment under the Policy;

   d. Was notified that the failure to provide the certification would result in a delay in future coverage under the Policy; and has lost or will lose such other health insurance coverage due to exhaustion of a COBRA continuation provision, a loss of eligibility for the other coverage, or a termination of Employer contributions for the other coverage.

   The Effective Date of coverage for the Retiree or eligible Dependent enrolled during this Special Enrollment Period will be the first day of the Insurance Month following the date on which the Retiree or Dependent enrolled.

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. 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 for which premium is submitted in a timely manner.

Coverage Following Termination of Individual Coverage. A Covered Person may be entitled to the following continuation coverage options following termination of coverage:

COBRA Continuation Coverage. If the Insured Person's Employer or former Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), You may be entitled to temporarily extend Your coverage under the health plan at group rates, plus an administration fee, in certain instances where Your coverage under the health plan would otherwise end. The Insured Person's former Employer is legally

responsible for informing You of Your specific rights under COBRA. Therefore, please consult with the Insured Person's former Employer regarding the availability and duration of COBRA continuation coverage.

Certificate of Creditable Coverage.
According to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a certificate of Creditable Coverage will be provided to the Insured Person by the Company when the Insured Person or a Dependent ceases to be eligible for benefits under the Group Policyholder's health benefit plan. A certificate of Creditable Coverage may be used to reduce or eliminate a Pre-Existing Condition exclusion period imposed by a subsequent health plan. Creditable Coverage information for Dependents will be included on the Insured Person's Certificate, unless the Dependent's address of record or coverage information is substantially different from the Insured Person's. Please contact the Company's customer service department if You need a duplicate certificate of Creditable Coverage. If You meet HIPAA eligibility requirements, You may be able to obtain individual coverage using Your certificate of Creditable Coverage.

- **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 services has been reviewed properly. When this happens, the Covered Person is encouraged 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/her problem or grievance requires additional action, the Covered Person may file a formal appeal. The Company's appeals 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 written comments, documents, records, and any other information relating to the appeal, regardless of whether this information was submitted or considered in the initial determination. The Covered Person may designate a representative to file an appeal on their behalf by providing written notice that includes the issue in dispute, the Covered Person's signature and the representative's signature.

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. 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 the appeal.

For appeals involving a decision based on Medical Necessity, the Company's written response will describe the criteria or guidelines used and the clinical reasons for its decision and the option to request external review. For determinations 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.

II. Experimental and/or Investigational Procedures, Items, and Treatments

The Company will provide a special appeals review procedure if all of the following criteria are met:

(1) The Covered Person has a life-threatening or seriously debilitating condition;

(2) A Physician certifies that standard therapies either (a) have not been effective in improving the Covered Person's condition, (b) would not be medically appropriate or (c) would not be more beneficial than the specific therapy proposed pursuant to criterion (3) below;

(3) The Covered Person or the Covered Person's Physician has requested a specific therapy that is likely to be more beneficial than any available standard therapy;

(4) The Company has denied coverage for the specific therapy requested pursuant to criterion (3) above, unless coverage for such therapy is excluded by this Policy and/or Certificate; and

(5) The specific therapy requested pursuant to criterion (3) above would be a Covered Benefit except for the Company's determination that it is experimental or under investigation.

For purposes of this section:

- "Life-threatening" means diseases or conditions where either (a) the likelihood of death is high unless the course of disease is interrupted, or (b) the outcome is potentially fatal and the endpoint of clinical intervention is survival.
- "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

Such procedure will be an external, independent medical review process conducted in accordance with applicable state law, based on relevant medical and scientific evidence.

III. The Appeals Process

If the Covered Person disagrees with a Company decision regarding an authorization or a claim, the dispute shall be directed to the Company either by telephone or in writing. The appeal must be filed within one hundred eighty (180) days of receiving a denial notice or explanation of benefits. To initiate the standard appeal, the Covered Person may call the Company's Customer Service Department to request an appeal form or write the Appeals Department at the address below:

Appeals Department
P.O. Box 6106
Cypress, CA 90630
Fax: 1-866-704-3420

Urgent Appeal: Appeals involving an imminent and serious threat to the Covered Person's 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. Urgent appeal requests may be initiated by calling Customer Service or faxing a written request to the Appeals Department. If the request does not meet the criteria for an Urgent Appeal, it will be reviewed under the standard appeal process. If the appeal requires urgent review, the Company will make a determination not later than seventy-two (72) hours of the Company's receipt of the appeal.

Standard Appeal: If the appeal does not qualify as an urgent appeal, it will be reviewed as a standard appeal. The Appeals Department will provide a written response regarding the outcome within thirty (30) calendar days from receipt of the appeal for an authorization denial and within sixty (60) calendar days from receipt of an appeal for a claim denial.

Independent Medical Review. You may apply to the California Department of Insurance for a review by expert independent medical professionals if You believe that a health care service eligible for payment under this Certificate has been improperly denied, modified or delayed by the Company due to a finding that the service is not Medically Necessary. The review will be made at no cost to You.

You may apply for an independent medical review if all of the following criteria are met:

(1) One of the following has occurred:
   - A Provider has recommended a health care service as Medically Necessary,
   - A Covered Person has received urgent care or emergency services that a Provider has determined to be Medically Necessary, or
   - A Covered Person has been seen by a Provider for diagnosis or treatment of the medical condition for which You seek independent review.

(2) The disputed service has been denied, modified or delayed by the Company on the basis that the service is not Medically Necessary.

(3) You have filed a grievance with the Company and either the disputed decision has been upheld or the grievance remains unresolved after thirty (30) days. This time period is reduced to three (3) days in the case of a grievance that requires expedited review, and it may be waived in extraordinary and compelling cases.

Independent medical reviews will be conducted in accordance with applicable state law.

Quality of Care/Quality of Service Review

All quality of clinical care and quality of service complaints are investigated by the Company. The Company conducts reviews by investigating the complaint and consulting with treating Providers and other UnitedHealthcare internal departments. Medical records are requested and reviewed as necessary and, as such, the Covered Person may

need to sign an authorization to release medical records. The Company will notify the Covered Person in writing regarding the disposition of the complaint within thirty (30) days of receipt of the complaint. Please be aware that the results of the quality of clinical care review are confidential and protected from legal discovery in accordance with state law.

IV. Binding Arbitration

Any and all disputes of any kind whatsoever, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the Policy were unnecessary or unauthorized or were improperly, negligent, or incompetently rendered), except for claims subject to ERISA, between the Covered Person (including any heirs or assigns) and the Company, or any of its parents, subsidiaries or affiliates (collectively, "UnitedHealthcare"), shall be submitted to Binding Arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. The Covered Person and the Company are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of Binding Arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in the county in which the Covered Person lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by federal and California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, UnitedHealthcare may assume all or part of the Covered Person's share of the fees and expenses of JAMS and the arbitrator, provided the Covered Person submits a hardship application to JAMS. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of Binding Arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking damages, shall be subject to Binding Arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1–16, shall also apply to the arbitration.

By enrolling with the Company both the Covered Person (including any heirs or assigns) and the Company agree to waive the constitutional right to a jury trial and instead voluntarily agree to the use of binding arbitration as described in this Certificate.

V. Complaints

If a complaint is not resolved to the satisfaction of the Covered Person, the Covered Person or their designated representative has the right to file a complaint or seek other assistance from the California Department of Insurance. Assistance is available by calling or writing to the:

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013

1-800-927-HELP (calling within California)
1-213-897-8921
(calling from outside California)
TDD: 1-800-482-4833

The Department of Insurance should be contacted only after discussions with the

insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

VI. 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.

Accident means an acute Injury that happens suddenly, unexpectedly and without design of the person injured.

Acupressure means a Medically Necessary treatment provided by a licensed Provider that involves the compression of blood vessels by means of needles in surrounding tissues.

Acupuncture means a Medically Necessary treatment provided by a licensed acupuncturist that involves stimulation of anatomical points on the body by a variety of techniques.

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.

Alcohol, Drug or Other Substance Abuse means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to the activities of daily living on a recurring basis. Alcohol, Drug or Other Substance Abuse does not include addiction to, or dependency on, tobacco, tobacco products or foods.

Calendar Year means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.

Calendar Year Deductible means the amount of Covered Expense shown on the Schedule of Benefits that a Covered Person is responsible for paying each Calendar Year before benefits are payable under the Policy. Covered Expense that a Covered Person has to pay due to any additional Deductibles or any Copayments will not be applied toward satisfying the Calendar Year Deductible.

Certificate means this summary of the terms of Your benefits, along with the Schedule of 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.

Cognitive Rehabilitation Therapy is therapy for the treatment of functional deficits as a result of traumatic brain injury and cerebral vascular insult. It is intended to help in achieving the return of higher level cognitive ability. This therapy is direct (one-on-one) patient contact.

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

Coinsurance Maximum means the Coinsurance Maximum shown on the Schedule of Benefits. When a Covered Person has paid an amount of Coinsurance during the Calendar Year equal to one of the Coinsurance Maximums, 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 for the type of Provider for which the Coinsurance Maximum has been reached.

Company means UnitedHealthcare Insurance Company.

Complications of Pregnancy means conditions requiring Inpatient confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, puerperal infection and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy. A non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible, are considered Complications of Pregnancy.

Copayment means that portion of Covered Expenses which is the responsibility of the Covered Person and which is shown as Copayments on the Schedule of Benefits. Copayments do not apply toward the Deductible and do not accrue toward the Coinsurance Maximum. Copayments will continue to be required after the Coinsurance Maximum has been reached.

Covered Expense means an expense that is incurred for a Medicare Eligible Expense for a Covered Service provided to a Covered Person while that Covered Person is insured under the Policy, and does not exceed the Medicare Eligible Expense and does not exceed the smallest of any Policy Maximum that may apply to the Covered Expense. For any other Covered Service under the Policy which is not a Medicare Eligible Expense, a Covered Expense shall not exceed the lesser of billed charges or Usual and Customary Charges and shall not exceed the smallest of any Policy Maximum that apply to the Covered Expense.

Covered Person means the Insured Person or the Dependent(s) of the Insured Person who are insured under the Policy. Covered Persons are sometimes called "You" and "Your."

Covered Service means a service or supply that is:

1. Performed, prescribed, directed or authorized by a Provider; and
2. Medically Necessary for the treatment of an Injury or Sickness.

Creditable Coverage means coverage under any of the following:

1. A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employer Retirement Income Security Act of 1974;
2. A group health benefit plan provided by a health insurance carrier or health maintenance organization;
3. An individual health insurance Policy or evidence of coverage;
4. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
5. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928; (medical and dental care for certain members and former members of the armed services);
6. Chapter 55 of Title 10, United States Code;
7. A medical care program of the Indian Health Service or of a tribal organization;
8. A state health benefits risk pool;
9. A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employee Health Benefit Program);
10. A public health plan (as defined in federal regulations);
11. A health benefit plan under Section 5 (e) of the Peace Corps Act; or
12. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include coverage consisting solely of the following:

1. Coverage only for Accidents, or disability income insurance, or any combination thereof;
2. Liability insurance, or coverage issued as a supplement to liability insurance;
3. Workers' Compensation or similar insurance;
4. Automobile medical payment insurance;
5. Credit-only insurance;

6. Coverage for on-site medical clinics; or
7. Other similar insurance coverage specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Creditable Coverage does not include any of the following, if offered separately:

1. Limited scope dental or vision benefits;
2. Long term care, nursing home care, home health care, community-based care, or any combination thereof;
3. Medicare supplemental health insurance;
4. Coverage supplemental to coverage under Chapter 55 of Title 10, United States Code; or
5. Similar supplemental coverage provided to coverage under a group health plan.

