

SERFF Tracking Number: UHLC-126865241 State: Arkansas  
Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 47264  
Company Tracking Number: GRPRETRX-POL-0112  
TOI: H17G Group Health - Prescription Drug Sub-TOI: H17G.000 Health - Prescription Drug  
Product Name: PRESCRIPTION DRUG  
Project Name/Number: RX WRAP/GRPRETRX-POL-0112

## Filing at a Glance

Company: UnitedHealthcare Insurance Company

Product Name: PRESCRIPTION DRUG SERFF Tr Num: UHLC-126865241 State: Arkansas  
TOI: H17G Group Health - Prescription Drug SERFF Status: Closed-Approved- State Tr Num: 47264  
Closed

Sub-TOI: H17G.000 Health - Prescription Drug Co Tr Num: GRPRETRX-POL-0112 State Status: Under Review  
Filing Type: Form Reviewer(s): Stephanie Fowler  
Authors: Wanda Augustus, Judith Davenport, Becky Kieran, Martha Blanke, Gerry McCadden  
Disposition Date: 01/14/2011  
Date Submitted: 11/08/2010 Disposition Status: Approved-Closed  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: RX WRAP Status of Filing in Domicile: Not Filed  
Project Number: GRPRETRX-POL-0112 Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Large  
Group Market Type: Employer Overall Rate Impact:  
Filing Status Changed: 01/14/2011 Deemer Date:  
State Status Changed: 11/23/2010 Submitted By: Gerry McCadden  
Created By: Wanda Augustus  
Corresponding Filing Tracking Number: GRPRETRX-POL-0112

Filing Description:

UnitedHealthcare Insurance Company (UnitedHealthcare), a member of the UnitedHealth Group family of companies, is submitting the enclosed large group outpatient prescription drug policy forms for your review and approval.

This is a group outpatient prescription drug product that UnitedHealthcare intends to offer to large employers in order for them to provide coverage for their eligible retirees. This fully insured product is a state governed commercial "wrap" plan that will augment the coverage that the retiree has under one of our UnitedHealthcare Medicare Part D prescription drug plans. Pursuant to CMS guidance, a significant benefit of the commercial wrap product is its ability to provide

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maximum coverage and benefits in the coverage gap under the Medicare Coverage Gap Discount Program (section 1860D-14A of the Social Security Act) when combined with a basic (no gap coverage) Part D plan. Attached to the Supporting Documentation tab in the SERFF submission is a CMS Memo, dated June 2, 2010, which recognizes the employer group's ability to provide a commercial (non-Part D) wrap-around coverage that supplements a basic Part D benefit package. This policy has been designed to provide that commercial wrap-around coverage.

Coverage under the Certificate will include all eligible retirees under the group's Part D plan, and will be extended to a retiree's eligible dependents who are also covered under the group's UnitedHealthcare Medicare Part D prescription drug plan.

This policy is filed with variable ranges which allow the employer Policyholder to elect various options (i.e. deductibles, copayments, etc.) and create their own custom plan design. The Policyholder also may elect to include drug benefits that are in addition to those that would be covered by Medicare Part D drug plan.

Prescription drugs are obtained through UnitedHealthcare's participating pharmacies which include most major pharmacy and supermarket chains, as well as many independent pharmacies. If a participating pharmacy is not available, drugs may be obtained at a non-participating pharmacy and will be covered under the policy.

These forms have never previously been submitted to your state for UnitedHealthcare.

Thank you very much for your consideration of this filing.

## Company and Contact

### Filing Contact Information

Judith Davenport, Manager  
5995 Plaza Dr.  
Cypress, CA 90630  
judy.davenport@uhc.com  
714-226-3507 [Phone]  
714-226-3238 [FAX]

### Filing Company Information

UnitedHealthcare Insurance Company  
185 Asylum Street  
Hartford, CT 06103  
(860) 702-5000 ext. [Phone]  
CoCode: 79413  
Group Code: 707  
Group Name:  
FEIN Number: 36-2739571  
State of Domicile: Connecticut  
Company Type: Life and Health  
State ID Number:

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## Filing Fees

SERFF Tracking Number: UHLC-126865241 State: Arkansas  
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Fee Required? Yes  
Fee Amount: \$200.00  
Retaliatory? No  
Fee Explanation: \$50.00 X 4 FORMS +\$200.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare Insurance Company	\$200.00	11/08/2010	41656397

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/14/2011	01/14/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	12/09/2010	12/09/2010	Judith Davenport	12/09/2010	12/09/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Review Status	Note To Reviewer	Judith Davenport	01/13/2011	01/13/2011

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## Disposition

Disposition Date: 01/14/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Memorandum from CMS (referenced in Filing Description of "General Information" tab)	Accepted for Informational Purposes	Yes
Supporting Document	Waiver of Deemer	Approved	Yes
Form	POLICY	Approved	Yes
Form	GROUP APPLICATION	Approved	Yes
Form	ENROLLMENT FORM	Approved	Yes
Form	CERTIFICATE	Approved	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 12/09/2010  
Submitted Date 12/09/2010  
Respond By Date 01/10/2011

Dear Judith Davenport,

This will acknowledge receipt of the captioned filing. Please see our attached letter.

Please feel free to contact me if you have questions.

Sincerely,  
Stephanie Fowler

# Arkansas Insurance Department

Mike Beebe  
Governor



Jay Bradford  
Commissioner

December 9, 2010

Ms. Judith Davenport  
Manager  
UnitedHealthcare Insurance Company  
5995 Plaza Dr.  
Cypress, CA 90630

RE: Form GRPRETRX-POL-0112  
Submission Date: November 8, 2010

Dear Ms. Davenport:

Thank you for the form filing which we received in our office on November 8, 2010 .

Pursuant to the provisions of Ark. Code Ann. 23-79-109(b), the period for review of this filing is being automatically extended an additional thirty (30) days until January 8, 2010.

We request that you sign and return this form letter in order to waive all rights to deemer on this filing.

Sincerely,

*Stephanie Fowler*  
Stephanie Fowler  
Compliance Officer  
Life and Health Division

SRF

I, \_\_\_\_\_, representing \_\_\_\_\_, do hereby acknowledge receipt of this letter and waive all rights to deemer on this filing.

\_\_\_\_\_, \_\_\_\_\_  
Dated Signature and Title

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 12/09/2010  
Submitted Date 12/09/2010

Dear Stephanie Fowler,

### Comments:

In regard to your request for us to waive the deemer for review of this filing, we have the following response.

### Response 1

Comments: The signed waiver has been attached to the Supporting Documentation tab.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Waiver of Deemer

Comment: Attached is our waiver of deemer for the review of this filing.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We thank you for your continued attention to this filing.

Sincerely,

Becky Kieran, Gerry McCadden, Judith Davenport, Martha Blanke, Wanda Augustus

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**Note To Reviewer**

**Created By:**

Judith Davenport on 01/13/2011 01:04 PM

**Last Edited By:**

Stephanie Fowler

**Submitted On:**

01/14/2011 01:11 PM

**Subject:**

Filing Review Status

**Comments:**

On 12/9/10 you asked for a review extension to 1/8/11. We're just checking on the status of your review of this filing which was submitted on 11/8/10.

Thank you for your time and attention.

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## Form Schedule

### Lead Form Number: GRPRETRX-POL-0112

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/14/2011	GRPRETR X-POL- 0112	Policy/Cont ract/Fratern al Certificate	POLICY	Initial		47.000	GRPRETRX- POL-0112.pdf
Approved 01/14/2011	GRPRETR X-GRP-NA- AR	Application/ Enrollment Form	GROUP APPLICATION	Initial			GRPRETRX- GRP-NA- AR.pdf
Approved 01/14/2011	GRPRETR X-APP-NA- AR	Application/ Enrollment Form	ENROLLMENT FORM	Initial			GRPRETRX- APP-NA- AR.pdf
Approved 01/14/2011	GRPRETR X-0112-AR	Funding Agreement (Annuity, Individual and Group)	CERTIFICATE	Initial		43.300	GRPRETRX- 0112-AR.pdf

**UNITEDHEALTHCARE INSURANCE COMPANY**  
(the "Company")  
[Hartford, Connecticut]

**GROUP OUTPATIENT [PRESCRIPTION] DRUG INSURANCE POLICY**

UnitedHealthcare Insurance Company (the "Company") will provide the Policy benefits to each Covered Person in consideration and acceptance of the Group Policyholder's application and premium, and subject to all Policy provisions.