Creditable Coverage does not include either of the following, if offered as independent, non-coordinated benefits:

1. Coverage only for a specified disease or illness; or
2. Hospital indemnity or fixed indemnity insurance.

Custodial Care means care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, and using the toilet; feeding or preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, Respite Care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. The mere provision of Custodial Care by a medical professional, such as a Physician, licensed nurse or registered therapist, does not mean the services are not custodial in nature. If the nature of the services can be safely and effectively performed by a trained non-medical person, the services will be considered Custodial Care.

Deductible means the amount of Covered Expense a Covered Person must pay before benefits become payable under the Policy.

Dependent means:

1. A person who is the Insured Person's Spouse or Domestic Partner who is not legally separated from the Insured Person; or
2. A person age 65 or older who is (1) eligible for coverage under the Employer's Retiree welfare benefit plan; and (2) is eligible for, and enrolled in, Medicare Part A and Part B.

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

Diabetes Equipment and Diabetes Supplies means any of the following: blood glucose monitors, including monitors designed to assist the visually impaired; blood glucose testing strips; insulin pumps and all related necessary supplies; Ketone urine testing strips; lancets and lancet puncture devices; pen delivery systems for the administration of insulin; podiatric devices to prevent or treat diabetes-related complications; insulin syringes; and visual aids, excluding eyewear to assist the visually impaired with proper dosing of insulin. The following prescription items are covered if determined to be Medically Necessary: Insulin; Prescriptive medications for the treatment of diabetes; and glucagon.

Domestic Partner means either of two adults who have established a partnership in California by filing a Declaration of Domestic Partnership with the Secretary of State and, at the time of the filing, all of the following requirements are met: (a) Both persons have a common residence; (b) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity; (c) The two persons are not related by blood in a way that would prevent them from being married to each other in this state; (d) Both persons are at least 18 years of age; (e) Either of the following: (i) Both persons are members of the same sex: (ii) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62; and (f) Both

persons are capable of consenting to the domestic partnership.

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

Durable Medical Equipment means durable items or appliances that:

1. Are Medically Necessary;
2. Are able to withstand repeated use;
3. Are designed to serve a medical purpose;
4. Generally are not useful to a Covered Person in the absence of a medical condition, Injury or Sickness;
5. Are not disposable;
6. Are not customarily found in a Physician's office; and
7. Are needed for functional rather than cosmetic reasons.

This term does not include charges for the repair or maintenance of such equipment.

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

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the Covered Person's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. In the case of a pregnant woman, an Emergency Medical Condition exists if the Covered Person is in active labor, meaning labor at a time in which either of the following would occur:
   a. there is inadequate time to effect safe transfer to another Hospital prior to delivery; or
   b. a transfer may pose a threat to the health and safety of the Covered Person or the unborn child.

An Emergency Medical Condition does not include services provided at a Hospital emergency room that a prudent layperson could have obtained at a Physician's office or where there is a pattern of the Covered Person visiting multiple emergency rooms for the purpose of seeking prescriptions for pain medications.

Emergency Services means Covered Services that are:

1. Furnished by a Provider qualified to furnish Emergency Services; and
2. Needed to evaluate or stabilize a medical emergency. (See the definition of Emergency Medical Condition.)

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

Experimental and/or Investigational Procedures mean those particular services, supplies or treatments not covered under the Policy as described in the Exclusions and Limitations sections of the Certificate.

Facility means a health care or residential Facility that is duly accredited by and licensed by the state in which it operates to provide medical Inpatient, residential day treatment, partial Hospitalization, Skilled Nursing Services or Outpatient care, or a Facility for the diagnosis or treatment of Alcohol, Drug, or Other Substance Abuse, or mental illness.

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

Home Health Aide means a person who has completed Home Health Aide training, as required by the state in which the individual is working. Home Health Aides must work under a plan of care ordered by a Physician and under the supervision of a licensed nurse or licensed therapist.

Home Health Aide Services mean Medically Necessary personal care such as bathing, exercise assistance and light meal preparation, provided by trained individuals and ordered along with skilled nursing and/or therapy visits.

Home Health Care means the Home Health Care provided by a certified Home Health Care Agency according to a Physician's written treatment plan for care of a Covered Person in the Covered Person's place of residence. Services appropriate to the needs of the individual patient are planned, coordinated and made available through a multidisciplinary health team.

Home Health Care Agency means an organization duly licensed and certified or otherwise authorized as a Home Health Care Agency pursuant to the laws of the state in which the Covered Person resides and meets Medicare's requirements for Home Health Care agencies and which is engaged in arranging and providing nursing services, Home Health Care services, and other therapeutic and related services.

Home Health Care Visit means up to two (2) hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist, or up to four (4) hours of Home Health Aide Services.

Hospice means a specialized form of interdisciplinary health care for a Covered Person with a life expectancy of six (6) months or less due to a terminal illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Covered Person who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the Covered Person receiving Hospice services.

Hospice Care means the care provided to a Covered Person when the goal of treatment is to provide supportive care and counseling during the terminal phase of an illness. Hospice Care is provided through a hospice care agency for Covered Persons who have a terminal Sickness, for which the prognosis of life expectancy is six (6) months or less, and who no longer elect to pursue aggressive medical treatment for the terminal Sickness.

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.

Injury means bodily Injury due to an Accident occurring while a Covered Person is insured under the terms and conditions of the Policy.

Inpatient means being registered as an Inpatient in a Hospital or a Facility upon the recommendation of a Provider, and incurring charges for room and board.

Inpatient Services mean those Covered Services provided to a Covered Person in a Hospital or Skilled Nursing Facility bed that is not in the Outpatient department of such 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.

Intensive Care Unit means a separate part of a Hospital or Facility that provides:

1. Treatment to patients in critical condition;
2. Continuous special nursing care or observation by trained and qualified personnel; and
3. Life-saving equipment.

Intramuscular means an injection into the muscle.

Intravenous means an injection into the vein.

Late Enrollee means a person or a Dependent who declined enrollment in the Policy when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

Learning Disability means a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance, and which is not a result of generalized Mental Retardation, educational or psycho-social deprivations, psychiatric disorder or sensory loss.

Maternity means prenatal and postnatal care, childbirth, or any Complications of Pregnancy of an Insured Person or the Insured Person's covered Dependent Spouse.

Medically Necessary (or Medical Necessity) means, for Covered Services eligible for payment under **Section One,** an intervention if recommended by the treating Physician 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. "Cost-effective" does not necessarily mean the lowest price.

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:

- The "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 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 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 contradictory, decisions about such new interventions should be based on convincing expert opinion.
- An intervention is considered cost-effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

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

Medicare Benefit Period means the period of time used by Medicare to measure Your coverage under Medicare Part A. Your first Benefit Period begins on the day You enter a Hospital as a Medicare patient. It ends sixty (60) days after You leave the Hospital (counting the day of Your discharge) or, if You have to go from the Hospital to a Skilled Nursing Facility, it ends sixty (60) days after You leave the Skilled Nursing Facility. If You are Hospitalized again within sixty (60) days, the second Hospital stay is considered part of Your first Medicare Benefit Period.

Medicare Eligible Expense means expenses of the kind covered by Medicare, to the extent recognized as reasonable and Medically Necessary by Medicare. Payment of benefits under the Policy for Medicare Eligible Expenses will be based on the same payment conditions and determinations of Medical Necessity as are applicable under Medicare.

Medicare Part A or Part B Deductible means the amount of health care charges Medicare requires You to pay before Medicare Part A or Part B benefits are paid.

Medicare Part B Excess Charges means the difference between the actual Medicare Part B approved amount and the Medicare-approved Part B charge for non-assigned Claims. The billed charges must not exceed any limitation established by Medicare or state law.

Mental Retardation and Related Conditions means conditions based on the following three criteria: intellectual functioning level (IQ) is below 70–75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less).

Neuromuscular Skeletal Disorders means misalignments of skeletal structures and muscular weaknesses, imbalance and disorders related to the spinal cord, neck and joints. All such disorders must be documented and demonstrated through X-rays or bodily function limitations.

Open Enrollment Period means a period of time as specified in the application of the Group Policyholder and approved by the Company during which Retirees may enroll themselves and their eligible Dependents under the Policy. The Open Enrollment Period, if any, is shown on the Policy Information Page.

Out-of-Pocket Expense Maximum, if any, is shown on the Schedule of Benefits. When a Covered Person has paid an amount during the Calendar Year equal to the Out-of-Pocket Expense Maximum excluding Pharmacy Coinsurance and the Calendar Year Deductible, 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.

Outpatient means receiving treatment from a Provider in a Facility other than on an Inpatient basis.

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 health insurance provided by the Policy on Insured Persons.

Physician means only a person who is licensed and practices within the scope of the license as a doctor of medicine (M.D.) or as a doctor of osteopathy (D.O.).

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

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.

Preauthorization means the medical review process that examines the Medical Necessity of a procedure or service and that must be obtained by the Covered Person from the Company's Administrator prior to receiving such procedure or service from a Provider. If Preauthorization is required, it must be obtained to avoid a reduction in benefits under the Policy.

Provider means a person, group, Facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this Certificate and any supplemental benefit materials.

Rehabilitation Services mean the individual or combined and coordinated use of medical, physical, cognitive rehabilitation, occupational and speech therapy for training or retraining individuals disabled by Sickness or Injury.

Respite Care means the short-term services provided to Covered Persons receiving authorized Hospice services who have disabilities that require care and/or supervision while allowing the caregivers temporary relief. Services may be provided:

1. In a nursing home or Hospital, and includes personal care, nursing intervention, supervision, meal preparation, and a room.
2. In an adult foster care home or personal care home, and includes personal care, housekeeping, supervision, meal preparation, transportation, and a room.
3. In an adult day health care Facility, and includes personal care, nursing services, supervision, meal preparation, and transportation.
4. In the individual's own home by a home care attendant or primary caregiver, and includes personal care, housekeeping, meal preparation, supervision, and transportation.

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 age 65 or older; (3) is eligible for, and enrolled in, Medicare Part A and Part B; and (4) who is entitled to benefits under the Policy.

Semi-Private Room Rate means the most common charge for a two-bed room in a Hospital, Facility, or Skilled Nursing Facility, as determined by the Company.

Sickness means a physical illness, disease or Complications of Pregnancy.

Significant Break in Coverage means a period of sixty-three (63) consecutive days during all of which an individual does not have any Creditable Coverage. Waiting periods and HMO affiliation periods during which an individual does not have coverage are not taken into account in determining a Significant Break in Coverage.

Skilled Nursing Facility means a comprehensive freestanding rehabilitation Facility or a specially designed unit within a Hospital licensed by the state in which it is doing business to provide Skilled Nursing Services.

Skilled Nursing Services mean the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide.

Skilled Rehabilitation Care means the care provided directly by or under the direct supervision of a licensed Provider acting within the scope of his or her licensure.

Special Enrollment Period means a period of time, mandated by the Health Insurance Portability and Accountability Act of 1996, where persons or Dependents who are not insured under the Policy may enroll for coverage as specified in the Special Enrollment provision.

Spouse means a legally recognized husband or wife under the laws of the state where the Policy is delivered.

Subacute and Transitional Care means levels of care needed by a Covered Person who does not require Hospital acute care, but who requires more intensive licensed Skilled Nursing Services than are provided to the majority of patients in a Skilled Nursing Facility.

Subcutaneous means an injection under the skin.

Telehealth means a health service, other than a Telemedicine service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine means professional services given a Covered Person through an interactive telecommunication system by a Provider at a distant site.

Temporomandibular Joint Dysfunction means a condition affecting the upper or lower jawbone, or associated bone joints that is unrelated to any external traumatic episode.

Urgent Care means Covered Services rendered at an Urgent Care Facility which are appropriate to the treatment of an Injury or Sickness that is not an Emergency Medical Condition, but requires prompt medical attention. Urgent Care includes the treatment of minor Injuries as a result of Accidents, the relief or elimination of acute pain, or the moderation of an acute Sickness.

Usual and Customary Charge means the lesser of:

1. A Provider's usual Charge for furnishing treatment, service or a supply; or
2. The charge the Company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same area and whose Injury or Sickness is comparable in nature and severity.

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 and a Schedule of Benefits. The Certificate and Schedule of Benefits 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 error. 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.

Medical Records. The Company shall have access to medical 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 medical 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.

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.

Notes

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Toll-Free **1-800-851-3802**, TTY **711**
8 a.m. – 8 p.m. local time, Monday – Friday

www.UHCRetiree.com
Learn more online

2016

Plan Guide

What you need to know about your plan.

MODESTO IRRIGATION DISTRICT

UnitedHealthcare® MedicareRx for Groups (PDP)

Effective: January 1, 2016 through December 31, 2016

Group Number: 1500

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

Working with you to create a positive Medicare experience.

Dear Retiree,

We are pleased that your former employer or plan sponsor has selected UnitedHealthcare® to offer health care coverage for all eligible retirees. At UnitedHealthcare we believe you deserve more than just a good insurance plan to help maintain your health. We want to work with you to help you live a healthier life.

We want to:

- Help you get access to the care you may need when you need it
- Give you tools and resources to be in control
- Try to help you find ways to save money, so you can spend less on health care coverage and more on the things that matter most to you
- Be there for you when and where you need us

In this book you will find:

- A description of this plan and how it works
- Information on benefits, programs and services — and how much they cost
- Details on how to enroll
- What you can expect after you enroll

Your 2016 plan information is also available online at www.uhcgroup.net. You will need your Group number found on the front cover of your booklet to access the website.

Enrolling is easy.

1. Find the Enrollment Request Form(s) in the "Enrollment" section of this book.
2. Fill out completely — make sure you sign and date the form(s).
3. Return your completed form(s) in the enclosed envelope before your enrollment deadline.

We're with you every step of the way.

If you have any questions, please give us a call. Our Customer Service team has been specially trained on the details of your plan. They are happy to answer any questions you have.

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

Learn more online at **www.UHCRetiree.com**

[1]2014 UnitedHealth Group Annual Report

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NOTES

Plan INFORMATION

Benefit highlights

MODESTO IRRIGATION DISTRICT 01500

Effective January 1, 2016 to December 31, 2016

This is a short description of plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Prescription Drugs	Your Cost	
Initial coverage stage	Network Pharmacy (30-day retail supply)	Mail Service Pharmacy (90-day supply)
Tier 1: Preferred generic	$10 copay	$20 copay
Tier 2: Preferred brand (includes some generic)	$20 copay	$40 copay
Tier 3: Non-preferred brand (includes some generic)	$35 copay	$70 copay
Tier 4: Specialty tier	$35 copay	$70 copay
Coverage gap stage	After your total drug costs reach $3,310, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost	
Catastrophic coverage stage	After your total out-of-pocket costs reach $4,850, you will pay the greater of $2.95 copay for generic (including brand drugs treated as generic), $7.40 copay for all other drugs, or 5% of the cost	

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

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

Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change each plan year.

UnitedHealthcare® MedicareRx for Groups (PDP)

Let's start with a description of your plan and how it works. Your plan sponsor has selected a UnitedHealthcare® MedicareRx for Groups (PDP) plan. What is a MedicareRx for Groups plan? The word "Group" means that this is a plan designed just for plan sponsors, like yours. Only eligible retirees of your plan sponsor can enroll in this plan. You can't get it anywhere else. This plan is also known as a Medicare Part D plan.

Original Medicare (Parts A and B) helps pay for some of the costs of hospital stays and doctor visits, but it doesn't cover prescription drugs. Medicare Part D plans help with prescription drugs costs. You can get Part D coverage through a private insurance company, like UnitedHealthcare.

The UnitedHealthcare® MedicareRx for Group (PDP) plan can provide peace of mind and could help you save time and money when it comes to your prescription drugs.

When to enroll in a Medicare Part D plan:

You turn 65 or become Medicare eligible. This is your initial enrollment period. It's your first chance to enroll in Medicare Part D.

You need a Medicare Part D plan but never had one before. Or, you want to change to a different group-sponsored plan. Enroll during your plan sponsor's annual Open Enrollment Period.

You retire and move out of a different group-sponsored plan. Or, you move out of the plan's service area. These are examples of Special Election Periods and may happen for various reasons.

Make sure you are signed up for Medicare.

You must be entitled to Medicare Part A and/or enrolled in Medicare Part B to be eligible to enroll in this plan.

- If you're not sure if you are enrolled, check with your local Social Security office
- If you have Part B you must continue paying your Medicare Part B premium to keep your coverage under this group-sponsored plan
- If you stop your payments, you may be disenrolled from this plan

One drug plan at a time.

This plan includes prescription drug coverage. You can only have prescription drug coverage under one plan. If you enroll in another stand-alone Medicare Part D plan or a medical plan that includes prescription drug coverage, you may be disenrolled from this plan.

Remember: If you drop your group-sponsored retiree health coverage, you may not be able to re-enroll. Limitations and restrictions vary by plan sponsor.

Plan basics

Your plan sponsor has selected the UnitedHealthcare® MedicareRx for Groups plan for your Medicare Part D prescription drug coverage. Choosing the right prescription drug plan involves looking at the costs, benefits, access to pharmacies, covered prescription drugs and so much more. We want to help you get the most out of your dollar, so you can feel good about your plan.

Here are some of the highlights of your new plan:

Get dedicated service.
We're here for you. Our Customer Service team has been specially trained to know all the ins and outs of your plan.

Commonly used drugs.
The plan's drug list (formulary) includes all of the drugs covered by Medicare Part D in brand or generic form. Your plan may include additional drug coverage beyond what Medicare allows.

Visit our large network of pharmacies.
UnitedHealthcare has over 65,000 national, regional and local chains, as well as thousands of independent neighborhood pharmacies in its network. Using a UnitedHealthcare network pharmacy can help make sure you are getting the lowest cost available through your plan.

Call us if you have any questions.

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

Learn more online at **www.UHCRetiree.com**

[1]2015 Internal Report Data

Plan basics

How your prescription drug coverage works.
Your Medicare Part D prescription drug coverage includes thousands of brand name and generic prescription drugs. To check if your drugs are covered, please review your plan's drug list.

	How it works
What pharmacies can I use?	You can choose from over 65,000 pharmacies across the United States including national chain, regional and independent local retail pharmacies.
What will I pay for my prescription drugs?	What you pay will depend on the coverage your plan sponsor has arranged. Your exact cost may depend on what drug cost tier your prescription belongs to. Your cost may also change during the year based on the total cost of the drugs you have taken. To learn more about your coverage, please refer to your Benefit Highlights or your Summary of Benefits.
What is a tier?	Drugs are divided into different cost levels or tiers. In general, the higher the tier, the higher the cost of the drug.
Do I need to keep paying my Part B monthly premium?	Yes. Medicare requires that you continue to pay your Part B monthly premium (to Social Security). If you stop paying your monthly Part B premium, you may be disenrolled from your plan.
Can I have more than one prescription drug plan?	No. Medicare only allows you to have one Medicare prescription drug plan at a time. If you enroll in another Medicare prescription drug plan OR a Medicare Advantage plan that includes prescription drug coverage, you may be disenrolled from this plan.

Plan basics

	How it works
What is IRMAA?	IRMAA stands for the Income-Related Monthly Adjustment Amount. If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain limit, you may pay a Part D income-related monthly adjustment amount (Part D-IRMAA) in addition to your monthly plan premium. This extra amount is paid directly to Social Security, not to your plan. Social Security will contact you if you have to pay Part D-IRMAA, based on your income.
What is a Medicare Part D Late Enrollment Penalty (LEP)?	You may pay a late enrollment penalty if, at any time after you first become eligible for Part D, there's a period of at least 63 days in a row when you didn't have Part D or other creditable prescription drug coverage. Creditable coverage means that the prescription drug coverage you have had is at least as good as or better than what Medicare provides. The late enrollment penalty is an amount added to your monthly Medicare premium which you may have to pay. When you become a member, your plan sponsor will be asked to attest or validate that you have had continuous Part D plan coverage. If your plan sponsor asks for information about your prescription drug coverage history, please respond as quickly as possible to avoid the risk of paying a penalty in error. Once you become a member, more information will be available in your Evidence of Coverage (EOC).

How your prescription drug coverage works

Prescription Drug Coverage

Your drug list covers thousands of brand name and generic prescription drugs. Review the plan drug list to make sure your prescription drugs are covered.

The price you pay for a covered drug will depend on two factors:

1 The drug tier for your drug.

Each covered drug is assigned to a tier. Generally, the lower the tier, the less you pay.

Tier	Cost	Description
Tier 1	Low	Includes most generic prescription drugs.
Tier 2	↕	Includes many common brand name drugs and some higher-cost generic prescription drugs.
Tier 3		Includes non-preferred generic and non-preferred brand name drugs.
Tier 4 (Specialty)	High	Includes unique or very high-cost drugs.

2 Your drug payment stage.

Your plan has different stages of drug coverage. When you fill a prescription, the amount you pay depends on the stage you're in.

Initial Coverage	Coverage Gap (Donut Hole)	Catastrophic Coverage
In this drug payment stage: • You pay a co-pay or co-insurance (percentage of a drug's total cost), the plan pays the rest • You stay in this stage until your **total drug costs** reach $3,310	Your plan provides additional coverage through the gap. • You continue to pay the same co-pay or co-insurance as you did in the initial coverage stage • You stay in this stage until your total **out-of-pocket costs** reach $4,850	After your total **out-of-pocket costs** reach $4,850: • You pay a small co-pay or co-insurance amount • You stay in this stage for the rest of the plan year

Annual deductible: If your plan has a deductible, you pay the total cost of your drugs until you reach the deductible amount set by your plan. Then you move to the initial coverage stage. If you don't have a deductible, your coverage begins in the initial coverage stage.

Total Drug Costs: The amount you pay (or others pay on your behalf) and the plan pays for prescription drugs. This does not include premiums.

Out-of-Pocket Costs: The amount you pay (or others pay on your behalf) for prescription drugs. This does not include premiums, or the amount the group plan or plan sponsor pays for prescription drugs.

Ways to help you save

Find local pharmacies from our nationwide network with ease.
Choose from more than 65,000 national, regional and local chains, as well as thousands of independent neighborhood pharmacies. Your pharmacist and UnitedHealthcare work with you to make sure you're taking the right prescriptions at the right times.

Pharmacy Saver.™ Save on the cost of generic prescription drugs. Many, but not all, of the pharmacies in UnitedHealthcare's national pharmacy network participate in a special program that could help you save more on your prescription drugs. This program is called the Pharmacy Saver™ program.[1] With the Pharmacy Saver program, you can fill your prescriptions for as low as $1.50 at participating pharmacies located in grocery, discount and drug stores where you already shop.

Best of all, Pharmacy Saver is easy. No additional enrollment is necessary. Simply take your qualifying prescription to a participating pharmacy, show your UnitedHealthcare member ID card, and they can help you switch.

Here are just some of the national and local retailers with pharmacies that participate in the Pharmacy Saver program:

Note: Other pharmacies are available in our network. Members may use any pharmacy in the network, but may not receive Pharmacy Saver pricing. Pharmacies participating in the Pharmacy Saver program may not be available in all areas.