The Policy becomes effective on the Policy Effective Date shown on the Policy Information Page and [continues in force until the first anniversary of the Policy Effective Date][continues in force until January 1<sup>st</sup> of the following year], unless it terminates earlier as provided herein. Thereafter, the Policy remains in force for twelve (12) months [beginning on each following anniversary of the Policy Effective Date][beginning each January 1<sup>st</sup>], subject to the Policy Termination section.

The Policy is delivered in and governed by the laws of the State of **Arkansas**.

Signed for by UnitedHealthcare Insurance Company at our Home Office in Hartford, Connecticut.

**UNITEDHEALTHCARE INSURANCE COMPANY**

[Officer's Signature]

[Officer's Name and Title]

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Policy Provisions	Page Number
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## GENERAL PROVISIONS

**CERTIFICATE.** [The Group Policyholder will receive individual Certificates for delivery to each Insured Person.] [The Company will deliver Certificates to each Insured Person.] These Certificates summarize the benefits provided by this 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 the insurance valid for such person. In this event, the Company's only liability is the proper refund of unearned premiums. If a premium adjustment requires the refund of unearned premium, the maximum refund is the six (6)-month period preceding the date the Company receives proof of the adjustment. The Company can request such information while the Policy is in force and for one (1) year after the Policy ends.

**CONFORMITY TO STATE AND FEDERAL LAW.** The Company amends any provision of the Policy that conflicts with state or federal law on the Policy Effective Date to the minimum requirements of the law.

**CONSENT OF COVERED PERSON NOT REQUIRED.** The Policy shall be subject to amendment, modification or termination per Policy Provisions without the consent of Covered Persons.

**DEFINITIONS.** The Certificate provides the definitions of terms used in the Policy.

**ENTIRE CONTRACT.** The Policy, the attached copy of the Certificate, and the Group Application constitute the entire contract between the parties. All statements made by the Group Policyholder and by Insured Persons are representations not warranties. A statement from the Insured Person will only support a contest of the coverage provided by the Policy when the Company provides a copy of the statement to the Insured Person.

Only an officer of the Company may change the Policy or extend the time for payment of any premium. No change will be valid unless made in writing and signed by an officer of the Company. Any change so made will be binding on all persons referred to in the Policy. No agent has the implied or expressed authority to determine insurability, make any contracts in the name of the Company, or cancel, alter or amend any provision of the Policy.

**GROUP POLICYHOLDER NOT OUR AGENT.** The Group Policyholder is not an agent of the Company.

**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.

**MISSTATEMENT OF AGE.** Misstatement of the Covered Person's age will subject premiums to an equitable adjustment. If the amount of benefit is dependent upon age, the benefit will be that which would have been payable based upon the Covered Person's correct age.

**[NON-PARTICIPATING.** The Policy is non-participating and does not share in the Company's profits or surplus earnings.]

**NOT IN LIEU OF WORKERS' COMPENSATION.** The Policy is not instead of, and does not impact any requirement for coverage by Workers' Compensation Insurance.

**RECOVERY RIGHT DUE TO CLERICAL ERROR.** When payments made under the Policy are due to clerical error, the Company has the right to recover any such payment it made in error. The Company has the right to recover from the person an amount equal to the amount paid by the Company.

**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 is specified by the Policy, such commencement of coverage will be effective as of 12:00 a.m. of that date.

**TIME LIMIT ON CERTAIN DEFENSES.** The validity of insurance shall not be contested because of any statement, except fraudulent misstatements, with respect to insurability made by any person, after the insurance has been in force for two (2) years during the Covered Person's lifetime.

**WAIVER OF RIGHTS.** The Company's failure to enforce any provision of the Policy does not affect the Company's 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.

## PREMIUM PROVISIONS

**PAYMENT OF PREMIUMS.** The insurance provided by the Policy is not in effect until the Company accepts the first premium payment for such insurance. Each following premium payment is payable on or before the due date for insurance to remain in effect. [The Group Policyholder is responsible for paying all premiums as they become due.] Premiums are payable on or before the Premium Due Date, unless the Company agrees to some other mode of payment. Premiums are payable to the Company at its Home Office.

**PREMIUM RATE CHANGE.** The Company may change any Premium Rate on any of the following dates:

1. any Policy Anniversary; or
2. the date any of the Policy's terms are changed, including any federal or state law or regulation affecting the Company's liability under the Policy.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least [31-60] days advance written notice of any change in Premium Rates.

Misstatement of the age, family status or geographic location of an Insured Person and/or Dependent will subject premiums to an adjustment.

**GRACE PERIOD.** After the first premium payment, the Company shall allow a Grace Period of [31-60] days following each Premium Due Date. During the Grace Period, coverage under the Policy will remain in effect provided the Company receives the premium before the end of the Grace Period. If any premium is unpaid at the end of the Grace Period, the Policy will terminate in accordance with the Policy Termination section of the Policy.

**PREMIUM AMOUNT.** The amount of premium due is the sum of the products obtained by multiplying each rate shown on the Premium Rate Schedule by the number of persons to which each such rate applies.

## POLICY TERMINATION

**TERMINATION BY THE COMPANY.** The Company may terminate the Policy on any Premium Due Date:

1. for nonpayment of the required premiums;
2. when the Company determines the Group Policyholder has committed fraud or made other intentional misrepresentations; or
3. for noncompliance with a material plan provision, including failure to comply with contribution and participation requirements and failure of the Group Policyholder to perform its obligations under the Policy in good faith.

The Policy may terminate on an earlier date when both the Group Policyholder and the Company agree to such termination.

**TERMINATION BY GROUP POLICYHOLDER.** The Group Policyholder may terminate the Policy at any time by giving notice to the Company. The Policy will terminate on the date the Company receives the notice or some later date on which the Group Policyholder and the Company have agreed. The Group Policyholder is responsible for premium payments through the date of termination.

**AUTOMATIC TERMINATION.** The Policy will terminate, without any action on the part of the Company, on the day before the due date of any premium that remains unpaid at the end of the Grace Period.

**INSURED PERSON NOTIFICATION.** In the event of Policy termination, the Group Policyholder is responsible for written notification to Insured Persons of such termination.

**PROVIDING MISLEADING OR FRAUDULENT INFORMATION.** At its discretion, the Company may terminate or rescind the Policy upon [31-60] days written notice to the Group Policyholder if the Group Policyholder knowingly provides materially misleading or fraudulent information to the Company on any application documents.

## POLICY INFORMATION PAGE

[GROUP POLICYHOLDER:] [Enter Policyholder Name here]

[POLICY NUMBER:] [Enter Policy Number here]

[GROUP NUMBER:] [Enter Group Number here]

[POLICY EFFECTIVE DATE:] [Enter Policy Effective Date here]

[POLICY ANNIVERSARY:] [Enter Anniversary Date here]

[CONTRIBUTIONS:] [Insured Persons make contributions for the following:  
Personal Prescription Drug Insurance Yes  No   
Dependent Prescription Drug Insurance Yes  No

[WAITING PERIOD:] [Enter Waiting Period here]

[ELIGIBILITY:] [Enter Eligibility Information here]

[PREMIUM DUE DATE:] [Enter Premium Due Date here]

[PREMIUM IS PAYABLE:] [Enter Payable Information here]

[BENEFIT PLAN(S):] [Enter Benefit Plans Covered by Policy]

THE MONTHLY PREMIUM RATE SCHEDULE IS ATTACHED TO THIS POLICY INFORMATION PAGE.