[1] Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, co-pay amounts may be higher.

To see a listing of drugs available through Pharmacy Saver or to find a participating pharmacy, visit **UnitedPharmacySaver.com**.

More ways that could help you save

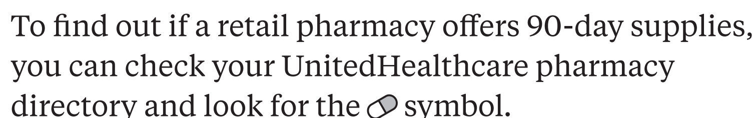
You could save money on prescription drugs with exclusive member pricing at pharmacies in your local grocery, drug and discount stores.

You could save on the medications you take regularly.

If you prefer the convenience of mail order, you could save time and money on your maintenance medications with our mail service pharmacy. You will have access to licensed pharmacists and, in addition, you can receive automatic refill reminders with OptumRx Mail Service Pharmacy.

Get a 90-day[1] supply at retail pharmacies.

In addition to your Mail Service Pharmacy, most retail pharmacies offer 90-day supplies for some prescription drugs.



To find out if a retail pharmacy offers 90-day supplies, you can check your UnitedHealthcare pharmacy directory and look for the 💊 symbol.

Ask your doctor about trial supplies.

Before you get a prescription for a one-month supply, ask your doctor about a trial supply. A trial supply allows you to fill a prescription for less than 30 days. This way you can pay a reduced co-pay or co-insurance and make sure the medication works for you before getting a full month supply.

The UnitedHealthcare Savings Promise

UnitedHealthcare is committed to keeping your costs down for prescription drugs. As a member of our Medicare Prescription Drug plans, you have our Savings Promise that you'll get the lowest price available. That low price may be your plan co-pay, the pharmacy's retail price or our contracted price with the pharmacy.

Explore lower cost options.

Each covered drug in your drug list is assigned to a tier. Generally, the lower the tier, the less you pay. If you're taking a higher-tier drug, you may want to talk to your doctor to see if there's a lower-tier drug you could take instead.

Have an annual medication review.

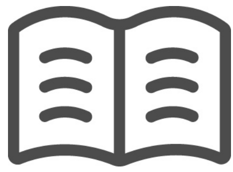
Schedule some time to have an annual medication review with your doctor, to make sure you are only taking the drugs you need.

[1]Your plan sponsor may provide coverage beyond 90 days. Please refer to the Benefit Highlights or Summary of Benefits for more information.

Call Medicare to see if you qualify for Extra Help.

If you have a limited income, you may be able to get Extra Help from Medicare. If you qualify, Medicare could pay up to 75% or more of your drug costs. Many people qualify and don't know it. There's no penalty for applying, and you can re-apply every year.

Toll-Free **1-800-633-4227**, TTY **1-877-486-2048**, 24 hours a day, 7 days a week



2016 Summary of BENEFITS

UnitedHealthcare® MedicareRx℠ for Groups (PDP)

Group Name (plan sponsor): MODESTO IRRIGATION DISTRICT
Group Number: 01500
S5921-802

Y0066_150629_152255

Summary of Benefits

January 1, 2016 - December 31, 2016
This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

Your Medicare Prescription Drug Coverage

This plan is offered through your plan sponsor.

If you choose to enroll in a Medicare Prescription Drug plan or Medicare Advantage plan that is not offered by your plan sponsor, you may lose the option to enroll in a plan offered by your plan sponsor in the future. You could also lose coverage for other plan sponsor retirement benefits you may currently have. Once enrolled in our plan, if you choose to end your membership outside of your plan sponsor's open enrollment period, re-enrollment in any plan your plan sponsor offers may not be permitted, or you may have to wait until their next open enrollment period.

It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree prescription drug coverage options and other benefits before submitting a request to enroll in a plan not offered by your plan sponsor, or a request to end your membership in our plan.

For more information please call UnitedHealthcare® MedicareRx℠ for Groups (PDP) at the number listed below.

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

Sections in this booklet

- Things to Know About UnitedHealthcare® MedicareRx℠ for Groups (PDP)
- Monthly Premium and Deductible
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at **1-877-558-4749**.

Things to Know About UnitedHealthcare® MedicareRx℠ for Groups (PDP)

Hours of Operation

You can call us 8 a.m. to 8 p.m. local time, 7 days a week

UnitedHealthcare® MedicareRx℠ for Groups (PDP) Phone Numbers and Website

- If you are a member of this plan, call toll-free **1-888-556-6648**.
- If you are not a member of this plan, call toll-free **1-877-558-4749**.
- Our website: **www.UHCRetiree.com**

Who can join?

To join UnitedHealthcare® MedicareRx℠ for Groups (PDP), you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, live in our service area, and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor). Available in all counties in all 50 states, the District of Columbia, and all US territories.

Which drugs are covered?

You can learn about the complete plan formulary (list of Part D prescription drugs) and any restrictions by calling us. We can also send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of four "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

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

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

Which pharmacies can I use?

We have a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's pharmacy directory at our website www.UHCRetiree.com. Or, call us and we will send you a copy of the pharmacy directory.

Summary of Benefits

January 1, 2016 - December 31, 2016

Monthly Premium and Deductible

How much is the monthly premium?	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
How much is the deductible?	This plan does not have a deductible.

Prescription Drug Benefits

Initial Coverage

You pay the following until total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Standard Retail Cost-Sharing

Tier	One-month supply
Tier 1 (Preferred Generic)	$10 copay
Tier 2 (Preferred Brand, includes some Generics)	$20 copay
Tier 3 (Non-Preferred Brand, includes some Generics)	$35 copay
Tier 4 (Specialty Tier)	$35 copay

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Preferred Generic)	$20 copay
Tier 2 (Preferred Brand, includes some Generics)	$40 copay
Tier 3 (Non-Preferred Brand, includes some Generics)	$70 copay
Tier 4 (Specialty Tier)	$70 copay

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310.

After you enter the coverage gap, we will continue to pay our share of the cost of your drugs and you pay your share of the cost. You will need to use

	your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you. **Standard Retail Cost-Sharing** (see table below)

Standard Retail Cost-Sharing

Tier	Drugs covered	One-month supply
Tier 1 (Preferred Generic)	All	$10 copay
Tier 2 (Preferred Brand, includes some Generics)	All	$20 copay
Tier 3 (Non-Preferred Brand, includes some Generics)	All	$35 copay
Tier 4 (Specialty Tier)	All	$35 copay

Standard Mail Order Cost-Sharing

Tier	Drugs Covered	Three-month supply
Tier 1 (Preferred Generic)	All	$20 copay
Tier 2 (Preferred Brand, includes some Generics)	All	$40 copay
Tier 3 (Non-Preferred Brand, includes some Generics)	All	$70 copay
Tier 4 (Specialty Tier)	All	$70 copay

Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (including brand drugs treated as generic) and $7.40 copay for all other drugs.
Non-Formulary (drugs not covered under Medicare Part D)	Your Plan Sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see the Additional Drug Coverage list for more information.

Plan INFORMATION

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-558-4749. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-558-4749. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电1-877-558-4749。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電1-877-558-4749。 我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-558-4749. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d’interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d’assurance-médicaments. Pour accéder au service d’interprétation, il vous suffit de nous appeler au 1-877-558-4749. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-558-4749 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-558-4749. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-877-558-4749번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-558-4749. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا.
للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 9474-855-778-1 سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-558-4749 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-558-4749. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

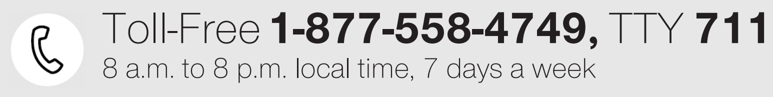
Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-558-4749. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-558-4749. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-558-4749. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-558-4749にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

For more information, please contact Customer Service at:



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

www.UHCRetiree.com

If you are a member of a group sponsored plan (your coverage is provided through a former employer, union group or trust), please call the UnitedHealthcare Customer Service number on the back of your member ID card.

A UnitedHealthcare® Medicare Solution

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

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2016 Required INFORMATION

Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, co-pay amounts may be higher. Other pharmacies are available in our network. Members may use any pharmacy in the network, but may not receive Pharmacy Saver pricing. Pharmacies participating in the Pharmacy Saver program may not be available in all areas.

You are not required to use OptumRx to obtain a 90 or 100-day supply of your maintenance medications. If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-888-279-1828. OptumRx is an affiliate of UnitedHealthcare Insurance Company.

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

Premium and/or co-payments/co-insurance may change each plan year.

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

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

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2016 DRUG LIST

This is an alphabetical partial list of Brand name and Generic drugs covered by the plan.

- **Brand name** drugs appear in **bold** type
- Generic drugs appear in plain type

Each drug is in one of four tiers, which is listed after the drug name.

- Each tier has a co-pay or co-insurance amount
- For a full description of the tiers, see the Summary of Benefits in this book

For more information or for a complete list of covered drugs, please call Customer Service. Our contact information is on the first page of this book.

This list was last updated August 1, 2015.

A

Acamprosate Calcium DR (Tablet Delayed-Release), T3

Acetaminophen/Codeine (Tablet), T1

Acetazolamide (Tablet), T2

Acetazolamide ER (Capsule Extended-Release 12 Hour), T3

Acyclovir (Tablet), T1

Adacel (Injection), T2

Adcirca (Tablet), T4

Advair Diskus (Aerosol Powder), T2

Advair HFA (Aerosol), T2

Aggrenox (Capsule Extended-Release 12 Hour), T3

Albenza (Tablet), T4

Alcohol Prep Pads, T2

Alendronate Sodium (Tablet), T1

Alfuzosin HCl ER (Tablet Extended-Release 24 Hour), T1

Allopurinol (Tablet), T1

Alprazolam (Tablet Immediate-Release), T1

Amantadine HCl (100mg Capsule, 50mg/5ml Syrup, 100mg Tablet), T2

Amiodarone HCl (200mg Tablet), T1

Amitiza (Capsule), T2

Amitriptyline HCl (Tablet), T3

Amlodipine Besylate (Tablet), T1

Amlodipine Besylate/ Benazepril HCl (Capsule), T1

Ammonium Lactate (12% Cream, 12% Lotion), T2

Amoxicillin (250mg Capsule, 500mg Capsule, 500mg Tablet, 875mg Tablet), T1

Amoxicillin/Clavulanate Potassium (Tablet Immediate-Release) (Generic Augmentin), T1

Amphetamine/ Dextroamphetamine (10mg Tablet Immediate-Release, 12.5mg Tablet Immediate-Release, 15mg Tablet Immediate-Release, 20mg Tablet Immediate-Release, 30mg Tablet Immediate-Release, 5mg Tablet Immediate-Release, 7.5mg Tablet Immediate-Release), T2

Amphetamine/ Dextroamphetamine ER (10mg Capsule Extended-Release 24 Hour, 15mg Capsule Extended-Release 24 Hour, 20mg Capsule Extended-Release 24 Hour, 25mg Capsule Extended-Release 24 Hour, 30mg Capsule Extended-Release 24 Hour, 5mg Capsule Extended-Release 24 Hour), T3

Anagrelide HCl (Capsule), T1

Anastrozole (Tablet), T1

Androderm (Patch 24 Hour), T2
Androgel (Packet), Androgel Pump (Gel), T2
Anoro Ellipta (Aerosol Powder), T2
Argatroban (Injection), T4
Atenolol (Tablet), T1
Atenolol/Chlorthalidone (Tablet), T1
Atorvastatin Calcium (Tablet), T1
Atovaquone/Proguanil HCl (Tablet) (Generic Malarone), T2
Atripla (Tablet), T4
Atrovent HFA (Aerosol Solution), T3
Aubagio (Tablet), T4
Avastin (Injection), T4
Avonex (Injection), T4
Azathioprine (Tablet), T1
Azelastine HCl (0.05% Ophthalmic Solution), T3
Azelastine HCl (0.1% Nasal Solution), T2
Azelastine HCl (0.15% Nasal Solution), T2
Azilect (Tablet), T2
Azithromycin (100mg/5ml Suspension, 200mg/5ml Suspension, 250mg Tablet, 500mg Tablet, 600mg Tablet), T1
Azopt (Suspension), T2

B

Baclofen (Tablet), T1
Balsalazide Disodium (Capsule), T3
Belsomra (Tablet), T2
Benazepril HCl (Tablet), T1
Benazepril HCl/ Hydrochlorothiazide (Tablet), T1
Benicar (Tablet), T2
Benicar HCT (Tablet), T2
Benlysta (Injection), T4
Benztropine Mesylate (Tablet), T2
Betaseron (Injection), T4
Bethanechol Chloride (Tablet), T1
Bicalutamide (Tablet), T1
Bisoprolol Fumarate (Tablet), T2
Bisoprolol Fumarate/ Hydrochlorothiazide (Tablet), T2
Brimonidine Tartrate (0.15% Ophthalmic Solution), T2
Brimonidine Tartrate (0.2% Ophthalmic Solution), T2
Brintellix (Tablet), T3
Budesonide (3mg Capsule Extended-Release 24 Hour), T4
Bumetanide (Tablet), T1
Buprenorphine HCl (Tablet Sublingual), T3
Bupropion HCl (100mg Tablet Immediate-Release, 75mg Tablet Immediate-Release), Bupropion HCl SR (100mg Tablet Extended-Release 12 Hour, 150mg Tablet Extended-Release 12 Hour, 200mg Tablet Extended-Release 12 Hour), Bupropion HCl XL (150mg Tablet Extended-Release 24 Hour, 300mg Tablet Extended-Release 24 Hour), T1
Buspirone HCl (Tablet), T1
Butrans (Patch Weekly), T2
Bydureon (Injection), T2
Byetta (Injection), T3
Bystolic (Tablet), T2

C

Cabergoline (Tablet), T2
Calcitriol (Capsule), T1
Calcium Acetate (Capsule), T2
Captopril (Tablet), T1
Captopril/Hydrochlorothiazide (Tablet), T1
Carafate (Suspension), T3
Carbaglu (Tablet), T4
Carbamazepine (100mg/5ml Suspension, 200mg Tablet, 100mg Tablet Chewable), Carbamazepine ER (100mg Capsule Extended-Release 12 Hour, 200mg Capsule Extended-Release 12 Hour, 300mg Capsule Extended-Release 12 Hour, 200mg Tablet Extended-Release 12 Hour, 400mg Tablet Extended-Release 12 Hour), T2
Carbidopa (25mg Tablet), T4

Carbidopa/Levodopa (10mg-100mg Tablet Immediate-Release, 25mg-100mg Tablet Immediate-Release, 25mg-250mg Tablet Immediate-Release), Carbidopa/Levodopa ER (25mg-100mg Tablet Extended-Release, 50mg-200mg Tablet Extended-Release), Carbidopa/Levodopa ODT (10mg-100mg Tablet Dispersible, 25mg-100mg Tablet Dispersible, 25mg-250mg Tablet Dispersible), T1

Carboplatin (Injection), T2

Carvedilol (Tablet), T1

Cayston (Inhalation Solution), T4

Cefdinir (300mg Capsule, 125mg/5ml Suspension, 250mg/5ml Suspension), T2

Cefuroxime Axetil (Tablet), T1

Celecoxib (Capsule), T3

Cephalexin (250mg Capsule, 500mg Capsule, 750mg Capsule, 125mg/5ml Suspension, 250mg/5ml Suspension), T1

Chantix (Tablet), T3

Chlorhexidine Gluconate Oral Rinse (Solution), T1

Chlorthalidone (Tablet), T1

Cilostazol (Tablet), T1

Cimetidine (Oral Solution, Tablet), T1

Cinryze (Injection), T4

Ciprodex (Otic Suspension), T2

Ciprofloxacin HCl (Tablet Immediate-Release), T1

Citalopram Hydrobromide (Tablet), T1

Clindamycin HCl (Capsule Immediate-Release, Oral Solution), T1

Clonazepam (Tablet Immediate-Release), T1

Clonazepam ODT (Tablet Dispersible), T3

Clonidine HCl (Tablet Immediate-Release), T1

Clopidogrel (75mg Tablet), T1

Clozapine (Tablet Immediate-Release), T2

Clozapine ODT (Tablet Dispersible), T2

Colchicine (0.6mg Tablet) (Generic Colcrys), T2

Combigan (Ophthalmic Solution), T2

Combivent Respimat (Aerosol Solution), T2

Comtan (Tablet), T3

Copaxone (Injection), T4

Creon (Capsule Delayed-Release), T2

Crestor (Tablet), T2

Cromolyn Sodium (Ophthalmic Solution), T1

Cyclophosphamide (Capsule), T3

Cyproheptadine HCl (4mg Tablet), T3

D

Daliresp (Tablet), T3

Dapsone (Tablet), T2

Desmopressin Acetate (Tablet), T2

Dextroamphetamine Sulfate (Tablet Immediate-Release), Dextroamphetamine Sulfate ER (Capsule Extended-Release), T3

Dextrose 5%/NaCl (Injection), T2

Diazepam (1mg/ml Oral Solution), T1

Diazepam (Tablet Immediate-Release), Diazepam Intensol (5mg/ml Concentrate), T1

Diclofenac Potassium (Tablet), T1

Diclofenac Sodium DR (25mg Tablet Delayed-Release, 50mg Tablet Delayed-Release, 75mg Tablet Delayed-Release), Diclofenac Sodium ER (100mg Tablet Extended-Release 24 Hour), T1

Dicyclomine HCl (10mg Capsule, 20mg Tablet), T1

Digoxin (125mcg Tablet), T3

Digoxin (250mcg Tablet), T3

Dihydroergotamine Mesylate (Injection), T2

Diltiazem HCl (Tablet Immediate-Release), Diltiazem HCl ER (240mg Capsule Extended-Release, 300mg Capsule Extended-Release) (Generic Cardizem CD), (360mg Capsule Extended-Release) (Generic Tiazac), T1

Diphenoxylate/Atropine (Tablet), T3

Disulfiram (Tablet), T2

Divalproex Sodium (125mg Capsule Sprinkle), Divalproex Sodium DR (125mg Tablet Delayed-Release, 250mg Tablet Delayed-Release, 500mg Tablet Delayed-Release), Divalproex Sodium ER (250mg Tablet Extended-Release 24 Hour, 500mg Tablet Extended-Release 24 Hour), T1

Donepezil HCl (10mg Tablet Immediate-Release, 23mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), Donepezil HCl ODT (10mg Tablet Dispersible, 5mg Tablet Dispersible), T1

Dorzolamide HCl/Timolol Maleate (Ophthalmic Solution), T1

Doxazosin Mesylate (Tablet), T1

Doxepin HCl (100mg Capsule, 10mg Capsule, 150mg Capsule, 25mg Capsule, 50mg Capsule, 75mg Capsule, 10mg/ml Concentrate), T3

Doxycycline Hyclate (Capsule Immediate-Release), T1

Dronabinol (10mg Capsule), T4

Dronabinol (2.5mg Capsule, 5mg Capsule), T3

Duloxetine HCl (Capsule Delayed-Release), T2

Durezol (Emulsion), T2

Dymista (Suspension), T3

E

Edarbi (Tablet), T3

Edarbyclor (Tablet), T3

Eliquis (Tablet), T2

Elmiron (Capsule), T3

Enalapril Maleate (Tablet), T1

Enalapril Maleate/ Hydrochlorothiazide (Tablet), T1

Enbrel (Injection), T4

Entacapone (Tablet), T3

Entecavir (Tablet), T4

EpiPen (Injection), T2

Eplerenone (Tablet), T2

Epzicom (Tablet), T4

Equetro (Capsule Extended-Release 12 Hour), T3

Erythromycin (Ophthalmic Ointment), T1

Erythromycin Base (Tablet), T3

Escitalopram Oxalate (Tablet), T1

Estradiol (0.5mg Tablet, 1mg Tablet, 2mg Tablet) (Generic Estrace), T3

Eszopiclone (Tablet), T3

Ethambutol HCl (Tablet), T2

Ethosuximide (250mg Capsule, 250mg/5ml Oral Solution), T2

Etoposide (Injection), T2

Exjade (Tablet Soluble), T4

F

Famotidine (Tablet), T1

Fareston (Tablet), T4

Farxiga (Tablet), T3

Fenofibrate (145mg Tablet, 48mg Tablet) (Generic Tricor), (160mg Tablet, 54mg Tablet) (Generic Lofibra), T1

Fentanyl (Patch 72 Hour), T3

Finasteride (5mg Tablet) (Generic Proscar), T1

Firazyr (Injection), T4

Flecainide Acetate (Tablet), T1

Flovent Diskus (Aerosol Powder), T2

Flovent HFA (Aerosol), T2

Fluconazole (Tablet), T1

Fluocinolone Acetonide (Otic Oil), T3

Fluphenazine HCl (Tablet), T1

Fluticasone Propionate (Suspension), T1

Furosemide (Tablet), T1

Fuzeon (Injection), T4

G

Gabapentin (100mg Capsule, 300mg Capsule, 400mg Capsule, 600mg Tablet, 800mg Tablet), T1

Gammagard Liquid (Injection), T4

Gemfibrozil (Tablet), T1

Gentamicin Sulfate (0.1% Cream, 0.1% Ointment, 0.3% Ophthalmic Ointment, 0.3% Ophthalmic Solution), T1

Gilenya (Capsule), T4

Gleevec (Tablet), T4

Glimepiride (Tablet), T1

Glipizide (10mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), Glipizide ER (10mg Tablet Extended-Release 24 Hour, 2.5mg Tablet Extended-Release 24 Hour, 5mg Tablet Extended-Release 24 Hour), T1

Glipizide/Metformin HCl (Tablet), T1

Bold type = Brand name drug Plain type = Generic drug

Glucagen Hypokit (Injection), T3

Glucagon Emergency Kit (Injection), T2

H

Haloperidol (Tablet), T1

Harvoni (Tablet), T4

Humalog Kwikpen (100unit/ml Injection), Humalog Mix 50/50 Kwikpen, Humalog Mix 75/25 Kwikpen, Humalog Mix 50/50 Vial, Humalog Mix 75/25 Vial, Humalog Vial (Injection), T2

Humira (Injection), T4

Humulin 70/30 Kwikpen, Humulin N Kwikpen, Humulin 70/30 Vial, Humulin N Vial, Humulin R Vial (Injection), Humulin R U-500 Vial (Concentrated Injection), T2

Hydralazine HCl (Tablet), T1

Hydrochlorothiazide (12.5mg Capsule, 12.5mg Tablet, 25mg Tablet, 50mg Tablet), T1

Hydrocodone/Acetaminophen (10mg-325mg Tablet, 2.5mg-325mg Tablet, 5mg-325mg Tablet, 7.5mg-325mg Tablet), T2