# Outpatient Prescription Drug Plan Application for Group Coverage

APPLICATION is hereby made to **UNITEDHEALTHCARE INSURANCE COMPANY** (Herein called "UnitedHealthcare") for group coverage based upon the following statements and representations:

EMPLOYER INFORMATION			
Employer's Legal Name	Tax ID Number		
<input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other			
Employer's Address	City	State	ZIP
Executive Contact	Title		
E-mail Address	Fax (     )	Phone (     )	
Benefits Administrator Contact	Title		
Address (if different)	City	State	ZIP
E-mail Address	Fax (     )	Phone (     )	
Name and address of any affiliated or subsidiary firms whose Employees are to be covered			
Industry/Nature of Business (be specific)	SIC Code	Years in Business	
Is this employer group subject to ERISA regulations? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain why:			
Is this business currently in Chapter 11 or has the business filed for bankruptcy within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Proposed Effective Date:     /     /	Proposed Renewal Date:     /     /	Open Enrollment Period:     /     /	
Group Size: Number of Employees: _____     Number of Employees not eligible for group coverage: _____ Number of Retirees: _____     Number of retirees not eligible for group retiree coverage: _____			
Estimated First Monthly Premium \$ _____ accompanies this Application (if applicable)	Group Policyholder Premium Contribution %: _____		
<input type="checkbox"/> Group Retiree Drug Plan _____ (Note: To be completed by UnitedHealthcare Sales Representative)			
EMPLOYER STATEMENT			
The Employer hereby applies for the insurance coverage indicated and agrees to all of the following:			
a. The Employer represents that all the information on this Application is true and complete, and that UnitedHealthcare may rely on this Application in deciding whether to provide coverage. If the Application is not complete, or if the information provided on the Application is inconsistent with any request for proposal for coverage submitted to UnitedHealthcare, UnitedHealthcare reserves the right to re-rate the premium associated with such coverage, or reject the Application. If this Application is accepted, it becomes part of our Policy with UnitedHealthcare.			
b. Any material misstatement or omission of information on this Application, any request for proposal for coverage, or on any enrollment form will be considered a misrepresentation and may be the basis of later termination or rescission of coverage issued on the basis of the submitted information.			
c. Employer understands and agrees that no coverage will be effective before the date determined by UnitedHealthcare (the "Effective Date") and only if the Employer has paid the first month's premium and this Application has been received and accepted by UnitedHealthcare.			
d. Covered persons are not insured prior to the Effective Date. If proof of insurability is required, insurance is not effective until UnitedHealthcare has approved this proof.			
e. No statement, representation or promise shall have any effect unless contained in a document signed by an officer or Underwriting Manager of UnitedHealthcare, either contained in, or attached to, the Application.			
f. All statements and descriptions in this application form are deemed to be representations and not warranties.			
g. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.			
EMPLOYER			
Officer's Name	Title		
Officer's Signature	Date		
UNITEDHEALTHCARE REPRESENTATIVE			
UnitedHealthcare Representative's Name	Title		
UnitedHealthcare Representative's Signature	Date		

Underwritten by

**UnitedHealthcare Insurance Company**

# **Enrollment** Request Form

**Outpatient Prescription Drug Plan**

**Required Information**

Employer/Former Employer Name:	
Employer ID #:	Employer Subsidy Group #:
Employer Billing #:	

# 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 $\frac{\text{mm}}{\text{mm}} / \frac{\text{dd}}{\text{dd}} / \frac{\text{yyyy}}{\text{yyyy}}$	Source of Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newly Eligible <input type="checkbox"/> Special Enrollment
--	--

## 1. Personal Information

Applicant Last Name		Applicant First Name		MI	Suffix
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth $\frac{\text{mm}}{\text{mm}} / \frac{\text{dd}}{\text{dd}} / \frac{\text{yyyy}}{\text{yyyy}}$	Marital Status of Applicant: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow [ <input type="checkbox"/> Domestic Partner]			
Name of Retiree			Relation to Retiree: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child [ <input type="checkbox"/> Domestic Partner]		
Medicare Claim #	Part A Effective Date $\frac{\text{mm}}{\text{mm}} / \frac{\text{dd}}{\text{dd}} / \frac{\text{yyyy}}{\text{yyyy}}$	Part B Effective Date $\frac{\text{mm}}{\text{mm}} / \frac{\text{dd}}{\text{dd}} / \frac{\text{yyyy}}{\text{yyyy}}$	Part D Effective Date $\frac{\text{mm}}{\text{mm}} / \frac{\text{dd}}{\text{dd}} / \frac{\text{yyyy}}{\text{yyyy}}$		
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 $\frac{\text{mm}}{\text{mm}} / \frac{\text{dd}}{\text{dd}} / \frac{\text{yyyy}}{\text{yyyy}}$		Telephone # ( )	
Address		City		State	Zip
Doctor's Name		Doctor's Telephone # ( )			

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 **<1-888-556-6648>**, 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
			<u>    </u> / <u>    </u> / <u>    </u> mm / dd / yyyy	
			<u>    </u> / <u>    </u> / <u>    </u> mm / dd / yyyy	

### FOR OFFICE USE ONLY

RETIREE  YES  NO GROUP # \_\_\_\_\_

PLAN CODE \_\_\_\_\_

SPOUSE[, DOMESTIC PARTNER,] OR CHILD

YES  NO

VERIFICATION: \_\_\_\_\_ DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Initial

### FOR EMPLOYER USE ONLY

Enrollee is eligible for retiree coverage

Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Initial

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.
7. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**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: \_\_\_\_\_



**Please Open To Continue Completing Form**



# Duplicate of Form

# Duplicate of Form

# Duplicate of Form

UNITEDHEALTHCARE INSURANCE COMPANY  
[Hartford, Connecticut]

***GROUP OUTPATIENT [PRESCRIPTION] DRUG  
INSURANCE CERTIFICATE  
[RETIREE DRUG BENEFIT PLAN]***

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

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

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

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

Any Certificate issued in the State of Arkansas will be governed by Arkansas law.

**PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS PRESCRIPTION BENEFITS MAY BE OBTAINED.**

**[PROVIDER DIRECTORIES MAY BE OBTAINED FROM THE ADMINISTRATOR.]**

UNITEDHEALTHCARE INSURANCE COMPANY

[Officer's Signature]

[Officer's Name and Title]

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# *WELCOME TO UNITEDHEALTHCARE*

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

## *WHAT IS THIS PUBLICATION?*

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

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

## *WHAT ELSE SHOULD I READ TO UNDERSTAND MY BENEFITS?*

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

## *WHAT IF I STILL NEED HELP?*

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

- [By calling [1- XXX-XX-XXXX] from 7:00 a.m. to 9:00 p.m. Monday through Friday]
- [By accessing Our customer service Web site at [xxxxxxx@xxx.com]]

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

[UnitedHealthcare Insurance Company]  
[P.O. Box XXXX]  
[City] [State] [Zip]  
[1-XXX-XXX-XXXX]

[UnitedHealthcare's Web site is:]  
[www.[xxxxxxxxxxx].com]

# *Administrators*

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

**FOR ELIGIBILITY AND BENEFITS VERIFICATION:**

[UnitedHealthcare Insurance Company]  
[P.O. Box XXXX]  
[Cypress, California XXXXX]  
[1-XXX-XXX-XXXX]

**FOR PAYMENT OF CLAIMS:**

[UnitedHealthcare Pharmacy Department]  
[P.O. Box XXXX]  
[Cypress, California XXXXX]  
[1-XXX-XXX-XXXX]

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

## SECTION ONE

# *Your Outpatient [Prescription] Drug Benefits*

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- Outpatient [Prescription] Drug Benefits
- Limitations and Exclusions

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

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

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

## *I. OUTPATIENT [PRESCRIPTION] DRUG BENEFITS*

You or Your Physician may contact the Company at [1-XXX-XXX-XXXX], [or Our Web site [www.xxxxxxxx.com]], to determine if a particular Drug is covered under this plan or to obtain a list of covered Drugs. Your Physician is not obligated to prescribe a covered Drug and may prescribe any FDA approved Drug he or she feels is [Medically Necessary] [appropriate] for Your treatment. **[However, prescriptions for medications not on the list of covered Drugs which have not received preauthorization from Your Part D coverage will not be a Covered Expense under this Policy.]**

**COVERED EXPENSE.** Covered Expense includes expenses that are incurred for a Covered Service and provided to a Covered Person in accordance with the provisions of this Certificate. The Covered Expense will not exceed the negotiated or contract cost for prescriptions filled at a Participating Pharmacy. [Covered Expenses include the Unit supply usually prescribed by a Provider or a [30-35]-day supply.]