Hydromorphone HCl (Tablet Immediate-Release), T1

Hydroxychloroquine Sulfate (Tablet), T1

Hydroxyurea (Capsule), T1

Hydroxyzine HCl (10mg/5ml Oral Solution), T3

I

Ibandronate Sodium (Tablet), T2

Ibuprofen (100mg/5ml Suspension, 400mg Tablet, 600mg Tablet, 800mg Tablet), T1

Ilevro (Suspension), T2

Imiquimod (Cream), T3

Insulin Syringes, Needles, T2

Intelence (100mg Tablet, 200mg Tablet), T4

Invanz (Injection), T3

Invokamet (Tablet), T2

Invokana (Tablet), T2

Ipratropium Bromide (0.02% Inhalation Solution), T1

Ipratropium Bromide (0.03% Nasal Solution, 0.06% Nasal Solution), T1

Ipratropium Bromide/Albuterol Sulfate (Inhalation Solution), T1

Irbesartan (Tablet), T1

Irbesartan/Hydrochlorothiazide (Tablet), T1

Isentress (Tablet), T4

Isoniazid (Tablet), T2

Isosorbide Dinitrate (10mg Tablet Immediate-Release, 20mg Tablet Immediate-Release, 30mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), Isosorbide Dinitrate ER (40mg Tablet Extended-Release), T1

Isosorbide Mononitrate (10mg Tablet Immediate-Release, 20mg Tablet Immediate-Release), Isosorbide Mononitrate ER (120mg Tablet Extended-Release 24 Hour, 30mg Tablet Extended-Release 24 Hour, 60mg Tablet Extended-Release 24 Hour), T1

Ivermectin (Tablet), T2

J

Janumet (50mg-1000mg Tablet Immediate-Release, 50mg-500mg Tablet Immediate-Release), Janumet XR (100mg-1000mg Tablet Extended-Release 24 Hour, 50mg-1000mg Tablet Extended-Release 24 Hour, 50mg-500mg Tablet Extended-Release 24 Hour), T2

Januvia (Tablet), T2

Jardiance (Tablet), T2

Jentadueto (Tablet), T3

K

Kalydeco (Packet), T4

Kazano (Tablet), T3

Ketoconazole (2% Cream, 2% Shampoo, 200mg Tablet), T1

Ketorolac Tromethamine (Ophthalmic Solution), T2

Kionex (Powder), T2

Klor-Con 8 (Tablet Extended-Release), Klor-Con 10 (Tablet Extended-Release), T2

Klor-Con M20 (Tablet Extended-Release), T1

Kombiglyze XR (Tablet Extended-Release 24 Hour), T2
Korlym (Tablet), T4

L

Labetalol HCl (Tablet), T1
Lactulose (Oral Solution), T1
Lamivudine (Tablet), T2
Lamotrigine (Tablet Immediate-Release), T1
Lamotrigine ODT (Tablet Dispersible), T3
Lantus Solostar (Injection), Lantus Vial (Injection), T2
Lastacaft (Ophthalmic Solution), T2
Latanoprost (Ophthalmic Solution), T1
Latuda (Tablet), T4
Leflunomide (Tablet), T1
Letrozole (Tablet), T1
Leucovorin Calcium (Tablet), T2
Leukeran (Tablet), T2
Levemir FlexTouch (Injection), Levemir Vial (Injection), T2
Levetiracetam (Tablet Immediate-Release), T1
Levocarnitine (Tablet), T2
Levocetirizine Dihydrochloride (Tablet), T1
Levofloxacin (Tablet), T1
Levothyroxine Sodium (Tablet), T1
Lialda (Tablet Delayed-Release), T2
Lidocaine (Gel, Ointment, 2% Viscous Solution), T2
Lidocaine/Prilocaine (Cream), T2
Lindane (1% Lotion, 1% Shampoo), T3
Linzess (Capsule), T2
Liothyronine Sodium (Tablet), T1
Lisinopril (Tablet), T1
Lisinopril/Hydrochlorothiazide (Tablet), T1
Lithium Carbonate (150mg Capsule Immediate-Release, 300mg Capsule Immediate-Release, 600mg Capsule Immediate-Release, 300mg Tablet Immediate-Release), Lithium Carbonate ER (300mg Tablet Extended-Release, 450mg Tablet Extended-Release), T1
Loperamide HCl (Capsule), T1
Lorazepam (0.5mg Tablet Immediate-Release, 1mg Tablet Immediate-Release, 2mg Tablet Immediate-Release), Lorazepam Intensol (2mg/ml Concentrate), T1
Losartan Potassium (Tablet), T1
Losartan Potassium/Hydrochlorothiazide (Tablet), T1
Lotemax (0.5% Gel, 0.5% Ointment, 0.5% Suspension), T3
Lovastatin (Tablet), T1
Lumigan (Ophthalmic Solution), T2
Lupron Depot (Injection), Lupron Depot-PED (Injection), T4
Lyrica (Capsule), T2
Lysodren (Tablet), T4

M

Medroxyprogesterone Acetate (Tablet), T1
Meloxicam (Tablet), T1
Mercaptopurine (Tablet), T2
Meropenem (Injection), T2
Metformin HCl (1000mg Tablet Immediate-Release, 500mg Tablet Immediate-Release, 850mg Tablet Immediate-Release), Metformin HCl ER (500mg Tablet Extended-Release 24 Hour, 750mg Tablet Extended-Release 24 Hour) (Generic Glucophage XR), Metformin HCl ER (1000mg Tablet Extended-Release 24 Hour) (Generic Fortamet), T1
Methadone HCl (10mg/5ml Oral Solution, 5mg/5ml Oral Solution, 10mg Tablet, 5mg Tablet), T2
Methimazole (Tablet), T1
Methotrexate (Tablet), T1
Methscopolamine Bromide (Tablet), T3
Methyldopa (Tablet), T3
Methylphenidate HCl (Tablet Immediate-Release) (Generic Ritalin), T2
Methylprednisolone Dose Pack (Tablet), T1
Metoclopramide HCl (Tablet), T1
Metolazone (Tablet), T2
Metoprolol Succinate ER (Tablet Extended-Release 24 Hour), T1
Metoprolol Tartrate (Tablet Immediate-Release), T1
Metronidazole (Tablet Immediate-Release), T2
Midodrine HCl (Tablet), T2

Migergot (Suppository), T2
Minocycline HCl (Capsule Immediate-Release), T1
Minoxidil (Tablet), T1
Mirtazapine (15mg Tablet Immediate-Release, 30mg Tablet Immediate-Release, 45mg Tablet Immediate-Release, 7.5mg Tablet Immediate-Release), Mirtazapine ODT (15mg Tablet Dispersible, 30mg Tablet Dispersible, 45mg Tablet Dispersible), T1
Modafinil (Tablet), T3
Montelukast Sodium (4mg Packet, 10mg Tablet, 4mg Tablet Chewable, 5mg Tablet Chewable), T1
Morphine Sulfate ER (Tablet Extended-Release) (Generic MS Contin), T2
Multaq (Tablet), T2
Mupirocin (Ointment), T1
Myrbetriq (Tablet Extended-Release 24 Hour), T2

N

Naltrexone HCl (Tablet), T2
Namenda (10mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), T3
Namenda (10mg/5ml Oral Solution), Namenda XR (Capsule Extended-Release 24 Hour), T2
Naproxen (Tablet Immediate-Release), T1
Nasonex (Suspension), T3
Neomycin/Polymyxin/Hydrocortisone (Otic Solution, Otic Suspension), T2
Nesina (Tablet), T3
Nevanac (Suspension), T2
Niacin ER (Tablet Extended-Release), T2
Nicotrol Inhaler, T3
Nitrofurantoin Macrocrystals (50mg Capsule) (Generic Macrodantin), T3
Nitrofurantoin Monohydrate (100mg Capsule) (Generic Macrobid), T3
Nitrostat (Tablet Sublingual), T2
Norethindrone Acetate (Tablet), T1
Nortriptyline HCl (10mg Capsule, 25mg Capsule, 50mg Capsule, 75mg Capsule, 10mg/5ml Oral Solution), T1
Norvir (100mg Capsule, 80mg/ml Oral Solution, 100mg Tablet), T3
Nuedexta (Capsule), T3
Nutropin AQ (Injection), T4
Nuvigil (Tablet), T3
Nystatin (Cream, Ointment, Oral Suspension, Topical Powder), T1
Nystop (Powder), T1

O

Olanzapine (Tablet Immediate-Release), T1
Omega-3-Acid Ethyl Esters (Capsule) (Generic Lovaza), T3
Omeprazole (10mg Capsule Delayed-Release, 40mg Capsule Delayed-Release), T1
Omeprazole (20mg Capsule Delayed-Release), T1
Ondansetron (24mg Tablet Immediate-Release, 4mg Tablet Immediate-Release, 8mg Tablet Immediate-Release), Ondansetron ODT (4mg Tablet Dispersible, 8mg Tablet Dispersible), T1
Onglyza (Tablet), T2
Opana ER (Crush Resistant) (Tablet Extended-Release 12 Hour Abuse-Deterrent), T2
Opsumit (Tablet), T4
Orenitram (0.125mg Tablet Extended-Release), T3
Orenitram (0.25mg Tablet Extended-Release, 1mg Tablet Extended-Release), T4
Orenitram (2.5mg Tablet Extended-Release), T4
Oseni (Tablet), T3
Oxcarbazepine (Tablet), T2
Oxybutynin Chloride (5mg/5ml Syrup, 5mg Tablet), T1
Oxybutynin Chloride ER (Tablet Extended-Release 24 Hour), T2
Oxycodone HCl (Tablet Immediate-Release), T1
Oxycodone/Acetaminophen (10mg-325mg Tablet, 2.5mg-325mg Tablet, 5mg-325mg Tablet, 7.5mg-325mg Tablet), T2

P

Pantoprazole Sodium (Tablet Delayed-Release), T1
Pataday (Ophthalmic Solution), T2
Pegasys (Injection), T4
Penicillin V Potassium (Tablet), T1

T1 = Tier 1   T2 = Tier 2   T3 = Tier 3   T4 = Tier 4

Perforomist (Nebulized Solution), T3
Periogard (Solution), T1
Permethrin (Cream), T2
Phenytoin Sodium Extended (Capsule), T1
Pilocarpine HCl (Tablet), T2
Pioglitazone HCl (Tablet), T1
Pioglitazone HCl/Glimepiride (Tablet), T1
Pioglitazone HCl/Metformin HCl (Tablet), T1
Polyethylene Glycol 3350 (Powder) (Generic Miralax), T1
Pomalyst (Capsule), T4
Potassium Chloride ER (10meq Capsule Extended-Release, 8meq Capsule Extended-Release, 8meq Tablet Extended-Release), T2
Potassium Chloride ER (10meq Tablet Extended-Release, 20meq Tablet Extended-Release), T1
Potassium Citrate ER (Tablet Extended-Release), T2
Potiga (Tablet), T4
Pradaxa (Capsule), T2
Pramipexole Dihydrochloride (Tablet Immediate-Release), T2
Pravastatin Sodium (Tablet), T1
Prazosin HCl (Capsule), T1
Prednisolone Acetate (Suspension), T2
Prednisone (5mg/5ml Oral Solution, 10mg Tablet, 1mg Tablet, 2.5mg Tablet, 20mg Tablet, 50mg Tablet, 5mg Tablet), Prednisone Intensol (5mg/ml Concentrate), T1
Premarin (Vaginal Cream), T2
Prezista (100mg/ml Suspension, 150mg Tablet, 600mg Tablet, 800mg Tablet), T4
Pristiq (Tablet Extended-Release 24 Hour), T3
ProAir HFA (Aerosol Solution), ProAir RespiClick (Aerosol Powder), T2
Procrit (10000unit/ml Injection, 2000unit/ml Injection, 3000unit/ml Injection, 4000unit/ml Injection), T3
Procrit (20000unit/ml Injection, 40000unit/ml Injection), T4
Proctosol HC (Cream), T1
Proctozone-HC (Cream), T1
Progesterone (Capsule), T1
Prolensa (Ophthalmic Solution), T3
Promethazine HCl (12.5mg Tablet, 25mg Tablet, 50mg Tablet), T3
Propranolol HCl (10mg Tablet Immediate-Release, 20mg Tablet Immediate-Release, 40mg Tablet Immediate-Release, 60mg Tablet Immediate-Release, 80mg Tablet Immediate-Release), Propranolol HCl ER (120mg Capsule Extended-Release 24 Hour, 160mg Capsule Extended-Release 24 Hour, 60mg Capsule Extended-Release 24 Hour, 80mg Capsule Extended-Release 24 Hour), T1
Propylthiouracil (Tablet), T1
Pulmicort Flexhaler (Aerosol Powder), T3
Pyridostigmine Bromide (Tablet), T1