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

1. [Federal Legend Drugs: any medicinal substances that bear the legend "Rx Only."]
2. [State Restricted Drugs: any medicinal substance that may be dispensed by prescription only according to state law.]

[Covered Services may also include certain Over-the-Counter Medications as described in this Policy.]

**[MAIL SERVICE PHARMACY PROGRAM.** The Company offers a Mail Service Pharmacy Program. The Mail Service Pharmacy Program provides convenient service and savings on maintenance medications that You may take on a regular basis by allowing You to purchase certain Drugs for receipt by mail. You get high quality medications mailed directly to Your home or address of Your choice within the United States. Shipping and handling is at no additional charge. [Prescription maintenance Drugs may be dispensed for up to three Prescription Units or up to a [90-100]-day supply. The [Copayment][Coinsurance] amount is specified in the Schedule of Benefits.

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

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

Medications such as antibiotics, Drugs used for short-term or acute illnesses, and Drugs that require special packaging (including refrigeration), are not available through our Mail Service Pharmacy Program. If You are starting a new medication, please request two prescriptions from Your Provider. Have one filled immediately at a Participating Pharmacy while mailing the second prescription to UnitedHealthcare's Mail Service Pharmacy. Once You receive Your medication through the mail service, You should stop filling the prescription at the Participating Pharmacy.]

**[PREAUTHORIZATION FOR SELECTED DRUGS.** [This Policy does not require preauthorization. However, coverage provided under your Medicare Part D plan issued by the Company might require preauthorization for selected Drugs. You must satisfy any preauthorization requirements under your Part D coverage in order to be eligible to receive a benefit under this Policy.] Please check your Part D coverage for any preauthorization requirements.]

## ***II. LIMITATIONS AND EXCLUSIONS OF BENEFITS***

No benefits are payable for any of the following:

- [1. Drugs or medicines purchased and received prior to the Covered Person's Effective Date or subsequent to the Covered Person's termination.]
- [2. Prescriptions or devices that are covered under Medicare Part B benefits. Therapeutic devices or appliances, even though they may require a prescription. This includes: hypodermic needles; syringes (except insulin syringes when provided by a [Participating Pharmacy] for use with covered Self-Injectable medications); support garments; and other non-medical substances.]
- [3. All non-prescription contraceptive jellies, ointments, foams or devices.]
- [4. Drugs dispensed by a Hospital, rest home, sanitarium, skilled nursing facility, convalescent care facility, nursing home or similar institution while confined as a patient or when covered under Medicare Part A.]
- [5. Self-Injectable Drugs.]
- [6. Dietary supplements, including vitamins, mineral products, and fluoride supplements; health or beauty aids and diet pills, herbal supplements and/or alternative medicine; and dental related products, such as topical fluoride, medicated dental rinses and children's fluoride vitamins.]
- [7. Medications which may be properly received without charge under local, state or federal programs or which is reimbursable under other insurance programs, including Workers' Compensation and Medicare, or medications furnished by any other Drug or medical service for which no charge is made to the Covered Person.]
- [8. Medications prescribed for experimental or non-FDA approved indications, unless prescribed in a manner consistent with a specific indication in Drug Information for the Health Care Professional, published by the United States Pharmacopoeial Convention or in the American Hospital Formulary Services edition of Drug Information; medications limited to investigational use by law; or medications that are determined not to be effective for the specific diagnosis or that do not follow community practice standards [unless preauthorized under Your Part D plan].]
- [9. Patent Drugs [or medications available without a prescription (over-the-counter)] or for which there is a non-prescription equivalent available, even if ordered by a Physician.]
- [10. Drugs or medicines used or taken primarily to improve or otherwise modify the Covered Person's external appearance.]
- [11. Over-the-Counter smoking cessation products including, but not limited to, nicotine gum, nicotine patches, nicotine nasal spray or any other Drug containing nicotine or other smoking deterrent medications.]

- [12. Administration or injection of any Drug.]
- [13. Drugs purchased outside the United States and its territories.]
- [14. Off-Label Drugs. There are certain exceptions. Please see the definition of "Off-Label Drug" in the **Definitions** section of this Certificate]
- [15. Drugs used to promote fertility, including injectable infertility Drugs.]
- [16. Drugs used to promote hair growth.]
- [17. Drugs when used for the treatment of sexual or erectile dysfunction, impotence, and anorgasmy or hyporgasmy, such as Viagra, Cialis, Levitra, and Caverject.]
- [18. Drugs when used for treatment of anorexia, weight loss, or weight gain, including, but not limited to, prescription or non-prescription weight loss medications, weight control programs, supplies or supplements.]
- [19. Outpatient Drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.]
- [20. Barbiturates and Benzodiazepines.]
- [21. Immunizing agents and injectables, biological sera, blood plasma or medications prescribed for parenteral use.]
- [22. Federal Legend oral contraceptives and prescription diaphragms.]
- [23. Elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to: athletic performance, cosmetic purposes, anti-aging and mental performance.]
- [24. New prescription medications or supplies until they are reviewed for safety, efficacy and cost effectiveness.]
- [25. Compound Medication: any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount[, unless preauthorized by your Part D coverage].]
- [26. Drugs prescribed by a dentist or Drugs used for dental treatment.]
- [27. Drugs used for diagnostic purposes.]
- [28. Saline and irrigation solutions.]
- [29. Replacement of lost, stolen or destroyed medications.]

- [30. Unit dose/convenience dosage forms: Unit dose, pre-packaged medications, individual packets, etc.]
- [31. Medications that are prescribed by Physicians or other Providers who are excluded from Medicare program participation.]
- [32. Drugs used for the symptomatic relief of cough and colds.]

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

### **Early Refills**

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

Early refills for vacation supplies are limited to a one-time fill of up to [30-35] days per calendar year.

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

SECTION TWO

## *Payment Responsibility*

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- Claims Policies and Procedures
  - Coordination of Benefits
- 

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

### *I. CLAIMS POLICIES AND PROCEDURES*

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

**If a UnitedHealthcare Participating Pharmacy is Not Available.** The outpatient [Prescription] Drug benefit is generally honored only at a Participating Pharmacy. If a Participating Pharmacy is not available, the Covered Person must pay the Non-Participating Pharmacy the retail price for the prescription Drug and then file a Claim for direct reimbursement, in accordance with the instructions in the Non-Participating Pharmacy Reimbursement or Direct Reimbursement section below.

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

[UnitedHealthcare Pharmacy Department]  
[P.O. Box XXXX]  
[CITY] [STATE] [ZIP]

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

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

**LIMITATION OF LIABILITY.** 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 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 a covered loss occurs or begins, or as soon thereafter as reasonably possible.

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

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

**TIME OF PAYMENT OF CLAIMS.** Benefits for incurred outpatient [Prescription] Drug expenses that are covered under the Policy will be paid within thirty (30) days of receipt of a proper Claim by the Company. If a Claim does not contain all of the information necessary to pay or deny the Claim, the Company will request the required additional information within thirty (30) days of receipt of the Claim by the Company. If

the requested information is not provided within forty-five (45) days of the date it is requested, the Company will deny the Claim and provide the reasons for denial in writing.

**PAYMENT OF BENEFITS TO COVERED PERSON.** All benefits, unless assigned under the Policy, are payable to the Covered Person.

**DEATH OR INCAPACITY OF COVERED PERSON.** In the event of the Covered Person's death or incapacity and in the absence of written evidence to the Company of the qualification of a guardian for the Covered Person's estate, the Company may, in its sole discretion, make any and all payments of benefits under the Policy to the individual or institution that, in the opinion of the Company, is or was providing the Covered Person's care and support.

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

**LEGAL ACTIONS.** Any Person may not bring legal action for benefits against the Company:

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

## ***II. COORDINATION OF BENEFITS***

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

### **What is a Plan?**

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

1. group, blanket or franchise insurance coverage;
2. prepaid coverage under service Plan contracts, or under group or individual practice;
3. any coverage under labor-management trustee 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 apply to one part, each part is a separate Plan. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no Coordination of Benefits between those separate contracts.

### **What is a Covered Expense?**

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

**ORDER OF BENEFIT DETERMINATION RULES.** The following rules determine the order of benefit payment:

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

**EFFECT ON BENEFITS.** Benefits will be reduced when the Policy is secondary to one or more other Plans. Benefits will be reduced when the sum of:

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

**RIGHT TO RECEIVE AND RELEASE INFORMATION.** For determining the applicability and implementing the terms of this Coordination of Benefits provision or any provision of similar purpose of any other Plan, the Company may release or obtain from any insurance company or other organization or person any information, with respect to any Covered Person, which the Plan deems to be necessary for such purposes. Any Covered Person claiming benefits must furnish information necessary to implement this provision.

**REIMBURSEMENT OF PAYMENT.** Payments made by any organization may be reimbursed by the Company subject to Policy limitations. Such reimbursements will fully discharge the Company's liability under the Policy.

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

### **THIRD PARTY LIABILITY AND NON-DUPLICATION OF BENEFITS**

1. **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 Member'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.

The security interest the Covered Person grants to the Company, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the Covered Person's health care services for injuries caused by 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. **Medicare Benefits.** The Company shall not furnish benefits under the Policy which duplicate the benefits the Covered Person is entitled to as a Medicare beneficiary.
- c. **TRICARE Benefits.** The Company shall not furnish benefits under the Policy which duplicate the benefits to which the Covered Person is entitled under TRICARE. If payment is made by the Company in duplication of the benefits available under TRICARE, the Company may seek reimbursement up to the amount of benefits which duplicate such benefits under TRICARE.
- d. **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*

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- Who is a Covered Person?
- Termination of Benefits

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### *I. WHO IS A COVERED PERSON?*

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

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

The Insured Person must be a former employee of the Employer: (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); [and] [(2) who is age 65 or older]; [and (3) who is eligible for, and enrolled in, a Medicare Part D plan issued by the Company].]

[Eligible Dependents include a Spouse [or Domestic Partner] [or a Dependent child] of the Insured Person enrolled under the Policy if such Spouse [or Domestic Partner] [or child] is (1) eligible for coverage under the Employer's Retiree welfare benefit plan; [and] [(2) [in the case of a spouse or Domestic Partner] is age 65 or older]; [and (3) is eligible for, and enrolled in, a Medicare Part D plan issued by the Company].]

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

**EFFECTIVE DATE.** The Retiree or their eligible Dependent may be enrolled for coverage under the Policy in one of the four ways described below. Subject to payment of the applicable premium, the Company's receipt of the appropriate enrollment forms and the Delayed Effective Dates provision below, Personal Insurance becomes effective as indicated in this section.

1. **[Open Enrollment.** If a Retiree or eligible 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 [31-60] Days of an Eligibility Date.** If a Retiree or eligible Dependent does not enroll during an Open Enrollment Period, but does enroll within [31-60] days after first becoming eligible for coverage under the Policy, Personal 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 coverage during an Open Enrollment Period or within [31-60] days of becoming eligible, and subsequently requests enrollment, Personal Insurance will become effective on the first day of the Insurance Month following the end of the next Open Enrollment Period after the date on which the Person enrolled, unless the Person is eligible for Special Enrollment.]
4. **[Special Enrollment.** A Special Enrollment Period of [31-60] days is provided for a Retiree or eligible Dependent to enroll for coverage under the Policy if the Retiree or eligible Dependent:
  - a. had other 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 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
  - e. 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 Person enrolled during this Special Enrollment Period will be the first day of the Insurance Month following the date on which the Person 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.** At its discretion, the Company may terminate or rescind the Policy or a Covered Person's coverage thereunder, if the following are true:

1. such Covered Person knowingly provides the Company with fraudulent information upon which the Company relies; and

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

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

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

**COVERAGE OPTIONS FOLLOWING TERMINATION OF INDIVIDUAL COVERAGE.** Following termination of coverage, a Covered Person may be entitled to coverage under the employer group's primary Part D plan or an individual Medicare Part D plan.

## SECTION FOUR

# *Decisions Regarding Benefits*

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

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### ***I. APPEALING A DECISION RELATING TO BENEFITS***

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

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

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

[UnitedHealthcare Insurance Company]  
[Appeals Department]  
[ADDRESS]  
[CITY] [STATE] [ZIP]  
[1- XXX-XXX-XXXX]

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

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

## ***II. THE APPEALS PROCESS***

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

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

## ***III. STATEMENT OF ERISA RIGHTS***

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

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

6. ERISA provides that most benefit appeal determination notices will be forwarded to You, in writing, within a reasonable period not to exceed sixty (60) days from the date of the plan's receipt of the benefit appeal request.
7. Your participation in a voluntary appeal level does not affect Your legal review rights, or any rights You have under Your plan. Any statute of limitations will be tolled during the time You participate in a voluntary review level.
8. You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor office and Your state insurance regulatory agency.

## SECTION FIVE

# *Definitions*

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

**[[30-35]-DAY SUPPLY** means, for most oral medication, the maximum amount (quantity) of medication that may be dispensed per single [Copayment] [Coinsurance amount] at any one time during a [30-35]-day period.]

**[[90-100]-DAY SUPPLY** means, for most oral medication, the maximum amount (quantity) of medication that may be dispensed per single mail service [Copayment] [Coinsurance amount] at any one time during a [90-100]-day period.]

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

**[BRAND NAME DRUG** means a pharmaceutical product protected by a patent issued to the original innovator or marketer. The patent prohibits the manufacture of the Drug by other companies without consent of the innovator, as long as the patent remains in effect.]

**[CALENDAR YEAR** means January 1, 12:00 a.m. to December 31, 11:59 p.m. of the same year.]

**[[CALENDAR][PLAN] YEAR DEDUCTIBLE** means the amount of Covered Expense shown on the Schedule of Benefits that a Covered Person is responsible for paying each [Calendar][Plan] Year before benefits are payable under the Policy. [Until You satisfy the Deductible, You will pay one hundred percent (100%) of the Company's contracted rate with the pharmacy for Prescription Drugs and that amount will be applied toward the Covered Persons Deductible.] [Until You satisfy the Deductible, the Covered Person will pay one hundred percent (100%) of the billed charges for covered Prescription Drugs and that amount will be applied toward the Covered Person's Deductible.]

**[CERTIFICATE** means this summary of the terms of Your benefits. The Certificate is attached to and is part of the Policy issued to the Group Policyholder and is subject to the terms of the Policy.]

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

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

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

**[COPAYMENT]** means that portion of Covered Expenses which are the responsibility of the Covered Person and which are shown as Copayments on the Schedule of Benefits. Copayments do not apply toward the Deductible and do not accrue toward the Out-of-Pocket Expense Maximum. Copayments will continue to be required after the Out-of-Pocket Expense Maximum has been reached.]

**[COVERED EXPENSE]** means an expense that:

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

**[COVERED PERSON]** means the Insured Person [or the eligible Dependent(s) of the Insured Person] who [is][are] insured under the Policy.]

**[DEDUCTIBLE]** means the amount of Covered Expense a Covered Person must pay before benefits become payable under the Policy. Until You satisfy the Deductible, You will pay 100% of the Company's contracted rate with the pharmacy for the medication and that amount will be applied toward Your Deductible. The Deductible is calculated on a [Calendar][Plan] Year basis and not applied toward the Deductible the following year.] [Amounts previously applied to your Deductible under a similar Prescription Drug plan from a different carrier to a self-funded benefit plan are not applied to this outpatient Prescription Drug Plan.] [After satisfying Your Deductible, You will pay only a [Copayment] [Coinsurance] each time You fill a prescription [or purchase Over-the-Counter Medications]. Your [Copayment] [Coinsurance] are shown in the Schedule of Benefits in Section Seven of this Certificate.]