Q

Quetiapine Fumarate (Tablet Immediate-Release), T1
Quinapril HCl (Tablet), T1
Quinapril/Hydrochlorothiazide (Tablet), T1

R

Raloxifene HCl (Tablet), T2
Ramipril (Capsule), T1
Ranexa (Tablet Extended-Release 12 Hour), T2
Ranitidine HCl (Tablet), T1
Rapaflo (Capsule), T2
Rebif (Injection), T4
Renagel (Tablet), T2
Renvela (800mg Tablet), T2
Restasis (Emulsion), T2
Revlimid (Capsule), T4
Reyataz (150mg Capsule, 200mg Capsule, 300mg Capsule, 50mg Packet), T4
Ribavirin (200mg Capsule), T2
Ribavirin (200mg Tablet), T3
Rifabutin (Capsule), T3
Rifampin (Capsule), T2
Riluzole (Tablet), T2
Rimantadine HCl (Tablet), T2
Risperidone (Tablet), T1
Rituxan (Injection), T4
Rivastigmine Tartrate (Capsule Immediate-Release), T2
Rizatriptan Benzoate (10mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), T2

Rizatriptan Benzoate ODT (10mg Tablet Dispersible, 5mg Tablet Dispersible), T3
Ropinirole HCl (Tablet Immediate-Release), T1
Rozerem (Tablet), T3

S

Santyl (Ointment), T3
Saphris (Tablet Sublingual), T3
Savella (Tablet), T2
Selegiline HCl (5mg Capsule, 5mg Tablet), T2
Selzentry (Tablet), T4
Sensipar (30mg Tablet), T2
Sensipar (60mg Tablet, 90mg Tablet), T4
Serevent Diskus (Aerosol Powder), T2
Seroquel XR (Tablet Extended-Release 24 Hour), T2
Sertraline HCl (Tablet), T1
Sildenafil (Tablet), T2
Silver Sulfadiazine (Cream), T2
Simvastatin (Tablet), T1
Sodium Fluoride (Tablet), T1
Sodium Polystyrene Sulfonate (Suspension), T2
Sotalol HCl (Tablet), Sotalol HCl AF (Tablet), T1
Sovaldi (Tablet), T4
Spiriva Handihaler (18mcg Capsule), Spiriva Respimat (2.5mcg/ACT Aerosol Solution), T2
Spironolactone (Tablet), T1
Strattera (Capsule), T3
Suboxone (Film), T3
Sucralfate (Tablet), T1
Sulfamethoxazole/Trimethoprim (Tablet), Sulfamethoxazole/Trimethoprim DS (Tablet), T1
Sulfasalazine (Tablet Immediate-Release), T1
Sulfazine EC (Tablet Delayed-Release), T1
Sumatriptan Succinate (Tablet), T2
Suprax (100mg/5ml Suspension, 200mg/5ml Suspension, 100mg Tablet Chewable, 200mg Tablet Chewable), T2
Suprax (400mg Capsule, 500mg/5ml Suspension), T2
Symbicort (Aerosol), T2
Symlinpen 120 (Injection), T4
Symlinpen 60 (Injection), T3
Synthroid (Tablet), T2

T

Tamiflu (30mg Capsule, 45mg Capsule, 75mg Capsule, 6mg/ml Suspension), T3
Tamoxifen Citrate (Tablet), T1
Tamsulosin HCl (Capsule), T1
Tarceva (Tablet), T4
Targretin (75mg Capsule, 1% Gel), T4
Tasigna (Capsule), T4
Tecfidera (Capsule Delayed-Release), T4
Telmisartan (Tablet), T1
Telmisartan/Hydrochlorothiazide (Tablet), T1
Temazepam (Capsule), T2
Terazosin HCl (Capsule), T1
Terbinafine HCl (Tablet), T1
Testosterone Cypionate (Injection), T2
Theophylline (80mg/15ml Oral Solution), Theophylline CR (100mg Tablet Extended-Release, 200mg Tablet Extended-Release), Theophylline ER (300mg Tablet Extended-Release 12 Hour, 450mg Tablet Extended-Release 12 Hour, 400mg Tablet Extended-Release 24 Hour, 600mg Tablet Extended-Release 24 Hour), T1
Thymoglobulin (Injection), T4
Timolol Maleate (Ophthalmic Solution), T1
Tivicay (Tablet), T4
Tizanidine HCl (Tablet), T1
Tobramycin Sulfate (Ophthalmic Solution), T1
Tobramycin/Dexamethasone (Ophthalmic Suspension), T2
Topiramate (Tablet Immediate-Release), T1
Topotecan HCl (Injection), T4
Torsemide (Tablet), T1
Tracleer (Tablet), T4
Tradjenta (Tablet), T3
Tramadol HCl (Tablet Immediate-Release), T1
Tramadol HCl/Acetaminophen (Tablet), T1
Tranexamic Acid (100mg/ml Injection, 650mg Tablet), T2
Transderm-Scop (Patch 72 Hour), T3
Travatan Z (Ophthalmic Solution), T2
Trazodone HCl (Tablet), T1

T1 = Tier 1 T2 = Tier 2 T3 = Tier 3 T4 = Tier 4

Tretinoin (Capsule), T4
Triamcinolone Acetonide (0.025% Cream, 0.1% Cream, 0.5% Cream, 0.025% Ointment, 0.1% Ointment, 0.5% Ointment), T2
Triamcinolone in Orabase (Paste), T2
Triamterene/ Hydrochlorothiazide (37.5mg-25mg Capsule, 50mg-25mg Capsule, 37.5mg-25mg Tablet, 75mg-50mg Tablet), T1
Tribenzor (Tablet), T2
Trihexyphenidyl HCl (Elixir), T3
Trulicity (Injection), T2
Truvada (Tablet), T4

U

Uloric (Tablet), T2
Ursodiol (300mg Capsule, 250mg Tablet, 500mg Tablet), T3

V

Valacyclovir HCl (Tablet), T2
Valganciclovir (Tablet), T4
Valsartan (Tablet), T1
Valsartan/ Hydrochlorothiazide (Tablet), T1
Verapamil HCl (120mg Tablet Immediate-Release, 40mg Tablet Immediate-Release, 80mg Tablet Immediate-Release), Verapamil HCl ER (120mg Tablet Extended-Release, 180mg Tablet Extended-Release, 240mg Tablet Extended-Release), T1
Versacloz (Suspension), T4
Vesicare (Tablet), T2
Victoza (Injection), T2
Virazole (Inhalation Solution), T4
Viread (40mg/gm Powder, 150mg Tablet, 200mg Tablet, 250mg Tablet, 300mg Tablet), T4
Voltaren (Gel), T3
Vytorin (Tablet), T3
Vyvanse (Capsule), T3

W

Warfarin Sodium (Tablet), T1
Welchol (3.75gm Packet, 625mg Tablet), T2

X

Xarelto (Tablet), T2
Xolair (Injection), T4

Z

Zafirlukast (Tablet), T2
Zenpep (Capsule Delayed-Release), T2
Zetia (Tablet), T2
Zirgan (Gel), T3
Zolpidem Tartrate (Tablet Immediate-Release), T3
Zonisamide (Capsule), T1
Zostavax (Injection), T3
Zytiga (Tablet), T4

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

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Additional
DRUG COVERAGE

Bonus Drug List

Your plan sponsor (employer, union or trust) offers a bonus drug list. The prescription drugs in this list are covered in addition to the drugs in the plan's formulary (drug list).

The cost tier for each prescription drug is shown in the list.

Although you pay the same co-pay or co-insurance for these drugs as shown in your Summary of Benefits and Evidence of Coverage, the amounts you pay for these additional prescription drugs **do not apply to your Medicare Part D out-of-pocket costs**. Payments for these additional prescription drugs (made by you or the plan) are treated differently from payments made for other prescription drugs.

Coverage for the prescription drugs in the bonus drug list is in addition to your Part D drug coverage. Unlike your Part D drug coverage, you are unable to file an appeal or grievance for drugs in the bonus drug list. If you have questions, please contact Customer Service using the information on the cover of this book.

If you get Extra Help from Medicare to pay for your prescription drugs, it will not apply to the drugs in this bonus drug list.

This is not a complete list of the prescription drugs available to you or the restrictions and limitations that may apply through the bonus drug list. For a complete list, please contact Customer Service using the information on the cover of this book.

Drug	Tier	Quantity Limits
Genitourinary agents - drugs to treat bladder, genital and kidney conditions		
Erectile Dysfunction		
Cialis (10mg, 20mg)	3	Maximum of 6 tablets per 30 days
Levitra	3	Maximum of 6 tablets per 30 days
Staxyn	3	Maximum of 6 tablets per 30 days
Stendra	3	Maximum of 6 tablets per 30 days
Viagra	3	Maximum of 6 tablets per 30 days
Nutritional supplements - drugs to treat vitamin & mineral deficiencies		
Cyanocobalamin (Vitamin B12) Injection	1	

Bold type = Brand name drug Plain type = Generic drug

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Drug	Tier	Quantity Limits
Folic Acid (Rx only)	1	
Mephyton	3	
Multiple Vitamin Injection	1	
Phytonadione Injection	1	

Bold type = Brand name drug Plain type = Generic drug

A UnitedHealthcare® Medicare Solution

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, co-payments, and restrictions may apply.

Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change from time to time during each plan year. You will receive notice when necessary.

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

NOTES

What's NEXT

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Here's what you can expect next

1 **UnitedHealthcare® will process your enrollment.**
And if there are any questions or we need additional information, we will be in touch.

2 **You will receive your member ID card.**
You will want to put this in your wallet to start using it as soon as your plan is effective. You may not need to use your red, white and blue Medicare card very often so be sure to put that somewhere safe.

3 **Review your Welcome Guide.**
Once you're enrolled in the plan, you will receive a Welcome Guide that gives you more information on how your benefits work and how to get the most out of your plan.

4 **Start using your plan on your effective date.**
And remember to use your member ID card.

5 **After your effective date, register online at the website listed below.**
Get easy, convenient access to all your plan information.

Give us a call if you have any questions.

We are always ready to help you but it may save time if you have some information handy when you call. Be sure to let the Customer Service representative know that you are calling about a group-sponsored plan. In addition, it is helpful to have:

- Your group number on the front of this book
- Medicare claim number and Medicare effective date — you can find this on your red, white and blue Medicare card
- Name of your pharmacy
- List of current prescription drugs and dosages

Give us a call if you have any questions.

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

Learn more online at **www.UHCRetiree.com**

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

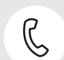
Enrollment INSTRUCTIONS

UnitedHealthcare® MedicareRx for Groups (PDP) is a Prescription Drug plan. UnitedHealthcare® RxSupplement™ is an Outpatient Prescription Drug Plan that works together with your Prescription Drug plan.