**[DEPENDENT]** means a person who is the Insured Person's Spouse [or Domestic Partner] who is not legally separated from the Insured Person[, or the Insured Person's Dependent child,] and who is covered under a Medicare Part D plan issued by the Company.]

**[DEPENDENT INSURANCE]** means the group health insurance provided by the Policy for Dependent(s) of the Insured Person.]

**[DOMESTIC PARTNER]** means an individual (other than a relative of the Insured Person) who for the Calendar Year: (1) has his or her personal place of abode in the home of the Insured Person; (2) is a member of the Insured Person's household; and (3) the Insured Person has designated as a Domestic Partner with the Administrator, in accordance with the Administrator's reasonable procedures; provided, however, that an individual shall not be considered a Domestic Partner if the Insured Person has a Spouse or other Domestic Partner.]

**[DRUGS OR PRESCRIPTION DRUGS]** mean those pharmaceutical substances required by law to be dispensed by prescription [or certain Over-the-Counter Medications].]

**[EFFECTIVE DATE]** means, with respect to any Covered Person, the date such Covered Person is first insured under the Policy.]

[**EMPLOYER** means the Group Policyholder approved by the Company for participation in the coverage provided by the Policy.]

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

[**GROUP POLICYHOLDER** means the person, partnership, corporation or trust as shown on the Policy Information Page of the Policy.]

[**HOSPITAL** means an acute care Facility operated pursuant to state laws and:

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

[**INSURANCE MONTH** means that period of time:

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

[**INSURED PERSON** means the Retiree for whom coverage is in effect as provided by the Policy.]

[**MEDICALLY NECESSARY (OR MEDICAL NECESSITY)** refers to an intervention, if, as recommended by the Treating Physician and by the Company's medical director to be all of the following:

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

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

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

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

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

[**NON-PARTICIPATING PHARMACY** means a pharmacy that has not contracted with the Company.]

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

- The Drug is approved by the FDA;
- The Drug is prescribed by a Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
- The Drug is Medically Necessary to treat the condition;
- The Covered Person has failed, is intolerant of, or has contraindications to standard therapies;
- The Drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition 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 section shall prohibit the Company from use of a formulary[,] [Copayment,] [or] [Coinsurance].]

**[OPEN ENROLLMENT PERIOD** means a period of time as specified in the application of the Group Policyholder and approved by the Company during which Insured Persons 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** means the maximum out-of-pocket expense shown in the Schedule of Benefits. When a Covered Person has paid an amount during the [Calendar][Plan] Year equal to the Out-of-Pocket Expense Maximum [including] [excluding] [Pharmacy] [Copayments] [Coinsurance] [and] [the [Calendar][Plan] 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.]

**[OVER-THE-COUNTER MEDICATIONS** mean medications that may be sold directly to a consumer without a prescription from a Physician, as compared to prescription drugs which may only be sold to consumers possessing a valid prescription.]

**[PARTICIPATING PHARMACY** means a pharmacy that has contracted with the Company to provide outpatient [Prescription] Drugs to a Covered Person at negotiated costs.]

**[PLAN YEAR** means any consecutive twelve-month period beginning on the Effective Date shown in the Policy [other than a Calendar Year].

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

**[PERSONAL INSURANCE** means the group prescription Drug insurance provided by the Policy on Insured Persons.]

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

**[POLICY** means the Group Health Insurance Policy issued by the Company to the Group Policyholder.]

**[POLICY ANNIVERSARY** means the annual date stated as the "Policy Anniversary" on the Policy Information Page of the Policy.]

**[POLICY EFFECTIVE DATE** means the date stated as the "Policy Effective Date" on the Policy Information Page of the Policy.]

**[PRESCRIPTION UNIT** means the maximum amount (quantity) of medication that may be dispensed per single Copayment. For most oral medications, a Unit represents a [30-35]-day supply [or 90-100]-day supply (through the mail service benefit)] of medication. For other medications, a Unit represents a single container, inhaler unit, vial, package or course of therapy. [The Unit will be tripled, e.g., 3 containers, 3 inhaler units, etc., if the medication is dispensed through the mail service benefit for a [90-100]-day supply.] For Drugs that could be habit-forming, a Unit may be set at a smaller quantity for the Covered Person's protection and safety.]

**[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 Part D]; [and] [(4) who is entitled to benefits under the Policy].]

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

**[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.]

**[WE, OUR, US AND COMPANY** mean UnitedHealthcare Insurance Company.]

**[YOU AND YOUR** mean the Insured Person.]

## SECTION SIX

# *General Provisions*

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**CERTIFICATE.** Each Covered Person will receive individual Certificates. These Certificates summarize the benefits provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

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

**CONFORMITY TO STATE AND FEDERAL LAW.** The Company amends any provision of the Policy that conflicts with state or federal law on the Policy Effective Date to the minimum requirements of the law.

**GROUP POLICYHOLDER NOT OUR AGENT.** The Group Policyholder is not an agent of the Company.

**PROVIDER AS INDEPENDENT AGENT.** The Company does not undertake to directly furnish any health care service under the Policy. The obligations of the Company under the Policy are limited to the payment for health care service provided to Covered Persons by Providers who are independent agents.

**OUTPATIENT [PRESCRIPTION] DRUG RECORDS.** The Company shall have access to outpatient [Prescription] Drug and treatment records of Covered Persons to determine benefits, process Claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably related to the Policy benefits. Each Covered Person shall complete and submit to the Company such additional consents, releases and other documents as may be requested by the Company in order to determine or provide benefits under the Policy. The Company reserves the right to reject or suspend a Claim based on lack of supporting outpatient [Prescription] Drug information or records.

**RECOVERY OF PAYMENTS.** The Company reserves the right to deduct from any benefits properly payable under the Policy the amount of any payment which has been made:

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

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

**DISCHARGE OF LIABILITY.** Any payment made in accordance with the provisions of the Policy shall fully discharge the liability of the Company to the extent of such payment.

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

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

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

## SECTION SEVEN

# *Schedule of Benefits*

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### *OUTPATIENT [PRESCRIPTION] DRUG BENEFIT*

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

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

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

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

### *Drug Tiers*

Every Drug on the Drug List is in one of 4 Tiers. In general, the higher the Tier number, the higher your cost for the Drug:

Tier 1 – includes [most][all] generic Drugs and some brand-name Drugs

Tier 2 – includes many common brand-name [and some higher-cost generic] Drugs

Tier 3 – includes non-preferred brand-name Drugs [and non-preferred generic Drugs]

Tier 4 – includes unique or very high-cost Drugs

### *Drug List*

To find out which Tier your Drug is in, look it up in the Drug List. If you need a copy of the Drug List, you may [access it by going online at [www.xxxxxxxx.com] or] request a paper copy by calling Customer Service Department at [X-XXX-XXX-XXXX].

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

### **The Drug List can change during the year**

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

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

### **Do changes to your Drug coverage affect you right away?**

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

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

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

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

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

**The Plan's Pharmacy Directory.** In most situations You must use a Participating Pharmacy to get Your covered Drugs. A Participating Pharmacy is a pharmacy that has a contract with the Company to provide Your covered Drugs. The term "covered Drugs" means all of the Drugs that are covered by this Policy. The *Pharmacy Directory* has a list of Participating Pharmacies and it explains how You can use the mail order service. It also explains how You can get a long-term supply of a Drug (such as filling a prescription for a three month's supply). You can access the Pharmacy Directory online at [www.XXXXXXX.com] or request a paper copy by calling Customer Service at [1-XXX-XXX-XXXX].

**Using Non-Participating Pharmacies.** We generally cover drugs filled at a Non-Participating Pharmacy only when You are not able to use a Participating Pharmacy.

**Note:** If You use a Non-Participating Pharmacy, You may be responsible for paying the difference between what We would pay for a prescription filled at a Participating Pharmacy and what the Non-Participating Pharmacy charged for Your prescription.

Here are the circumstances when We would cover prescriptions filled at a Non-Participating Pharmacy:

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

### ***WHAT IS YOUR SHARE OF COST FOR DRUGS COVERED UNDER THIS PLAN?***

<b>[Out-of-Pocket Expense Maximum</b>	<b>[\$100-\$3,000]]</b>
<b>[[Calendar][Plan] Year Deductible</b>	<b>[\$100-\$3,000]]</b>

The Copayment or Coinsurance for a covered Drug depends on:

1. Which Medicare Part D Drug Payment Stage you are in;
2. The Tier for the Drug; and
3. Where You fill Your prescription.

### ***Drug Payment Stages***

As shown below, there are various “Drug Payment Stages” for your [Prescription] Drug coverage under Your Medicare Part D coverage. How much You pay under this [Prescription] Drug Policy for a Drug also may depend on which of these stages You are in at the time You get a prescription filled or refilled under Your Part D coverage[, or purchase Over-the-Counter Medications that are covered by this Policy].

We keep track of the costs of Your Prescription Drugs and the payments You have made when You get Your prescriptions filled or refilled at the pharmacy. This way, We can tell You when You have moved from

one Drug Payment Stage to the next. [For each month in which You fill a prescription, You will receive an Explanation of Benefits in the mail indicating what Drug Payment Stage you are in.]

For some Drugs, You can get a longer-term supply (also called an “extended supply”) when You fill Your prescription. This can be up to a [90-100]-day supply. The tables below show what You pay when You get a [30-35]-day supply and a longer-term up to [90-100]-day supply of a Drug.

**[Yearly Deductible Stage:** For Medicare Part D coverage, You begin in this payment stage when You fill Your first prescription of the year. During this stage **You pay the full cost** of Your plan Drugs until You have satisfied any Part D Deductible. Your Medicare Part D Evidence of Coverage (EOC) explains rules for using Your coverage for Drugs under Your primary Medicare Part D plan and what You pay for Drugs under that plan.

[You also may have a yearly Deductible for this [Prescription] Drug Policy [that will run concurrently with Your Part D Deductible requirement].] [This Policy will not cover any Drugs if your Part D coverage Deductible has not yet been satisfied.]

**[You have no coverage under this Policy for the Yearly Deductible Stage]**

[Your cost share during the Yearly Deductible Stage of coverage is:

	<b>Participating Pharmacy</b> (when You get a [30-35]-day supply (or less) of a covered Drug)	<b>The Plan’s Participating Pharmacy Mail Service Pharmacy Program</b> (When You get a longer-term supply up to [90-100] days of a covered Drug)
<b>Tier 1</b>	[[[\$0-\$30] Copayment] [[0%-100%] Coinsurance]	[[[\$0-\$60] Copayment] [[0%-100%] Coinsurance]
<b>Tier 2</b>	[[[\$0-\$150] Copayment] [[0%-100%] Coinsurance]	[[[\$0-\$300] Copayment] [[0%-100%] Coinsurance]
<b>Tier 3</b>	[[[\$0-\$150] Copayment] [0%-100%] Coinsurance]	[[[\$0-\$300] Copayment] [[0%-100%] Coinsurance]
<b>Tier 4</b>	[[[\$0-\$500] Copayment] [0%-100%] Coinsurance]	[[[\$0-\$1000] Copayment] [0%-100%] Coinsurance]

]

**Initial Coverage Level Stage (ICL):** During the Initial Coverage Level Stage, Your Part D coverage plan pays its share of the cost of Your covered Prescription Drugs, and You pay Your share. Your share of the cost will vary depending on the Drug and where You fill Your prescription. You stay in this stage until Your Part D Drug payments for the year total the Medicare ICL for the [Calendar][Plan] Year. At that time You enter the Coverage Gap Stage.

[During this ICL Stage, no benefits are available under this [Prescription] Drug Policy [with the exception of [Over-the-Counter Medications and] certain Drugs that are not covered by Medicare Part D coverage].]

**[You have no coverage under this Policy for the Initial Coverage Level (ICL) Stage]**

[Your cost share during the Initial Coverage Level Stage of coverage is:

	<b>Participating Pharmacy</b> (when You get a [30-35]-day supply (or less) of a covered Drug)	<b>The Plan's Participating Pharmacy Mail Service Pharmacy Program</b> (When You get a longer-term supply up to [90-100] days of a covered Drug)
<b>Tier 1</b>	[[[\$0-\$30] Copayment] [[0%-100%] Coinsurance]	[[[\$0-\$60] Copayment] [[0%-100%] Coinsurance]
<b>Tier 2</b>	[[[\$0-\$150] Copayment] [[0%-100%] Coinsurance]	[[[\$0-\$300] Copayment] [[0%-100%] Coinsurance]
<b>Tier 3</b>	[[[\$0-\$150] Copayment] [0%-100%] Coinsurance]	[[[\$0-\$300] Copayment] [[0%-100%] Coinsurance]
<b>Tier 4</b>	[[[\$0-\$500] Copayment] [0%-100%] Coinsurance]	[[[\$0-\$1000] Copayment] [0%-100%] Coinsurance]

]

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

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

[Your cost share during the Coverage Gap Stage of coverage is:

	<b>Participating Pharmacy</b> (when You get a [30-35]-day supply (or less) of a covered Drug)	<b>The Plan's Participating Pharmacy Mail Service Pharmacy Program</b> (When You get a longer-term supply up to [90-100] days of a covered Drug)
<b>Tier 1</b>	[[[\$0-\$30] Copayment] [[0%-100%] Coinsurance]	[[[\$0-\$60] Copayment] [[0%-100%] Coinsurance]
<b>Tier 2</b>	[[[\$0-\$150] Copayment] [[0%-100%] Coinsurance]	[[[\$0-\$300] Copayment] [[0%-100%] Coinsurance]
<b>Tier 3</b>	[[[\$0-\$150] Copayment] [0%-100%] Coinsurance]	[[[\$0-\$300] Copayment] [[0%-100%] Coinsurance]
<b>Tier 4</b>	[[[\$0-\$500] Copayment] [0%-100%] Coinsurance]	[[[\$0-\$1000] Copayment] [0%-100%] Coinsurance]

]

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

[During this stage You will still have coverage for Drugs under this [Prescription] Drug Policy for [Over-the-Counter Medications or for] certain Drugs that are not covered by Your Part D Drug coverage.]

**[You have no coverage under this Policy for the Catastrophic Coverage Stage]**

[Your cost share during the Catastrophic Coverage Stage of coverage is:

	<b>Participating Pharmacy</b> (when You get a [30-35]-day supply (or less) of a covered Drug)	<b>The Plan's Participating Pharmacy Mail Service Pharmacy Program</b> (When You get a longer-term supply up to [90-100] days of a covered Drug)
<b>Tier 1</b>	[[[\$0-\$30] Copayment] [[0%-100%] Coinsurance]	[[[\$0-\$60] Copayment] [[0%-100%] Coinsurance]
<b>Tier 2</b>	[[[\$0-\$150] Copayment] [[0%-100%] Coinsurance]	[[[\$0-\$300] Copayment] [[0%-100%] Coinsurance]
<b>Tier 3</b>	[[[\$0-\$150] Copayment] [0%-100%] Coinsurance]	[[[\$0-\$300] Copayment] [[0%-100%] Coinsurance]
<b>Tier 4</b>	[[[\$0-\$500] Copayment] [0%-100%] Coinsurance]	[[[\$0-\$1000] Copayment] [0%-100%] Coinsurance]

]

**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.**

SERFF Tracking Number: UHLC-126865241 State: Arkansas  
 Filing Company: UnitedHealthcare Insurance Company State Tracking Number: 47264  
 Company Tracking Number: GRPRETRX-POL-0112  
 TOI: H17G Group Health - Prescription Drug Sub-TOI: H17G.000 Health - Prescription Drug  
 Product Name: PRESCRIPTION DRUG  
 Project Name/Number: RX WRAP/GRPRETRX-POL-0112

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Accepted for Informational Purposes	01/14/2011