Please complete BOTH the Enrollment Request Forms on the next page using the instructions provided below. You can also enroll right over the phone by giving us a call at the number listed below.

Plan Information	Please confirm the Plan Sponsor and Group Number match what is listed on the front cover of this booklet. If the information is incorrect or missing, please provide the correct information.
	Include the date you expect your coverage to begin.
Applicant Information	You must complete a separate form for each person enrolling in this Prescription Drug plan.
	Please write your name exactly as it appears on your red, white and blue Medicare card. This is how it will appear on your member ID card.
	Attach a copy of your Original Medicare card or your Letter of Verification from Social Security or the Railroad Retirement Board, if possible.
Sign and Date BOTH Enrollment Request Forms	In order to process this form, **you must sign the form where indicated**.
	If someone helped you complete this form, that person must also sign this form and indicate his/her relationship to you. If you are receiving assistance from a sales agent, broker, or other individual employed by or contracted with our plan, he/she may be paid a commission based on your enrollment in the plan.
	If your authorized representative helped you complete this form, he/she must sign the form and submit a copy of the court order or Durable Power of Attorney that allows them to act on your behalf, if requested by the plan.
Return BOTH Enrollment Request Forms	Return the completed form in the enclosed envelope and send to: UnitedHealthcare P.O. Box 29200 Hot Springs, AR 71903-9200
	Incomplete information may delay your enrollment.

Questions? Call Customer Service:



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

Learn more online at **www.UHCRetiree.com**

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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.

NOTES

ENROLLMENT REQUEST FORM

To enroll in the UnitedHealthcare® MedicareRx for Groups (PDP) plan, please provide the following:

1. Plan information:
Plan Sponsor Name MODESTO IRRIGATION DISTRICT
GPS Employer ID 1500
GPS Branch Number 001

I prefer to receive materials in the following language: ☐ Spanish ☐ Chinese (Spoken ☐ Cantonese ☐ Mandarin) ☐ Other ______________________ Please contact us at **1-877-558-4749**, TTY **711**, 8 a.m. – 8 p.m. local time, 7 days a week if you need information in another format such as large print.	Plan Sponsor use ONLY: Please date stamp this document to indicate when you received the completed and signed form. **Effective Date Requested:** ____ /____ /____ (i.e., your proposed effective date, or on what day your coverage should begin)

2. Applicant information – as it appears on your Medicare card: [(Please print in black or blue ink.)]

☐ Mr. ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Initial

Birth Date ____ /____ /____	Sex ☐ Male ☐ Female	Home Telephone Number ( ) –

Permanent Residence Street Address (P.O. box not allowed)			
City	State	ZIP	County

Mailing Address (only if different from your Permanent Street Address) (P.O. box allowed for mailing only)		
City	State	ZIP

Email Address	
Emergency Contact	
Contact Telephone Number ( ) –	Contact Relationship to You
In the future, would you be willing to receive materials through electronic means? ☐ Yes ☐ No	

3. Please provide your Medicare insurance information:

Use your red, white and blue Medicare card to complete this section — or — attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. You must have Medicare Part A or Part B (or both) to join a Medicare Prescription Drug plan. An incorrect or incomplete Medicare Claim Number may cause a delay or denial of coverage.	Medicare Claim Number Part A (Hospital) Effective Date ____ /____ /____ Part B (Medical) Effective Date ____ /____ /____

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Last Name First Name Medicare Claim Number

4. Please answer the following questions:

Some individuals may have other drug coverage including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits or State Pharmaceutical Assistance programs.

Will you have other **prescription drug coverage** in addition to our plan? ☐ Yes ☐ No

If **"yes,"** please list your other coverage and your identification (ID) number(s) for this coverage:

Name of Other Coverage ______________________________

ID Number for Coverage ______________ Group Number for Coverage ______________

Do you, on your own or through your spouse, have any additional primary, supplemental or liability plan other than Medicare that includes prescription drug coverage? ☐ Yes ☐ No

Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If **"yes,"** Name of Institution ______________________________

Address of Institution ______________________________

City ______________________________

State ______________________________

ZIP ______________________________

Telephone Number of Institution ( ) –

5. Please read this important information:

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a Late Enrollment Penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage through your Medicare Advantage plan that will meet your needs. By joining UnitedHealthcare® MedicareRx for Groups (PDP), your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan and your plan Sponsor send you, and if you have questions, contact your Medicare Advantage plan or your plan Sponsor.

UnitedHealthcare MedicareRx for Groups is a Medicare Prescription Drug plan available through your plan Sponsor. If you enroll in an individual Prescription Drug plan in the future, you could lose your group sponsored coverage and you may not be able to re-enroll. Before you decide to change your coverage, ask your plan Sponsor about your options.

6. ATTENTION – Please sign and date:

Release of Information: The information on this Enrollment Request Form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the state law where I live) means that I have read and understand the contents of this Enrollment Request Form, including the Statements of Understanding.
You must sign and date this Enrollment Request Form in order for it to be processed.

Applicant Signature (or signature of authorized representative, please complete box below)	**Today's Date** ____ /____ /____

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Last Name First Name Medicare Claim Number

7. Authorized representative information:

If you are the authorized representative of the applicant, you must provide the following information and sign below.

If signed by an authorized representative of the applicant, this signature certifies that:

(1) this person is authorized under State law to complete this enrollment and
(2) documentation of this authority is available upon request by Medicare.

Last Name	First Name	
Address		
City	State	ZIP
Telephone Number ( ) –	**Relationship to Applicant**	
Signature	**Today's Date** ____ /____ /____	

8. If someone assisted you in completing this form, please have that person complete the information below:

Signature (of individual who assisted in completing this form)	**Today's Date** ____ /____ /____
☐ Plan Representative, check here if you signed above and assisted in completing this form.	Relationship to Applicant

9. UnitedHealthcare MedicareRx for Groups use only:

Plan ID Number	
Effective Coverage Date ____ /____ /____	IEP ____________ AEP ____________ SEP (type) ____________
GPS Employer ID Number	GPS Branch Number
Licensed Sales Representative Signature	
Print Name	
Agent ID Number	Telephone Number ( ) –

10. Employer use only:

☐ Enrollee is Eligible for Retiree Coverage	Effective Date ____ /____ /____	Initials

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

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Statements of Understanding

By electing enrollment in this plan, I agree to the following:

UnitedHealthcare® MedicareRx for Groups (PDP) is a Medicare Prescription Drug plan and has a contract with the Federal government. This prescription drug coverage is in addition to my coverage under Medicare. I need to keep my Medicare Part A or Part B, and I must continue to pay my Medicare Part B premium. I can only be in one Prescription Drug Plan at a time. By enrolling in this Plan, I will automatically be disenrolled from any other prescription drug plan of which I may be a member. If I have prescription drug coverage, or if I get prescription drug coverage, from somewhere other than this plan, I will inform you. I may have to pay a late enrollment penalty for Medicare's prescription drug coverage. This would only apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I have a late enrollment penalty from Medicare, I will receive a letter making me aware of the penalty and what the next steps are.

Enrollment in this plan is generally for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.

UnitedHealthcare MedicareRx for Groups is available in all states, the District of Columbia, and the territories.

I understand that I must use network pharmacies except in an emergency when I cannot reasonably use the plan's network pharmacies. Once I am a member of UnitedHealthcare MedicareRx for Groups, I have the right to appeal plan decisions about payment or services if I disagree.

Upon enrollment, I will receive a Welcome Guide that includes an Evidence of Coverage document. The Evidence of Coverage will have more information about the drug coverage offered by the plan, as well as the terms and conditions.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

My information, including my prescription drug event data, will be released to Medicare and other plans, only as necessary, for treatment, payment and healthcare operations. Medicare may also release my information for research and other purposes which follow all applicable Federal statutes and regulations.

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NOTES

Underwritten by
UnitedHealthcare Insurance Company

Required Information

Employer/Former Employer Name: MODESTO IRRIGATION DISTRICT	
Employer ID #: 1500	Employer Subsidy Group #: 1500
Employer Billing #: 001	

Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

Please complete the entire form ▪ Incomplete information can delay the enrollment process
(Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

Date of Retiree's Retirement ____ / ____ / ____ (mm / dd / yyyy)	Source of Enrollment ☐ Open Enrollment ☐ Newly Eligible ☐ Special Enrollment

1. Personal Information

Applicant Last Name	Applicant First Name	MI	Suffix

☐ Male ☐ Female	Date of Birth ____ / ____ / ____ (mm / dd / yyyy)	Marital Status of Applicant: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Name of Retiree	Relation to Retiree: ☐ Self ☐ Spouse ☐ Child

Medicare Claim #	Part A Effective Date ____ / ____ / ____ (mm / dd / yyyy)	Part B Effective Date ____ / ____ / ____ (mm / dd / yyyy)	Part D Effective Date ____ / ____ / ____ (mm / dd / yyyy)

Permanent Residence Street Address (P.O. Box is not allowed)	City	State	Zip

Home Telephone # ( )	Alternate Telephone # ( )	E-mail Address

In the future, would you be willing to receive materials through electronic means? ☐ Yes ☐ No

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.

Institution Name	Date of Admission ____ / ____ / ____ (mm / dd / yyyy)	Telephone # ( )	
Address	City	State	Zip
Doctor's Name	Doctor's Telephone # ( )		

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Applicant Last Name	Applicant First Name	MI	Medicare Claim #

2. Benefit Coordination / Other Insurance Carrier Information

1. Do you have other health insurance? ☐ Yes ☐ No If Yes, complete Section 1a. – 1e. below.

2. Are you permanently disabled? ☐ Yes ☐ No If Yes, complete the following:

   2a. Date disability began: ____ / ____ / ____ (mm / dd / yyyy)

3. Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

If you have special needs, this document may be available in other formats or languages upon request. Please contact us at **1-877-558-4749,** TTY users should call **711**. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week.

Do you work or plan to work? ☐ Yes ☐ No

1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date	1e. Other Employer Name and Address
			____/____/____ mm dd yyyy	
			____/____/____ mm dd yyyy	

FOR OFFICE USE ONLY	FOR EMPLOYER USE ONLY
RETIREE ☐ YES ☐ NO GROUP # ____________ PLAN CODE ____________ SPOUSE OR CHILD ☐ YES ☐ NO VERIFICATION: ________ (Initial) DATE ______/______/______	☐ Enrollee is eligible for retiree coverage Effective Date: ______/______/______ ________ Initial

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TEAR HERE

Applicant Last Name | Applicant First Name | MI | Medicare Claim #

3. Terms and Conditions

I am requesting enrollment under the UnitedHealthcare Insurance Company ("UnitedHealthcare") Group Retiree Policy. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.
2. UnitedHealthcare or its designee shall have access and use of my medical records for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
3. Any material omission or intentional misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my coverage.
4. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).
5. My current prescription drug coverage under Part D is provided by a UnitedHealthcare plan. I understand that if my coverage under the Part D plan ends, this coverage will also end.
6. All statements and descriptions in this enrollment form are deemed to be representations and not warranties.

I certify that I have read the Terms and Conditions printed on this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

Print Name of Applicant:	
Signature of Applicant or Authorized Representative:	Today's Date:

Signature

Authorized Representative Information

If you are the authorized representative (Responsible Party, Power of Attorney, Family Member, etc.), you must sign above and provide the following information:

Name: ______________________ Date: ______________

Address: ______________ City: ______________ State: ____ Zip code: ______

Relationship to Enrollee: ______________________

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NOTES

Give us a call if you have any questions:

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

www.UHCRetiree.com

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