**Comments:**  
SEE ATTACHED READABILITY CERTIFICATION.

**Attachment:**  
READABILITY CERTIFICATION (SERFF).pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved	01/14/2011

**Comments:**  
The Application is attached under the "Forms Schedule" tab.

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Memorandum from CMS (referenced in Filing Description of "General Information" tab)	Accepted for Informational Purposes	01/14/2011

**Comments:**  
SEE ATTACHED INFORMATION.

**Attachment:**  
6-2-10 CMS Memo.pdf

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Waiver of Deemer	Approved	01/14/2011

**Comments:**  
Attached is our waiver of deemer for the review of this filing.

**Attachment:**  
Waiver of Deemer.pdf

# UnitedHealthcare Insurance Company

THIS IS TO CERTIFY THAT THE FOLLOWING FORM(S) HAVE ACHIEVED A FLESH READING EAST TEST SCORE OF:

FORM NUMBER	FLESH SCORE
GRPRETRX-POL-0112	47
GRPRETRX-0112-AR	43.3



SIGNATURE

Paul D. Kallmeyer  
Assistand Secretary, UHIC  
TYPE NAME AND TITLE

November 8, 2010  
DATE



**CENTER FOR MEDICARE**

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DATE: June 2, 2010

TO: All Part D Sponsors

FROM: Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C & D Data Group  
Cheri Rice, Deputy Director, Medicare Plan Payment Group

SUBJECT: Medicare Coverage Gap Discount Program Beginning in 2011: Additional Guidance Concerning Part D Supplemental Benefits, Employer Group Waiver Plans, Platino Plans, and Subrogation Claims

This memorandum provides Part D sponsors with additional 2011 guidance specific to:

- Determining the applicable discount if the Part D sponsor is offering Part D Supplemental Benefits with fixed copays in the coverage gap;
- Establishing new Employer Group Waiver Plan requirements to submit attestations and to make benefit package information available for audit;
- Clarifying that the applicable discount is applied before additional Platino coverage is applied; and
- Coordinating benefits with other non-Part D payers that incorrectly paid primary to Medicare.

**Part D Supplemental Benefits**

CMS stated in the May 21, 2010 guidance that for 2011, any Part D plan that wishes to offer Part D supplemental benefits on applicable drugs covered between the plan's initial coverage limit (ICL) and the Medicare Part D catastrophic threshold using coinsurance will use the rules described as follows: Plan, manufacturer and beneficiary liabilities shall be determined at the claim level. The value of supplemental benefits that must be calculated first on any claim for an applicable drug will consist of the difference between the proposed supplemental coinsurance and coinsurance under the basic benefit (100% for 2011). Thus, for a brand drug supplemental benefit of 60% coinsurance, the value of the supplemental benefits that must be applied first (plan liability) would be 40% (100% - 60%) of the negotiated price of the drug. The amount of the discount would then be calculated as 50% of [the negotiated price (as defined in 42 CFR 423.100) less the supplemental benefit]. Beneficiary cost sharing will be the remainder of the negotiated price after the plan liability and discount amounts have been applied.

For 2011, we have determined that the same formula will be required for Part D plans offering fixed copay supplemental gap coverage. For example, if the negotiated price of the drug is \$100 and the Part D plan's benefit has a copay of \$60 prior to application of any discount, then the value of the supplemental benefit that must be applied first would be \$40 (\$100-\$60). The amount of the discount would then be calculated as 50% of (\$100- \$40) or \$30. In other words, the plan may offer an actuarial equivalent copay prior to the application of the coverage gap discount. To be clear, for 2011 Part D plan benefit packages may not incorporate the coverage gap discount into their benefit design and establish copays that apply after the discount amount. Thus, in the case of either a coinsurance or copay design, the amount the beneficiary pays at point-of-sale would generally be approximately 50% of their expected cost sharing under the plan's benefit package.

Using either coinsurance or copay designs, when supplemental benefits apply, the dispensing fee is to be included in the plan liability portion of the claim to the extent that such liability is equal to or greater than the dispensing fee.

### **Application of the Coverage Gap Discount to Part D Employer Group Waiver Plans (EGWPs)**

As stated in the section above, the value of supplemental benefits provided under a Part D enhanced benefit plan must be calculated prior to the application of the Medicare manufacturer coverage gap discount. This requirement also applies to Part D benefits provided by sponsors of employer group health and waiver plans (EGWPs).

Since EGWP sponsors do not submit bids for their Part D EGWP benefit packages (because they are paid the national Part D bid amount), CMS does not require sponsors of EGWPs to submit Part D benefit information, including Part D supplemental (enhanced) benefit information. Absent the supplemental information collection, CMS cannot validate that the application of the coverage gap discount has been calculated correctly by the Part D sponsor. Therefore, beginning in 2011, a Part D sponsor of EGWPs will be required to attest, as part of its contract with CMS, that if the sponsor provides supplemental coverage via any of its enhanced benefit plans, it will apply the manufacturer coverage gap discount only after the plan's supplemental benefits have been applied. Sponsors will also attest to the accuracy of the discount amounts submitted on the prescription drug event (PDE) data and provide documentation, upon request, to CMS's third party administrator (TPA) when required. CMS will develop an audit approach and perform targeted audits of PDE data to ensure Part D sponsors have correctly applied the manufacturer discounts to EGWPs beginning in CY 2011.

**We note that if EGWP benefits are restructured to provide commercial (non-Part D) wrap-around coverage that supplements a basic Part D benefit package, sponsors would be permitted to apply the manufacturer coverage gap discount **before** any coverage or financial assistance is provided by the other commercial payer (See §1860D-14A(c)(1)(A)(v) of the Act).**

## **Platino Plans**

As required by the 2010 Call Letter, Platino plans submit Part D bids that reflect only basic benefits, and do not include any supplemental benefits required by the Commonwealth of Puerto Rico. Supplemental coverage required by the Commonwealth is, therefore, considered “other health coverage”. In accordance with §1860D-14A(c)(1)(A)(v), Part D sponsors offering Platino plans shall apply the applicable discount for applicable beneficiaries receiving applicable drugs before such other health coverage is applied. We also note that Platino plan enrollees are not entitled to an income-related subsidy under section 1860D-14 and, therefore, are not excluded from the definition of applicable beneficiary.

## **Applicability of the Coverage Gap Discount to Coordination of Benefits with Other Non-Part D Payers that Incorrectly Paid Primary to Medicare**

The need for payer-to-payer coordination of benefits arises when other payers that are not Part D sponsors either pay, but should not have paid at all, or pay more than they should have because they paid out of the correct payer order. In these situations, Part D sponsors are required to work directly with these providers of other prescription drug coverage to accept subrogation of such claims and resolve these coordination of benefits issues. However, these claims are not eligible for the coverage gap discount because the beneficiary would be assumed not to have encountered a coverage gap on the original claim. It should also be noted that the majority of these situations involve Medicaid programs seeking payment for dual eligible beneficiaries who, by definition, are not applicable beneficiaries for purposes of the coverage gap discount. Thus, plan sponsors should apply discounts to eligible claims submitted by network pharmacies and by beneficiaries, but not to those submitted by other payers.

# Arkansas Insurance Department

Mike Beebe  
Governor



Jay Bradford  
Commissioner

December 9, 2010

Ms. Judith Davenport  
Manager  
UnitedHealthcare Insurance Company  
5995 Plaza Dr.  
Cypress, CA 90630

RE: Form GRPRETRX-POL-0112  
Submission Date: November 8, 2010

Dear Ms. Davenport:

Thank you for the form filing which we received in our office on November 8, 2010 .

Pursuant to the provisions of Ark. Code Ann. 23-79-109(b), the period for review of this filing is being automatically extended an additional thirty (30) days until January 8, 2010.

We request that you sign and return this form letter in order to waive all rights to deemer on this filing.

Sincerely,  
*Stephanie Fowler*  
Stephanie Fowler  
Compliance Officer  
Life and Health Division

SRF

I, Judith Davenport, representing UnitedHealthcare Insurance Company, do hereby acknowledge

receipt of this letter and waive all rights to deemer on this filing.

12-9-10  
Dated \_\_\_\_\_, Judith Davenport, Mgr, Compliance  
Signature and Title